The National Health and Nutrition Survey in Japan: 75 Years of History
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ABSTRACT

Objectives: The National Health and Nutrition Survey (NHNS; formerly the National Nutrition Survey) has been conducted every year in Japan for the past 75 years. From its start and to the present, it has changed in order to focus on the public health issues of the time, which is the unique characteristic of this survey. Therefore, our aim is to summarize the history and origins of the national survey and describe its present situation.

Methods: Previously published national reports were investigated to obtain information on the aims, survey areas, subjects, and survey items of the NHNS.

Results: The National Nutrition Survey in Japan was initiated with the aim of obtaining information about food supplies due to postwar food shortages. This survey has since been conducted with the goal of improving nutritional health and to allow the NHNS to more comprehensively promote health in accordance with enacted laws. The survey was designed to provide national representation through randomized selection and was initially conducted in separate parts on dietary intake and physical symptoms. At present, it is conducted in three parts that collect nutrition, physical, and lifestyle data. Consequently, the purpose and content of the NHNS have expanded over time. Throughout its 75-year history, the NHNS has continued to monitor Japanese dietary intake and health status, further contributing to various national policies on health, food systems, and nutrition.

Conclusion: The current state of health in Japan may be largely due to the contributions of the NHNS to public health through public health policy based on survey results. We hope that the NHNS continues to develop in the future and that this report will contribute to the development of public health worldwide.

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Key words: National Health and Nutrition Survey, public health, heath policy, Japan, history

I. Introduction

The National Health and Nutrition Survey (NHNS), formerly the National Nutrition Survey (NNS), has been conducted every year in Japan for the past 75 years. Over the past three-quarters of a century, the life expectancy and healthy life expectancy in Japan have become the highest in the world[1, 2]. While adapting to changing circumstances, such as economic growth and changes in dietary habits and lifestyle, the NHNS has continued to play a major role in gathering information about the dietary intake and health status of Japanese people, contributing to national policy, particularly for nutrition, using evidence-based results. From its start and to the present, it has changed in order to focus on the public health issues of the time, which is the unique characteristic of this survey. However, these changes have not been systematically documented. Therefore, we have summarized the long history of this nutrition survey, from its origins to the present.

II. Methods

We primarily investigated the aims, survey areas, subjects, and survey items of the NHNS by mainly reviewing the national reports of the annual survey, published by the Ministry of Health, Labour and Welfare (formerly the Ministry of Health and Welfare). In addition, we also reviewed the historical transition of underlying laws and applications of the survey results.
III. Results

1. Beginning of the NNS in 1945

The initial purpose of the NNS was to obtain information about food supplies as a result of postwar food shortages. In a memorandum titled “Nutrition Surveys of Civilian Population” published on December 11, 1945 by the General Headquarters of the Supreme Commander for the Allied Powers to the Japanese government, the following five imperatives were described: first, the need for factual information regarding nutritional health, actual food consumption, and food requirements in Japan; second, the establishment of a study group of properly qualified physicians and nutritionists to conduct nutrition surveys among the civilian population, including collecting information about the food consumption of individuals, using statistical sampling methods in areas approved by headquarters; third, implementation of standardization and coordination by the Japanese government in accordance with approved plans; fourth, the submission of a complete operational plan for approval (by December 20, 1945); and fifth, immediate implementation of the approved operational plans, with a deadline for submitting survey data collected from the field.

2. Survey area and extraction method

According to the memorandum, urban areas were of greatest concern; therefore, it was necessary to include the largest cities in the initial survey. Therefore, the first survey was conducted in the 35 wards of Tokyo prefecture in December 1945. The survey was conducted four times per year (February, May, August, and November), beginning in 1946, largely dividing the survey areas into urban and rural areas to compare between consumers and producers. The survey areas included four urban cities and 19 rural prefectures which were surveyed in February, and expanded to nine urban cities and 27 prefectures which were surveyed in May, August, and November. Furthermore, special target areas included three coal-producing regions in Hokkaido, Fukushima, and Fukuoka prefectures, and one mining region in Akita prefecture. Railway employees in Tokyo prefecture were also selected and assessed separately.

The survey area was extended to 46 prefectures in 1948, when it became a nationwide survey. The method for selecting survey participants was also changed from intentional selection to random selection, with random extraction implemented in three clusters (12 large, medium, and small cities with populations over 30,000) by means of a random number table. This method made it possible to select a sample that more accurately represented the population of Japan. From 1952, the survey area was selected using a stratified multi-stage sampling method in urban areas (six large and medium cities with populations over 100,000, and small cities with populations over 30,000), and rural areas (agricultural, fishing, and other areas). Surveys of special target areas, including the coal-mining and railway sectors, were abolished. In 1955, urban areas were divided into six large, medium, and small cities, in addition to urbanized and rural areas divided into agricultural (up to 70% of paddy cultivation or less), fishery, sericulture, forestry, and tea farming areas.

In the past, the purpose of the survey had been achieved by focusing on food production and consumption according to urban and rural areas. However, further nutrition improvement measures were required in order to identify the actual situation of each class. Over time, the styles of eating habits have gradually changed, and the nutritional deficiencies and eating habits within each social class have also changed. Therefore, the division of survey participants was revised in 1956 to collect data according to type of employment, resulting in the categorization of households into four categories of business with at least 0.3 hectares of farmland (0.5 hectares in Hokkaido) and five categories of business with less than 0.3 hectares of farmland. Since the reversion of Okinawa prefecture in 1972, the survey has collected data according to classification by population size, opportunity, expenditure class, and regional block in all 47 prefectures of Japan.

3. Survey items

At the beginning, the NHNS had been conducted in two parts: intake status and physical symptoms. Research included how the food was obtained, nutritional intake, how nutritional intake affects the physical condition, and what kind of nutritional deficiencies appear and to what extent. The oldest available results found in the 1946 survey reported that the quality and availability of nutrition differed in urban and rural areas, and that a lack of nutrition was noted in the form of symptoms of physical conditions such as anemia, stomatitis, loss of tendon reflex, abnormal menstruation, and poor milk secretion.
1) Physical survey

Physical surveys initially included twelve symptoms (anemia, angular stomatitis, glossitis and stomatitis, loss of patellar tendon reflex, edema, follicular keratosis, chronic diarrhea, menstrual disorder, bradycardia, poor secretion of breast milk, corneal xerosis and keratomalacia, and anostosis) as well as body weight, as part of the physical nutrition survey for assessing malnutrition\(^6\). Further changes included the addition of height in 1948, chest circumference in 1950, and seated height, chronic gastrointestinal injury, and tooth abnormality in 1952, as symptoms of malnutrition\(^7,8,21\), and exclusion of anostosis in 1948, and corneal xerosis and keratomalacia, glossitis and stomatitis, and chronic diarrhea in 1952\(^7,9\).

In a report of the 1956 survey, the physical survey was divided into a nutritional deficiency survey (including anemia, stomatitis, follicular keratosis, loss of patellar tendon reflex, tenderness of the gastrocnemius muscle, edema, and missing teeth and dental caries), and a physical survey (including height, body weight, upper arm circumference, chest circumference, sitting height, pulse, and blood pressure)\(^9\). Furthermore, the 1964 physical survey included grip strength and excluded upper arm circumference, tooth abnormality, and pulse\(^11\), and the 1972 survey included blood (specific gravity of whole blood and hemoglobin) and urine examinations as well as skinfold thickness, while excluding physical symptoms\(^10\).

However, blood and urine examinations were performed only occasionally\(^22\), with blood examination and expanding examination items continuously performed from 1989 until recently\(^23\). Furthermore, since 1986, the physical survey has included medical examinations by interview, to determine such things as the use of antihypertensive drugs, and exercise, drinking, and smoking habits\(^24\).

2) Nutrition survey

The nutrition survey was conducted four times per year (February, May, August, and November), and the investigators surveyed food and nutrient intake by food category, and acquisition method, by conducting visits over three consecutive days\(^21\). In the oldest detailed report, nutrition intake surveys included dietary status, collecting the name, amount, and acquisition method of foods, which was primarily conducted by a dietitian, avoiding holidays and other days with special changes in food intake\(^9\). All of the food consumed was recorded, separating obtained food intake and net intake, while not including waste before cooking, through means of weight measurements. If the amount of consumption was small and the measurement was difficult, a conservative standard amount was used instead\(^9\). Furthermore, since 1995, the proportional distribution of household members in total household intake were also recorded and it became possible to estimate individual intake using a household proportion method, dividing household intake by the proportion\(^20\).

The basic standardized methods of the nutrition survey had remained fairly consistent until recent years. The strength of the nutritional survey is that it has been conducted by a dietitian\(^9\) or by a registered dietitian since 1962.

The survey period in terms of days, however, has changed. Based on the report of the nutrition council, after 1964, the number of surveys was changed from four times a year to once per year in May (with the exception of November 1964) and the number of survey days has been revised from three consecutive days to five consecutive days\(^11\). The nutrition survey had been conducted annually for five consecutive days in May (excluding November 1966 when the Ministry of Health and Welfare comprehensive survey was conducted)\(^13\) and was revised to consist of three consecutive days in November starting in 1972\(^14\), followed by the addition of one day in November starting in 1995\(^19\), as it remains in present day.

The data sources for calculating nutrition have also changed over time, according to history of the food composition table in Japan. Initially, the Summary of Food Nutritional Values published by the research institute of the Ministry of Health and Welfare and the Analysis Table of Provisional Standard Food and Imported Food had been used since 1948, and the Standard Tables of Food Composition in Japan Revised Edition was introduced after the 1955 survey\(^9\). Following the 1964 survey, the Standard Tables of Food Composition in Japan Third Revised Edition was used, with unlisted foods found in the Supplemental Food Composition Table for the National Nutrition Survey and the Food Replace Table for the National Nutrition Survey\(^11\).

Following the 1971 survey, nutrition values were calculated using the composition table of weight average, created for 89 food groups, based on the consumption of conventional foods and food groups from the 1969 survey.
These were revised from the 1981 survey for the 1982 survey.

Since the 1988 survey, nutrition values have been principally calculated using the Standard Tables published by government agencies in Japan. Between 1988 and 2000, the Standard Tables of Food Composition in Japan Fourth Revised Edition had been used, with the Standard Tables of Food Composition in Japan Fifth Revised Edition used between 2001 and 2004, the Standard Tables of Food Composition in Japan Fifth Revised and Enlarged Edition between 2005 and 2010, the Standard Tables of Food Composition in Japan, 2010 between 2011 and 2017, and the Standard Tables of Food Composition in Japan, 2015 (Seventh Revised Edition) including the addendum published at the time of the survey used since the 2018 survey.

3) Dietary habits and Lifestyle habits survey

Since 1972, a dietary habits survey was added to the NNS nutrition and physical status survey, using a self-administered questionnaire that included items on snacks, night-meals, skipped meals, preferences, and health conditions, for example, in an initial survey for women in 1972. This survey changed the target groups, according to the survey topics set each year, to include people such as the elderly (aged over 60 years), children, and people who prepare meals. Since 2000, the survey has been continuously conducted with adults aged 20 years and over. Since the 2003 survey, the name of the questionnaire was revised from “the dietary habits questionnaire” to “the lifestyle habits questionnaire” in order to reflect the entire lifestyle concerning dietary habits, physical activity and exercise, rest (sleeping), drinking, smoking, and dental health.

4. Legislation, NNS/NHNS, and public health policies

The history of NNS/NHNS, including laws and survey components, is shown in Figure 1. Since 1945, the national nutritional survey has been conducted to clarify the actual nutritional intake in Japan and to provide basic information for establishing measures to improve nutritional intake, and for use as important reference material regarding imports required to meet domestic food needs, based on the Allied Forces Commander’s Memorandum of Understanding.

In 1952, the Nutrition Improvement Act was promulgated and enforced, providing the first legal support for the conventional national nutrition survey. The act can be summarized as follows: the country will carry out a national nutrition survey to clarify the state of health, nutrition intake, and the relationship between nutrition intake and economic burden, collected as basic data, to improve nutrition; national nutrition surveys shall include physical condition and nutrition intake surveys, and shall be conducted annually at a time determined by the Minister of Health and Welfare; the prefectural governor, under the direction and supervision of the Minister of Health and Welfare, will conduct affairs concerning the execution of national nutrition surveys, within jurisdiction. In other
words, the purpose had been extended beyond obtaining basic information regarding food imports to improve nutritional status for people, and the role of national and local governments had been clearly positioned for implementation.

The Health Promotion Act was promulgated in 2002, and enforced in May 2003, at which point the Nutrition Improvement Act was abolished. There are three key components to the NHNS: the Minister of Health, Labour and Welfare conducts a national health and nutrition survey to clarify the state of physical condition, nutrient intake, and lifestyle of the people, acting as a basic document for comprehensively promoting the health of the people; the Minister of Health, Labour and Welfare can function under the umbrella of the National Institutes of Biomedical Innovation, Health and Nutrition; prefectural governors (including mayors of cities or special wards with public health centers) can carry out the NHNS, within jurisdiction.

In recent years, the NHNS has also been used to monitor some target items identified for national health promotion in a program called “The second term of National Health Promotion Movement in the twenty first century (Health Japan 21 (the second term))” from 2013 fiscal year to 2022 (Table 1)\(^{36}\). Furthermore, new assessments have been made by prefectures, to address gaps in specific areas\(^{37-39}\) such as income due to the social environment\(^{37, 40, 41}\), and muscle mass among elderly people\(^{42}\). These results have contributed to the establishment of advanced and detailed policies, promoted in various fields, such as the national health promotion movement for comprehensively promoting public health, dietary reference intakes and dietary guidelines for preferable eating practices, the Japanese Food Guide Spinning Top for a well-balanced diet, the development of a food composition table from the selection of model foods to be analyzed, estima-

| Table 1 | Target of National Health Promotion monitoring from National Health and Nutrition Survey |
|---------|---------------------------------------------------------------------------------------|
| 1. Targets for achieving extension of healthy life expectancy and reduction of health disparities |
| 2. Targets for the prevention of incidence and progression of life-style related diseases (prevention of non-communicable diseases) |
| — Improvement of hypertension (reduction in average systolic blood pressure) |
| — Reduction in proportion of adults with dyslipidemia |
| — Increase in proportion of patients who continue diabetic treatment |
| — Prevention of increase in number of diabetic persons |
| 3. Targets for maintenance and improvement of functions necessary for engaging in social life |
| — Restraint of increase in undernourished elderly (BMI under 20 kg/m\(^2\)) |
| — Promotion of social participation in elderly people (employed or engaged in community activities) |
| 4. Targets for putting in place a social environment to support and protect health |
| — Strengthening of community ties (increase in proportion of individuals who think they are helping each other in their area) |
| — Increase in proportion of individuals who are involved in health promotion activities |
| 5. Targets for improvement of everyday habits and social environment relating to nutrition and dietary habits, physical activity and exercise, rest, alcohol, smoking, and dental and oral health |
| — Increase in the proportion of individuals maintaining optimal body weight (reduction in proportion of individuals with BMI ≥BMI 25 kg/m\(^2\) or <18.5 kg/m\(^2\)) |
| — Increase in proportion of individuals who consume appropriate quality and quantity of diet (reduction in salt intake and increase in consumption of vegetables and fruits) |
| — Increase in daily number of steps |
| — Increase in proportion of individuals who regularly exercise |
| — Reduction in proportion of individuals who do not take rest through sufficient sleep |
| — Reduction in proportion of individuals who consume alcohol over recommended limits (male > 40 g, female > 20 g per day) |
| — Reduction in proportion of adult smoking (quitting smoking among smokers who want to quit smoking) |
| — Reduction in proportion of individuals who are exposed to passive smoking at home, workplace, restaurants, governmental institutions, and medical institutions |
| — Maintenance and improvement of oral function (increase in proportion of individuals in their 60s with good mastication) |
| — Reduction in proportion of individuals with periodontal disease (reduction in proportion of individuals in their 20s with gingivitis) |
| — Increase in proportion of individuals who participated in dental check-up during a past year |
tions for populations exposed to food additives, and Shokuiku (meaning nutrition and dietary education).

IV. Discussion

The present study revealed that the first survey in Japan was conducted shortly after the end of World War II. Surprisingly, the Government of Japan was required to submit a complete operational plan only 10 days after December 11, 1945, on which a memorandum was published by General Headquarters, the Supreme Commander for the Allied Powers. Tokyo prefecture, which was selected as the target city, conducted a survey that same month. In the past 75 years, the survey has been conducted regularly. In Japan, the NHNS has contributed to the establishment of national policy by providing basic data about food supplies due to food shortages in the past, and is currently contributing to health promotion measures.

It is interesting that the first survey could be planned and implemented in such a short period. One reason is likely the Allied Powers desiring the survey, the Government of Japan planning the survey, and Tokyo prefecture conducting the survey had a common understanding of the importance of conducting urgent and accurate surveys to solve nutrition issues. Based on a report by the Chief of Nutrition in Tokyo prefecture, the survey at the time seems to have been carefully and quickly prepared (e.g., holding many meetings, preparing documents, and request for regional cooperation) and was conducted by an appropriately qualified study group that included physicians, public health nurses and nurses for physical surveys and dietitians for nutrition surveys following manual-based training for the sake of accuracy. With the understanding of the importance of the survey for evidence-based policy making and evaluation, adequate preparation and manual-based implementation by experts in the national and local government and public health centers could be important and unique to the start and continuation of the survey in Japan.

During these three-quarters of a century, the primary diseases for Japanese people have dramatically changed. Specifically, mortality among infants under 1 year of age and mortality from tuberculosis and pneumonia have significantly decreased (Figures 2 and 3). These changes are not necessarily the effect of diet alone, but have been enhanced by the NHNS, which is conducted to ensure the adequate supply of nutritious food. In contrast, mortality from cancers, coronary heart diseases (CHD) excluding hypertensive CHD, and pneumonia have increased, while age-adjusted mortality has declined. One of the issues facing Japanese society today is the aging population, and recent nutrition surveys have also investigated mastication ability and muscle mass among the elderly. With the progress of women in society and changes to the typical...
Figure 3  Trends in mortality from leading causes (A) and age-adjusted mortality from the top 4 leading causes by sex (B: M, male; F, female) between 1950 and 2018. Coronary heart disease (CHD) excluded hypertensive heart disease.
structure of the Japanese household over time, the impacts of diversifying lifestyles on social economics has also been clarified through data from the NHNS. Furthermore, recent surveys conducted once every four years using a larger sample size may contribute to public health policy that addresses regional disparities, using a study design that can not only make assessments at the national level, but also at the regional level.

Out of 20 countries that conduct national nutrition surveys, the NHNS (formerly NNS) of Japan has the longest history[40], with the second oldest being the National Health and Nutrition Examination Survey (formerly the National Health Examination Survey) in the United States, which was first conducted in 1959[45]. The continuous implementation may be the result of the unique implementation system, which conducts surveys using professional teams in public health centers throughout Japan. In other countries, staff members of the institutions conducting the surveys work as interviewers or are recruited as interviewers specifically for the surveys[46].

Strengths of NHNS include sample selection based on a study design to obtain a sample that is representative of the Japanese population, and consistent annual implementation. It should also be noted that this system is implemented at health centers belonging to each prefecture, carried out using professionals as investigators, with standardized manuals, making it possible to accurately evaluate the intake not only at the nutrient and food group level, but also at the dish or food level, as needed, since the dietary survey has mainly been conducted through dietary records. Furthermore, the NHNS committee for planning and conducting analyses includes experts in several related fields, including biomedical statisticians for survey planning and data analysis.

It is also necessary to mention some issues with the NHNS. First, modern dietary surveys performed in a single day do not reveal habitual intake. As in the past, it has been practically difficult to implement data collection over three consecutive days throughout four seasons due to the great expense and effort of the participants. Second, because nutrition intake was principally estimated by applying data from the Standard Tables of Food Composition at that time, comparing the results in the long term requires careful interpretation due to the impact of changes to the Tables, such as the analysis methods used and the variety of listed foods (including cooked food since 2001[47]). Also, current research does not capture information about specific processed foods and special dietary applications that are not listed in the Standard Tables of Food Composition. In the future, it might be necessary to include a wider range of foods that depend on the food composition table as well as the intake of diversified foods, including foods for special dietary needs and supplements. Third, the proportion of participants may be unevenly distributed between generations due to busy work schedules. Lastly, the NHNS is a continuous cross-sectional study and cannot be evaluated as a cohort. There are other national longitudinal questionnaire surveys that are being conducted in Japan, such as the Longitudinal Survey of Newborns in the 21st Century and the Longitudinal Survey of Middle-aged and Elderly Persons; however, no longitudinal dietary survey exists. If a longitudinal survey could be realized, the significance of that data would be even greater.

V. Conclusions

Since its initial development, the NHNS has played an important role in providing basic material for public health policies to solve many nutrition and health issues in Japan, while clarifying the purpose and role of its implementation. Adequate preparation and manual-based and uniformed implementation of the survey by experts in the national and local government and public health centers could be important and unique for the continuous implementation of high-quality surveys in Japan.

We hope that the NHNS, which has been conducted continuously, will be further developed in the future, and that this report will contribute to the advancement of public health worldwide.

Conflict of Interest

This study does not contain matters constituting a conflict of interest.

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日本の国民健康・栄養調査
—75年の歴史—

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【目的】国民健康・栄養調査（旧：国民栄養調査）は，我が国において，75年と長きにわたって国が実施してきた調査であり，時代に応じて公衆衛生上の課題に焦点を当てながら内容を変化させてきたことが特徴的である。そこで，国民健康・栄養調査について，そのはじまりから現在に至るまでの歴史をまとめるべきこととした。

【方法】国が公表した調査報告書を基に，目的，調査対象，調査内容等について調べた。

【結果】我が国の国民健康・栄養調査のはじまりは，戦後の食糧不足による食糧供給のための基礎資料を得ることを目的としていた。その後，国民の栄養状態は改善され，法整備が整えられた中で，健康の維持・増進をより包括的に促進できるようにすることを目的に実施されている。調査対象は，無作為抽出により国の代表性が得られるように設計されている。調査内容は，当初は栄養摂取量調査と身体的症候調査の2部で構成されており，現在は栄養摂取状況調査票，身体状況調査票，生活習慣調査票の3部で構成され，その内容は拡充してきた。国民健康・栄養調査から得られた結果は，わが国の食事摂取状況と健康状態をモニタリングするための貴重な基礎資料であり，健康，食環境，栄養分野等の様々な政策に寄与し続けている。

【結論】我が国の現在の健康水準には，第二次世界大戦後から現在に至るまでの75年間にわたって，国民の状態を明らかにしてきた国民健康・栄養調査と，その結果に基づいた健康政策及び栄養政策の取組の寄与するところが大きいと考えられる。今後も，国民健康・栄養調査の発展とともに，本報告が世界の公衆衛生の発展に寄与することを期待する。

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