

V. CONCLUDING COMMENTS

A great deal has happened since Bettcher et al. published their important 2001 paper. Empirical and descriptive studies have tended to confirm that trade liberalization and foreign direct investment may pose risks for tobacco control. More notably, however, significant normative developments have helped to clarify the extent of domestic regulatory autonomy under international trade and investment agreements. WTO case-law, the entry into force of the WHO FCTC, trends in international investment law and declarations by international bodies have all given support to the conclusion that States have a broad authority to engage in tobacco control under international law.

However, as States have developed stricter tobacco control laws, their authority has begun to be tested. At the time of writing, there are a number of international disputes under way. Ukraine and Honduras have requested consultations at the WTO with Australia concerning plain packaging. Philip Morris (Switzerland) et al. have brought an international investment claim against Uruguay in respect of tobacco packaging measures. Philip Morris (Asia) has brought a claim against Australia concerning plain packaging. Similarly, Philip Morris (Nor-

way) has brought a claim in Norwegian courts that invokes a trade agreement in respect of bans on the display of tobacco products at the point of sale.

These disputes suggest that the tobacco industry will use international trade and investment agreements to resist new regulatory developments that enhance tobacco control. In this context, policy coordination and legal capacity are becoming increasingly important because the failure to protect against these kinds of challenges and to defend them when they arise could result in setbacks for public health.

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ANNEX 1 – KEY DOCUMENTS

Resolution WHA59.26 International trade and health

The Fifty-ninth World Health Assembly,

Having considered the report on international trade and health;²²

Recalling resolutions WHA 52.19, WHA 53.14, WHA 56.23, WHA 56.27, WHA 57.14 and WHA57.19;

Recognizing the demand for information on the possible implications of international trade and trade agreements for health and health policy at national, regional and global levels;

Mindful of the need for all relevant ministries, including those of health, trade, commerce, finance and foreign affairs, to work together constructively in order to ensure that the interests of trade and health are appropriately balanced and coordinated,

1. URGES Member States:

(1) to promote multi-stakeholder dialogue at national level to consider the interplay between international trade and health;

(2) to adopt, where necessary, policies, laws and regulations that deal with issues identified in that dialogue, and to take advantage of the potential opportunities, and address the potential challenges, that trade and trade agreements may have for health, considering, where appropriate, using their inherent flexibilities;

(3) to apply or establish, where necessary, coordination mechanisms involving ministries of finance, health, and trade, and other relevant institutions, to address public-health related aspects of international trade;

²² Document A59/15.

(4) to create constructive and interactive relationships across the public and private sectors for the purpose of generating coherence in national trade and health policies;

(5) to continue to develop capacity at national level to track and analyse the potential opportunities and challenges of trade and trade agreements for health-sector performance and health outcomes;

2. REQUESTS the Director-General:

(1) to provide support to Member States, at their request and in collaboration with the competent international organizations, in their efforts to frame coherent policies to address the relationship between trade and health;

(2) to respond to Member States' requests for support of their efforts to build the capacity to understand the implications of international trade and trade agreements for health and to address relevant issues through policies and legislation that take advantage of the potential opportunities, and address the potential challenges, that trade and trade agreements may have for health;

(3) to continue collaborating with the competent international organizations in order to support policy coherence between trade and health sectors at regional and global levels, including generating and sharing evidence on the relationship between trade and health;

(4) to report to the Sixty-first World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

(Ninth plenary meeting, 27 May 2006 – Committee A, sixth report)

FCTC/COP4(5) Punta del Este Declaration on the Implementation of the WHO Framework Convention on Tobacco Control

Recalling the preamble of the Constitution of the World Health Organization, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being;

Recalling the preamble of the WHO Framework Convention on Tobacco Control (WHO FCTC), which states that the Parties to the Convention are determined to give priority to their right to protect public health, due to the devastating worldwide health, social, economic and environmental consequences of tobacco consumption and exposure to tobacco smoke;

Recognizing that the spread of the tobacco epidemic is a global problem with serious consequences for public health and that scientific evidence has unequivocally established that tobacco consumption and exposure to tobacco smoke cause death, disease and disability affecting all segments of the population in every country in the world, particularly the younger population;

Recognizing that measures to protect public health, including measures implementing the WHO FCTC and its guidelines fall within the power of sovereign States to regulate in the public interest, which includes public health;

Taking into account the fact that Article 5.3 of the WHO FCTC states that: "in setting and implementing their public health policies in respect of tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law";

Recalling Article XX (b) of The General Agreement on Tariffs and Trade (GATT 1947) which states that nothing in the agreement shall be construed to prevent the adoption or enforcement by any contracting party of measures necessary to protect human health, subject to the requirement that such measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail, or a disguised restriction on international trade;

Recalling Article 2.2 of the Agreement on Technical Barriers to Trade, which states that Members shall ensure that technical regulations are not prepared, adopted or applied with a view to or with the effect of creating unnecessary obstacles to international trade and for this purpose, technical regulations shall not be more trade-restrictive than necessary to fulfil a legitimate objective,

such as the protection of human health or safety, taking account of the risks non-fulfilment would create;

Recalling Article 7 of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which states that the protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare and to a balance of rights and obligations;

Recalling Article 8 of the TRIPS Agreement, which states that Members may adopt measures necessary to protect public health provided that such measures are consistent with the provisions of the said Agreement;

Recalling paragraph 4 of the Doha Declaration on the TRIPS Agreement and Public Health which states that: “the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, it can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health”;

Recalling also that paragraph 5(a) of the said Declaration recognizes in the light of paragraph 4 that: “while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include, (...) in applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular in its objectives and principles”;

The Parties to the WHO Framework Convention on Tobacco Control declare:

1. The firm commitment to prioritize the implementation of health measures designed to control tobacco consumption in their respective jurisdictions.
2. Their concern regarding actions taken by the tobacco industry that seek to subvert and undermine government policies on tobacco control.
3. The need to exchange information on the activities of the tobacco industry, at a national or international level, which interfere with the implementation of public health policies in respect of tobacco control.
4. That in the light of the provisions contained in Articles 7 and 8 of the TRIPS Agreement and in the Doha Declaration, Parties may adopt measures to

protect public health, including regulating the exercise of intellectual property rights in accordance with national public health policies, provided that such measures are consistent with the TRIPS Agreement.

5. That Parties have the right to define and implement national public health policies pursuant to compliance with conventions and commitments under WHO, particularly with the WHO FCTC.

6. The need to urge the United Nations Ad Hoc Interagency Task Force on Tobacco Control to support multisectoral and interagency coordination for the strengthening of the implementation of the WHO FCTC within the whole United Nations system.

7. The need to include the topic “challenges to tobacco control” in the agenda of the summit on non-communicable diseases, which will be organized by the United Nations in 2011.

8. The need to urge all countries that have not done so, to ratify the WHO FCTC and implement its provisions and take measures recommended in its guidelines.

(Sixth plenary meeting, 18 November 2010)

FCTC/COP4(18) Cooperation between the Convention Secretariat and the World Trade Organization

The Conference of the Parties,

Recalling the preamble to the WHO Framework Convention on Tobacco Control (WHO FCTC), which states that Parties to the Convention are “determined to give priority to their right to protect public health”;

Having considered the report by the Convention Secretariat on cooperation with international organizations and bodies for strengthening implementation of the Convention (document FCTC/COP/4/17);

Welcoming progress made in establishing cooperative relations with international organizations towards implementation of the Convention, particularly activities related to achievement of the Millennium Development Goals and other aspects of the global development agenda;

Recalling that the Fifty-ninth World Health Assembly noted the need for all relevant ministries, including those of health, trade, commerce, finance and foreign affairs, to work together constructively in order to ensure that the interests of trade and health are appropriately balanced and coordinated, and requested the Director-General to continue collaborating with the competent international organizations in order to support policy coherence between trade and health sectors at regional and global levels (resolution WHA59.26);

Recalling that the joint 2002 study by WHO and the World Trade Organization (WTO) Secretariat on WTO agreements and public health¹ recognizes that health and trade policy-makers can benefit from closer cooperation to ensure coherence between their different areas of responsibilities;

Mindful that closer cooperation with the WTO specifically on tobacco-control issues would support Parties to the WHO FCTC in implementing the Convention;

Recalling that WHO has observer status in the WTO Technical Barriers to Trade Committee and that it has ad hoc observer status in the TRIPS and GATS Councils,

1. REQUESTS the Convention Secretariat to invite WHO to develop, in consultation with the Convention Secretariat and appropriate international organizations or bodies, a comprehensive report for presentation to the fifth session

of the Conference of the Parties that explores options for cooperation with the WTO on trade-related tobacco-control issues as a means of strengthening implementation of the Convention, and that makes recommendations on the feasibility of implementing the identified options;

2. REQUESTS the Convention Secretariat to:

(1) cooperate with the WTO Secretariat with the aim of information sharing on trade-related tobacco control issues;

(2) monitor trade disputes regarding WHO FCTC-related tobacco control measures and other trade-related issues of relevance to the implementation of the Convention;

(3) facilitate information sharing on trade-related issues between Parties to the WHO FCTC, by creating links between Parties having similar problems;

(4) to communicate regularly with the relevant WHO offices on tobacco-control issues raised at WTO committees and report on these activities regularly to the Conference of the Parties.

(Tenth plenary meeting, 20 November 2010)

Declaration on the TRIPS Agreement and Public Health (Doha Declaration)

World Trade Organization
WT/MIN(01)/DEC/2
20 November 2001
(01-5860)

MINISTERIAL CONFERENCE

Fourth Session

Doha, 9 - 14 November 2001

DECLARATION ON THE TRIPS AGREEMENT AND PUBLIC HEALTH

Adopted on 14 November 2001

1. We recognize the gravity of the public health problems afflicting many developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics.
2. We stress the need for the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to be part of the wider national and international action to address these problems.
3. We recognize that intellectual property protection is important for the development of new medicines. We also recognize the concerns about its effects on prices.
4. We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all.

In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.

5. Accordingly and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include:

(a) In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.

(b) Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.

(c) Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

(d) The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge, subject to the most-favoured-nation and national treatment provisions of Articles 3 and 4.

6. We recognize that WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002.

7. We reaffirm the commitment of developed-country Members to provide incentives to their enterprises and institutions to promote and encourage technology transfer to least-developed country Members pursuant to Article 66.2. We also agree that the least-developed country Members will not be obliged, in respect of pharmaceutical products, to implement or apply Sections 5 and 7 of Part II of the TRIPS Agreement or to enforce rights provided for under these Sections until 1 January 2016, without prejudice to the right of least-developed country Members to seek other extensions of the transition periods as provided for in Article 66.1 of the TRIPS Agreement. We instruct the Council for TRIPS to take the necessary action to give effect to this pursuant to Article 66.1 of the TRIPS Agreement.

平成 24 年度厚生労働科学研究 地球規模保健課題推進研究事業
「わが国の生活習慣病対策を世界各国の政策へ適切に反映させるための比較政策的研究」
分担研究報告書

幼児・小児・青年期の健康的な栄養摂取の促進に関わる各国の対策

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研究概要

【目的】

近年、生活習慣病の発症リスクとして、小児期の肥満の増加が課題としてあげられており、小児の健康的な栄養摂取への対応は急務である。本研究は、幼児・小児を対象に健康的な栄養摂取を促進するために各国がどのような対策をとっているかを明らかにする。

【方法】

PubMed を使用し検索した文献、WHO や関連団体からの報告書、関係者へのヒアリングによる情報収集・分析をした。

【結果】

英国、フィンランド、スウェーデンの子どもに対するフードマーケティングの対策および学校給食における健康的な栄養摂取の対策について情報を収集することができた。英国はすでに、不健康な食品に焦点をあてた子どもに対するマーケティングの規制を、テレビやラジオの広告放送規制として実施していた。フィンランド、スウェーデンは、子どもに対する全般的なマーケティング規制から、不健康な食品に焦点をあてたマーケティングへの提言をまとめていたが、政策への反映は実現されていなかった。

学校給食については、フィンランド、スウェーデンともに、長い歴史があり、現在は給食の質に着目し、より健康的な栄養摂取ができるように対策を講じていた。

【結論】

各国がフードマーケティング規制、学校給食のどちらを優先し、対策をすすめているかは歴史的、文化的な背景により異なると考えられる。子どもに対する栄養摂取の対策は、子どもの肥満の問題視されるようになったここ最近、多く議論されるようになり、各国ともに、**Health in All policies** の視点から、放送関係者、教育関係者、市民団体と取り組みを進めているが、対策は途上の段階であった。

A. 研究の背景および目的

世界保健機関（WHO）は、第 51 回 WHO 総会（1998 年）で非感染性疾患に着目し、その予防と対策についての議決をした¹⁾。2002 年の World Health Report²⁾ による全世界の死因の 60% が非感染性疾患であるとの報告を受け、その後、栄養および身体的活動と健康に関する世界的戦略を次々と打ち出している³⁻⁴⁾。未だ感染症や低栄養が世界的な保健課題であると同時に、今や非感染性疾患、特に生活習慣病をどのように克服していくかが世界的な課題となっている。

特に、生活習慣病の発症リスクとして、小児期の肥満が課題としてあげられており、WHO は 2004 年に Global Strategy on Diet, Physical Activity and Health にて、健康的な食習慣の促進、高カロリー、糖分、塩分食品のマーケティングへの適切な対策の開発を推奨している。2010 年には、世界的に 5 歳未満児の約 20%（推測 4300 万人）が肥満もしくは肥満のハイリスク群になるとの報告もある⁵⁾。WHO でも、小児の肥満予防の集団的アプローチの戦略を設定するうえでの技術的な情報提供を行うようになっている^{6) - 7)}。日本においても、小学校入学前や中学校入学前の小児期の肥満が増加しているとの報告があり、^{8) - 9)}、小児の健康的な栄養摂取への対応は急務である。

本研究は、上記の背景もとに、幼児・小児・青年期を対象に健康的な栄養摂取を促進するために各国がどのような対策をとっているかを明らかにし、比較することを目的とする。

B. 研究方法

文献および関係者へのヒアリングによる情報収集・分析を実施した。文献レビューについては、PubMed にて「child」「food marketing」「school lunch」「nutrition」「policy」をフリーキーワードとし、各国の政策、政策展開を論じているものを採用した。さらに、WHO から発行されている本研究のトピックと関係の高い報告書も分析に利用した。また、本研究のトピックは、消費者団体や食品関連企業、政府機関などからの情報も重要と考え、PubMed ではヒットしない報告書などを拾い、広く情報収集をするために、Google 検索にて上記と同様のキーワードを使用しての検索も実施した。各論文および報告書内の参考文献からも重要と考えられた文献をスノーボール方式にて収集した。すべての情報や報告書に関して、情報の信頼性を確保するために、複数の文献および報告書の情報を重ねて内容を確認した。

関係者へのヒアリング調査では、主に各国の小児の栄養摂取についての現状、既に実施されている政策、将来に向けての政策展開の情報収集を行った。本年度は、比較的、生活習慣病対策が先進しているフィンランドおよびスウェーデンで、ヒアリング調査を実施した。

○ヒアリング先

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C. 結果

本年度は、子どもへのフードマーケティング対策が比較的発展している英国、学校給食などの健康的な栄養摂取対策が比較的発展しているフィンランド、スウェーデンを中心に情報収集を進めることができた。以下、各国の対策を報告する。

1) 英国における子どもに対するフードマーケティングの対策

英国では、2003年に放送通信法成立を受け、テレビ、ラジオ、通信、無線通信サービスの全体通して責任を持ち通信産業の管理をする独立規制機関、Ofcom (Office of Communication: 放送通信庁) が誕生した。子どもに対する高脂質、糖分、塩分を含有する食品および飲料 (Food and drink with High in Fat, Sugar or Salt (HFSS)) のテレビ広告の規制は、Ofcom が発行する放送広告コードにて規定されている。Ofcom はコード違反が認められた場合には制裁を科す権限が与えられており、放送事業者に対して免許没収、訂正放送、罰金の支払いを命じることができる機関である。

Ofcom は、2004年に文化・メディア・スポーツ大臣からの要請を受け、子どもの肥満と食品広告の関連についての調査をし、“テレビ広告の子どもたちの食品選択への影響がどの程度あるのかのエビデンスは不十分であるが、テレビ広告に対していくつ

かの特別な規制が必要であるだろう”と報告をした¹⁰⁾。同年に、保健省から発行された白書 “Choosing Health”の中でもこれらの結果は引用され、テレビ広告の規制および学校での HFSS 食品・飲料のマーケティングの規制について言及している¹¹⁾。

2007年に Ofcom が HFSS 食品・飲料のテレビ・ラジオ広告規制についての最終結論に至り、16歳未満の子どもを対象に広告の放送内容、放送時間制限の規制が発表された¹²⁾。この規制は、当時規定されていた4つの放送広告コードに反映されたが、2010年にその4つのコードが集約化され、新しい放送広告コードとしてリニューアルされ¹³⁾、その中で子ども・青少年に対する HSFF 食品および飲料広告の規制が規定されている (表1)。

表1でもわかるように、英国の放送広告コードでは、対象とする子ども = 16歳未満、HFSS 食品・飲料 = 2005年には、FSA (Food Standard Agency: 食品基準庁) により発行された栄養プロファイルに基づくものである (表2)¹⁴⁾。この栄養プロファイルは、食品の栄養素ラベリングにも使用されており、消費者がわかりやすいように、緑、黄、赤の信号のように表示されるようになっている (図1)¹⁴⁾。

2) フィンランドにおける健康的な栄養摂取促進の対策

フィンランドにおいて、子どもへのフードマーケティングへの提言が初めて文章化されたものとして、the National Institute of Health and Welfare, the Consumer Agency and Ombudsman, the National Food Agency, the National Board of

Education が協働で、2004 年に発刊したガイドライン「Children & Foodstuffs marketing」があるが¹⁵⁾、既存の消費者保護法 (Consumer Protection Act, 1978) を基盤として、子どもへのフードマーケティングに絞り、提言をまとめている (表 3)。

2008 年には、政府が発行した健康的な身体活動および栄養に関するガイドライン¹⁶⁾の中で、「子どもや若者に対するフードマーケティングは、ヘルスプロモーションのメッセージと相反するものであってはならない。必要であれば、国は自主規制団体と協力して、規制するシステムを作ることになるだろう」との記載がある。しかし、その後、国としての法的規制の対策の展開に発展はしていない¹⁷⁾。

また、フィンランドでは、国民全体がより健康的な食品を選択できるように、フィンランド心臓協会 (Finish Health Association) とフィンランド糖尿病協会 (Finish Diabetes Association) が、2000 年にハートシンボルの表示システムを立ち上げた¹⁸⁾。ハートシンボル表示のために、食品ごとに脂質、塩分、糖分などの栄養素の条件が決まっており、シンボルを利用したい食品関連企業が申請、利用許可、利用料の支払いにて、シンボルを利用できる。許可が得られた食品は、ハートシンボルが表示され、店頭にならべる (写真 1)。

フィンランドは、世界で最も早期に学校給食が開始された国である。小学生を対象に無料の学校給食プログラムが開始されたと言われている戦後の 1948 年の以前の 20 世紀初頭より、小さな規模であるが給食が存在していた。現在では、地方自治体の責任において、The Basic Education Act

(1998)、the General Upper Secondary Schools Act, the Vocational Education and Training Act (1998) で、小学校～大学までの無料でバランスのとれた給食サービスが保障されている。給食サービスは、the National Board of Education によるコアカリキュラムの中で、ただ単に栄養摂取のみではなく、教育、社会的な活動として位置づけられている。フィンランドでは自分自身でとりわけのカフェテリアスタイルによる給食のため、子どもたちが進んでバランスのとれた食事をとれるように、カフェテリアが子どもたちにとって心地よい場所であり、食事の味や温度にも特別な注意を払うことを推奨されている。2007 年に、the National Board of Education と the National Institute of Health and Welfare により、あめなどの甘いお菓子やソフトドリンクを学校内のカフェテリアや自動販売機で販売するべきでないとの提言をだしているが、対応への決定はそれぞれの学校に任されている^{19) - 20)}。

3) スウェーデンにおける健康的な栄養摂取促進の対策

スウェーデンは、子どもに対するフードマーケティングのみに焦点をあてた法律は整っていない。一般的に子どもに対する広告の規制として、TV and radio Law (1996) が存在する。この中では、テレビ広告は 12 歳以下の子どもに標的をあててはいけないこと、12 歳以下の子どもをターゲットとした番組内および番組の直後には広告をいれてはいけないこと、と述べられている。Marketing Act(2008)では、16 歳以下の子どもに対しての直接的なマーケティングは

禁止されている。

2003年に、スウェーデン政府の依頼により、the National Food Administration(現在の the National Food Agency)および the National Institute of Public Healthが健康的な栄養摂取習慣および身体的活動の増加に関する計画作成のための調査を実施した。2005年に調査結果がとりまとめられ、その中では79の提言があげられている。²¹⁾ その中で、6つが子どもに対するフードマーケティング対策への提言である(表4)。しかし、未だ提言が政策に反映されていないのが現状である²²⁾。

また、スウェーデンにおいても、国民全体のより健康的な食品のマーケティングに関して、1989年からキーホールシンボルの表示システムがある(写真2)²³⁾。それぞれの食品に対しての栄養素の条件が決まっており、条件をクリアした食品に対して、シンボルを表示することができる。食品関連企業がキーホールを利用したいときには、自主的かつ無料で利用することができ、表示に関しては、地方自治体の公衆衛生担当が監督の第一人者となっている。現在では、ノルウェー、デンマークにおいても同じキーホールシンボルが利用されている。

スウェーデンでは、学校給食については、1880年には既に貧困対策の一つとして位置づけられていた。その後、政府報告書や提案書で、適切な学校給食についての提言が出され、1997年に National Education Actにより、すべての7-16歳の生徒に対する無料の学校給食の義務化が定められた。2011年には、National Education Actの改正により、「無料」に加え「栄養分のある(nutritious)」という言葉も付け加えられ、

学校給食の質にも焦点が当てられるようになった。しかし、フィンランドと同様にカフェテリアスタイルでの給食サービスとなるため、野菜や果物を摂取しないなど、子どもたちの偏った栄養摂取が課題であるとのことであった²²⁾。

D. 考察

幼児・小児・青年期の健康的な栄養摂取を進める対策として、学校給食を中心とするより健康的な食事摂取を促す対策と、マーケティング規制による高脂質、糖分、塩分を含む不健康な食品の摂取を減らそうとする対策がみられた。各国がどちらを優先し、対策をすすめているかは歴史的、文化的な背景により異なる。

本年度の調査では、十分な情報が得られなかったため詳しく記さなかったが、英国では、2006年から2009年にかけて学校給食規則が整い、現在でも、生徒が無料で学校給食を受けられるのは一部である²⁴⁾。フィンランド、スウェーデンのように、学校給食が長い歴史をもち、教育政策に含まれる形で重要視されている国々では、その強みをいかし、対策が進んでいると考えられる。英国は、子どもたちが学校の外で食事をする機会がスウェーデン、フィンランドより多いと考えられ、子どもたちへの食品・飲料のマーケティングの規制にまずは比重をおき進んできたのではないだろうか。来年度は、英国の学校給食の現状もさらに調査をする必要がある。

また、米国においては、表現の自由からフードマーケティングの法的規制が難しいといわれており²⁵⁾、米国におけるフードマーケティングの現状も詳しく調べる必要が

ある。さらに不健康な食品摂取の減少を期待し、世界的に食品に含まれるカロリーや砂糖に対する課税の議論があがっている。今後、カロリー税、砂糖税の議論がどのように進んでいくか着目する必要がある。

今回の調査より、ヨーロッパ各国は、**Health in All Policies** の理念のもと、放送関係者、教育関係者、市民団体などを協働し、政策への反映、提言を進めており、社会環境に大きく影響される生活習慣病への対策として、種々業界との横断的な対応が進められていることがわかった。

わが国は、生活習慣病対策が世界的に進んでいる国であるが、子どもの肥満率が増加しているとの報告もある。生活習慣病対策として実施されている特定健康診査、特定保健指導や、学校、職場、市町村における一般健康診査などが2次予防としての役割を担っていると考えられるが、子どもたちをとりまく食に関する生活環境の変化を鑑み、集団的アプローチとしての、フードマーケティングへの対策を考えていく必要があるだろう。また、日本の強みとなるのは、やはり歴史が長い学校給食の制度であり、世界的に日本の学校給食制度を適切に反映させていくためにも、来年度は、日本の現状をさらに調べ、各国と比較することが必要となる。

E. 結論

幼児・小児・青年期の健康的な栄養摂取を進める対策として、学校給食を中心とするより健康的な食事摂取を促す対策と、マーケティング規制による高脂質、糖分、塩分を含む不健康な食品の摂取を減らそうとする対策がみられた。子どもに対する栄養

摂取の対策は、子どもの肥満が問題視されるようになったここ最近、多く議論されるようになり、各国ともに発展途上の段階であった。来年度は、日本の現状の調査も加え、日本の対策を各国と比較し、各国の政策へ反映させていくためへの提言をまとめることとする。

F. 研究発表

なし

G. 知的財産権の出願・登録

なし

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