

TABLE 1: Subjects number among public office workers according to smoking ban categories.

Smoking ban categories	Men				Married nonsmoking women			
	2001		2010		2001		2010	
	N	%	N	%	N	%	N	%
Total subjects								
Partial smoking ban	3785	37.3	2644	38.7	472	32.6	775	38.9
Early smoking ban (2003–2007)	4001	39.5	2576	37.7	651	44.9	733	36.8
Recent smoking ban (2008–2011)	2357	23.2	1620	23.7	326	22.5	486	24.4
Subjects aged 25–39 years <sup>a</sup>								
Partial smoking ban	1896	38.0	1412	38.8	177	31.1	442	42.0
Early smoking ban (2003–2007)	1952	39.2	1373	37.7	265	46.5	351	33.3
Recent smoking ban (2008–2011)	1137	22.8	855	23.5	128	22.5	260	24.7
Subjects aged 40–50 years <sup>a</sup>								
Partial smoking ban	1889	36.6	1232	38.5	295	33.6	333	35.4
Early smoking ban (2003–2007)	2049	39.7	1203	37.6	386	43.9	382	40.6
Recent smoking ban (2008–2011)	1220	23.7	765	23.9	198	22.5	226	24.0

<sup>a</sup>Categorized by age in June 2001.

Notes: Subjects number in other framework such as 2004 and 2007 was similar with this distribution (data not shown).

TABLE 2: Current smoker prevalence, decrease, and difference-in-differences (DID) estimates among male public office workers according to smoking ban categories.

Smoking ban categories	Current smoker prevalence				Effect size of the public office smoking ban DID estimates <sup>a</sup> , % point (95% CI)
	2001 %	2010 %	Decrease, % point (95% CI)	Decrease by percent change, %	
Total male workers	46.4	31.6	14.8 (13.5, 16.2)	31.9	
Partial smoking ban	46.8	32.9	13.9 (12.6, 15.3)	29.8	
Early smoking ban (2003–2007)	46.8	32.0	14.8 (13.5, 16.1)	31.6	0.9 (–3.0, 4.7)
Recent smoking ban (after 2007)	45.7	30.0	15.8 (14.4, 17.1)	34.5	1.8 (–1.5, 5.2)
Male workers aged 25–39 years <sup>b</sup>					
Partial smoking ban	47.4	33.3	14.1 (12.8, 15.5)	29.8	
Early smoking ban (2003–2007)	47.3	33.2	14.1 (12.8, 15.4)	29.8	0.0 (–5.5, 5.4)
Recent smoking ban (After 2007)	43.6	30.9	12.8 (11.4, 14.1)	29.2	–1.4 (–6.0, 3.3)
Male workers aged 40–50 years <sup>b</sup>					
Partial smoking ban	46.2	32.4	13.8 (12.5, 15.2)	29.9	
Early smoking ban (2003–2007)	46.4	30.7	15.7 (14.3, 17.0)	33.8	1.8 (–3.7, 7.4)
Recent smoking ban (After 2007)	47.7	28.9	18.8 (17.5, 20.1)	39.4	5.0 (0.2, 9.8)

<sup>a</sup>The category of “Partial smoking ban” was used as a reference. Positive value of DID estimates represents smoking cessation rates among male workers.

<sup>b</sup>Categorized by age in June 2001.

CI: confidence interval.

### 3. Results

Data were available for 247,195 (response rate: 87.3%) households in 2001, 220,836 (79.8%) in 2004, 229,821 (79.9%) in 2007 and 228,864 (79.1%) in 2010. Of these, subsamples of male public workers ( $n = 10, 143$ – $12,791$  in 2001,  $7,922$ – $9,188$  in 2004,  $8,416$ – $8,972$  in 2007 and  $6,840$ – $7,750$  in 2010) and husbands of female non-smoking public workers ( $n = 1, 449$ – $1,913$  in 2001,  $1,499$ – $1,853$  in 2004,  $1,996$ – $2,217$  in 2007 and  $1,994$ – $2,174$  in 2010) were analyzed (Figure 1). Sample numbers in 2001 and 2010 according to the smoking

ban categories and characteristics are shown in Table 1 and supplementary Table S1 and S2 in supplementary materials available online at <http://dx.doi.org/10.1155/2014/303917>.

Current smoker prevalence, the decrease and DID estimates (effect sizes) among male public office workers according to smoking ban categories are shown in Table 2. Current smoker prevalence decreased from 46.4% in 2001 to 31.6% in 2010 among total male workers. It could be assumed that 14.8% (31.9% of smokers) men stopped smoking during 2001–2010. DID estimates for early and recent smoking bans were not significant among total men: 0.9 (95%CI: –3.0, 4.7) and

TABLE 3: Current smoker prevalence, decrease, and difference-in-differences (DID) estimates among husbands of female nonsmoking public office workers according to smoking ban categories.

Smoking ban categories	Current smoker prevalence of husbands				Effect size of the public office smoking ban
	2001 %	2010 %	Decrease, % point (95% CI)	Decrease by percent change, %	DID estimates <sup>a</sup> , % point (95% CI)
Husbands of total female workers	52.7	34.9	17.8 (16.4, 19.2)	33.8	
Partial smoking ban	51.9	35.4	16.6 (15.2, 17.9)	31.9	
Early smoking ban (2003–2007)	47.2	32.3	14.9 (13.6, 16.3)	31.6	–1.6 (–10.5, 7.2)
Recent smoking ban (after 2007)	55.9	36.0	19.9 (18.5, 21.3)	35.6	3.3 (–4.3, 11.0)
Husbands of female workers aged 25–39 years <sup>b</sup>					
Partial smoking ban	58.2	34.4	23.8 (22.5, 25.1)	40.9	
Early smoking ban (2003–2007)	46.9	35.4	11.5 (10.1, 12.8)	24.5	–12.3 (–25.8, 1.1)
Recent smoking ban (After 2007)	59.2	38.5	20.8 (19.4, 22.1)	35.1	–3.0 (–14.6, 8.5)
Husbands of female workers aged 40–50 years <sup>b</sup>					
Partial smoking ban	48.1	36.6	11.5 (10.1, 12.9)	23.9	
Early smoking ban (2003–2007)	47.5	28.8	18.7 (17.4, 20.0)	39.4	7.2 (–4.7, 19.2)
Recent smoking ban (After 2007)	53.6	33.8	19.9 (18.5, 21.2)	37.0	8.4 (–2.0, 18.7)

<sup>a</sup>The category of “Partial smoking ban” was used as a reference. Positive value of DID estimates represents smoking cessation rates among husbands of female workers.

<sup>b</sup>Categorized by age in June 2001.

CI: confidence interval.

1.8 (–1.5, 5.2), respectively. The over 40s age groups indicated significant DID estimates of 5.0 (0.2, 9.8) for the recent smoking ban, although the younger groups did not show significant DID estimates for either smoking ban.

Table 3 shows current smoker prevalence, the decrease and DID estimates among husbands of female nonsmoking public office workers according to smoking ban categories. Spousal (husbands’) smoking prevalence decreased from 52.7% in 2001 to 34.9% in 2010 among total female nonsmokers. It could be assumed that 17.8% (33.8% of spousal smokers) husbands stopped smoking during 2001–2010. DID estimates for early and recent smoking bans on spousal smoking was not significant among total female workers. The over 40s age group indicated positive DID estimates for early and recent smoking bans of 7.2 (–4.7, 19.2) and 8.4 (–2.0, 18.7), respectively, although these were not statistically significant.

Table 4 shows DID estimates by several periods before and after 2007, such as 2007–2010, according to smoking ban categories. As for the recent smoking ban, after 2007, the DID estimate among the over 40s was significant for male current smoking and not statistically significant but had a positive value for spousal smoking; 5.7 (1.5, 10.0) and 4.6 (–3.5, 12.7), respectively, although those were nearly zero before 2007. The early smoking ban showed DID estimates for male current smoking were around zero with small range, while those for spousal smoking showed positive values among the over 40s, especially after 2004 including 2004–2010. DID estimates for 2004–2010 were rather higher than those for other time periods for both recent and early smoking bans, particularly among the over 40s; that is, statistically significant results of 5.5 (0.9, 10.1) for recent smoking ban among over 40s male workers, 11.8 (3.2, 20.5) for early smoking ban among husbands of all female workers, 13.6 (2.6, 24.6) for early

smoking ban among husbands of over 40s female workers and 11.0 (1.7, 20.2) for recent smoking ban among husbands of over 40s female workers. Furthermore, the sensitivity analysis showed smoking-related factors-adjusted DID results did not largely differ (data not shown).

#### 4. Discussion

There is insufficient evidence as to whether a complete smoking ban decreases tobacco use compared with a partial smoking ban [9]. We found that the complete workplace indoor smoking ban, particularly that recently implemented among over 40s public office workers, decreased workers’ smoking prevalence compared with a partial ban, especially after 2007. This result of decreased prevalence following a workplace smoking ban is in line with previous studies [14], suggesting a new aspect of the comparison between a complete smoking ban and a partial smoking ban. We also found the workplace smoking ban indicated positive values, although mostly non-significant, on the decrease of husbands’ smoking prevalence among over 40s female nonsmoking workers compared with a partial ban. This may imply an increase in smoke-free homes after the implementation of a workplace smoking ban among over 40s female nonsmoking workers. This is in line with previous studies that found smoke-free legislation stimulated the adoption of smoke-free homes [30]. The workplace smoking ban may have a beneficial impact on smoking workers, nonsmoking workers and their families. However, our findings remain tentative because of limited significant results and methodological weaknesses in this study.

In the WSFG in 2003 [10], construction of a comfortable working environment was highlighted rather than workers’

TABLE 4: Difference-in-differences (DID) estimates by before and after 2007 time durations, according to smoking ban categories.

Smoking ban categories	DID estimates <sup>a</sup>				
	Before 2007		After 2007	Before and after 2007	
	2001–2004 % point (95% CI)	2004–2007 % point (95% CI)	2007–2010 % point (95% CI)	2001–2010 <sup>b</sup> % point (95% CI)	2004–2010 % point (95% CI)
Total male workers					
Early smoking ban (2003–2007)	0.8 (–2.7, 4.3)	–1.6 (–5.3, 2.1)	1.0 (–3.0, 5.1)	0.9 (–3.0, 4.7)	–1.1 (–5.1, 2.9)
Recent smoking ban (after 2007)	0.6 (–2.5, 3.6)	–0.8 (–4.0, 2.5)	3.2 (–0.4, 6.7)	1.8 (–1.5, 5.2)	2.2 (–1.3, 5.7)
Male workers aged 25–39 years <sup>c</sup>					
Early smoking ban (2003–2007)	3.9 (–1.6, 9.4)	–3.8 (–9.8, 2.1)	–3.0 (–10.5, 4.5)	0.0 (–5.5, 5.4)	–6.8 (–12.9, –0.8)
Recent smoking ban (after 2007)	–1.7 (–6.5, 3.1)	–0.8 (–6.2, 4.5)	–2.5 (–9.1, 4.0)	–1.4 (–6.0, 3.3)	–2.3 (–7.6, 3.0)
Male workers aged 40 <sup>c</sup> –59 <sup>d</sup> years					
Early smoking ban (2003–2007)	–1.4 (–5.9, 3.2)	–0.6 (–5.3, 4.2)	2.8 (–2.0, 7.6)	1.8 (–3.7, 7.4)	3.2 (–2.1, 8.5)
Recent smoking ban (after 2007)	2.0 (–2.0, 5.9)	–1.2 (–5.4, 3.0)	<b>5.7 (1.5, 10.0)</b>	<b>5.0 (0.2, 9.8)</b>	<b>5.5 (0.9, 10.1)</b>
Husbands of total female workers					
Early smoking ban (2003–2007)	–8.4 (–17.1, 0.3)	6.4 (–2.0, 14.7)	2.1 (–5.8, 10.0)	–1.6 (–10.5, 7.2)	<b>11.8 (3.2, 20.5)</b>
Recent smoking ban (after 2007)	1.5 (–5.7, 8.8)	1.5 (–5.5, 8.5)	1.6 (–5.4, 8.6)	3.3 (–4.3, 11.0)	4.2 (–3.2, 11.6)
Husbands of female workers aged 25–39 years <sup>c</sup>					
Early smoking ban (2003–2007)	–15.2 (–31.0, 0.5)	4.6 (–10.6, 19.8)	0.0 (–14.6, 14.7)	–12.3 (–25.8, 1.1)	8.7 (–5.9, 23.2)
Recent smoking ban (after 2007)	1.0 (–12.1, 14.0)	–1.3 (–14.5, 11.9)	–6.8 (–20.4, 6.8)	–3.0 (–14.6, 8.5)	–8.7 (–21.4, 3.9)
Husbands of female workers aged 40 <sup>c</sup> –59 <sup>d</sup> years					
Early smoking ban (2003–2007)	–6.0 (–16.4, 4.5)	8.1 (–2.0, 18.2)	2.8 (–6.6, 12.2)	7.2 (–4.7, 19.2)	<b>13.6 (2.6, 24.6)</b>
Recent smoking ban (after 2007)	1.0 (–7.7, 9.7)	2.0 (–6.4, 10.3)	4.6 (–3.5, 12.7)	8.4 (–2.0, 18.7)	<b>11.0 (1.7, 20.2)</b>

<sup>a</sup>The category of “Partial smoking ban” was used as a reference. Positive value of DID estimates represents smoking cessation rates.

<sup>b</sup>Represented from Tables 2 and 3.

<sup>c</sup>Age in baseline period.

<sup>d</sup>Age in follow-up period.

CI: confidence interval.

health. However, workers’ health harm reduction was prioritized in a recent report for workplace smoke-free policy by the MHLW in 2010 [31]. In the context of the new report and the HPL [11] in Japan, all employers have a responsibility and statutory duty to provide and maintain a working environment which is safe and free from risks to health including SHS exposure. Although we only accessed public office workers in the study, generally, the most heavily exposed and most at risk are those working in the hospitality industry such as bar workers, waiters and waitresses [32]. Intake of SHS in bar staff can be four times higher than that arising from living with at least one smoker [33]. The health risks to these employees are therefore especially high, and need to be prevented. Governments initially tend to implement the law affecting only public or unavoidable places [32]. This may widen the degree of inequality in the smoking ban between public and non-public places, although compliance with the law is also important. Thus, from the equity perspective, complete smoking ban policies for all workplaces, including not only public office but also the hospitality industry, must be required.

Unlike the USA where tobacco taxation differs by states, the same cigarette price is applied throughout Japan and there are no media anti-smoking campaigns [11]. Therefore, the

impact of these measures which are most influential factors on smoking behavior could be ignored as a strength of this study. Simultaneously, the underlying downward trend in smoking prevalence observed between 2001 and 2010 could be taken into account by the DID method [16].

*4.1. Workplace Smoking Ban and Husbands’ Smoking.* A workplace smoking ban may increase awareness of the dangers to nonsmokers of SHS, and help establish norms regarding the inappropriateness of smoking around nonsmokers. The norm of unacceptable smoking around nonsmokers, resulting from compliance with the indoor smoking ban policy, might influence people to adopt such rules voluntarily for their homes [14], and might improve husbands’ smoking cessation by enhancing conjugal support and communication [34]. Thus, the mechanism between the workplace smoking ban and home smoking behavior may decrease husbands’ smoking.

In a previous review, workplace smoking bans were deemed to have a smaller effect on smoking behavior than home smoking bans in studies that analyzed both workplace and home smoking bans simultaneously [14]. However, according to the above mechanism, voluntary home smoking bans may mediate between workplace smoking bans and

smoking behavior. Thus, the adjustment for home smoking bans may result in underestimation of the effect of workplace smoking ban; that is, although the variable of home smoking ban was not used in the current study, it may be appropriate for evaluation on the effect of a workplace smoking ban.

**4.2. Effect Modifications.** In this study, large age group differences in the effect of a smoking ban on smoking behaviors were seen. Generally, smoking cessation may be more difficult for older than for younger adults, because of a longer duration of smoking and thus a stronger nicotine dependence. However, the observed age group difference in the study is not surprising, because older people are more likely to conduct healthy behavior change than younger people [35]. Although few previous studies have examined the smoking ban using age group stratification, a lower effectiveness of smoking restrictions among young populations was observed [36], consistent with this study. Johnson et al. note that older people are more likely than young people to try to avoid unnecessary risks owing to their accumulated experience of health risks over a lifetime [35]. Another reason for the age group differences might be similar to resistance to the smoking ban by adolescents who start smoking as a form of rebellion [37], and thus a positive effect of smoking ban was not observed among the under 40s. Furthermore, different personal compositions, such as age and housing tenure, might cause a difference, although the results of sensitivity analyses adjusting these covariates did not materially differ.

In terms of difference due to implementation period, the effect of recent smoking ban was observed, particularly in 2007–2010, although the effect of the early smoking ban, which was implemented in 2003–2007, was not stable (Table 4). This might be due to a potential interaction. The smoking ban was one component of a multi-component effort to reduce tobacco use. The prefectural execution of the complete indoor smoking ban might occur during a period when other tobacco control strategies were relatively steady in the prefecture. A recent smoking ban might have a better interaction effect with a recently improved environment which promotes smoking cessation than an early smoking ban, because population norms against smoking had been reinforced by recent other tobacco control measures such as increased tobacco taxation and improved cessation assistance [11]. Thus, it is not generally possible to attribute all changes in smoking behavior to the smoking ban.

In terms of husbands' smoking, a wide range of baseline smoking prevalence by stratified categories might result in unstable DID estimates with limited significance. This might be due to chance and small sample size.

**4.3. Limitations.** There are several other limitations in the study. First, smoking outcomes were self-reported without biomarker validation, but the reliability of self-reporting smoking behavior was generally high [38]. Second, because this study is based on repeated cross sections instead of longitudinal data, changes in one individual could not be specified. Therefore, results may be biased by accidental distributions between different years. Longitudinal studies,

however, have the problem that disadvantaged people are likely to leave the study. In this study, all respondents with characteristics of disadvantage could be included. Furthermore, the prefecture-based proxy indicator, which was used for intervention identification, may also lead to an ecological fallacy, an accident or underestimation by misclassification. Third, because public workers were studied, the ability to generalize from the results might be limited. The smokers in public offices might be more susceptible to pressure to change their behavior [14]. Therefore, this may lead to overestimation. Fourth, the execution of the smoking ban was not random. For example, Kanagawa prefecture implemented its own legislation to provide a smoke-free environment. In some cases, it has been argued that antismoking sentiments drove the passage of the law and reductions in smoking behaviors. We could not control for antismoking sentiments in the population, although strong leadership on making-decision by local governors was believed to be important for the implementation of legislation in Japan [39].

## 5. Conclusions

We examined whether a workplace complete indoor smoking ban would reduce male workers' smoking and female workers' husbands' smoking, compared with a partial ban, among Japanese public workers. The effectiveness of smoking bans considerably varied by age and period. A complete workplace indoor smoking ban, particularly one recently implemented among public office workers aged over 40, may reduce male workers' smoking and female workers' husbands' smoking compared with a partial ban, although other categories indicated weak, negative or no impact on smoking cessation.

## Conflict of Interests

The authors declare that there is no conflict of interests regarding the publication of this paper.

## Acknowledgments

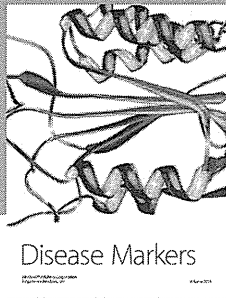
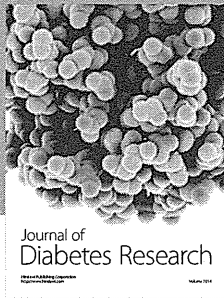
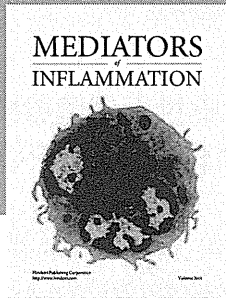
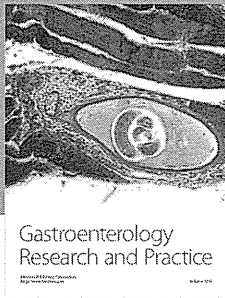
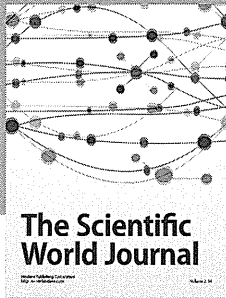
We thank Dr. A. Oshima and Dr. M. Nakamura for valuable comments. We also thank Dr. J. Mortimer for her English language editing. This study was supported by the Ministry of Health, Labour and Welfare (Grant; Comprehensive Research on Life-Style Related Diseases including Cardiovascular Diseases and Diabetes Mellitus (H25-010)).

## References

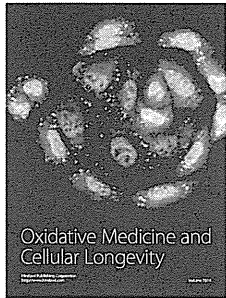
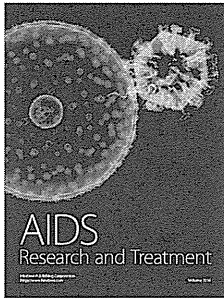
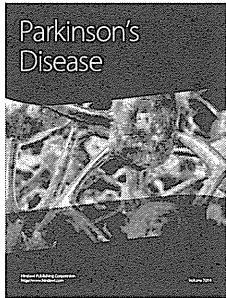
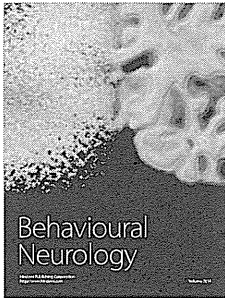
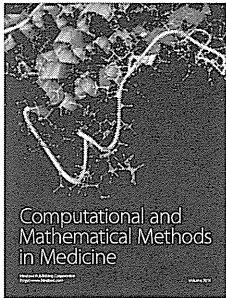
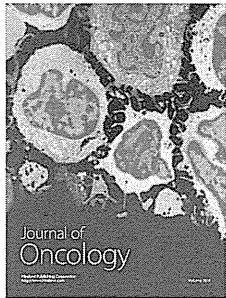
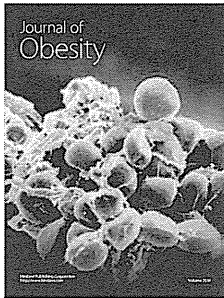
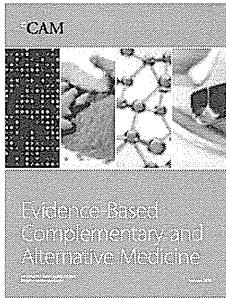
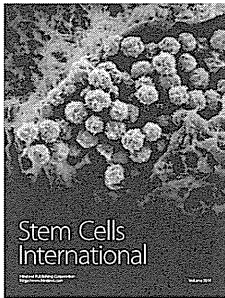
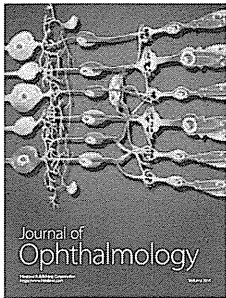
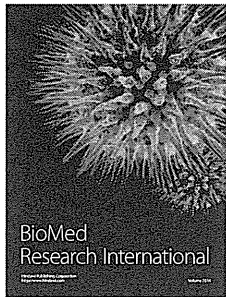
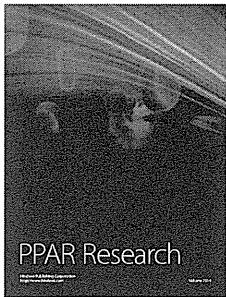
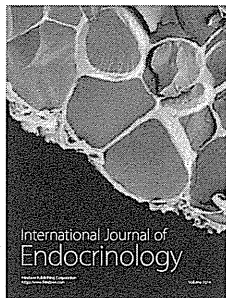
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ミニ特集 たばこの規制に関する世界保健機関枠組条約

## 「たばこの規制に関する世界保健機関枠組条約」第 11 条 「たばこ製品の包装及びラベル」について

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### WHO Framework Convention on Tobacco Control (FCTC) Article 11: Packaging and Labelling of Tobacco Products

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**Abstract** The World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) requires member countries to implement measures aimed at reducing the demand for tobacco products. FCTC article 11 describes the important forms of health communication and packaging regulations. And this article recommends on large pictorial health warnings and encourages more effective forms of disclosure on constituents and emissions. Furthermore, article 11 recognizes the importance of the package as a promotional vehicle for tobacco companies and requires the removal of potentially misleading packaging information, including the terms “light” and “mild.” The Conference of the Parties (COP) adopted guidelines for implementation of article 11 on “Packaging and labelling of Tobacco Products”. Some countries, such as Canada, the U.S.A., Australia, EU countries etc. positively promoted tobacco control by implementing countermeasures such as the graphic health warning labels and plain packages. These countermeasures showed the significant effects of decreasing smoking rate and preventing smoking initiation in young people. Furthermore, these warning labels were effective for the literally challenged. However, the Japanese government has not implemented these countermeasures, and only limited texts are shown on Japanese tobacco packaging. Therefore, Japan should emulate approaches taken by other countries, and promote the tobacco control policy in accordance with FCTC.

**Key words:** tobacco (たばこ), Framework Convention on Tobacco Control (たばこ対策枠組み条約), warning label (健康被害警告ラベル), plain package (プレーンパッケージ)

#### 1. はじめに

「平成 26 年全国たばこ喫煙者率調査」(1) による日本国内の喫煙率は, 成人男性の平均喫煙率が 30.3%, 女性は 9.8% であり, 男性の場合, 昭和 41 年以降のピーク時 (83.7%) と比較すると, 46 年間で約 1/3 までの減

少が見られる。これらの要因として, 公共の場における禁煙エリアの設置や禁煙車の増大, たばこの大幅増税, たばこに関する法制度の確立, 禁煙治療の保険適応, さらに, 「健康日本 21」における禁煙者の増加を目指した喫煙率の目標設定等が考えられ, これまで日本国内では喫煙率の減少へ向けたさまざまな対策が実施されてきた。しかしながら, 現在の日本国内の喫煙率は, 他の先進国と比較しても非常に高い水準にあり (2), 喫煙による有害性が社会的にも広く認識されているアメリカやカナダ等の先進国と比較すると, 2 倍もの差が生じている (2)。そのため日本国内においても, 今後, 人々へ喫煙・受動喫煙の健康被害の認識を高めるための普及啓発を行

受付 2014 年 8 月 22 日, 受理 2014 年 9 月 4 日  
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い、喫煙率の減少へ向けた対策をより一層推進させていく必要がある。

また、世界保健機関 (WHO) は、たばこが公衆の健康に深刻な影響を及ぼす世界的な問題になっているとの見解から、たばこの規制に関する世界保健機関枠組条約 (WHO Framework Convention on Tobacco Control; WHO FCTC) を 2005 年に発効した。ここでは、締約国に対して、たばこ消費の削減に向けた広告・販売への規制や密輸対策等が求められている。また、たばこによる健康被害を食い止めるべく、たばこのパッケージ警告を通じて行われるヘルスコミュニケーション専用の条項が 2 つ含まれており (3)、その一つに、たばこの健康警告についてうたった「第 11 条：たばこ製品の包装及びラベル」がある。実際、FCTC 第 11 条では、160 以上の締約国に対して「たばこ使用の有害な影響を示す健康警告を表示すること」と定められており (3)、2008 年 11 月に開催された COP3 (第 3 回締約国会議) で採択された第 11 条のガイドラインでは、喫煙を主な要因とする特有の疾病をパッケージの両面に大きく明確に描いた健康警告の表示が義務付けられた (4)。さらに、各締約国が WHO FCTC の義務を履行することを支援するために発行されたプラン、MPOWER (5, 6) では、たばこ消費を減らすための効果的な政策の実施へ向けた国内法の制定を実践的に支援する方策が述べられ、その中では、喫煙の危険性を人々に周知させるための健康警告の重要性についても強調されている。このようなたばこ対策に関する FCTC が発効されることにより、各国では喫煙に対する政策が進められ、これにより喫煙率の低下を導くなど、着実な効果が伺える。

本文では、FCTC 第 11 条についての具体的な内容を紹介すると共に、FCTC が示すたばこ対策に関する近年の国内外での動向について記す。

## 2. FCTC 第 11 条：たばこ製品の包装及びラベル

第 11 条、条文を以下に記す (外務省訳文) (7)。

1. 締約国は、この条約が自国について効力を生じた後三年以内に、その国内法に従い、次のことを確保するため、効果的な措置を採択し及び実施する。
  - (a) たばこ製品の包装及びラベルについて、虚偽の、誤認させる若しくは詐欺的な手段又はたばこ製品の特性、健康への影響、危険若しくは排出物について誤った印象を生ずるおそれのある手段 (特定のたばこ製品が他のたばこ製品より有害性が低いとの誤った印象を直接的又は間接的に生ずる用語、形容的表示、商標、表象による表示その他の表示を含む。) を用いることによってたばこ製品の販売を促進しないこと。これらの手段には、例えば、「ロー・タール」、「ライト」、「ウルトラ・ライト」又は「マイルド」の用語を含めることができる。
  - (b) たばこ製品の個装その他の包装並びにあらゆる外側

の包装及びラベルには、たばこの使用による有害な影響を記述する健康に関する警告を付するものとし、また、他の適当な情報を含めることができること。これらの警告及び情報は、

- (i) 権限のある国内当局が承認する。
  - (ii) 複数のものを組合せを替えて表示する。
  - (iii) 大きなもの、明瞭 (めいりょう) なもの並びに視認及び判読の可能なものとする。
  - (iv) 主たる表示面の 50 パーセント以上を占めるべきであり、主たる表示面の 30 パーセントを下回るものであってはならない。
  - (v) 写真若しくは絵によることができ、又は写真若しくは絵を含めることができる。
2. たばこ製品の個装その他の包装並びにあらゆる外側の包装及びラベルには、1 (b) に規定する警告に加え、たばこ製品の関連のある含有物及び排出物である国内当局が定めるものについての情報を含める。
  3. 締約国は、1 (b) 及び 2 に規定する警告その他文字による情報をたばこ製品の個装その他の包装並びにあらゆる外側の包装及びラベルに自国の主要な一又は複数の言語で記載することを要求する。
  4. この条の規定の適用上、たばこ製品に関する「外側の包装及びラベル」とは、当該たばこ製品の小売販売に使用されるあらゆる包装及びラベルをいう。

以上のような内容から、第 11 条では、締約国に、たばこ製品の包装とラベルに健康上の警告とメッセージの表示をさせる具体的で強制力のある義務を課しており、その厳守すべき達成期限についても明確に述べられている。

## 3. たばこ包装上の健康警告表示に関する国内外での動向

### 1) 健康被害警告ラベル

2000 年に世界で最も早く画像による健康被害警告ラベルを導入したカナダをはじめ、現在は、アメリカ、オーストラリア、ヨーロッパ、アフリカ、東南アジア等の国々においても、たばこ規制における政策の手段として、警告ラベルが取り入れられており (8-12)、2010 年に警告ラベルの表示を実施した国が 34 ヶ国であったのに対し、2014 年では 63 ヶ国まで増加した。また、これら警告ラベルのたばこ包装上での表示については、「主たる表示面の 50 パーセント以上を占めるべきであり、主たる表示面の 30 パーセントを下回るものであってはならない」と 11 条で定められていることから、各締約国では、この規定を満たすためのさまざまな対応が取られている (表 1, 項目 2, 3, 4)。各国の包装上の表示面積の割合は、国ごとでも異なり、アメリカ、カナダ、オーストラリアなどの先進諸国では包装の 50% 以上が警告表示で占められている。また、先進国のみでなく、タイやマレーシ

アなどの東南アジアの地域でも同様な傾向が見られ、文字のみでなく、図 1 に示すようにタイやカナダなどで取り扱われる画像入りの健康被害警告表示やプレーンパッケージを取り入れる国も増加傾向にある。しかしながら、近年、警告表示に関する活動がさらに広まる中で (14)、アメリカでは、警告表示を義務付けたアメリカ薬品食品局 (FDA) に対して、「表現の自由」に反する憲法違反とのことから、たばこ会社が訴訟を引き起こすなど、警告表示に反する動きも見られる (15, 16)。

カナダ保健省が国民に対して実施した、健康被害警告ラベルに対する意識調査によると、たばこの外箱両面に大きく表示される警告表示は、人々の目に触れやすい情報源であることから、小学生などの子供をはじめ、多くの喫煙者及び非喫煙者が、ラベル表示によりたばこの有害性に対して高い認識を持つことが可能になるとの結果が報告されている (17)。また、アメリカやヨーロッパ等では、画像入りの警告表示が、思春期の若者に対する喫煙の誘発を抑制する効果を示したことや (9, 18)、喫煙者に対して禁煙を増加させる手段としても有効であり、また、喫煙率が高く、識字率の低い集団に対して健康情報を伝える上でも画像入りの健康警告表示は効果的であると、高く評価されている (19-22)。さらに、イギリス、オランダ、オーストラリア、ブラジル、ニュージーランドで実施された調査結果からは、包装上の健康被害警告ラベルに国内の禁煙電話相談サービス(クイットライン)の連絡先を表示することで、その利用者が大幅に増加し、禁煙に繋がるケースも多く見られた (図 1A, E) (23-26)。

このように、喫煙対策における健康警告表示の取り組みが進む中、国外で販売される日本のたばこ製品についても、その国の法規制に対応した警告表示が使用されていることから、同じ日本のたばこ製品でありながら、海

外で販売する際には、画像入りの警告を表示している国も多い。

一方、日本国内でも FCTC に対応するため、たばこ事業法施行規則第 36 条の規定により、別表第一に挙げられる次の警告文、

- 喫煙は、あなたにとって肺がんの原因の一つとなります。疫学的な推計によると、喫煙者は肺がんにより死亡する危険性が非喫煙者に比べて約 2 倍から 4 倍高くなります。
- 喫煙は、あなたにとって心筋梗塞の危険性を高めます。疫学的な推計によると、喫煙者は心筋梗塞により死亡する危険性が非喫煙者に比べて約 1.7 倍高くなります。
- 喫煙は、あなたにとって脳卒中の危険性を高めます。疫学的な推計によると、喫煙者は脳卒中により死亡する危険性が非喫煙者に比べて約 1.7 倍高くなります。
- 喫煙は、あなたにとって肺気腫を悪化させる危険性を高めます。

及び第二に挙げられる次の警告文、

- 妊娠中の喫煙は、胎児の発育障害や早産の原因の一つとなります。疫学的な推計によると、たばこを吸う妊婦は、吸わない妊婦に比べ、低出生体重の危険性が約 2 倍、早産の危険性が約 3 倍高くなります。
- たばこの煙は、あなたの周りの人、特に乳幼児、子供、お年寄りなどの健康に悪影響を及ぼします。喫煙の際には、周りの人の迷惑にならないように注意しましょう。
- 人により程度は異なりますが、ニコチンにより喫煙への依存が生じます。
- 未成年者の喫煙は、健康に対する悪影響やたばこへの依存をより強めます。周りの人から勧められても決して吸ってはいけません。

合計 8 種類の警告文が設けられているものの、日本のた

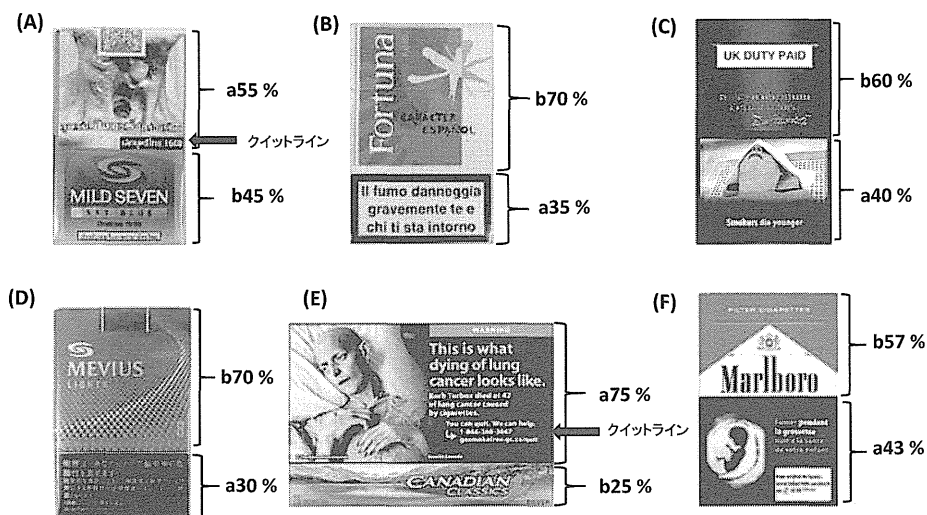


図 1 各国におけるたばこ包装上の健康警告表示の例 (a; 健康警告表示, b; ブランド名)。(A) タイ, (B) イタリア, (C) UK, (D) 日本, (E) カナダ, (F) フランス [写真画像及び引用文献 (27) より]。

表1 締約国におけるたばこ包装・健康警告表示に関する規制事項 (13)

たばこ包装上の健康警告表示	オーストラリア	カナダ	タイ	マレーシア	フランス	イギリス	韓国	イタリア	アメリカ	ドイツ	フィリピン	日本
1 包装上の健康被害警告表示の法的な義務はあるか	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2 包装の主要面に占める健康被害警告表示面積の割合 (%)	82.5	75	55 <sup>a</sup>	50	48	48	30	35	50	35	15	30
3 包装の主要面前面に占める健康被害警告表示面積の割合 (%)	75	75	55	40	43	43	30	30	50	30	30	30
4 包装の主要面後面に占める健康被害警告表示面積の割合 (%)	90	75	55	60	53	53	30	40	50	40	0	30
5 健康被害警告を包装の主要面上方に表示するよう法的な規制があるか	Yes	Yes	Yes	Yes	No	No	No	No	Yes	No	No	No
6 健康被害警告の文字の形式、大きさ、色についての法的な規制があるか	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
7 健康被害警告の効果・持続性を維持させるため、常に最新の多様な警告内容を並列的に交替で表示しているか	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 健康被害警告は国内の公用語で表示されているか	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9 たばこ警告表示が、納税印紙などの必要不可欠な、いかなるマーキングによっても隠されてはいけないことが、法的に規制されているか	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes
10 包装上の健康被害警告表示には写真や図が使用されているか	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No <sup>b</sup>	No
11 健康警告表示はたばこ製品の個装その他の包装並びにあらゆる外側の包装及びラベルに表示されているか	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
12 健康警告表示は、国内で製造されるもの、領内に輸入されるもの、免税品を含む全てのたばこ製品を対象に規制されているか	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
13 たばこ警告表示が、たばこ産業の責務を減免するものではないことを法的に言及しているか	No	Yes	No	No	No	No	No	No	No	No	No	No
14 包装上の健康警告表示は、喫煙による健康被害を表示しているか	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15 特定の健康被害警告表示を法的に規制しているか	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16 いくつかの特定の健康警告表示が法的に義務付けられているか	14	16	10	6	16	16	1	16	9	17	4	8
17 健康被害警告に関する違反に関して法的な罰金が要求または設立されているか	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

[27]

表1 (続き)

たばこ包装上の健康警告表示	オーストラリア	カナダ	タイ	マレーシア	フランス	イギリス	韓国	イタリア	アメリカ	ドイツ	フィリピン	日本
18 包装上での健康影響に対する誤解を招く可能性のある“ロータール”、“ライト”、“ウルトラライト”、“マイルド”などの情報表示を禁止するよう法的に規制されているか	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No
19 健康影響に対して誤解を招く可能性のある図やサインまたは色や数字を含む包装及びラベルの使用が法的に規制されているか	Yes	No	Yes	No	Yes	Yes	No	Yes	No	Yes	No	No
20 たばこの包装やラベル上に香料を表す表現を使用することができないことが法的に規制されているか	Yes	Yes	Yes	No	No	No	Yes	No	No	No	No	No
21 銘柄や商標の一部として使われる場合も含め、包装上にたばこ主流煙の(タール、ニコチン、一酸化炭素)イールド数値の表示を法的に禁ずることが規制されているか	Yes	タール、ニコチン、CO等6種類	—	—	タール、ニコチン、CO	タール、ニコチン、CO	タール、ニコチン	タール、ニコチン、CO	—	タール、ニコチン、CO	—	タール、ニコチン
22 包装上にたばこの含有物や排出物に関する定量的な情報を表示することが法的に規制されているか	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
23 たばこの含有物や排出物に関する定量的な情報を包装の前後主要面に記載することが法的に規制されているか	No	No	No	No	—	—	Yes	—	—	—	—	—
24 包装上にたばこの安全性をほのめかす可能性を持つ“消費期限”を表示することが法的に規制されているか	Yes	No	No	No	No	No	No	No	No	No	No	No
25 クイットラインを包装上あるいは商標と共に記載することを法的に規制しているか	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	No	No
26 プレーンパッケージの使用が法的に規制されているか	Yes	No	No	No	No	No <sup>e</sup>	No	No	No	No	No	No
27 無煙たばこの販売を完全に禁ずるための国際的な法律あるいは規制を取り入れているか	No	No	Yes	No	No	No	No	No	No	No	No	No
Yesの回答数	20	17	17	15	14	13	12	12	12	10	9	9

<sup>a</sup> 2014年7月2日に85%へ変更。

<sup>b</sup> 2014年7月22日に画像健康警告表示の導入に合意。

<sup>c</sup> 2015年にプレーンパッケージ導入予定。

ばこ会社や特定の販売業者は、これら 8 種類の中から各 1 種類ずつ、計 2 種類をたばこ包装の主要 2 面へそれぞれ 30% 以上の面積を使って表示することが義務付けられているだけである。画像による警告表示、文字や色、表現などの規制もなく、未だ FCTC で求められる最低限の条件を満たす警告表示に留まったままであることから、日本のたばこ会社に対する国内外での対応の違いについて反対する意見も多い。

## 2) 外箱上での製品の含有物と排出量の表示

第 11 条では、たばこの外箱における健康被害警告表示のラベル化に加え、「たばこ製品の関連のある含有物及び排出物であって国内当局が定めるものについての情報を含める」と記載されている (3)。これまで、日本の財務省が所管するたばこ容器の包装に対する規定では、パッケージ上にタール及びニコチンの排出量のみ表示することが定められていた。これら値の表示は、他の多くの国々においてもたばこ容器の包装に表示されており、そのほとんどは、国際標準化機構 (ISO) が定めた統一された方法で測定されていることから、他国とのたばこ製品を比較する上では有効な表示である。しかしながら、これらの表示は、多くの消費者に対し、低いタールとニコチンの排出量が、曝露やリスクの低減を意味するなどの誤った認識を招く危険性も懸念されている (28-32)。たばこの吸い方は、個人によってさまざまであり、低タールと表示されたたばこを吸う場合には、無意識のうちに吸い方を変えている可能性も考えられ、他のたばこを吸う場合と同程度のニコチンを摂取している可能性も高い (33)。このように、たばこを吸い込む深さや頻度等については、個人によってもさまざまであるため、タール・ニコチンの排出量の表示のみでは、たばこの有害性を評価することは不可能である。このようなことから、第 11 条のガイドラインでも、「締約国は、包装及びラベルに、タール、ニコチンおよび一酸化炭素などのイールド\*の数値を表示することは、ブランド名または商標の一部として使用される場合も含め禁止するべきである」と勧告されている (4)。これを受け、多くの国々では、パッケージ上における排出量の表示を取り除く動きが見られ、特にオーストラリアでは、排出量の表示を禁止することが法的にも規制されている (表 1, 項目 21)。また、代わりに特定の有害成分の情報を、その健康影響の説明と共に表示することで (34)、消費者に対して有害性を伝える有効な手段として効果を示し (35)、さまざまなたばこブランドにおける相対的リスクに関する誤った認識を招く危険性も回避できるものとして、高い評価が得られている (29)。

\*: 紙巻たばこのパッケージに表示されているタール〇〇 mg、ニコチン〇〇 mg という数字は、紙巻たばこ一本あたりの「含有量」でなく、スモッキングマシンが一定の方法で吸引した主流煙に含まれるタールとニコチン量である。正式には yield (イールド: 収量) と呼ばれる (33)。

## 3) 誤解を招く包装情報の禁止

さらに、FCTC の第 11 条では、包装上での健康影響に対する誤解を招く可能性のある情報表示を禁止するよう要求されている。「light」、「mild」、「low tar」などの用語は、本質的に消費者に誤解を与え、消費者の多くがこれらの製品に対して有害性が低く、禁煙がより容易であると誤って認識する危険性を有していることから、現在までに、50 ヶ国を超える国々が包装上にこれらの用語を使用することを禁止してきた。また、マレーシアやタイなどの国々では、禁止用語のリストを拡大させる動きも見受けられ、他の誤解を招くような表現 («cool», «extra», «special», «smooth», «premium», «natural») についても禁止用語として挙げている。

一方、アメリカ、イギリス、カナダ、オーストラリア、ニュージーランド等の国々では、「light」や「mild」等の用語を除くだけでは、たばこに対する人々の誤った認識を回避させることは難しいと主張する声も多く、実際に、人々が、たばこの外箱のデザインや色などによって、味や香りのイメージの印象を受ける傾向が強いことが示されている (36-39)。そのため、用語の禁止と併用して、たばこのパッケージの統一化や下記に示すプレーンパッケージの導入をより一層推進させる必要性も考えられる。

また、日本国内では、たばこ事業法施行規則 36 条 2 において、「会社又は特定販売業者は、「low tar」、「light」、「ultra light」又は「mild」その他のたばこの消費と健康との関係に関して消費者に誤解を生じさせるおそれのある文言を容器包装に表示する場合は、消費者に誤解を生じさせないために、当該容器包装を使用した紙巻等たばこの健康に及ぼす悪影響が他の紙巻等たばこと比べて小さいことを当該文言が意味するものではない旨を明らかにする文言を、当該容器包装に表示しなければならない」とも定められている。そのため、FCTC 第 11 条において、誤った印象を生ずるおそれのある手段として使用が禁止されている用語についても、日本では継続的な使用を認める記述になっており、このことは、たばこ対策を進める上での妨げになる可能性もあることから、今後、使用の可否について検討が必要と考えられる。

## 4. たばこプレーンパッケージ

先に述べたように、たばこの有害性に関する誤った認識は、ブランドのイメージや色など、販売を促進させるような外箱表示の情報が関与している可能性が考えられる。特に、同系色の色合いや包装上での空白の割合は、人々に対して、たばこ製品の強度や潜在的リスクの認識を操作する可能性が高く、実際には、色とブランドイメージを排除することで、各ブランドのリスクに対する誤った確信が低減するという調査結果も報告されている (38)。また、第 11 条施行のために発効されたガイドラインでは、たばこ製品特有の色使い・画像・マークなどの使用が禁じられた「プレーンパッケージ」に関する勧

告も含まれており、「締約国は、標準的な色とフォントスタイルで表示されるブランド名および製品名以外のロゴ、色、ブランドイメージ、または販売促進情報の使用を制限または禁止する対策の採用を検討すべきである(ブレンパッケージ)」(4)とされている。

オーストラリアは、2012年に世界で最も早くブレンパッケージを導入した国であり、オーストラリアのたばこのパッケージ表示は、単色無地で、ロゴ等も一切使用せず、たばこ会社は商品名と社名のみを決まった色、書体、サイズの文字で決まった場所に表示しなければならない。また、パッケージの表4分の3と裏全面には、たばこに関連する病気など、健康に対するたばこの害を訴える警告画像を印刷することが要求されている(図2A)。実際、このブレンパッケージの導入は、オーストラリア国内の喫煙率の低下にも貢献しており、オーストラリアの喫煙率は、2010年から2013年の間に15.1%から12.8%にまで減少した(39)。このことから、ブレンパッケージは、たばこ対策を進める上で非常に有効な手段と言える。イギリスでは、既に2015年からブレンパッケージの導入が決定されており、導入に向けたたばこパッケージの指針案も発表されている(図2B)。また、ニュージーランドやアイルランド等の国でも法的な規制の設立を進める動きがあるなど(4)、導入を検討する国も徐々に増えてきている。その他、ASEAN諸国や香港等のアジア(40)、南米(41)等でも試験的にブレンパッケージを導入することで、若者から成人まで幅広い喫煙者層に対する喫煙率の低下に効果を示している。一方、オーストラリアでは、たばこ会社が、ブレンパッケージの導入により不当に会社のトレードマークを奪われたとして、このことが法律上での知的財産権の侵害に値するとの理由から、オーストラリア

最高裁判所に対して異論を唱えた。結果として、裁判所によりこれらの異論は受け入れられなかったものの、たばこ会社は再度訴訟を引き起こし、ブレンパッケージの使用義務への反論はより一層強まっている。

## 5. ま と め

2005年にWHOよりたばこ対策に関するFCTCが発効されて以降、先進国をはじめとする世界各国では、喫煙に対するさまざまなたばこ対策が進められてきた。中でも、画像健康警告表示やブレンパッケージ実施の先駆けとなったカナダやオーストラリアでは、たばこ対策におけるさまざまな規制を強化することで、喫煙率の低下にも大きく貢献してきた。また、東南アジア等の途上国においても、これらに続く対策が急速に進められている。一方、日本国内では、FCTCに対応すべく「たばこ事業法施行規則」による規制が定められているものの、それらはFCTCで求められる最低限の条件を満たすのみであり、喫煙者の健康影響や禁煙の必要性に対する認識も浅く、世界的にも高い喫煙率を維持したままである。そのためにも、さまざまな媒体を通じてFCTCに基づいたたばこ対策の情報を国民へ広く周知させていくと共に、喫煙に関する教育・啓発にも力を注いでいく必要がある。日本は、経済面や産業面で最先端を進む国であると共に、健康面や環境面においても先進的な力を発揮していくため、FCTCの批准国として、たばこ対策をより一層強力に進めていく必要がある。

## 謝 辞

本総説は、厚生労働科学研究費補助金(循環器疾患・糖尿病等生活習慣病対策政策研究事業、たばこ規制枠組み条約を踏まえたたばこ対策に係る総合的研究)の助成を受けたものである。

本論文に関わる利益相反はない。

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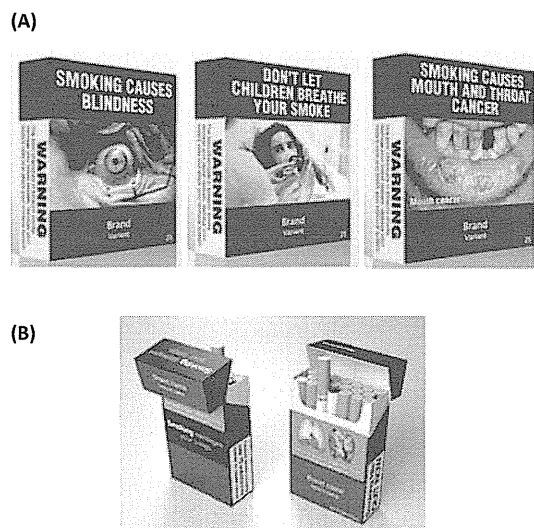


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## Law and Policy of Tobacco Regulation in Japan

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- I Introduction (The Right to Smoke and the Rights of Nonsmokers)
- II Secondhand Smoke Prevention Measures
- III Measures to Prevent Smoking by Minors
- IV Measures to Reduce the Number of Smokers
- V Dramatic Reform of Tobacco Regulation
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### I Introduction (The Right to Smoke and the Rights of Nonsmokers)

Smokers assert that they have the right to smoke; however, the right to smoke certainly does not imply the right to smoke as much as one pleases. Moreover, in the opinion dated September 16, 1970 (Minshu, Vol. 24, No. 10, p. 1410), the Grand Bench of Japan's Supreme Court also stated that "even if the right to smoke is included in the fundamental human rights protected by Article 13 of the Constitution, it does not mean that such rights must be protected at all times and places." That is, the right to smoke has limitations. At certain times and in certain places, this right is not protected. As natural human rights, the right to smoke is intrinsically limited to the extent to which it does not harm the survival or health of others. However, if the right to smoke exists, it should cease once it causes problems (including health damage) for those around the smoker.

On the other hand, the rights of nonsmokers can be understood as the right to not be forced to inhale secondhand smoke (passive exposure to tobacco smoke, passive smoke) and the right to breathe clean air, free from the pollution of tobacco smoke. A substantial number of people believe that the rights demanded by nonsmokers interfere with the smokers right to smoke or that these rights of nonsmokers will eventually lead to an absolute prohibition of smoking. However, such opinions are a result of a major misunderstanding. In the following statements, I present three rights actually demanded by nonsmokers.

First, nonsmokers only demand restrictions on smoking in public places. The right nonsmokers assert is, essentially, nothing more than the provision of private areas for

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smoking, keeping public areas smoke free. They are merely asking for restriction on smoking in public places.

Second, the demands of nonsmokers do not interfere with smokers' right to smoke in any way. As stated previously, similar to natural rights, the right to smoke should be intrinsically limited to the extent to which it does not harm the survival or health of others. On the one hand, the right demanded by nonsmokers could be summarized as "I don't mind if you smoke freely in places where it will not harm the survival or health of others, but please do not pollute the air breathed by nonsmokers." In other words, they want nothing more than actualization of the intrinsic limitations on the right to smoke<sup>1)</sup>.

Third, nonsmokers are not demanding a total prohibition on smoking. Obviously, as previously stated, the right demanded by nonsmokers necessitates a prohibition on smoking in public spaces; however, such a demand would not prohibit smoking in private spaces. Practically, it is nothing more than a plea for the institutionalization of existing spatial restrictions on smoking.

This study provides a legal theory (legal commentary and legislative theory) on the legal problems involved in tobacco regulations in Japan (problems involving the relationship between rights and duties) based on the right to smoke and the rights of nonsmokers as described above, while considering and analyzing governmental regulations.

From a government regulation perspective, cigarettes are not regulated by the Food Sanitation Act, despite being a consumer good that is consumed orally (i.e., through the mouth). Although cigarettes cause numerous diseases and their discontinuation after prolonged and/or continuous consumption is extremely difficult, they are not even regulated by the Narcotics and Psychotropic Control Act. Further, nicotine, a major component of cigarettes, due to its toxicity is identified as a poisonous substance by the Poisonous and Deleterious Substances Control Act (Article 2.1, Attachment 1); however, the tobacco plant itself is not considered as a poisonous substance.

Currently, the different laws regulating cigarettes in Japan include the Act on Prohibition of Smoking by Minors (enacted in 1900), the Tobacco Business Act (enacted in 1984) (originally, this law promoted cigarettes more than it regulated them), the Tobacco Tax Act (enacted in 1984), and the Industrial Safety and Health Act (enacted in 1992, amended in 2014). More recently, the Health Promotion Act (enacted in 2002) and other laws have been enacted, and the WHO Framework Convention on Tobacco Control (adopted in 2003, effective since 2005) was also adopted globally. Furthermore, many local governments now have various ordinances prohibiting smoking in the streets (since 2002; subsequently enacted in each region). Ordinances preventing secondhand smoke

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1) See Yasutaka Abe, 1980, "The Rights of Smokers and Nonsmokers, Regulation of Tobacco Smoking, Vol. 1 (Kitsuenken, Kenenken, Tabako no Kisei (Jo))", *Jurist*, No. 724, p. 45.

(passive exposure to tobacco smoke, passive smoke) were enacted in Kanagawa and Hyogo Prefectures (adopted in 2009 and 2012). In light of this, Japan's situation seems to have changed remarkably since the past decade. Yet, when compared with other countries, particularly developed ones, Japan remains a veritable smoker's paradise<sup>2)</sup>.

However, measured by the WHO Framework Convention on Tobacco Control, Japan requires even stronger government regulations on cigarettes. In the current Japanese society, the government and its citizenry are in agreement. The government can be perceived as the entity entrusted with balancing the complex interests of the public. Similar to environmental rights and the right to know, tobacco regulation is also a problem of balancing interests. Governmental regulations based on administrative law have played a significant role in balancing such interests. The prevention of damage and disputes and the improvement of society can be listed as reasons for the existence of administrative law<sup>3)</sup>; however, governmental regulation based on administrative law must also be used to build a better society by preventing damage and disputes caused by smoking.

The question to be addressed is "based on the WHO Framework Convention on Tobacco Control, what administrative law measures should be taken to regulate tobacco in Japan?" Thus, what follows is a presentation of the legal challenges facing Japan in the realm of tobacco regulation.

While exploring the possible means of tobacco regulation, 1) the enhancement of secondhand smoke prevention measures to protect the health of nonsmokers is inevitable from the viewpoint of protection health and preventing damage to non-smokers; however, 2) due to the currently pronounced levels of smoking by minors, preventive measures are required for their protection. Further, 3) as many smokers themselves desire to quit, but are unable to do so, smoking reduction measures are needed to protect the health of current smokers. In addition to concrete tobacco measures that can be taken considering Japan's current legal system, I believe that dramatic reforms will also be necessary to address the legal challenges facing Japan in the realm of tobacco regulation.

This study first explains the direction of concrete tobacco regulation measures from the three perspectives mentioned above: (II) secondhand smoke prevention measures, (III)

2) For an American perspective on tobacco regulation in Japan, see Mark A. Levin, 1997, "Smoke around the rising sun: An American Look at Tobacco Regulation in Japan," *Stanford Law & Policy Review*, vol.8, pp. 99-106, Eric A. Feldman, 2004, "The Limits of Tolerance: Cigarette, Politics, and Society in Japan," Eric A. Feldman and Ronald Bayer eds., *UNFILTERED: Conflicts over Tobacco Policy and Public Health*, Harvard University Press, pp. 38-67.

3) 1) Prevention and straightforward resolution of disputes and damage; 2) control of disorder and the improvement of society; and 3) the direct provision or the securement of the provision of the services needed for daily life can be considered as three reasons for the existence of administrative law. For more on the reasons for the existence of administrative law, see Yasutaka Abe, 1997, *The Administrative Law System [New Edition]* (*Gyosei no Ho Shisutemu (Shinpan)*), Yuhikaku, p. 2.ff, Yasutaka Abe, 2008, *Interpreting Administrative Law (Gyoseiho Kaishakugaku)*, Yuhikaku, p. 2.ff.

measures to prevent smoking by minors, and (IV) smoking reduction measures, while presenting the direction of tobacco regulation regarding the consideration of concrete legal issues. Thereafter, (V) dramatic reform of tobacco regulation will be examined.

## II Secondhand Smoke Prevention Measures

Smoking creates environmental tobacco smoke<sup>4)</sup>, which can cause diseases in nonsmokers through the inhalation of secondhand smoke<sup>5)</sup>. Accordingly, secondhand smoke prevention measures must be enhanced to prevent harm to and protect the health of nonsmokers. However, secondhand smoke prevention measures involve diametrically opposed interests of smokers and nonsmokers. Therefore, a solution supported by the authority of a governmental regulation is required<sup>6)</sup>.

Places where secondhand smoke becomes problematic include workplaces, public spaces, streets, and homes. In Part II, secondhand smoke measures will be considered with a focus on three areas—tobacco regulation in the workplace (1–2), tobacco regulation in public spaces (3–7), and tobacco regulation in the streets (8–9).

### 1. The need for smoke-free workplaces

Since train stations, airports, airplanes, hospitals, and other public places have become smoke free or have separate designated smoking areas, the evident remaining problem area is the workplace. Article 71.2 of the Industrial Safety and Health Act reads “To improve the standards of safety and cleanliness in the workplace...employers must strive to establish continued and systematic measures to create a comfortable work environment.” Regarding the measures to create a comfortable work environment, employers have the sole responsibility of making their “best efforts.”

At the 186<sup>th</sup> ordinary session of the Diet on March 13, 2014, The Ministry of Health, Labor and Welfare submitted a bill to amend a portion of the Industrial Safety and Health Act, which was passed on June 19 of the same year. Article 68.2 of the revised act

4) The smoke inhaled by smokers when smoking is referred to as “mainstream smoke.” Once it is exhaled it is referred to as “exhaled smoke.” The smoke that drifts from the lit portion of the cigarette is referred to as “sidestream smoke.” Indoors, the combination of exhaled and sidestream smoke is referred to as environmental tobacco smoke (ETS). For more on ETS, see *Smoking and Health, Report of the Committee on Smoking and Health Problems [New Edition] (Shinpan) Kitsuen to Kenko, Kitsuen to Kenko Mondai ni kansuru Kentokai Hokokusho*, 2002, Hokendojinsha, p. 175. ff.

5) The research demonstrating how secondhand smoke causes various serious diseases is too numerous to list here, but, as an official report, the 2006 U.S. Surgeon General Report (SGR) concludes that secondhand smoking of environmental tobacco smoke is unsafe at any level. See *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014* on the U.S. Surgeon General’s website, available at <http://www.surgeongeneral.gov/library/reports/tobaccosmoke/index.html> (last visited April 14, 2014).

6) See Yasutaka Abe, 1980. “The Rights of Smokers and Nonsmokers, Regulation of Tobacco Smoking [Vol. 2] (Kitsuenken, Kenenken, Tabako no Kisei (Ge)), *Jurist*, No. 725, p. 109. ff.