

The Role of States in Controlling the Obesity Epidemic, and a Personal Autonomy to Decide

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Abstract

Obesity has reached pandemic proportions in the world. Who is to blame for this: the person or the State (or both?). An increase in diseases associated with excess weight is also worldwide reported, such as Diabetes, Hypertension and some types of cancers. Therefore, the economic impacts of these comorbidities are an important issue to be discussed by States and citizens. Although the World Health Organization (WHO) has set and classified obesity as a disease more than 30 years ago, the American Medical Society was until recently (2010) not so sure about this definition. This article discusses the relevance of the implementation of public health policies for prevention and control of obesity, along with the possible ethical limitations to these actions, considering the autonomy of individuals regarding their health.

Keywords

Obesity, Comorbidities, Public Health Policies, Autonomy of the Citizen

1. Introduction

Treating obesity no longer simply means to treat only the person affected by obesity. Currently, the global epidemic that corresponds to excess weight affects more than half the world's population, and its prevalence is rising, especially in developing countries, such as Latin American countries, Africa and some parts of Asia. Who is to blame for this: people or governments? Or should both be held responsible for looking after solutions? A thorough and broader analysis of regulatory issues involving the control of overweight is mandatory, along with a

better understanding of its determinants in such countries, which face one of their greatest challenges in public health when dealing with such harm to the health of their citizens.

2. Legal Aspects of Obesity and Health

Many national Constitutions show specific approaches towards the right to health nowadays. The Brazilian Federal Constitution of 1988, also known as “Citizen’s Constitution” describes in the Articles 196-202 the right of every Brazilian citizen to health, considering that health is “a right of all [citizens] and a duty of State” (F.C. 1988, article 196) [1]. Thus, it seems that this State becomes responsible in a comprehensive way to health, “*lato sensu*”, that is, not only for treating diseases such as obesity, but also regarding their prevention—which is particularly true for chronic diseases. Such a prevention happens in a multidisciplinary way and involves wide aspects of Public Health Policies in developing countries, such as regulation of food legislations within the countries, control and periodic measurement of health problems associated with excess weight and also the need to build prospects on the natural history of the disease, its evolution among populations and to anticipate trends of its increase in prevalence [2] [3].

3. Government Power

In Brazil, the prevention of diseases historically have a repressive profile, such as past examples of successful eradication campaign of Yellow Fever in the first decades of the 20th century, commanded by the Researcher Oswaldo Cruz in Rio de Janeiro [4] [5], and also by the episode known as the “Vaccine Revolt”, in which citizens were unwilling to subjugate their personal health decisions to officers and authorities that worked very much apart of their realities, in distant government rooms [6] [7].

Nowadays excess weight affects more than 50% of the Brazilian population, and around 20% of the whole population has obesity [8]. These numbers are very close to other prevalence numbers in Latin America. A person affected by obesity has, according to many observational prevalence studies, a higher frequency of comorbidities such as diseases like hypertension and especially diabetes, which clearly involve higher health costs for the State [9]. A recent research regarding the costs of obesity in Brazil found an important increase in values spent by the Brazilian government, divided among the primary, secondary and tertiary health care levels [10]. Therefore it is important to understand that the reasons for the intervention of the State on health care do not simply imply the individual health—*i.e.*, a person’s health status—but there is also a strong economic interest of the State in the high amounts of money and investment involved in maintaining the health of its population as a whole, through the Unified Health System of Brazil, a.k.a. ‘SUS’, and involve a significant percentage of the national Gross Domestic Product of the country [11].

In addition to these aspects of national financial control, increasing state

intervention in the health of their fellow citizens is not unique to Brazil. The regulation of health in the world involves “biopower” mechanisms widely described in the literature, and has in Michel Foucault its most important exponent [12] [13]. Foucault describes in his works the processes through which citizen delegate to the state the task of organizing and “categorizing” people through biological characters as “healthy” or “not healthy”, and his work is essential to understand the historical process of public health control systems, along with Canguilhem, who described, more than 70 years ago, how the building of parameters of what is normal and which, instead, will become pathological, is the landmark of modern medicine and public health [14].

Other authors such as Esposito, Mahieu, Revel and Agamben have taken Foucault’s legacy far beyond his origins, assisting and deepening this understanding of the state control on the private health of citizens worldwide [15] [16] [17] [18] [19].

4. A Citizen’s Autonomy

Up to which extent does a person/a citizen has the autonomy to decide about his/her health status?

This is a current and relevant issue and possibly the core of this analysis. Bio-power has taken the empty positions of this process of “categorization” of citizens on behalf of their health, and the state acts in its own interest (not the citizen’s), perhaps as a “Leviathan”, frequently without taking into account the own individual view of each citizen [20]. In a certain sense, we return to the saga of John Landless in Britain, as the Magna Carta of England was issued, in the year of 1215, and for the first time in history a “right to due process” was registered, beginning a “Streit” between the citizen and the State for the control of societies [21].

Obesity as a disease is itself a definition that until recently was under strong questioning by representative bodies of the official health community, especially in the United States [22] [23]. Although WHO in the late twentieth century had already defined obesity as a disease (or health outcome) [24] and attributed it to an specific International Classification of Diseases (ICD) [25], the American Medical Society by 2012 had not yet developed a favorable consensus to define obesity as a disease [26]—which would lead to the need for the construction of public and private health policies towards its control and treatment—*i.e.*, more costs to finance “the war on obesity”. This key point is especially worth of attention, because the cost of obesity depends essentially that health plans (for the United States of America) and health authorities (for the rest of the world countries) recognize obesity as a disease, directly associated with other health problems, and this proven association as a strong evidence, through definitive scientific studies, would support health decisions and an increase in health financing [27] [28].

According to a report on Obesity issued by the American Medical Society in 2010, there were not so far enough scientific reasons to define obesity as a disease.

The reasoning for this was that although obesity was associated with other diseases among populations, in the individual this association was not entirely relevant or consistent [29]. As a matter of fact, the last 10 years have witnessed a controversy from studies describing the “Obesity Paradox”, which is an aspect of “protection” offered by some degree of excess weight, that was clear when patients had higher levels of obesity [30] [31]. This stood against the logic thought that there would be a linear association of the degree of obesity with the prevalence of comorbidities, most necessarily by the prevalence of diseases associated with overweight [32].

A work of 2013 entitled “*What’s wrong with fat?*” [33] made it clear that, individually, many American citizens were questioning their therapists about whether there would be a real risk of being overweight, when lifestyle to these same persons would be an individual choice to be exercised with autonomy, and not as a burden [34].

In fact, in a society oriented by liberal values such as the United States of America, where the intervention of the State over the individual is execrated and strongly repudiated [35], it is understandable that individuals will argue and oppose a possible health system in which decisions would be taken solely by “health authorities” and not by the individual [36].

A different reality occurs in Latin American societies, in which state intervention is usually more concrete [37] [38], and acts in conjunction with the initiatives of individuals, in order to possibly achieve balanced results between collective interest and individual plans [39] [40].

Such facts result from differences in historically diverse social values, not only influencing the organization of health systems in each country and culture, but also determining the consequences of such health systems for their individuals.

5. Unavailability of the Human Body

Since the Roman law there is a debate on the rights of personality, especially on the human body. At that time the body already belonged to the State. The figure of the “*habeas corpus*” was created in order to guarantee the right of freedom of the Roman citizen [41].

The influence of Roman law on our legal structure is undeniable and highly noticeable. Nowadays the ethical justification is questioned in specific situations such as in organ donations. However, as a general rule, the state defines the limits of the use of our body [42].

This debate is directly related to the topic of our thesis. The autonomy of the individual to decide their health behaviors, and body weight levels compatible with the welfare and the choices of each person are faced with ideals defined by statistical averages, that exclude from this definition the individual freedom and the choice to decide about what to do with his/her own body. Cosmetic procedures are allowed, according the current legal codes, but are considered exceptions to the general rule of unavailability of the body, and to the definition of reasonable and proper limits placed by health authorities. Bariatric surgery is

another example that deserves a deeper understanding of the right of a subject to modify his/her body and to modify it and to rebuild it fully, reducing the food absorption area, and on the right the surgeon, acting on behalf of the State and of health maintenance, to change physiology and to reset it, seeking weight loss and the pursuit of health ideals pursued by the State to its citizens and to citizens with themselves.

6. The “Functionings Approach”

The Brazilian researcher Maria Clara Dias [43], in her recent book “**The Functionings Approach**”, brings a new definition of what would be the basis of modern bioethics. In addition to the essential knowledge of justice built by Rawls, Dworkin, Amartya Sen and Martha Nussbaum, the Brazilian university professor builds an inclusive, comprehensive bioethical framework and covers current issues that had not been addressed by the earlier theories. In this sense, obesity is not analysed simply as an objective issue, defined by numbers and limits as usual, such as Dworkin and Rawls might have suggested, and not as a free individual choice, as it might be understood by the view of Amartya Sen or Nussbaum, but as an empirical and individual choice regarding the own body and its image, which would be based on the values and functionings of each individual, using the personal functional systems that each person has built for him/herself [44]-[49].

Thus, the ideal body and health status it would not be a state decision, but rather the result of the empirical analysis of the values of each person, in their specific context.

7. Intermediate Solution: “Nudge”

In the current medical literature the association between excess of weight and health problems in the general population is generally well established. The pathogenesis described for the obesity epidemic is multifactorial and involve especially 2 factors: 1) the food patterns that happened over the recent decades (a phenomenon also named “Nutritional Transition” and 2) the reduction in the levels of population mobility—physical inactivity, along with other reasons.

Would there a way of encouraging people to change their habits and to make better decisions for the development of healthier routines and choices more associated with healthy patterns?

“Behavioral Economics” studies show a way. Food choices, for instance, ARE strongly influenced the pattern of distribution of options in a restaurant. Placing fruits and vegetables at the beginning of a gondola of a restaurant, for example, increases the amount of consumption of such foods, considered healthier choices. On the opposite way, when placing pizzas and fried foods at the entrance, on the beginning of the available options, and moving apples and fruits to the end, a significant reduction in the choice of fruits happens, and a consequent increase in consumption of pizza and fried foods is measured. Shall public health policies suggest the distribution of food in public institutions, an improvement is quite

likely to occur, perhaps imperceptible by the individual, and especially not restricting his/her decisions and options—but rather “nudging”— with a possible significant impact on the health of the populations [50].

Policies to influence individuals on making healthier decisions with a positive impact on a personal level were initially tested at a Cafeteria of the Harvard University, and such an approach is extensively studied by the Law School of that University, to stimulate healthier habits and avoiding to influence in a repressive way on the freedom of choice.

It could be argued that the state would again be interfering in the decisions of individuals. But a strong argument is that such influences would be mild, and most importantly, positive to every citizen’s health, and not simply favorable to the State.

Applying public policies influences such as the “nudge” type to whole populations could be one of the fairest, effective and cheap available approaches towards overweight, respecting citizen’s choices and their right to choose according to the functionings approach. In Brazil, the creation of “gyms for older people” in neighborhoods and the installation of specific equipments for such vulnerable populations encourages the participation of them in such activities, and would be examples of how to positively influence people into making healthier decisions. It is a way to prevent highly frequent diseases in the elderly, such as hypertension and obesity [51].

We claim that respecting the decisions of the individual could be reconciled with the interests of the State.

8. Conclusions

Obesity is a disease characterized by excessive accumulation of body fat and involves a variety of environmental and genetic factors in its etiology. In recent decades there has been a “Nutritional Transition” that, associated with an increased sedentary lifestyle, resulted in the obesity epidemic. Excess weight is a risk factor associated with health outcomes, which in turn raises high costs for the State.

The implementation of public policies towards obesity is becoming increasingly necessary and discussed by authorities throughout the world. It is always advisable not to interfere in the autonomy of each individual, their body weight and health behaviors. In this context, policies based on the “nudge” principle are supposed to be the most appropriate and effective, respecting ethical theories such as the functionings approach. Through preserving freedom of choice and mildly inducing the individual to make healthier decisions, the interests of the state and of the people are met in building fairer obesity control policies. Thus, it is reasonable that such strategies could be implemented and, over time, adapted to the reality of each population and culture.

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