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Commentary

Ethical Standards to Guide the Development of Obesity Policies and Programs

Comment on "Ethical Agreement and Disagreement about Obesity Prevention Policy in the United States"

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Abstract

The recent report by Barnhill and King about obesity prevention policy raises important issues for discussion and analysis. In response, this article raises four points for further consideration. First, a distinction between equality and justice needs to be made and consistently maintained. Second, different theories of justice highlight one additional important source of disagreement about the ethical propriety of the proposed obesity prevention policies. Third, another point of contention arises with respect to different understandings of the principle of respect for autonomy due to its often-mistaken equation with simple, unfettered freedom. Finally, based on a more robust definition of autonomy, the key issues in obesity prevention policies can be suitably re-framed in terms of whether they advance just social conditions that enable people to realize human capabilities to the fullest extent possible.

Keywords

Obesity Prevention, Public Health Ethics, Autonomy, Positive and Negative Liberty, Equality, Justice, Capabilities

The article by Barnhill and King on ethical agreement and disagreement about obesity prevention policy in the US (1) offers an insightful analysis of the underlying sources of confusion, tension and conflict that arise in setting ethical standards for obesity policies and programs. The issue of obesity prevention is timely and salient, and it is important to conduct careful normative analyses of such policies as they raise distinct ethical concerns relative to other public health prevention goals. Unlike the ethically acceptable restrictions to reduce and prevent cigarette smoking, for example, the justification for obesity prevention policies cannot rest squarely on the harm principle, i.e., the need to prevent adverse health consequences to others exposed to second-hand smoke. Although some have argued that obesity is "contagious" (2) because exposure promotes acceptance of the empirical norm of being overweight, the various policies now under consideration are more clearly analogous to motorcycle helmet laws, where the primary goal is to prevent harms that individuals inflict on themselves. Barnhill and King argue that the issues raised by obesity prevention policies are most commonly cast, and can best be understood, in terms of achieving an ethically appropriate balance between the principles of autonomy and equality. In this Commentary, I raise several additional points for further consideration.

As Barnhill and King state, a number of new policy proposals, such as taxes on sugary drinks and banning the sale of large sugary drinks, have generated significant public controversy. In their analysis, Barnhill and King make two main points. First, they indicate that disagreements may arise over the relative weight that should be given to the principles of autonomy versus equality. Second, they explain that each principle contains multiple dimensions, which can result in further disagreements. For example, in debates about taxes on soda pop, not only is the issue a matter of balancing autonomy and equality, but additional disagreements may also arise internal to the principle of equality itself, such as achieving equality in health versus equality in income.

In response, I would like to bring up four points. The first issue is one of clarification. In the article, the authors equate equality with fairness and justice, and thereafter, use the terms interchangeably. The conflation of equality and justice, however, masks a critical distinction between inequality and inequity. Although the sheer existence of health disparities is widely invoked in popular calls for justice, differences in health status are due to many causes, only some of which can be considered unjust. Genetic diseases, for example, result in significant health disparities, but they are not within human power to control or the result of rectifiable social arrangements. Sickle-cell anemia is more prevalent in African and African-American populations, and while it is tragic, its distribution is not a matter of the justice of social conditions. Thus, it might be more apt to locate the central issue in analyses of public health prevention policies in tensions between the principles of justice and autonomy.

The preceding reformulation is important because there are critical differences in theories of justice that are lost when justice is equated with equality. In terms of justice, the driving force behind contentious debates about the provision of healthcare services in America today can be more fruitfully cast in terms of disputes between egalitarian theories of justice versus meritocratic theories, or theories of moral desert. In theories of justice based on moral desert, people get what they deserve: good people are rewarded and bad people punished

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(3,4). In light of these different theories of justice, one major source of disagreement lies in the degree to which individuals can and should be held morally accountable for their behavior. Differences in health status that are due to freely chosen behaviors may result in health inequalities, but they do not oblige society to act if they are indeed the result of the free and autonomous choices of the individual agent. From the perspective of moral desert, if someone gets sick or injured because they choose to engage in foolish and imprudent activities, then they are getting what they deserve and the result is not unjust. And there's the rub. At the heart of disagreements about what to do about obesity is the degree to which citizens believe that individuals have the capacity to make free and autonomous choices about what and how much they ingest, or whether such choices are significantly determined by one's position in the social structure, which leads to my third point.

Another major point of confusion and disagreement stems from the use and meaning of the term autonomy. Unfortunately, in popular accounts, autonomy is frequently equated with individual freedom, in particular, in the sense of freedom from external constraint, or what Berlin describes as negative liberty (5). As originally articulated by Mill (6), this view of liberty is deeply entrenched in American culture, and provides the bedrock foundation for claims that constraints on individual freedom are ethically warranted only when such actions cause harm to others. Policies that limit individual freedom for the benefit of the individual herself are quickly tarred with charges of paternalism (7). Before the effects of second-hand smoke were scientifically confirmed, policies to restrict smoking faced difficult challenges in the court of public opinion, but this sentiment quickly changed when proof of harm to others emerged. Obesity prevention policies now face a similar uphill battle, but the case for harm to others here rests on shaky grounds, with little prospect for solid scientific evidence emerging in the foreseeable future. Where public health advocates have gone wrong is in allowing the terms of the debate to be dictated by the facile equation of autonomy with negative liberty.

Following Dworkin, Frankfurt and others (8–10), freedom can be thought of the absence of restrictions to act on first-order desires, i.e., whatever urges one happens to feel in the moment. In contrast, autonomy is the ability to formulate and act on the second-order desires; it is the capacity to choose to act on felt first-order desires or not, based on values about the kind of person one aims to be and the life plans one seeks to achieve. Based on this definition, mounting evidence indicates that the exercise of autonomy is strongly associated with positive health; Wilkinson in fact argues that it is the most powerful factor in determining individual health status (11,12). From this perspective, debates about whether soda pop taxes infringe on autonomy are a red herring, irrelevant to larger questions of reducing health disparities and improving the overall health of the population. The problem is not that people have too much autonomy, it is that they do not have enough, or more precisely, that its current distribution is grossly unfair, in the ethically relevant meaning of the principle.

Extending the point, Sen has mounted trenchant critiques of the Rawlsian principle of fair equality of opportunity, arguing that such opportunities are cruel fictions when many options are foreclosed or delimited by the effects of poverty, inferior education, racism, disproportionate exposure to environmental toxins (e.g., cockroaches as asthma triggers, lead paint in low income housing, etc.), and other similar accidents of birth (13).[1] As a result, socially identifiable segments of the population cannot exercise the same degree of autonomy as those who occupy other more affluent positions in the social structure. In contrast, under the conditions of what Sen terms "substantive freedom", socially valued capabilities need to be fairly distributed first in order for people to exercise autonomy as it relates to the more important issue of the capacity to pursue worthwhile, rewarding and respect worthy life plans. In this light, it is clear that those segments of the population that can exercise the greatest degree of autonomy choose not to smoke, to watch their weight, stay physically active, and so on, whether or not the level of taxes on soda pop is raised or large sizes banned.

In conclusion, the primary ethical concern in analyzing various obesity prevention policies should be their impact on the least well-off segments of society. This concern must be seen in the context of questions about whether the obesity epidemic is destined to follow in the footsteps of smoking epidemic, where virtually identical policies have aggravated health disparities and further stigmatized the afflicted. Taxing soda pop and banning the sale of larger (and hence cheaper) soda pop containers are inherently regressive, and rationalizations that these policies are being enacted in the name of justice deeply flawed and misleading. Telling poor people what they can or cannot buy with food stamps is insulting, another assault on the dignity of those who have already suffered most. While many have lamented the priority given to the right over the good in the modern era (14), the high level of interest in Sen's capabilities approach and Dworkin's expositions of luck egalitarianism suggest that the field of public health recognizes that "health" is an inherently value-laden term (15–20), and hence, it is time to make the normative issues of justice and autonomy more central and explicit to achieving the goals of public health. As Dawson and Verweij note (21), the shift could "open up a rich discussion about the kind of society we want to live in."

Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests.

Author's contribution

DB is the single author of the manuscript.

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1. A familiar example of this line of thinking may be found in the justification for social programs like Head Start. There is widespread acknowledgement that students from vastly disparate social backgrounds cannot be said to have the same opportunity to succeed in school, and hence, society must compensate for evident deficiencies in order to bring everyone up to an equal starting line.

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