Obesity Prevention: A Responsive Communitarian Approach (Part 1)

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by Amitai Etzioni

Editor’s Note: This is the first installment of a two-part post by Amitai Etzioni examining the nation’s anti-obesity policies through the lens of a responsive communitarian philosophy. Today, Etzioni lays out a responsive communitarian framework and uses it to diagnose the problems with our current methods of fighting obesity. Tomorrow [1], Etzioni describes how these current policies should be refocused. Julia Milton contributed research assistance to this post.

For more on obesity, see the March issue of [2] Health Affairs [2], a thematic volume on child obesity.

The problem and suggested treatments. Obesity is defined [3] by the Centers for Disease Control and Prevention as a condition in which a person has a body mass index (BMI) of 30 or higher (having a BMI between 25 and 30 is classified as overweight). Thirty-four percent of American adults qualified as obese in 2006, according to the CDC, more than double the 1980 rate of 15 percent. Two-thirds of Americans are obese or overweight.

To treat this “obesity epidemic,” health experts and elected official have focused on the promotion of "lifestyle" changes, in particular encouraging people to take in fewer calories (mainly by dieting) and burn off more (by increased exercising). Some policies have focused on education and sharing information, including media campaigns, warnings from the public health authorities and medical professionals, Michelle Obama’s “Let's Move” campaign against childhood obesity, and state and local nutritional labeling requirements for restaurants and stores. The 2010 health care bill will soon require all restaurant chains with 20 or more outlets to display nutritional information on their menus.

Some policies go further. Various public agencies and private corporations have introduced measures that seek to provide financial incentives to those who reduce their weight, and to levy penalties on those who do not. Companies such as Safeway that run their own insurance programs grant up to 20 percent reductions in premiums as “bonuses” to employees who meet certain health standards, which include [4] having what is considered a healthy BMI.

Alabama penalizes obese state workers through increased health insurance premiums, and North Carolina does it through moving obese employees to health care plans that cover less of their costs. (For an overview of employers’ and employees’ attitudes towards obesity-prevention programs, see Jon Gabel and...
coauthors’ “Obesity and the Workplace: Current Programs and Attitudes Among Employers and Employees,” in *Health Affairs.*

Still other policies feed into and magnify social norms that are critical of people who are obese and favorable toward those who are not.

**Criteria for assessment: a responsive communitarian approach.** A responsive communitarian approach to assessing obesity reduction policies falls between two extreme positions. At one extreme is a radical libertarian position that allows only the sharing of information. From this perspective, people who are obese damage themselves. If they prefer to ignore the relevant health information, even if this leads to a shorter and less healthy life, that is their problem, not the government’s.

If one points to the public costs of obesity, especially to the health care costs not absorbed by the individuals involved, a libertarian approach suggests that that we should eliminate public health insurance and allow insurance companies to charge different rates, so that the costs of one person’s obesity will not be imposed on others.

At the opposite extreme is authoritarian communitarianism of the kind found in East Asian societies like Singapore and Malaysia. It fully supports a whole array of incentives, disincentives, social pressures, and even coercive measures. According to this kind of communitarianism, obese people impose heavy costs on the community, and hence it is legitimate to induce them to reduce these costs.

The intermediary position of responsive communitarianism takes as its starting point that we face two major normative claims—that of autonomy and that of the social good—and that neither a priori trumps the other. We hence need to find criteria that will help determine when public policy should tilt in one direction or the other.

**The example of privacy protection.** To briefly illustrate this approach, I draw on a public policy domain other than public health—that of privacy protection. Libertarians tend to hold that privacy is sacrosanct. If there are conditions in which it can be set aside, the burden of proof is on those who seek to so act, say, for the sake of national security. Authoritarian communitarians hold that the common good requires surveillance and insists the burden of proof is on those who hold that there are areas in which privacy should prevail.

A responsive communitarian suggests that, given that both privacy and public safety have a strong normative standing, we must find ways to determine which should take precedent under what conditions. Because changing public policies, individual habits, and norms as a rule have considerable human, economic, and political costs, changes should be introduced only if there are compelling reasons. and the status quo is sufficiently damaging. The 2001 attack on the American homeland met this criterion. Whether or not the rise in obesity also does is explored below.

A second criterion is to determine the relative costs to one core element of a good society imposed by enhancing the other. Thus, a minor intrusion into privacy for the sake of great gains in security can be much more readily justified than major
intrusions into privacy for the sake of minor security gains. We shall see that this criterion greatly helps in assessing drives to curb obesity.

Combining these two criteria suggests the merit of an autonomy/social good index. The best score on such an index would be accorded to policies that promote a great deal of social good while generating little to no intrusion, and the lowest score to policies with the opposite profile.

A third criterion is derived from a key sociological observation that many interventions have antagonistic side effects. The extent to which these side effects can be ameliorated impacts the standing of the policies at issue. For instance, in assessing the merit of fostering HIV testing, which has personal and public merit, the question is to what extent the confidentiality of the results (that is, privacy) is protected to prevent loss of jobs and insurance and other antagonistic side effects. A similar challenge, we shall see, is faced by obesity reduction policies.

**Is rising obesity a significant problem? (Criterion I).** In the case of obesity, a relatively strong case has been made that it leads to serious health risks. Obesity is associated with increased risk of heart disease, stroke, hypertension, high cholesterol, liver and gallbladder disease, endocrine disorders, sleep apnea, and osteoarthritis, as well as kidney disease and diabetes. It has been demonstrated to decrease life expectancy by approximately five to seven years.

Obesity also generates considerable public costs. In 2006, U.S. medical spending on obese people exceeded spending on their not obese counterparts by $1,429, or 42 percent, and obesity-related medical spending reached as much as $147 billion a year in 2008. In 2006, treatment for obesity-related conditions accounted for 8.5 percent of Medicare spending and 11.8 of Medicaid spending. By 2030, obesity-related health care costs could range from $860 billion to $956 billion annually.

In short, the overwhelming consensus is that obesity is a serious and rising problem. By this criterion, a major public policy drive to curb obesity is fully justified.

**The intrusion/social good balance (Criterion II).** The fact that there is a major problem by itself provides only a partial justification for intervention. The next question that responsive communitarians must face is the extent of intrusion compared to the benefits gained. It turns out that as far as obesity is concerned, major interventions that focus on changing lifestyles generate rather limited benefits. Robust data leave little doubt that most people are unable to lose significant amounts of weight and maintain the loss.

Moreover, a very large number of discussions about the value of lower body mass confute data about benefits of “naturally” low (pre-dieting) BMI — about which there is much data — with the benefits of lowering one’s BMI. It is much less clear that those relative few who significantly lower their body mass and keep it low gain the same benefits that ‘naturally’ lower body mass confers. There are data which show that even relatively small weight losses are highly beneficial for those at risk for or afflicted with type 2 diabetes, but the correlation between other illnesses and BMI is often less clear and more complicated because various intermediary variables are involved.
While the gains to personal and social good are limited, the intrusion is considerable. However, this intrusion is not due to strong government interventions of the kind found in other areas (for instance, polices that outright ban smoking in public spaces). Intrusion here results from social pressures on obese people and discrimination against them, which inadvertently are fueled by obesity reduction public health campaigns, and from the great efforts required by the individuals involved — and the professionals who seek to counsel them — to change their lifestyles. Not only do most fail after considerable effort and expenditure, but maintaining a healthy body mass for those whose “set” mass is higher is a lifelong struggle.

The high level of effort required stands out when it is compared to other changes that also promote health, such as reducing consumption of salt and red meat, and increasing sunscreen use and medication compliance. In addition, there are economic costs. Americans spend $40 billion per year \[20\] on weight loss programs and products. And health care professionals spend some of their scarce time on weight counseling.

In short, by this criterion the obesity reduction policies under consideration score rather unfavorably. We shall see that this observation does not lead one to suggest that these policies should be abandoned, but only that they should be greatly refocused.

**Side effects: do no harm (Criterion III).** Obesity reduction policies that focus on reducing caloric intake are particularly problematic because as a side effect, they often generate behaviors that have ill effects on a significant number of the people involved. There is relatively little data on the subject, arguably because the suggestion that dieting causes harm flies in the face of the preoccupation with urging people to lose weight. Data that are available do show that many people, especially women and girls, engage in various unhealthy behaviors in order to lose weight. Data that are available do show that many people, especially women and girls, engage in various unhealthy behaviors in order to lose weight [21], including following unhealthy fad diets and abusing laxatives, or taking dangerous medications such as “phen-fen [22].’” People who yo-yo diet [23], a behavior in which they lose weight and regain it several times over, are subject to increased risks for high blood pressure, high cholesterol, gallbladder disease, and other health problems.

Eating disorders like anorexia, bulimia, and binge eating disorder may not be directly caused by cultural pressures to lower one’s BMI, but they seem to occur much more frequently [24] in societies and periods in which lower body mass is strongly promoted. In addition, psychological factors [25] should be considered. These include lower self esteem, guilt, and a higher risk for clinical depression which are unwittingly propelled by the obesity reduction campaigns.

In addition, obesity reduction campaigns feed into the stigmatization of and discrimination against people with a high body mass. By and large, a communitarian would look favorably on relying on norms and informal social controls, rather than on coercion and pressures, to foster behavior change. Changes in norms lead to changes in preferences, which lead to voluntary compliance and content individuals. By contrast, coercive and economic inducements at best leave a residue of alienation and at worst promote the search for ways to persist in the preferred behavior and still avoid the penalties or gain the rewards. The great success of preventing
smoking in public and encouraging people to pick up after their dogs are notable cases-in-point of changing behavioral norms.

In the case of obesity, however, the norm is already quite powerful and the social pressures are already rather strong. Forty-three percent of overweight and obese people report that they experienced weight bias from their employers or supervisors. More than two-thirds of obese and overweight people (69 percent) report that they had experienced bias by doctors. Many obese people report that physicians often blame their symptoms on their weight, and are reluctant to treat them because of their weight. Thirty-one percent of nurses stated that they would prefer not to care for obese patients, and twenty-four percent agreed that obese patients “repulsed” them. Forty-three percent of teachers agreed with the statement that “most people feel uncomfortable when they associate with obese people.” Teachers have lower expectations for their overweight students.

In addition obesity reduction policies tend to reinforce and exacerbate the stigmatization of people with a high BMI. Obese people are viewed as “lazy, less competent, and lacking in self-discipline” by their co-workers. Overweight people earn up to six percent less than their non-overweight colleagues (which, incidentally, means that increases in their premiums will have an even greater financial impact) and get fewer promotions. There is “consistent evidence of weight discrimination at virtually every state of the employment cycle, including career counseling, selection, placement, compensation, promotion, discipline, and discharge.” If such discrimination against the obese is legitimized in the form of additional financial penalties written into insurance policies, it will only become more persistent.

Furthermore, many obesity reduction policies have a disproportionate effect on the poor and minorities. A letter to the Senate signed by 46 organizations, including the American Heart Association, the American Cancer Society, and the American Diabetes Association, argued that insurance penalties would negatively impact lower-income families who need the coverage most. Such policies ignore the fact that many poor people do not have access to the resources that would enable them to make healthy lifestyle changes. Low-income neighborhoods have fewer supermarkets that carry healthy food, and the healthy food those stores do carry is stocked in smaller quantities and is of poorer quality than at stores in higher-income neighborhoods. Also, healthy food is significantly more expensive than junk food. A 2,000-calorie-per-day diet consisting entirely of junk food costs $3.52 a day, while the same number of calories in healthier food would cost $36.32 per day, according to one study.

There is no ready way to nullify these side effects. They add to the doubts raised by the ways obesity reduction policies are focused.

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[5] Obesity and the Workplace: Current Programs and Attitudes Among Employers and Employees:
http://content.healthaffairs.org/cgi/content/abstract/28/1/46
[7] East Asian societies like Singapore and Malaysia:
[8] responsive communitarianism:
http://www.gwu.edu/~icps/RCP%20text.html
[9] we face two major normative claims:
[13] diabetes:
[14] decrease life expectancy:
http://www.annals.org/content/138/1/24.abstract
[15] U.S. medical spending on obese people:
http://content.healthaffairs.org/cgi/content/abstract/28/5/w822
[17] conflate data: http://healthaffairs.org/blogdata
http://us.macmillan.com/rethinkingthin
[18] highly beneficial for those at risk for or afflicted with type 2 diabetes:
http://content.nejm.org/cgi/content/abstract/346/6/393
[19] less clear and more complicated: http://jama.ama-assn.org/cgi/content/full/293/15/1861
[20] Americans spend $40 billion per year:
http://www.businessweek.com/debateroom/archives/2008/01/the_diet_indust.html
[21] engage in various unhealthy behaviors in order to lose weight:
[22] phen-fen:
[23] People who yo-yo diet:
http://win.niddk.nih.gov/publications/cycling.htm
[24] occur much more frequently:
http://www.nytimes.com/2010/01/10/magazine/10psyche-t.html
[26] experienced weight bias:
http://www.nature.com/oby/journal/v14/n10/pdf/oby2006208a.pdf
[27] blame their symptoms on their weight, and are reluctant to treat them:
http://us.macmillan.com/rethinkingthin
[28] prefer not to care for obese patients:
http://www.yaleruddcenter.org/resources/upload/docs/what/bias/Weigh
[29] Teachers have lower expectations:
[30] earn up to six percent less:
http://ideas.repec.org/a/wly/hlthec/v13y2004i9p885-899.html
[31] consistent evidence of weight discrimination:
http://philpapers.org/rec/ROEWDI
[32] A letter to the Senate:
[33] fewer supermarkets that carry healthy food:
http://yaleruddcenter.org/resources/upload/docs/what/reports/RuddRep
ortAccessoHealthyFoods2008.pdf
[34] healthy food is significantly more expensive than junk food:
http://www.adajournal.org/article/PIIS0002822307018007/abstract