Equity and Health Care: The Case of Obesity

John D. Blum, Loyola University, Chicago, U.S

Abstract: **Changes in lifestyles and increased consumption of unhealthy foods have fueled a global epidemic in obesity which in turn is triggering the development and spread of chronic illnesses. As such, government health policy makers must factor obesity and weight related diseases into an ever expanding array of public health challenges. This essay concerns how legal equities are achieved by governments faced with the need to prioritize resources in addressing obesity matters. The article centers on the application of a basic, elemental health right in reference to weight related illnesses at the micro level, and recommends a corollary obligation by government at the macro level. The primary argument presented is that individual health rights are enhanced by developing basic standards both in guiding, and measuring the performance of public authorities in allocating resources in the obesity arena, as well as in other public health priority making contexts.**

Key Words: **Obesity, public health, constitutional law, right to health, resource allocation, government responsibility.**

1. INTRODUCTION

Meeting obligations in health care presents difficult challenges for governments around the globe, as they are forced to balance individual and public needs with tresource constraints. While limitations in public capacities may be overcome in part, by vision and creativity, ultimately some type of rationing is a reality in virtually every public health system. Resource allocation in health care is particularly challenging as this area stands at the convergence of persistent and evolving demands impacted by a host of primary and secondary variables (i.e. disease, demographics, culture, and politics). The need to set priorities forces health policy makers to appreciate the role of law in public health development and implementation. This essay concerns how legal principles impact health decision making in the context of the recent epidemic in obesity, a strange disease in terms of human history, but like other diseases, one layered with complexities and dire consequences. In general terms, this piece considers broader questions of equity in the manner in which public authorities allocate limited resources to meet the demands of the obesity epidemic. Specifically the article will examine how resource limitations are affected by a constitutional right to health, and how those considerations

maybe impacted through the adoption of a defined governmental obligation in public health, using obesity as the context. The framework of analysis will be drawn from an American and Western concept of constitutional law, but the discussion will be generic in nature and applicable to legal systems across borders.

2. OBSERVATIONS ON OBESITY

According to the World Watch Institute, it is estimated that the global overweight population has surged to 1.1 billion, now comparable to the globe's underfed population. While the growing list of statistics concerning human weight must be viewed cautiously, the trend lines are clear, namely individuals across the world are markedly heavier than in the past, and as a consequence the rates of related chronic illnesses are growing. In 2003, the International Obesity Taskforce identified every region in the world as being at risk for fat related illnesses. The WHO estimates that there 20 million people whose weight exceeds a body mass index of 25, making them overweight, and that there are 3 million individuals on the planet who can be classified as obese, with a body mass index over 30. Though both diet related conditions, being overweight and obese, place individuals at risk for chronic health problems, it is the condition of obesity that is of greatest concern. Obese individuals face the prospects of premature death, as the condition results in diseases such as Type 2 diabetes, cancers and cardiovascular illness. While serious at any age, obesity is particularly alarming when it affects children, impacting developmental capacities and sparking chronic illnesses at early ages, resulting in shortened life spans.

Studies of the causes of obesity have uncovered a myriad of complex, interrelated elements, from wide scale availability of less healthy foodstuffs, to poverty, urbanization and changes in lifestyles, with markedly less physical activity. Coupled with the growing awareness of the causative factors is an expanding scientific appreciation of the psychological complexities of this condition, making a simple solution to the problem unrealistic. The increases in national obesity rates generate cost concerns in economic terms, as well as in relationship to the years of disability, reducing the quality of life, as well as life expectancy. In reference to disability adjusted life years (dalys) a higher body mass index accounts for 16% of the burden of disease. The economic strains placed on individual country health systems attributable to obesity are troubling. The WHO

projects that China could lose $558 billion dollars during the next ten years due to chronic illness attributable to diet, and in the United States the cost of extra fat comes in at $93 billion, 9 percent of the national medical bill.

Governments around the world have adopted a range of approaches to deal with the increase in weight related

disorders. At macro levels, health policy makers have developed strategies targeting weight related illnesses, including traditional health education measures, exercise programs, food labeling, as well as measures directed at food product pricing and agriculture policies. On an individual treatment level a range of possible approaches exists inclusive of diet and exercise, behavioral and drug therapies, and even surgery. Personal weight related treatment measures drive questions of efficacy and effectiveness, and translate not only into broad health policy concerns, but raise specific insurance coverage issues for individuals. Whatever approaches are pursued at population and individual levels to prevent excessive weight gain ,and deal with resultant illnesses, they must be balanced against the realities of resources and the range of other obligations confronted by governments.

3. INDIVIDUAL RIGHTS TO COLLECTIVE RESPONSIBILITY

Turning to a legal focus on equity and law in the obesity context, the most apparent point of departure concerns the application of constitutional right law principles to this area. While not unique to weight related illness, a constitutional rights perspective is built around an argument that the state can neither ignore, nor under treat individuals, suffering from illnesses spawned by obesity, based upon the existence of a personal right to health. Many nations around the world have constitutions which on their face provide their citizens a basic, general, legal right to health, often being more of an aspiration than a firm principle. Purposely, a foundational right to health may be limited in the language of a particular constitution. For example, a narrower health right can be found in Bulgaria's Constitution, article 52, where a right to health is delineated as a right to health insurance and conditional free care, as well as an obligation of the state to promote public health. In other instances, the right to health has been created by judicial interpretations, based on the spirit of the constitution in question, as a jurisprudential construction of the sum total of related rights. In South Africa, a right to health emerges from a combination of rights to life, dignity, bodily/psychological integrity and privacy. Interestingly enough, although the United States spends more resources than any nation in the world on health, it has no constitutional right to health, but rather individuals claiming elemental health rights must resort to arguments based on matters of status or procedure in given contexts.

No doubt, the existence of a constitutionally explicit or structured right to health is compelling from legal and policy perspectives, and can be a lever to compel government responses to meet individual needs. But constitutional rights which restrain government activities that infringe on life, liberty or property are easier to apply than those which mandate

affirmative activities particularly those requiring significant resource expenditures. Where a right to health emerges from a generic(or limited) constitutional health obligation, or a judicial construct, that right may be viewed as weak or overly vague, and subject to limitations. Even if the hand of the state is compelled by constitutional law to act, such a mandate will be conditioned, and likely subjected to resource compromises, as is evident in major court decisions in the area. In the South African case of Soobramoney v. Minister of Health Kwazulu-Natal, the Constitutional Court took the position that a social-economic right, such as health, was resource dependent, and that the right itself is constricted in its application by funding availability. The Canadian Supreme Court in Auton v. British Columbia recognized a fundamental right of Canadians to core health services, but ruled that the Canadian Charter of Rights wasn't violated by a province's refusal to fund certain services. In the United States in Harris v. McRae, its Supreme Court has recognized an individual liberty interest in allowing a woman to choose an abortion, but also has ruled that government is under no obligation to fund this procedure.

In terms of public policy, however, a more developed constitutional right to health could serve as a basis to develop normative principles that have social value beyond individual entitlement questions. Equitable priority setting process in areas such as obesity would be enhanced if constitutional rights conceptions were expanded beyond ones that are focused on individual need. A new, broader formulation of the right to health, building on a floor of individual liberties, should move foundational human right concepts into articulated government health mandates. As such, the focal points of the right to health could become twofold, one pillar resting on the individual, and the second pillar, of equal importance, resting on the duties of the state. Thus, a reframed rights construct in the context of obesity would place emphasis not just on the specific services an individual suffering resultant chronic illnesses is entitled to, but be fundamentally inclusive of legal obligations of government in addressing population health matters regarding weight related diseases.

While the jurisprudential mandate compelling state obligation emerges from the same point of constitutional origin as the individual's right to health, the legal responsibility on the part of government is a distinct, logical corollary to a personal entitlement. Simply put, if health is a personal right, it is government which must promote such right, as a matter of basic constitutional obligation. Clearly this framework doesn't diminish the resource allocation issue as the government mandate for health is still locked into the realities of resource constraint. But the focus of an expanded, constitutionally based health duty, rests on development

of workable processes that meet a threshold of rationality, and are tailored broadly to the problem in question (namely obesity). The individual right to health of citizens suffering from obesity related illnesses can't be ignored, but the community based focus on the public health needs of the overweight becomes an equally fundamental point of obligation and inquiry.

The issue of how governments should make decisions that are equitable, and procedurally appropriate, is one characterized by considerable precedent. A model that may be drawn on comes out of the widely applied 1905 American Supreme Court case of Jacobson v. Massachusetts which evaluates state legislation in public health based on four factors; need, appropriateness, balance and harm avoidance. The Jacobson model and variations of it, are used frequently as a guide for determining the constitutionality of government health actions, and could easily be reapplied as a fourfold template to direct governmental behavior in meeting state public health obligations.

While the elements noted in Jacobson developed to evaluate government conduct in the exercise of state power are helpful, they are better related to evaluation of a specific policy, rather than setting a current foundation for achieving broad, public equity. In this regard four other basic principles should be considered to add a second foundational element to the individual health right. First, government actions in dealing with major public health matters such as obesity must be directed to the largest number of its citizens who will benefit the most from given interventions. Secondly, conditioning the first element, a government health mandate should require a particular obligation to assist those who are least able to help themselves, namely the poor and underserved. Third, health policy makers must develop a reasonable scheme for addressing public health issues that utilizes decision making methodologies, which are empirically based and applied in a rigorous manner. Related to the need for sound decision making is the fourth element in this scheme, the need for transparency in decision making, so that the public , and if need be, the courts, are clear about how a government authority applied the previous three elements in this list. The four elements noted (decision making for the broadest affected public, special focus on the poor and underserved, empirically based actions and transparency) all operate in the shadow of resource restraint, but collectively help achieve equities in government decision making, and likely would meet the dictates of constitutional muster in most nations.

In regards to obesity, the duty of government would be first to coalesce its activities around the largest population groups affected by weight related illnesses. This does not mean to suggest that numbers alone should drive health policy, but "greatest good for the greatest number"

should be an important consideration in advancing a public health right jurisprudence. Government approaches to obesity may require that the "greatest good' is achieved by focusing on childhood obesity issues in order to forestall the development of costly, life shortening chronic illnesses. In essence health mandates aren't driven just by raw numbers, but rather must be directed at the largest population groups for which interventions are most meaningful. The resource issues in obesity illnesses are complex, as they must be calculated in immediate and long term ways, and undoubtedly needs in this area will outweigh capacity. Tragically the epidemic in obesity impacts the poor disproportionately, often who are forced to consume cheap, unhealthy foods, and as poor people live in the cross currents of so many other health problems, the combined effects of weight related illnesses may be dire. Equity demands that governments have an obligation to protect the interests of the most vulnerable, so a key element in an expanded public health legal mandate must be a special duty to serve the poor and underserved.

The third requirement, application of sound methodology to decision making, lies at the heart of the rationing process in dealing with obesity (and other public health problems). The constitutionally recognized obligation on the part of governments to set priorities must reflect current science, and be able to withstand rigorous assessment. No doubt, problems concerning weight related illnesses, both in prevention and treatment, are complex and unfolding, subject to variable approaches. Still, the right to health should be developed in such a manner as to require government health policy makers to adopt standards that are both current and measureable. Lastly, in order for governments to meet their public health obligations, they must do so in a manner that is discernable, open for all to examine, and as such, transparent. While paternalism is certainly rooted in the fabric of government science policy, a fundamental sense of human rights in health requires a level of accountability that forces policy makers to be forthright about how their respective positions were developed and implemented.

4. CONCLUDING THOUGHTS

It can be argued that the individual right to health is not only fragile, but in all too many parts of the world ill defined or non-existent. To build on the weak right to health by bifurcating it into a dual concept of individual and community may only tend to further dissipate whatever limited potential this reed of jurispru dence contains. While such an argument is understandable, the core idea presented in this essay is built on the notion that the current right to health focused on the individual, vital as it may be, inherently is limited by the realities of resource. Health becomes a more vibrant right when it is approached

fundamentally, as both a matter of entitlement and commensurate public obligation. Foundational law must be developed to both require and guide government actors in a manner that enhances public responsibilities in health and assists in crafting workable policies. The four elements noted, broad population focus, emphasis on the poor and underserved, empirical soundness, and transparency, provide a floor for guiding government health mandates and this proposed expansion of law may be a mechanism for achieving fairness in priority setting. Obesity presents a timely context in which to explore current and evolving right concepts and expansion of the elemental right to health, as it is sadly a mirror of current and future public health complexities where the needs for equity are, and will continue to, be most compelling.

REFERENCES

1. Auton v. British Columbia, 3 S.C.R. 675 (2004).

2. Jay Bhattacharya, Neeraj, "Health Insurance, Obesity and its Economic Costs" Economic research Services, USDA, E-FAN-)4-004.

Constitution of Bulgaria, Art. 52.

3. Dardinger v. Anthem Blue Cross 98 Ohio St.3d 77 (2002) – A good example of the types of insurance coverage cases seen in the United States.

4. Mathew Herper, "The Hidden Cost of Obesity" Forbes, July 24, 2006.

5. Harris v. McRae, 448 U.S. 297 (1980).

6. Jacobson v. Massachusetts, 197 U.S. 11(1905).

7. Timothy S.Jost, "The Tenuous Nature of the Medicaid Entitlement" Health Affairs, vol.22 no. 1 (2003) 145-153. In the United States claims for specific insurance coverage of health are often brought as actions that rest on entitlement obligations or on breach of the contract terms of a given health insurance policy. Both entitlement and contract breach are highly anecdotal, and fail to establish a necessary floor for human rights that can be achieved in the constitutional and broader legislative arenas.

International Association for the Study of Obesity, "International Obesity taskforce", lasted visited May 4, 2008. found at http://www.iotf.org.

8. Eleanor D. Kinney, Brian A. Clark, " Provisions for Health and Healthcare in the Constitutions of Countries of the World" 37 Cornell International law Journal 285 (2004).

Legislature of the State of Idaho, House Bill No. 708, A Bill to Require Coverage of Morbid Obesity" (2004)

Mayo Clinic, "Bariatric Surgery "last visited May 4, 2008, found at http://www.mayoclinic.org/bariatric.surgery.

9. Wendy McElroy, "Obesity is Personal, Not Public Health Problem" FoxNews.Com, May 4, 2005.

Soobramoney v. Minister of Health, KwaZulu-Natal, 1998 (1) SA 430(D).

Universal Declaration of Human Rights, Art 25.1,1948. World Watch Institute,"Chronic Hunger and Obesity Epidemic Eroding Global Progress", last visited may 4, 2008, found at http://www.worldwatch.org/node/1672.

John D. Blum, a U.S. citizen, is the John J. Waldron Research Professor of Health Law and Policy at Loyola University Chicago. Professor Blum holds a BA from Canisius College, a J.D. from Notre Dame Law School and an SM from the Harvard School of Public Health. He has been a member of the Loyola faculty since 1986 and was the founding director of Loyola's Beazley Institute for Health Law and Policy http://www.luc.edu/healthlaw. . His research focuses on health regulation and health policy in the U.S., as well as in other national contexts.