5.8 Case 2: Obesity Prevention in Children: Media Campaigns, Stigma, and Ethics

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5.8.1 Background

Worldwide obesity has doubled since 1980 and kills some 2.8 million adults each year (World Health Organization [WHO] 2012). Childhood obesity also has increased at alarming rates with some 42 million children estimated to be overweight (WHO 2013). Among Organisation for Economic Cooperation and Development (OECD) countries, the United States has the highest rate of obesity (OECD 2012). More than 35 % of adults and almost 17 % of children are obese (Ogden et al. 2012), with especially high rates among poor and minority children (Centers for Disease Control and Prevention [CDC] 2012).

Childhood obesity has serious short- and long-term health consequences. Obese children are more likely to have risk factors for cardiovascular disease, including high cholesterol and blood pressure; type 2 diabetes; skeletal problems; sleep apnea; and mental health issues, such as low self-esteem and depression (CDC 2012; Reilly et al. 2003). Children now account for half of all new cases of type 2 diabetes. Obese children are also subject to systematic discrimination (Strauss 2002). More than 50 % of overweight children become obese adults who experience elevated health risks for heart disease, stroke, diabetes, osteoporosis, lower-body disability, some types of cancer, and premature mortality (Freedman 2011; CDC 2012).

The burdens of obesity are also economic. Rising health care costs are mostly driven by obesity-related costs. Estimates indicate that in 2008 some 10 % of medical spending in the United States was related to obesity, amounting to as much as $147 billion (Finkelstein et al. 2009). Experts estimate obesity-related costs will account for 21 % of medical spending by 2018 if obesity rates continue to rise (United Health Foundation 2009).

As the human and financial costs of obesity have become better recognized, government officials and public health leaders increasingly have called for strong action. Comprehensive approaches that act on environmental and social determi-

nants of food choice and activity level are widely recommended (OECD 2012). The complexity of such an approach is reflected in the following recommended policies and strategies: taxing unhealthy foods and beverages, such as soda and snack food, to make them cost prohibitive; providing agricultural subsidies to lower the cost of healthy foods, such as fresh produce and whole grains; setting standards to lower sodium levels and prohibit the use of trans fatty acids in food products; banning unhealthy foods from public schools and child care facilities; restricting or banning the advertising of unhealthy foods to children; posting calorie counts on restaurant and take-out menus; using "counter-advertising" to show the harmful effects of unhealthy foods; redesigning communities and streets to incorporate parks, sidewalks, and bike paths; and reducing sedentary behavior by limiting time viewing television and playing computer games (Frieden et al. 2010; Butland et al. 2007).

Children's status as developing agents further complicates childhood obesity prevention. Parents have primary responsibility for rearing children and considerable discretion over cultural and lifestyle matters, including many daily decisions that directly affect a child's food and activity-related environments and behaviors (Blacksher 2008). Some measures would likely confer benefit regardless of parental behavior (e.g., banning food advertising to children or removing trans fats from packaged foods). But others will have their intended effect only if parents make certain choices, some of which will require that they change their health-related habits.

Many preventive measures will be controversial because they involve government action and seek to shape personal choice. Perhaps the least controversial of the measures enable healthier choices by providing people with information and making healthy options more available and affordable; however, many are more coercive, ranging from those that eliminate and restrict choice to those that guide choice through disincentives and default policies (Nuffield Council on Bioethics 2007). Intervening in voluntary choices where effects impose no harm to others constitutes strong paternalism and is difficult though not impossible to justify (Childress et al. 2002). However, society may justifiably intervene to prohibit behaviors that expose others to serious harms, and this "harm principle" has been appealed to as the basis for removing children from homes where parental practices are judged to contribute to severe childhood obesity and attendant comorbidities (Murtagh and Ludwig 2011). Removing a child from the home poses other potential harms, further complicating the ethical dilemma (Black and Elliott 2011). These ethical considerations in combination with the difficulty of changing health habits makes obesity prevention one of the more challenging public health priorities of the twenty-first century.

5.8.2 Case Description

Your state is the poorest in the nation with high rates of childhood poverty, obesity, and diabetes. Located in the southeastern part of the United States in what is known as the "stroke belt," adults disproportionately suffer from stroke and its risk factors—hypertension, high cholesterol, diabetes, and obesity. As the state's new commissioner of health, the governor has tasked you with making obesity prevention a public health priority. The governor is concerned about public health and rising health care costs. More than 50 % of the state's children and some 20 % of adults are enrolled in Medicaid (a federal-state program that provides health care services for low-income Americans), making it the largest item in the state budget.

The governor has requested that you convene and chair a 12-member task force to make recommendations for a statewide obesity prevention strategy. Six seats are reserved for state legislator appointees because the recommendations will need political support to be implemented. The other seats are reserved for public health, health care, and community representatives. For several months, task force members debated measures that eliminate or restrict adult choice through government action, such as taxes and bans on unhealthy foods and drinks. Those who favored such measures argued they would be the most effective, citing the success of tobacco taxes and smoking bans in reducing smoking, and could be justified on grounds that obesity-related costs constitute an economic harm to others (Pearson and Lieber 2009). Yet, many task force members, particularly elected representatives, found such measures objectionable forms of government intrusion into adult choices.

Task force members did, however, agree to tackle obesity prevention in children on grounds that the state has a role in protecting them. To that end, they endorsed measures to improve school lunches and to remove vending machines that sell soda and other sugary beverages from public school grounds. Task force members also wanted to invest in a statewide media campaign about the causes and harms of childhood obesity because they believed it would raise awareness and promote informed choices. They also thought a media campaign would help to change social norms, which they deemed essential to long-term change in their state, where fried and fatty foods are part of the cultural heritage.

Task force members cannot, however, agree on the orientation of such a campaign. Some favor an approach used by a nearby state that has attracted attention for its graphic depiction of obese and unhappy children accompanied by hard-hitting messages, such as "It's hard to be a little girl if you're not." Opponents believe the campaign blames the victims and further stigmatizes obese children. They propose instead an approach that highlights environmental barriers to healthy choices and depicts unhealthy food as the culprit, not those who consume it. But proponents of the more hard-hitting approach say it is honest about the facts and highlights the essential role of parents in regulating children's behavior. To support their case, they cite the use of similarly graphic media campaigns in tobacco cessation efforts and note that public health efforts have often relied on stigma as a tool of disease prevention, despite the controversy (Bayer 2008; Burris 2008). The task force has formulated a series of questions to take up at the next meeting.

5.8.3 *Discussion Questions*

1. What harms are associated with childhood obesity?
2. Are the harms of obesity and tobacco use analogous? Is the economic cost of obesity a harm to others in the same way that secondhand smoke is a harm to others?
3. Do public media campaigns that depict images of obese children stigmatize them? What is stigma?
4. Is it ever ethically permissible to use stigmatization as a tool of disease prevention and health promotion? If so, in what sort of cases? Should children ever be the targets of stigmatization?
5. Do public media campaigns that highlight the role of parents in regulating children's food and activity-related environments and choices blame the victims?
6. Should the task force consider gathering community input, particularly from people who are overweight or obese, about the sorts of messages they would find effective in changing their health habits and also find ethically acceptable? If so, should children be included in these focus groups? If so, at what age?

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