



Health care, lifestyle and individual responsibility: a perverse blend? The case of obesity.

Ignas Devisch, Gent University & University College Artevelde Hogeschool

1. Introduction

There seems to be a growing importance of lifestyle in society and in health care in particular, which crystallizes in the contemporary interest for healthy food and physical fitness. Go to a supermarket and look around: innumerable products are promoted because of their healthy ingredients, be it to downsize our cholesterol, be it to upgrade our natural resistance. Also politics, health insurance and private insurance companies are more and more promoting mass sports, fitness and a healthy lifestyle.¹ In many countries a healthy lifestyle also is or is expected to become a criterion in obtaining healthcare services.² As we most of the time understand lifestyle as a merely individual matter, what then could be the consequences for health care if it would be a key principle in allocating health care services? If we

consider the individual as autonomous and regard the way he lives as his own free choice, would it therefore not be 'logical' to hold the patient as personally responsible to live healthy, in order to get insured or to maintain entrance to training programs or healthcare facilities? And if the individual would be unwilling to change his risky behavior, could he then also no longer appeal to health care services? In this text, we want to consider the possible consequences for a future health care based on the premise that lifestyle makes an integral part of health care and is considered as merely an individual matter. Although the premise is very logical, we want to ask ourselves the question what it would have to exclude, in order to be 'logic'? It is of course hard to predict future evolutions, but it is our objective to anticipate a possible and plausible evolution: the growing impact of individual conduct in health care. It is philosophically as well as ethically relevant to hypothesize about this problem, rather than to wait until the premise is widely accepted and then simply fine tune its logic.

We will illustrate the philosophical relevance of these questions with the case of obesity. In many countries, debates are going on about the responsibility of the individual for his own life and thus also for his obesity.³ If lifestyle is often a crucial factor in the treatment of obese patients, would it then not be reasonable to expect health care allocation to be based on it? Do we not have to assume that 'lifestyle will be an issue' in future health care?⁴

To pick up only one question: if for instance obese patients would fail to continue their training programs after intragastric balloon treatment, should they still be financially compensated for their 'bad behavior'? Or should we simply 'force them to diet'?⁵ Since as soon as we think about healthcare, scarcity of budgets are on our side. The question how to allocate healthcare and set priority rules, is not only inevitable, it is crucial for the way we relate healthcare to justice or equality and this also counts for the case of obesity. Which criteria are stipulated to allocate the limited health care means? Whose responsibilities are we talking about?

2. Lifestyle

2.1. Individualism

Economically as well as politically, individualism is the cornerstone of our times. In many areas, be it education, family matters or relationships, the individual is the reference point and it would be most surprising if this would change in the nearby future. It is today all about what I want to choose in my life conform my norms and principles. From the very beginning till the end of my life, I am expected to develop my life as I see it and no one should interfere with my personal choices, unless I ask someone to do so. As I prefer this car and that house, I choose the way I live and with whom I want to share it with. At first sight, this evolution seems only positive. Who can be opposed to more freedom and autonomy, if of course we prefer, from a political point of view, a liberal democracy upon a totalitarian regime? Nevertheless, the growing impact of individualism has many negative side effects as well. Let us for instance think about responsibility. If I am the sole director of my life, I might be the only one to blame if something goes wrong.⁶ In contrast with the revolutionary spirit of the sixties where inequalities between people were caused by 'the system', today, the individual is often the only actor left to blame if something goes wrong in his life. The active welfare state offers me chances and opportunities, but if I am 'unwilling' to make use of these opportunities, I and not the system will be held responsible for this. As Robert Veatch argued earlier in his *Transplantation ethics*, if one is free to engage in risky behaviors, one must be prepared to take the consequences (Veatch, 2000: 315).⁷ As such, individual responsibility is valuable, but the question is how we deal with it. We want to choose our own life and create our personal style autonomously, but are we really doing this? To what degree is e.g. lifestyle an autonomous and deliberate choice? Do not overestimate the ability and capability of individuals to make their genuine choices? Or in the particular case of obesity, since obesity is dramatically increasing today in industrialized countries, did we consciously choose one by one and all together to eat too much and practice less? Is the individual then the main responsible actor in this context or do we have to nuance this point of view? In the next paragraph, we argue why we need a thorough analysis of this complex problem.

2.2. Socialization and market principles

There are many structural reasons why obesity is a symptom of our times and not just a consequence of my or your risk behavior. Although we are familiar with most of them, let us discuss them schematically, because we need them further on in our analysis.

First of all, commercials and food advertisements are trying to seduce us all the time to consume their products.⁸ The food industry persists to get a grip on our food habits and tastes with food supplements, etcetera. These food habits are often unhealthy, because most food multinationals are in particular distributing fat and sweet food.⁹ This economic context is more than just a footnote in the debate on lifestyle, it is a crucial element. Obesity is especially a problem of contemporary society. Everywhere on the street, you can drink coke or eat burgers, an incentive which cannot be overestimated.¹⁰ Children or other vulnerable groups in society, are sometimes 'defenseless' in not giving in to the advertisements or the availability of junk food.¹¹ Since 'bad' food is everywhere, many of us find it hard to resist.

Therefore, among other facts, we eat more due to the fact that we are always in the possibility of eating and, most of all, of eating unhealthy food.

Secondly, many of us are not doing any physical activity at all and thus expend less energy than in the past, while we should just practice more since we ingest lot of energy. This is not simply because we are weak or unwilling to practice sports or to have any physical activity. A lot of structural facts are directing our behavior. Our jobs have evolved from physically intense to sedentary. During working hours, many of us do not even have the chance to consume energy. On top of that, the way people commute between home and office or school also changed dramatically in many western countries. In Belgium for instance, many children are brought by car by their parents to school, often because traffic is too dangerous for children (partially caused by the cars of parents driving their children to school)? Further on, often the environment does not offer us much chances for physical activity: no parks, no walking zones, etcetera.

This brings us to the third structural aspect in the analysis of obesity, i.e., the aspect of socialization. It is common sense that the food choices are strictly personally, but do we, as an individual, really choose what we eat? There are many reasons to doubt this. The point is not that we do not choose on our own and thus would not be responsible for our choices. Of course, the individual is responsible for his

choices, but the question is what makes us choose what we choose? Or to put it bluntly: is the choice for our food a well informed and deliberate choice?¹² Besides differences in taste and the complex matter of how we develop taste, the choice of what is on your plate is never just your own. If parents use a pile of butter on every piece of bread their baby devours, the taste or at least the weight of the baby will be influenced by this. As Eli Feiring writes: "It is hard to identify any action that is not partly determined by circumstance understood as the social contexts in which the individual finds herself or her traits of character (included the ability to choose)" (Feiring, 2008: 34). Next to that, there is at least a shared responsibility of society and economy, for co-organizing the style of our life as it is. It is of course the individual who makes his or her own choices, but the context within he or she can choose is not chosen.

3. The responsibility for lifestyle

Although holding the individual solely responsible for his lifestyle, sounds good and politically correct, it is simply not 'evidence based'. It is simply not obvious what it means that someone may reasonably be held personally responsible for his actions. Since scientific research on inherited aspects of e.g. obesity is only at the beginning, we cannot exclude that there are genetic or other non-intentional components involved.¹³ This may also count for other lifestyle-related topics like alcoholism or physical activity. Next to that, there might be good reasons to at least consider the fact that the consequences of being unable to make the right choices or to eat in a more or less disciplined matter, could therefore also be seen as a medical problem, and not only as a problem of individual responsibility or morality. If we think about lifestyle and its role in future health care, the question is therefore: how can we all share responsibility for the contribution of lifestyle to health?

The debate on the responsibility for lifestyle and health is pertinent and urgent. *The World Health Organization* (WHO) has ciphered that an unhealthy lifestyle generates most of the risk factors of disease.¹⁴ Health has everything to do with our style of living and if we strive for the promotion of health, we should deal with lifestyle. Making the public responsible for health is crucial in the prevention of many diseases related to lifestyle. If lifestyle changes can be settled we will not only be healthier, but health care will save a lot of money that can be spent elsewhere.

If we talk about responsibility for lifestyle and the future of health care, the question is not only where does the responsibility of the patient and that of other instances start; it is also a matter of which kind of responsibility we lean on. Dependent on the concept of responsibility, a wide variety of principles of a 'just and fair allocation' of healthcare, can be distilled.¹⁵ Given the basic objective of this paper, namely to hypothesize the impact of lifestyle in future health care, we will consider the question of responsibility by taking obesity as a case study. Within the huge variety of principles, we will consider what the treatment of obesity could look like if we distinguish two different types of responsibility: a 'looking-backward' or a 'looking-forward' responsibility (Feiring, 2008).

3.1. The pre-patient period

Let us start with the backward-looking responsibility. This principle leans on the idea that an individual is personally responsible for the choices he could make in his life, including his lifestyle-options. If I choose to smoke or not, to drink or not to eat fat or light food, I am responsible for it. Since health care resources are limited, priority could be given to these people who did not make irresponsible (read: unhealthy) choices in their 'pre-patient' period.¹⁶

This idea not only presupposes a well informed subject which can freely and deliberately choose between the several options of every decision in his life. The stance taken here is highly idealistic, if not simply unrealistic. Consider the case of weight-related issues like obesity and one can imagine how tough it would be to defend this starting point. Not only am I not informed about all the food I am consuming or is there the possibility of perceiving wrong information. Many commercials e.g. are set up to mislead us by over accentuating the presence of one substance in a product (contains 'omega 3'). It is highly speculative to suppose that we deliberately choose every bit of food we eat. And of course, also other determinates are highly relevant for obesity or weight-related diseases.¹⁷ In short, it is problematic to draw a line between what 'choices' and what 'circumstances' are.

How then can this principle be the basis for allocating health care? Next to that, to guarantee the informedness of the patient in his pre-patient period presupposes a highly dense network of knowledge distribution with a closed guarantee that everyone is indeed well informed. Otherwise, you can never

rely upon it if you want to pinpoint the responsibility of the patient for his lifestyle, once he enters health care.

Theoretically, it can and maybe should be the goal of public health to allow individuals to make informed choices about their health, whether they will take care of their health or not. Then, one could argue, the patient can never complain about his lack of information and thus is he responsible for his choices; consequently, his demand for health care assistance could be refused if he behaved 'irresponsible', or he could be asked to pay more than the responsible patient. But again, this presupposes that a patient is autonomously responsible for his health and lifestyle. As Civaner and Arda argue:

"Although this argument may be valid, it is nevertheless unsound, because its first premise is based on wrong information. It is now widely accepted that people's health is influenced by more factors than just their life-style. Indeed, it is well established that health is determined to a large extent by factors such as living conditions and familial environment, type of employment, access to food, quality of the health care services available and received, hereditary determinants, level of education, and social class. Taking all this into account, it becomes less easy to hold anyone responsible for becoming ill because they have failed to take proper care of their health. It is very difficult, if not impossible, for people who do not have access to the necessary nutritional resources, or for those who do not live in adequate housing, to be able to take sufficient care of their health" (Civaner and Arda, 2008: 267).

If patients have only limited control over their lifestyle or living conditions, it is unjustified to make them personally and solely responsible for this. If our actions are determined by internal and external factors and if it is very hard to draw a clear line between these two, then we have a strong argument against looking-backward responsibility. Next to that, the looking-backward principle can be a slippery slope: where does the individual responsibility stop? Am I responsible for drinking, smoking, or also for other aspects of my behavior? Could e.g. a doctor refuse surgery to a cyclist who cycled without his hands on

his handlebars? Could a hospital refuse patients who fell asleep in their cars because they are overworked? Although these examples are a bit extreme, they consequently apply the principle of backward-looking responsibility.

3.2. The care for the future self

The principle of forward-looking responsibility leans on the idea that once a patient enters health care, he will be well informed about his condition, about the causes of his disease and the future choices he can make to improve his health condition. If these conditions are fulfilled – and it takes a complex organization of health care to do this – then an important argument against looking-backward responsibility does not count here, since the question now becomes how to make future choices in a deliberate and well informed way, rather than punishing someone for making the wrong choices in the past. So we do not have to debate whether the patient is informed or not. However, not all arguments against looking-backward are countered by looking-forward. On the contrary, most arguments are still valid since the social circumstances or societal and economical conditions will not be changed by informing a patient. Although the principle of forward-looking responsibility might become an important instrument in future health care, we should therefore discuss it in a broader context.

4. Responsibility and capabilities

One of the aspects of the definition of health promotion in the charter of Ottawa of 1986, repeated in the charter of Bangkok of 2005 is “the process of enabling people to increase control over their health and its promotion.”¹⁸ This process engages a perspective, broader than the debate on rights and responsibilities. This debate leaves e.g. out of sight whether changing the societal and economic conditions would not have a more positive effect on health than holding the individual more and more responsible; or also the question how people can be empowered to increase control over their health?

In fact, the question is not whether we are responsible or not. We cannot but be responsible for our own life. Not only our entire moral system is based on it, the whole of society leans on the idea that every individual, to a certain degree, is responsible for what he did and does. No court could exist without this principle. As long as there is no alternative, this is one of society's cornerstones. But, as in a court room, we must not forget that there can be 'extenuating circumstances' which might decrease the personal responsibility (we are explicitly not talking about 'guilt') or embed certain actions or choices into their social context.

If we really want people to become healthier, and we assume that no public health system is so cynical not to want this, taking into account this broader context seems inevitable. The most urgent question is then how to 'empower' the forward-looking responsibility with other principles or supportive mechanisms, instead of moralizing or punishing the individual's behavior. Of course, we are the ones who decide to eat, to smoke, to drink, but we do not decide in a social vacuum. Depending on the social contexts or circumstances, depending on the 'we' it is embedded, the 'I' decides differently.

An interesting concept to apply in this context comes from the economist Amartya Sen. In many of his studies since the 1980's, Sen does not talk about equality of chances or equality of rights, but of equality of *capabilities*.¹⁹ Sen defines capability as the ability a person has to achieve desired states of being, such as being well-nourished, healthy, happy, and having an adequate quality of life.²⁰ Since Sen started his research on it, capabilities are widely discussed in different areas and health is one of them. Also Sen himself writes in 'Why health equity?':

"What is particularly serious as an injustice is the lack of opportunity that some may have to achieve good health because of inadequate social arrangements, as opposed to, say, a personal decision not to worry about health in particular. In this sense, an illness that is unprevented and untreated for social reasons (because of, say, poverty or the overwhelming force of a community-based epidemic), rather than out of personal choice (such as smoking or other risky behaviour by adults), has a particularly negative relevance to social justice. This calls for the further distinction between health achievement and the capability to achieve good health

(which may or may not be exercised). This is, in some cases, an important distinction, but in most situations, health achievement tends to be a good guide to the underlying capabilities, since we tend to give priority to good health when we have the real opportunity to choose (indeed even smoking and other addictive behaviour can also be seen in terms of a generated 'unfreedom' to conquer the habit, raising issues of psychological influences on capability – a subject I shall not address here)" (Sen, 2002: 660).

In this quote, Sen offers us a strong argument in looking beyond moralizing risky behavior: the 'unfreedom' to conquer habits and thus being incapable of making the 'right' choices. The question here is not how to punish the risky behavior of the (obese) individual, but how to improve the capability of this person. Inspired by Sen, Joshua Cohen writes more or less the same:

"The capabilities approach stresses that society should guarantee each individual's freedom to choose those functionings that are essential to survival and a minimally adequate quality of life, within the limits set by each individual's inherited health characteristics. Disease and disability threaten an individual's freedom to choose "basic" (healthrelated) functionings, possibly resulting in her inability to pursue life plans consistent with her naturally endowed health characteristics. Successful healthcare treatment can restore individuals to at least the range of basic functionings they would have had without disease and disability. But, in order to get the necessary treatment, individuals must have access to healthcare services." (Cohen, 2000: 393).

Quite similar to Sen's and Cohen's approach is what Buchanan writes in 'Autonomy, paternalism, and justice: ethical priorities'. Public health, he writes, should promote autonomy and therefore make an effort in clarifying principles of justice, instead of looking for arguments to override autonomy. Buchanan argues that looking for justifications to support paternalistic interventions, is misguided, empirically and ethically: ethically because autonomy is the fundamental precondition of moral agency, it provides the link between principles of justice and free human beings; empirically because people with the least

amount of autonomy, have the poorest health. Unhealthy living habits are strongly predicted by growing up and living in poverty (Buchanan, 2008: 18). Public health should therefore promote autonomy, not restrict it. To achieve equality in health, not only should social inequalities be eliminated, we must ensure that people have adequate opportunities to achieve good health.

5. Conclusion

Imagine that lifestyle is indeed an autonomous, conscious choice and that therefore obese patients are responsible for their habit, what about it? This would still not answer unambiguously the question whether we should treat these people differently. As Holm suggests, what about the non-obese-related instances of negative health effect of personal choice, should we then not treat them in the same way? (Holm, 2007: 209). As long as we are unable (or unwilling) to do this, is it not rational to conclude that many parties are responsible in the case of obesity and that it would indeed be a perverse blend to hold only one party responsible for it, as an inevitable implication of consequent individualism?

Secondly, food and physical activity are more than aspects of my health. They make an integral part of my sense of well being as a person, individually as well as socially. The medical look at food and physical activity leaves out of sight many important values of our lives which are related to our food patterns and social behavior. We should not make the mistake to limit ourselves to fine tune the logic of how exactly the individual is responsible. If we only keep on talking about the responsibility of the individual for his own life and thus also his obesity, we will leave many other possible premises out of sight. The objective of this paper was to draw our attention to that.

Thirdly, many basic questions remain unsolved today. Is for instance health an objective or a subjective value and is obesity a medical problem? Of course, it would be irrational to deny the medical problems of obesity. They are massive and we have to handle them. But the risk of medicalizing every aspect of our life, is high. Until today, we also do not know for sure the causes of obesity and their intertwining: there is only minor conclusive evidence in what way exactly obesity has to do with more energy intake or only less physical activity ²¹; and in Europe there is even no agreement on what is unhealthy food? (Matthews, 2008: 10). Why then act as if we are sure about the problem of obesity, its causes and its

consequences? Is it not tendentious to allocate a priori the responsibility for something which is not even well defined? It is what Neil McLaughlin in 'Stop blaming the patient' calls "our ignorance about health":

"While we know for sure that quitting smoking is a good thing, we can't apply such certainty to much else. The public is battered by contradictory studies on what's good or bad for you. Did you think you should lose some pounds? A recent study suggested that being slightly overweight can extend your life. Did your doctor tell you to lower your "bad" cholesterol? A new and disappointing examination of a cholesterol-lowering drug is making a lot of researchers think that might not be a good approach. (So we have wasted billions on such drugs?) Some physicians used to say drinking alcohol was bad; now a little may be good. Butter was bad; now we're told trans fats are as bad or worse. Dermatologists have long preached that you should avoid the sun lest you get skin cancer; now some researchers think indoor living and sunscreen-slathering have caused widespread vitamin D deficiencies, leading to more breast and prostate cancer and high blood pressure, among other ills. Just last week, a new study contradicted a study from the previous week that said aggressive lowering of blood sugar could be harmful to diabetics" (Mc Laughlin, 2008: 25).

To conclude, we want to plead for a broad framework from which to handle the question of lifestyle in general and that of obesity in particular. By narrowing the field of intervention in advance, the fundamental options are too easily taken for granted. There is today much ado about evidence based medicine, but if the fundamental options on which we base our evidence, can be picked at random, dependent on the mainstream ideas of the time, it would be much ado about nothing.

References

- Adams, C. (2007). Reframing the Obesity Debate: McDonald's Role May Surprise You. *The Journal of Law, Medicine & Ethics*, 35(1), 154-157.
- Anand, S., Peter, F., & Sen, A. K. (2004). *Public health, ethics, and equity*: Oxford university press.

Arribas-Ayllon, M., Sarangi, S., & Clarke, A. (2008). Managing self-responsibility through other-oriented blame: Family accounts of genetic testing. *Social Science & Medicine*, 66(7), 1521-1532.

Astrup, A., Bovy, M. W. L., Nackenhorst, K., & Popova, A. E. (2006). Food for thought or thought for food? - A stakeholder dialogue around the role of the snacking industry in addressing the obesity epidemic. *Obesity Reviews*, 7(3), 303-312.

Backett-Milburn, K. C., Wills, W. J., Gregory, S., & Lawton, J. (2006). Making sense of eating, weight and risk in the early teenage years: Views and concerns of parents in poorer socio-economic circumstances. *Social Science and Medicine*, 63(3), 624-635.

Biddle, S. J. H., & Mutrie, N. (2001). *Psychology of Physical Activity*
London, Routledge.

Blair, S. N. (1996). How much physical activity should we do? The case for moderate amounts and intensities of physical activity. *Research Quarterly for Exercise & Sport*, 67, 193-205.

Bray, G. A., York, B., & DeLany, J. (1992). A survey of the opinions of obesity experts on the causes and treatment of obesity. *American Journal of Clinical Nutrition*, 55(1), 151Sb-154.

Brudney, D. (2007). Are Alcoholics Less Deserving of Liver Transplants? *Hastings Center Report*, 37(1), 41-48.

Buchanan David, R. (2008). Autonomy, Paternalism, and Justice: Ethical Priorities in Public Health. *American Journal of Public Health*, 98(1), 15-21.

Civaner, M., & Arda, B. (2008). Do Patients Have Responsibilities in a Free-Market System? a Personal Perspective. *Nursing Ethics*, 15(2), 263-273.

Cohen, J. (2000). Patient Autonomy and Social Fairness. *Cambridge Quarterly of Healthcare Ethics*, 9(3), 391-399.

Cosner Jr, L. (2008). Lifestyle is an issue. *Modern Healthcare*, 38(13), 21-21.

Davey, R. C., & Stanton, R. (2004). The obesity epidemic: too much food for thought? *British Journal of Sports Medicine*, 38(3), 360-363.

Elfhag, K., & Rossner, S. (2005). Who succeeds in maintaining weight loss? A conceptual review of factors associated with weight loss maintenance and weight regain. *Obesity Reviews*, 6(1), 67-85.

- Erens, R., & Primatesta, P. (1999). Health Survey for England: London: HMSO.
- Fahlquist, J. N. (2006). Responsibility ascriptions and public health problems. *Journal of Public Health*, 14(1), 15-19.
- Feiring, E. (2008). Lifestyle, responsibility and justice. *Journal of Medical Ethics*, 34(1), 33-36.
- Finkelstein, E., A., & Trogon Justin, G. (2008). Public Health Interventions for Addressing Childhood Overweight: Analysis of the Business Case. *American Journal of Public Health*, 98(3), 411-415.
- Giordano, S. (2008). Should we force the obese to diet? *Journal of medical ethics : journal of the Society for the study of medical ethics*, 34(5), 319-319.
- Giordano, S. (2008). Should we force the obese to diet? *Journal of Medical Ethics*, 34(5), 319-320.
- Green, F., & Lord, J. (1994). Evaluation of scheme exists in Stockport. *British Medical Journal*, 309, 872-873.
- Hammond, J. M., Brodie, D. A., & Bundred, P. E. (1997). Exercise on prescription: guidelines for health professionals. *Health Promotion International*, 12(1), 33-41.
- Hardman, A. E., & Stensel, D. J. (2003). *Physical Activity and Health: The Evidence Explained* London: Routledge.
- Harris, J. (1999). Justice and Equal Opportunities in Health Care. *Bioethics*, 13(5), 392.
- Hawe, P., Degeling, D., & Hall, J. (1990). *Evaluating Health Promotion* London, MacLennan & Petty.
- Hawks, S. R., & Gast, J. A. (2000). The Ethics of Promoting Weight Loss. *Healthy Weight Journal*, 14(2), 25.
- Hesketh, K., Waters, E., Green, J., Salmon, L., & Williams, J. (2005). Healthy eating, activity and obesity prevention: a qualitative study of parent and child perceptions in Australia. *Health Promotion International*, 20(1), 19-26.
- Hilbert, A., Ried, J., Schneider, D., Juttner, C., Sosna, M., Dabrock, P., et al. (2007). Primäre Prävention der Adipositas bei Erwachsenen
Primary Prevention of Adult Obesity. An Interdisciplinary Analysis. *Herz - Kardiovaskuläre Erkrankungen*, 32(7), 542-552.

Hill, J. O., Peters J.C., Catenacci, V.A., Wyatt, H.R. (2008). International strategies to address obesity. *Obesity Reviews*, 9(Suppl.), 41-47.

Hillsdon, M., Foster, C., Cavill, N., Crombie, H., & Naidoo, B. (2005). *The Effectiveness of Public Health Interventions for Increasing Physical Activity among Adults: A Review of Reviews*. London: Health Development Agency.

Hillsdon, M., & Thorogood, M. (1996). A systematic review of physical activity promotion strategies. *British Journal of Sports Medicine*, 30, 84-89.

Holm, S. (2007). Obesity interventions and ethics. *Obesity Reviews*, 8(s1), 207-210.

Hunt, P., & Hillsdon, M. (1996). *Changing Eating and Exercise Behaviour*. Oxford, Blackwell.

Jallinoja, P., Absetz, P., Kuronen, R., Nissinen, A., Talja, M., Uutela, A., et al. (2007). The dilemma of patient responsibility for lifestyle change: Perceptions among primary care physicians and nurses. *Scandinavian Journal of Primary Health Care*, 25(4), 244-249.

Julian, S. (1998). Consequentialism, Reasons, Value and Justice. *Bioethics*, 12(3), 212-.

Kotzampassi, K., & Shrewsbury, A. D. (2008). Intra-gastric Balloon: Ethics, Medical Need and Cosmetics. *Digestive Diseases*, 26(1), 45-48.

Loughlan, C., & Mutrie, N. (1995). Conducting an exercise consultation: Guidelines for health professionals. *Journal of the Institute of Health Education*, 33, 78-82.

Marcus, B. H., & Forsyth, L. H. (2003). *Motivating People to be Physically Active*. Champaign, Ill, Human Kinetics.

Matthews, A. E. (2008). 'Children and obesity: a pan-European project examining the role of food marketing'. *Eur J Public Health*, 18(1), 7-11.

McCulloch, A. (2001). Social environments and health: cross sectional national survey. *BMJ: British Medical Journal*, 323(7306), 208-210.

McLaughlin, N. (2008/02/18). Stop blaming the patient. *Modern Healthcare*, 38(7), 1.

Minkler, M. (1999). Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century's End. *Health Education & Behavior*, 26(1), 121-141.

Muller, A., & Mackenbach (2002). Education, income inequality, and mortality: a multiple regression analysis. *BMJ: British Medical Journal*, 324(7328), 23-26.

Nestle, M. (2002). *Food politics. How the food industry influences nutrition and health*. Berkeley: University of California Press.

Nortvedt, P., Pedersen, R., GrÅ,the, K. H., Nordhaug, M., Kirkevold, M., SlettebÃ,, A., et al. (2008). Clinical prioritisations of healthcare for the aged-professional roles. *Journal of medical ethics : journal of the Society for the study of medical ethics*, 34(5), 332-335.

Perdue, W. C., Richards, E. P., & Acree, K. H. (2005). Legal Frameworks for Preventing Chronic Disease. *Journal of Law, Medicine & Ethics*, 33(4), 94-98.

Phillips, P. (2002). The rising cost of health care: can demand be reduced through more effective health promotion? *Journal of Evaluation in Clinical Practice*, 8(4), 415-419.

Reynolds, W. W., & Nelson, R. M. (2007). Risk perception and decision processes underlying informed consent to research participation. *Social Science and Medicine*, 65(10), 2105-2115.

Rhodes, R. (2005). *Justice in Medicine and Public Health*. *Cambridge Quarterly of Healthcare Ethics*, 14(01), 13-26.

Riddoch, C., Puig-Ribera, A., & Cooper, A. (1998). *Effectiveness of Physical Activity Promotion Schemes in Primary Care: A Review*. London: Health Education Authority.

Ried, J. (2008). Adipositasprävention zwischen Veranlagung und Verantwortung. *Obesity prevention between predisposition and personal responsibility*(03), 92-95.

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. *Analyzing Qualitative Data*, 173-194.

Robison, J., & Rogers, M. (1994). Adherence to exercise programmes. *Sports Med*, 17, 39-52.

Saguy, A. C., & Riley, K. W. (2005). Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity. *Journal of Health Politics, Policy & Law*, 30(5), 869-921.

Schmidt, H. (2007). *Personal Responsibility for Health â€” Developments Under the German Healthcare Reform 2007*

- Personal Responsibility for Health – Developments Under the German Healthcare Reform 2007. *European Journal of Health Law*, 14(3), 241-250.
- Sen, A. (1980). Equality of what? In S. McMurrin (Ed.), *Tanner Lectures on Human Values*. Salt Lake City: Cambridge University Press
- Sen, A. (2002). Health: perception versus observation. *BMJ: British Medical Journal*, 324(7342), 860-862.
- Sen, A. (2002). Why health equity? *Health Economics*, 11(8), 659-666.
- Sen, A. K. (1999). *Development as freedom*: Oxford university press.
- Sen, A. K. (2000). *Freedom, rationality and social choice*: Oxford university press.
- Sen, A. K. (2002). *Rationality and freedom*: Belknap press of Harvard university press.
- Sen, A. K. (2003). *On ethics and economics*: Blackwell.
- Simpson, R. W., Shaw, J. E., & Zimmet, P. Z. (2003). The prevention of type 2 diabetes - lifestyle change or pharmacotherapy? A challenge for the 21st century. *Diabetes Research and Clinical Practice*, 59(3), 165-180.
- Stott, N. C. H., & Pill, R. M. (1990). Advise Yes, Dictate No. Subjects' views on health promotion in the consultation. *Family Practice*, 7, 125-131.
- Stubbs, C. O., Lee, Amanda, J (2004). The obesity epidemic: both energy intake and physical activity contribute. *The medical journal of Australia*, 181(9).
- Syme, S. L. (1996). Rethinking disease: Where do we go from here? *Annals of Epidemiology*, 6(5), 463-468.
- Taylor, A. (2003). The role of primary care in promoting physical activity. *Perspectives on Health & Exercise*.
- Taylor, A. H., Doust, J., & Webborn, N. (1998). Randomised controlled trial to examine the effects of a GP exercise referral programme in Hailsham, East Sussex, on modifiable coronary heart disease risk factors. *J Epidemiol Comm Health*, 595-601.
- Vallgarda, S. (2001). Governing people's lives. *The European Journal of Public Health*, 11(4), 386-392.

van Hooren, R., Borne Bart, W. v. d., Curfs, L., & Widdershoven, G. (2007). Ethics of prevention: An interactive computer-tailored program. *Scandinavian Journal of Public Health*, 35(5), 503-509.

Veatch, R. M. (2000). *Transplantation ethics*. Washington: Georgetown University Press.

Warin, M., Turner, K., Moore, V., & Davies, M. (2008). Bodies, mothers and identities: rethinking obesity and the BMI. *Sociology of Health & Illness*, 30(1), 97-111.

Waxman, A. (2004). Why a global strategy on diet, physical activity and health? The growing burden of non-communicable diseases. *Public Health Nutrition*, 7(3).

Williams, B., & Sen, A. K. (1982). *Utilitarianism and beyond*: Cambridge university press.

Wormald, H., & Ingle, L. (2004). GP exercise referral schemes: Improving the patient's experience. *Health Ed J*, 63(4), 362-373.

Wormald, H., Waters, H., Sleep, M., & Ingle, L. (2006). Participants' perceptions of a lifestyle approach to promoting physical activity: targeting deprived communities in Kingston-Upon-Hull. *BMC Public Health*, 6(1), 202.

Wyatt, S., Winters, K., & Dubbert, P. (2006). Overweight and Obesity: Prevalence, Consequences, and Causes of a Growing Public Health Problem. *American Journal of the Medical Sciences*, 331(4), 166-174.

¹ The list of reports, studies and campaigns from political governments in Western Europe which aim to stimulate their citizens for physical activities and healthy food, is quite impressive. For example, if we look at the Netherlands from the end of the sixties until now, many large scale campaigns have been funded by the national government: 'Trim u fit' (1967), 'Sportreal' (1976), 'Sport, zelfs ik doe het' (1988) 'Flash' (2005). This list is only a selection; for further information see:

<http://www.minvws.nl/dossiers/sport/default.asp>.

² In Germany for instance, the 'law to strengthen competition among providers of statutory health-insurance scheme' from 1 april 2007 implicates that insured persons may no longer claim free treatment for complications arising from certain 'lifestyle choices' (Schmidt, 2007)

³ In Germany for instance, the ‘law to strengthen competition among providers of statutory health-insurance scheme’ from 1 April 2007 implicates that insured persons may no longer claim free treatment for complications arising from certain ‘lifestyle choices’ (Schmidt, 2007)

⁴ I’m referring at the letter of Lawrence Cosner ‘Lifestyle is an issue’. See (Cosner Jr, (2008).

⁵ See ‘Should we force the obese to diet?’ (Giordano, (2008).

⁶ Meredith Minkler gives a revealing illustration from the United States: “The 1996 –Welfare Reform Act, for example, which repealed America’s 60-year-old commitment to welfare entitlement for the poor, contained numerous undesired individual behaviors (such as becoming a teenage mother) and was in fact named the Personal Responsibility and Work Opportunity –Reconciliation Act” (Minkler, 1999: 128).

⁷ For a discussion of Veatch’s principle, see Daniel Brudney’s ‘Are alcoholics less deserving of liver transplants’ (Brudney, 2007).

⁸ As Meredith Minkler points out: “Americans not only are bombarded with advertisements for high-fat, high-calorie foods but consistently are provided large servings of such foods when they eat at most restaurants and fast-food establishments” (Minkler, 1999: 127-128).

⁹ See *Food politics. How the food industry influences nutrition and health* from Marion Nestle (University of California Press, 2002).

¹⁰ As Meredith Minkler wrote already in 1999: “Americans not only are bombarded with advertisements for high-fat, high-calorie foods but consistently are provided large servings of such of such foods when they eat at most restaurants and fast-food “ (Minkler, 1999: 127-128).

¹¹ See: ‘Children and Obesity: A Pan-European Project Examining the Role of Food Marketing’ (Matthews, 2008).

¹² See also ‘Obesity interventions and ethics’ (Holm, 2007).

¹³ As Sharon B. Wyatt and others write in ‘Overweight and obesity’: “Genetic predisposition increases susceptibility for weight gain and sets the parameters for body size but is rarely the sole cause of obesity. More than 20 genes have been discovered that may be linked to body fat in humans and chromosomal

sites of genes responsible for rare familial obesity syndromes have been identified. However, the exact mechanism by which these genes exert their pathophysiologic effects and their interaction with other environmental factors is unknown. The identification of these genes and exploration of candidate genes is an important avenue for future research regarding overweight and obesity" (Wyatt, 2006: 172).

¹⁴ World health organisation (2002). *The World health report: reducing risks, promoting healthy style*. Geneva: WHO, 1: "Most of the risk factors discussed in this report are strongly related to patterns of living, and particularly to consumption - where it can be a case of either too much or too little. At the other end of the scale from poverty lies "overnutrition" or, perhaps more accurately, "overconsumption"."

¹⁵ For a discussion of the tension in responsibility debates between efficiency concerns and moral concerns, see 'Responsibility ascriptions and public health problems' from Jessica Nihlèn Fahlquist (Fahlquist, 2006).

¹⁶ This expression stems from Murat Civaner and Berda Arda in their text 'Do patients have responsibilities in a free-market system? A personal perspective' (Civander and Arda, 2008: 266).

¹⁷ Backett-Milburn, K. C., W. J. Wills, S. Gregory, and J. Lawton. 'Making Sense of Eating, Weight and Risk in the Early Teenage Years: Views and Concerns of Parents in Poorer Socio-Economic Circumstances.' *Social Science and Medicine* 63, no. 3 (2006): 624-35; McCulloch A. Social environments and health: cross sectional national survey. *BMJ* 2001,323: 208-209; Muller A. Education, income inequality, and mortality: a multiple regression analysis. *BMJ* 2002; 324: 23-25. I discovered the last two references in (Civaner and Arda, 2008). See also (Holm, 2007).

¹⁸ See for further details : http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf and http://www.vig.be/content/pdf/ME_bangkokcharter_draft.pdf.

¹⁹ Anand, Sudhir, Fabienne Peter, and Amartya Kumar Sen. *Public Health, Ethics, and Equity*: Oxford university press, 2004. Sen, Amartya Kumar. *Development as Freedom*: Oxford university press, 1999; *Freedom, Rationality and Social Choice*: Oxford university press, 2000; *On Ethics and Economics, The Royer Lectures*: Blackwell, 2003; *Rationality and Freedom*: Belknap press of Harvard university press,

2002; Williams, Bernard, and Amartya Kumar Sen. *Utilitarianism and Beyond*: Cambridge university press, 1982.

²⁰ This is the description of Joshua Cohen in 'Patient Autonomy and Social Fairness' (Cohen, 2000: 393).

²¹ Christina Stubbs and Amanda Lee have argued in 'The obesity epidemic: both energy intake and physical activity contribute' that obesity is indeed a problem of at least both factors and not only of less physical activity. They conclude: "An increase in energy supply and consumption has made a major contribution to the obesity epidemic. It is probable that population physical activity level has also decreased, as both a cause and a consequence of the obesity epidemic" (Stubbs and Lee, 2004: 490).