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Perspective

Denial of Treatment to Obese Patients—the Wrong Policy on Personal Responsibility for Health

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Abstract

In many countries around the world, including Iran, obesity is reaching epidemic proportions. Doctors have recently taken, or expressed support for, an extreme 'personal responsibility for health' policy against obesity: refusing services to obese patients. This policy may initially seem to improve patients' incentives to fight obesity. But turning access to medical services into a benefit dependent on health improvement is bad policy. It conditions the very aid that patients need in order to become healthier on success in becoming healthier. Whatever else we may think of personal responsibility for health policies, this particular one is absurd. Unfortunately, quite a few personal responsibility for health policies use similar absurd conditioning. They mistakenly use as 'carrots' or 'sticks' for adherence the basic means to the same health outcomes that they seek to promote. This perspective proposes the following rule of thumb: *any conditional incentive for healthy choice should be in a currency other than the basic means to that healthy choice.*

Keywords

Obesity, Patient Compliance, Refusal to Treat, Health Promotion, Motivation

The global obesity epidemic

High body mass index (BMI) is now a greater global risk factor for mortality and morbidity than childhood underweight (1). Worldwide, 44% of diabetes, 23% of ischaemic heart disease and 7–41% of certain cancers are attributable to overweight (BMI between 25–29.9 kg/m²) and obesity (BMI ≥ 30 kg/m²). Once considered problems only in high income countries, overweight and obesity are now very common in low- and middle-income countries, particularly in urban settings. They also increase rapidly, with worldwide obesity having nearly doubled since 1980 (2). Obesity costs health systems a lot. In the United States, in 2008, the medical costs for obese people were estimated at 1,429 US dollars higher than for those at normal weight and the overall medical costs associated with obesity were estimated at 147 billion US dollars (3).

In Iran, the prevalence of obesity has also reached epidemic proportions. In one study published in 2001, 40% and 23.1% of the adults in Tehran were found to be overweight and obese respectively (4). One meta-analysis put the overall prevalence

of obesity among Iranian adults at 21.5% (5). In Iran, obesity specifically affects women and it varies considerably between age groups (5).

Doctors who reject obese patients

The armamentarium of policies on obesity treatment and prevention includes many that do not immediately engage patients, such as ensuring the availability of affordable fruits and vegetables, regulating sales of sugary drinks and of the content of prepackaged and restaurant food, and developing walkable cities, accessible public parks, and sports facilities. But some proposed policies engage patients more directly. For example, an increasing number of American workplaces have 'wellness' programs that give benefits like iPods or cash to employees who join gyms or simply lose weight. Recently, a senior bioethicist proposed an airline policy of calculating weight surcharges for luggage by summing up the weight of the luggage and that of the person holding the luggage—effectively making it more expensive for overweight people to fly, partly in order to 'discourage weight gain' (6).

In several recent cases around the world, doctors or primary care trusts (PCTs) refused to admit new obese patients (7,8). In one incident in the American state I live in, a primary care physician (a general practitioner) claimed that it's because her clinic lacks proper equipment, but she may have had additional motives. Earlier she had admitted that it is rather because she feels that if obese patients don't lose weight, then 'I'm paying the cost of other people's choices.' I assume that if she lacked the equipment for wheelchair-bound patients, she would go out and buy it. She may have had an ulterior motive to ramp up the "cost" of being obese—discouragement of weight gain (9,10).

A majority (54%) of doctors who responded in a survey published in the United Kingdom last year supported measures to deny treatment to the obese (as well as to smokers). Specifically, these doctors said that Britain's National Health Service should have the right to withhold non-emergency treatment from patients who do not lose weight (7).

We must tackle the obesity problem head on. But conditioning medical access on weight loss is not the way.

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What is not the problem with rejecting obese patients

So-called personal responsibility for health policies are often resisted on wrong grounds. For example, a common criticism is that supportive environments and communities are fundamental in shaping people's choices and in reducing obesity, smoking, and other risk factors that depend on personal choices and this somehow counts against personal responsibility policies. On this approach, the solution is social support rather than individual penalties. The food industry should be regulated, public parks and bike paths should be developed, and educators, doctors and other stakeholders should get behind the cause (11). Many writers who propose substituting incentives by 'upstream' health promotion measures make a similar point. The World Health Organization (WHO) may also make a related point when it warns, 'Individual responsibility can only have its full effect where people have access to a healthy lifestyle, and are supported to make healthy choices' (2).

I am not denying that social support is vital, or that other stakeholders have a major role to play as well. But that does not touch on the question whether policies that engage individual patients and their incentives directly make sense as well, alongside these social supports. On the face of it, the most promising approach would seem to be to use all the tools in our toolkit: to press social, legal, and educational levers as well as personal ones. And the latter do include the creation of evidence-based 'carrots and sticks' for health: material and other incentives and disincentives that make a healthier lifestyle more attractive than an unhealthy one, even in the short run.

Take the example of Iran. According to Iranian experts, 'The increased consumption of calorie-dense regular and fast foods and sucrose-enriched drinks, together with an increasingly sedentary lifestyle, appear to be major factors contributing to the obesity epidemic' (4). Among schoolchildren from Tehran, fast food consumption and mothers' BMI are both associated with overweight and obesity (12). Does it even make sense to distinguish here between social support and individual (mothers') choice? Social support would consist in institutional encouragement of healthy individual choices, such as the choices to diet and to feed one's children fewer fast foods. Individuals would usually be likelier to make such healthy choices if those choices were made comparatively 'cheaper', by which I mean easier or otherwise less taxing than less-healthy choices. And there is no reason to rule out in advance policies that would make healthy choices comparatively cheaper, not only by providing social support that makes them 'cost' individuals less than they would otherwise, but also by providing relevant carrots that make them cost them less *balance*, or sticks that make them cheaper than less-healthy *alternatives*.

It is also said against personal responsibility policies that unhealthy choices to smoke, eat fast food, underutilize cost-effective preventative services, and others, are disproportionately high among minorities and the economically worse off. Therefore, it is said, personal responsibility policies would disproportionately penalize minorities. They would seldom benefit from any 'carrots' on offer, and they would get many 'sticks'—for example, paying cigarette tax and 'fat tax', being rejected from certain jobs, and so forth (11,13,14).

Obesity and overweight are not *always* associated with low education or low economic status. Different studies from Iran have reached different conclusions on this (12). More fundamentally, insofar as personal responsibility policies work,

they increase patients' health a lot, and so they tend to be good for them on balance. Even as they 'penalize' them, they help them to get rid of disease burdens that could often blight their lives far more substantially than any penalties like cigarette tax, 'fat tax', and so forth. Such policies are especially good not especially bad for minorities who suffer from an excessive disease burden—even if in the short term what they amount to for minority patients are few carrots and many sticks (15).

Sir Michael Marmot has recently warned, 'evidence shows that actions aimed at encouraging individuals to make healthy choices will not be effective in reducing health inequalities—such actions may make inequalities worse.' His reason is that 'those with more education, for example, take heed of health messages to a greater extent than do those of lesser education' (16). But when unhealthy choices are more common among the poorer or less educated, as Marmot's work shows them to be, then the collective positive impact on the poor and less educated could remain greater than the one on the rich and educated. In any event, any health improvement, equal or unequal, should usually be welcomed.

The real problem with rejecting obese patients

Assume *for the sake of argument* that providing attractive incentives for weight losers and repulsive disincentives for weight gainers—conditional 'carrots and sticks'—would drive some obese people to eat less and exercise more. Assume that the health risk and the social shame associated with obesity are insufficient to deter the obese from overeating, but that they would respond to some other (dis)incentives. Even so, it would remain wrong to turn the doctor into a 'carrot'.

There are several reasons for that. Society would benefit tremendously from nurturing the notion that healthcare is a basic and an inalienable right, and from a culture in which doctors do not discriminate between patients but take them largely on the basis of medical need. We also face a substantial problem of stigma against obese patients. Rejection by doctors, with its penal undertones and implicit threat of remaining with no social support, might exacerbate that. Importantly, by inducing shame, augmented stigma may drive bringing on comfort feed and undermine, instead of facilitating, healthier eating.

But I would like to feature another reason why rejecting obese patients is the wrong policy response to the epidemic. According to a rule of thumb that I shall propose, *any conditional incentive for healthy choice should be in a currency other than the basic means to that healthy choice*—in this case, the preventative and treatment services that facilitate weight loss. Doctors, health managers, and health policy makers can help us lose weight and remain thin by using carrots and sticks. They may want to offer prizes such as iPods or museum tickets or maybe even cash to patients who lose weight—not doctors, otherwise unavailable healthy food, or access to basic sports facilities.

Too often the carrots that health officials offer as incentives for healthy choices are the very means that people need in order to make such choices. Take an example I discussed a few years ago. At the time, the American state of West Virginia's Medicaid (a coverage program for poor and/or disabled Americans) experimented with conditional prizes for 'adherent' patients only—for example, patients who kept medical appointments and took their medications. But among these exclusive prizes were mental healthcare and chemical-dependency services. So

thanks to the experiment, Virginians who needed psychiatric care or detox to restore order in their lives, potentially including the ability to keep appointments and take medications, had to have such order in their lives. Otherwise, psychiatrists and detox could remain out of reach (17).

Some policies that use the needed stepping stone to the solution as a carrot, which to be whisked away upon failure, are ongoing so-called pain contracts or opioid treatment agreements spell out rules that patients must follow to take opioid drugs safely. The contracts aim primarily to discourage patients from taking too much medication, mixing medications, and sharing or selling medications—all causes of a serious public health burden in the United States. These agreements may require patients to submit blood or urine drug tests, fill their prescriptions at a single pharmacy, or refuse to accept pain medication from any doctor other than the one against whom the particular contract is signed. Importantly, if patients fail to abide by the rules, the agreements often state that the doctor may drop them from their practice (18).

There is a lot to welcome in pain contracts and a lot to object to. What I would like to feature is the absurdity of one central element: using blocked access to care as the ‘stick’ for patients who fail and whose need of mental health or chemical-dependency care has thus typically become apparent.

It is conceivable to me that sometimes, the incentive or the disincentive effect of gaining or losing a basic health benefit such as access to one’s doctor are so strong that they might overwhelm any bad effect on health from being denied care. But I suspect that it is rarely the case. We already know that nonadherent patients either have serious difficulties adhering (they genuinely lack access to transportation, to free time, and to other means of medical adherence) or less interest in improving their medical adherence in that area of health (and hence in avoiding sticks given in that same currency). So the feat of rejection from care is typically going to fail to goad them to become adherent.

Why are doctors and health systems using rejection from care as the one ‘stick’ that, they promise, would motivate weight loss, smoking cessation, or opioid adherence? For some, the motive may be just getting rid of ‘difficult patients,’ whom they set up to fail. Perhaps West Virginia’s Medicaid reformers, some of whom were affiliated with fiscal conservative politician Newt Gingrich, sought simply to save money by slashing state benefits to poor or disabled patients. For doctors who care more genuinely for patients, perhaps like the primary care physician I mentioned earlier, the reason is probably that this is the only leverage they can pull. Their ‘toolkit’ does not contain alternate carrots and sticks. A possible lesson for health managers and policy planners is that we need to think more creatively about personal responsibility for health policies. If doctors, managers, and health policy makers had alternate carrots and sticks readily available, other than denial of necessary prevention and treatment, that would usually avoid the absurd situations I pointed out, where medical attention serves as a carrot or a stick for patients who need that attention unconditionally and who will often fail adherence testing.

Conclusion

I have argued that conditioning (continuous) access to a doctor on low BMI is an absurd response to the obesity epidemic for multiple reasons. One to which I drew special attention is the absurdity of conditioning the very aid that patients need in

order to become healthier on success in becoming healthier. Ethical and policy questions about personal responsibility for health are complex (19). But personal responsibility policies that involve such conditioning are clearly not the solution.

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Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests.

Author’s contribution

NE is the single author of the manuscript.

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