Can Human Rights Law Stop Weight Stigma Causing Healthcare Bias?

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Abstract: Overweight people can experience discrimination in many settings including healthcare. The World Health Organisation is calling for a de-stigmatising approach in public policies to address obesity. How can human rights law help?

In April 2022 I attended a Research Meet Up on obesity at the Aletta Jacobs School of Public Health where Dr Stuart W. Flint discussed the stigma around excess weight, which can lead to prejudicial treatment from doctors and others. This made me ponder the potential role of human rights principles in this context.

The debate on whether obesity is a condition or a disease is ongoing. The World Health Organisation (WHO) describes it as a complex multifactorial disease defined by excessive adiposity and linked to heightened risk for many noncommunicable diseases (NCDs). Health concerns associated with rising levels of obesity are not new. In 1997, the

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WHO declared obesity a major public health problem and a global epidemic. More recently, in its European Regional Obesity Report 2022, the WHO stated that almost two-thirds of adults and one in three children are living with excess weight, and these rates are growing. Excess weight ranks fourth as a risk factor for death, after high blood pressure, dietary risks, and tobacco. For some European countries, obesity is predicted to overtake smoking soon as the main risk factor for preventable cancer.

The obesity epidemic: weight-centred approaches

That obesity and excess weight are health risks is a non-contested fact. However, some critical voices are speaking out against conventional obesity-related policies. Traditional public health interventions have been characterised by a weight-centric approach, emphasising individual behaviours like calorie-restricted diet and exercise. However, as the WHO states, the obesity epidemic is a complex and multifactorial phenomenon that cannot simply be tackled by focusing on food and physical activity. Such a simplified approach can lead to false perceptions that often cause weight stigma. These may include negative beliefs that overweight individuals are lazy, irresponsible and lack self-discipline, despite evidence that genetic, socioeconomic and environmental factors all play a role in obesity development.

Weight stigma and discrimination

Flint defines weight stigma as prejudice attached to body size and shape more generally, typically directed against those in the overweight or obesity ranges. Perpetrators are often not strangers, but friends or family and victims may internalise derogatory attitudes which not only damages self-esteem but also negatively impacts their food choices and eating habits.
The World Obesity Federation campaign to end weight stigma, launched in 2018, highlighted that such blaming and shaming can result in people with obesity developing eating disorders and health problems including weight gain. Very importantly, weight stigma attitudes are considered predictive of discriminatory behaviours in different environments, such as workplaces, education and healthcare settings.

Bias in healthcare services

In a 2022 article, Flint discusses how empirical studies over a 40-year period show that people living with obesity experience weight stigma and discrimination from Health Care Practitioners (HCPs), even from those specialising in obesity. Implicit weight bias amongst HCPs can impact the level of support, care and empathy people living with obesity receive. Evidence indicates that physicians spend less appointment time, provide

less health education and have less respect for people with a higher body weight. Doctors also say that care of people who are not overweight is better use of their time compared to care of those with obesity. Individuals who report weight bias in the healthcare setting have less trust in their providers and are less inclined to access screening and services but more likely to have poorer outcomes and avoid future healthcare.
The WHO confirms the same issue and adds some interesting facts. The presence of obesity may be used to limit access to treatments for other diseases and conditions. For instance, islet transplants in people with type 1 diabetes are generally limited to people with a BMI below 26 kg/m2. Hence, restrictions on such interventions or requirements to lose weight prior to surgery might represent discrimination from healthcare professionals.

Human rights and a non-stigmatising healthcare approach
The WHO acknowledges the failure of traditional obesity control measures and highlights the importance of developing a non-stigmatising approach to public policy. International human rights law (IHRL) contains precepts that can inform such an approach.
One of these principles is the right to the highest attainable standard of health ('right to health') as found in the UN Covenant on Economic, Social and Cultural Rights (ICESCR) (Article 12) and further explained in General Comment 14 (GC14). In what follows, I will focus on three aspects of the right to health: a general one, unrelated to stigma but useful to develop a human rights-based approach to tackle the obesity epidemic, and two specifically related to stigma and discrimination.

1. *The highest attainable standard of health* is not confined to the right to healthcare. On the contrary, the right to health embraces a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life. These include underlying determinants such as food, nutrition, housing, access to safe, potable water and adequate sanitation, safe and healthy working conditions and a healthy environment.

Economic determinants of excess weight and obesity include the high cost of healthy foods and organised sport, economic crises, unaffordable housing, precarious work and deprivation. As shown by the WHO, these determinants influence the relative affordability of unhealthy diets for those on low or no incomes, widespread perception that unhealthy foods and beverages are cheaper than healthier options, and the pervasive marketing of unhealthy foods and beverages, especially to vulnerable populations such as children.

On the latter points, a combination of fiscal incentives, including broad-based taxes on unhealthy foods and beverages and subsidies on healthy foods has proved to be one of the most effective ways of shifting population consumption towards a better diet and reducing obesity.
The UN Special Rapporteur on the Right to Health Dainius Puras' statement on adoption of front-of-package warning labelling to tackle NCDs (non-communicable diseases) is a reminder to States that this could be a valuable regulatory tool. The food and beverage industry are increasingly implicated in the global obesity and NCDs epidemic and such labelling could help mitigate its detrimental impact on enjoyment of the right to health and other rights.

2. GC 14 states the obligations on member states to respect, protect and fulfil. According to these, states are obliged to refrain from interfering directly or indirectly with enjoyment of the right to health (respect); to take measures that prevent third parties from interfering with guarantees provided in the right to health (protect); and to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health (fulfil). This applies to the previous points regarding socioeconomic factors inherent to the right to health. Applied to the context of weight stigma and discrimination in healthcare services, this means states have a responsibility to ensure weight stigma does not interfere with realisation of the right to health (right to receive appropriate healthcare) and that public health legislation and policies address stigma in health services and take necessary measures to tackle it.

3. The right to health in all its forms and at all levels contains the following interrelated and essential elements: availability, accessibility, acceptability and quality. Here I will focus on the accessibility component. As described in GC14, the accessibility component has four overlapping dimensions, one of them being *non-discrimination*: health facilities, goods and services must be accessible to all without discrimination. Therefore, this, read in conjunction with the principles of equality and non-discrimination contained in the International Bill of Human Rights, constitutes a legal basis to inform nondiscriminatory attitudes towards people with obesity.

   Moreover, the accessibility component imposes the need to pay special attention to the most vulnerable or marginalised sections of the population. As shown by the WHO, recent research on obesity shows low-income groups in Europe know what constitutes a healthy diet but practical barriers include unaffordability, inaccessibility and

unavailability of foods. Therefore, strategies which only address inequities in information on excess weight and obesity may be ineffective without measures to enhance the ability of low-income and marginalised groups to act on this information.

The obesity epidemic cannot be addressed with one single intervention. We need to implement a range of policies that take into consideration all the factors around obesity, including the discrimination and stigma experienced by overweight people.