
Does Obesity Justify Big Government?

BY RADLEY BALKO

Last January media outlets reported that cancer had overtaken heart disease as the number-one killer in the United States. Sounds scary, no?

Fear not. As is usually the case, beyond the scary headline, deep into the copy, came the real story. *Both* diseases are in steady decline. Cancer rates and deaths from cancer have fallen every year since the early 1990s. The thing is, incidence and mortality rates of heart disease and stroke have fallen *even more* over the same period (25 percent since 1990). So while it's true that cancer has "overtaken" heart disease, that's really not the story. The story is that both are in decline, heart disease remarkably so.

Late last February, another health story hit the wires: Americans are living longer than ever before. Life expectancy is up across the board, among both genders and all ethnicities. The gaps in life expectancy between men and women and between black and white are shrinking, too.

At the same time all of this good news has transpired, the number of Americans classified as "obese" and "overweight" has been on a steadily upward trajectory since about the mid-1970s. In 1985 eight states reported that at least 10 percent of their populations were obese. By 1990 the number rose to 33. By 2001, it was all 50.

Of course, as you might expect, the scariest numbers about the condition of America's waistline are overblown—there are significant problems with the way the government measures obesity, which I'll discuss in a

moment. But most researchers agree that the average American is carrying 10–15 more pounds than he was 30 years ago.

If you believe the media, nutrition activists, and public officials, those extra 10–15 pounds portend a looming health-care catastrophe. U.S. Surgeon General Richard Carmona, for example, said in 2004 that childhood obesity is "every bit as threatening to us as the terrorist threat." A congressionally commissioned report from the Institute of Medicine published in the fall of 2004 called for massive government intervention to stave off the crisis. One author said we need "nothing short of a revolution." The World Health Organization warned, "If immediate action is not taken, millions will suffer from an array of serious health disorders."

But if we've been getting fatter for 30 years, shouldn't we be seeing at least the front end of this coming crisis? Why are we getting *healthier*? In fact, a closer look at the statistics suggests that even some of the diseases most associ-

ated with obesity are in retreat.

Take cancer, for example. In 2002 the BBC reported researchers had found that "the more excess weight a person carries, the greater their risk of certain types of cancer." In 2004 *USA Today* echoed that claim. "The nation's current epidemic of overweight and obesity is likely to drive up cancer rates in coming years," the paper wrote. The Associated Press said that "heart disease

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and diabetes get all the attention, but expanding waistlines increase the risk for at least nine types of cancer, too.” (Other sources put it at ten.)

But of the ten types of cancer commonly associated with obesity, deaths from nine—pancreatic, ovarian, gall bladder, stomach, prostate, kidney, colorectal, cervical-uterine, and breast—have *decreased* since 1992, some of them significantly. Only one—esophageal cancer—has seen an increase in mortality rates over that period.

And heart disease? Case Western Reserve University researcher and obesity skeptic Paul Ernsberger notes that “The greatest improvements are in cardiovascular disease deaths, which are most strongly linked to obesity.”

As noted, the gap in life expectancy between black and white is shrinking. But at the same time, blacks as a group have put on more weight than whites. Incidence of obesity among black women, for example, jumped 11.7 percent between 1988 and 2001, compared to 7.3 percent among white women. Yet black women increased their life expectancy by 2.3 years, versus 1.3 years for white women over that period. It’s true with men too. The rate of obesity among black men jumped by 7.5 percent, versus 7.0 percent among white men, yet black men on average added 4.2 years to their lives, versus 2.8 for white men. So blacks have narrowed the longevity gap with whites, even while widening (pardon the pun) the “obesity gap.”

In 2003 the *Journal of the American Medical Association* published a study commissioned by the Centers for Disease Control that said 400,000 annual American deaths are attributable to obesity. A Lexis search reveals that as of late fall 2004, that 400,000 figure had been cited over a thousand times in mainstream media outlets. It was also routinely cited by politicians, activists, and bureaucrats as justification for large-scale government intervention to curb our pudginess. At a *Time*-ABC News summit on obesity in June 2004, attendees were inundated with the refrain that “obesity will soon overtake smoking as the number one cause of preventable death in America.” Demands for government action inevitably followed.

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But there were fatal flaws in the CDC study’s methodology. First, it was a “meta” study, which incorporated data from dozens of other studies, some of them dating back to the 1940s, and attempted to apply that data to today’s demographics. Second, the study used the Body Mass Index (BMI) as its arbiter of obesity, a crude formula that factors only height and weight and which consequently mislabels as “overweight” or “obese” people who are extremely fit. According to the BMI, for example, half the National Basketball Association is either overweight or obese. But few would suggest they’re out of shape or unhealthy. Third, the study assumed that all premature deaths by obese people were

caused by obesity—a leap of faith, to say the least. Finally, the study lumped the “overweight” in with the “obese,” even though there’s little evidence that overweight has any seriously ill-effects on health. The study’s own data showed no correlation between being overweight and premature death, and in fact showed some benefit.

In December 2004 the CDC reluctantly admitted its study was flawed, but only by a little—20 to 25 percent. Critics insisted the flaws in the study’s methodology were much more significant, and in response the National Institutes of Health finally commissioned a review. In April an independent team of researchers led by the University of North Carolina’s Katherine Flegal released a new study sharply at odds with the original study. Flegal’s team determined that it exaggerated the effects of obesity by some 300 percent. She put the real number of annual deaths attributable to overweight and obesity closer to 100,000. What’s more, the new study found that modest overweight actually *protects* against premature death. When adjusted for the lives *saved* by extra weight, the number of deaths due to obesity falls to around 25,000—putting the original figure off by a factor of 15.

A subsequent internal investigation revealed that CDC officials were actually made aware of the original study’s flaws during the peer-review process. So why was

the more alarmist study published and relentlessly promoted anyway?

As it turns out, one of the co-authors of the original study was Dr. Julie Gerberding, who also happens to be the current director of the CDC. Comments from members of the internal-investigation team reveal that the study was likely published over objections from other scientists at the CDC because the head of the agency's name was on it.

Gerberding still refuses to accept the new numbers. She has told the media that the CDC will continue with its anti-obesity campaign, which will continue to ignore the subsequent study.

Governments Spring into Action

Local and state legislatures, the U.S. Congress, regulators at all levels of government, and public-health advocates have already seized on the idea that nearly a half million people are needlessly dying every year because of their love handles. The Bush administration has earmarked millions of federal dollars for anti-obesity initiatives (though not nearly enough for the obesity warriors). Congress is considering menu-labeling laws; some in Washington have suggested taxes on high-fat or high-sugar foods; and others are calling on the Federal Trade Commission to regulate the marketing of junk food. Many states have banned junk food from school cafeterias. And Medicare announced last summer that it would begin considering paying for treatment for obesity, a new entitlement that could prove nearly as costly as the prescription-drug benefit.

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None of this is to say extreme obesity is healthy, or even benign (though, as we've seen, some studies suggest a few extra pounds may give a mild protective effect, particularly among the elderly). The decline in incidence and deaths from heart disease and cancer are almost certainly due to advances in medical research and technolo-

gy. We're getting better at uncovering these diseases early, and with pharmaceutical marvels like statin drugs and chemotherapy, we're making huge leaps in treatment once we've diagnosed them. And it's of course likely that the gains we've made would be even more significant were the most obese among us a bit more svelte.

But the notion that our expanding waistlines have put us on the verge of a calamitous offensive against our health-care system simply isn't borne out by the evidence. And so these incessant calls for immediate, large-scale government interference in how we grow, process, manufacture, market, prepare, sell, and eat our food ring hollow, hyperbolic, and needlessly invasive.

A recent *Seattle Times* investigation of the obesity hype found that much of the panic can be traced back to an aggressive campaign in the late 1990s by the pharmaceutical companies with diet drugs like Phen-Phen in the pipeline to get the government in the business of weight-watching. In 1996 the industry convinced the federal government to move the goalposts when it comes to defining "overweight" and "obesity." At hearings dominated by researchers with ties to the pharmaceutical industry, an FDA panel eventually agreed. One magical

night in 1997, some 29 million Americans went to bed healthy and woke up the next morning "overweight" or "obese." And none of them gained a pound.

Debunking junk-science studies and bogus Chicken-Little pronouncements are important to refute the idea that obesity represents a looming health-care crisis. But those of us who value free markets and personal liberty wouldn't support government intervention even if the worst pronouncements of the anti-fat activists were proven true. What we put into our mouths, how often we exercise, and what we feed our children are simply none of the government's business. How did we get to the point where it could be?

There are two answers to that question, and they should be considered separately. First, we've vastly expanded the concept of "public health" to include

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government intervention into nearly every sphere of our lives. And second, our health-care system is slouching toward socialism, a troubling trend that undermines personal responsibility and exacts a public cost on private behavior.

Public Health

The proper conception of “public health” is innocuous enough. There are unquestionably some threats to our health and safety for which the remedies constitute a legitimate public good. They’re limited to risks to which no rational person would subject himself—examples might include communicable diseases like tuberculosis or typhoid, calamitous events like asteroid impacts or tsunamis, or biological or chemical terrorism. Under these limited circumstances, it’s understandable, even advisable, for a government limited to protecting the lives and property of its citizens to take collective measures to eradicate or minimize such risks, or minimize the damage should they come to pass.

But “public health” as it’s advocated today goes well beyond public goods. Over the last century, “public health” has come to mean state pressure coercing us to avoid risks, even risks we knowingly and willingly undertake. The most obvious and conspicuous example was alcohol prohibition. And though Prohibition took an untold number of lives, bred corruption, and legitimized criminal behavior, it is distinguishable from more recent expansions of public health in that lawmakers at least recognized it as a failure and repealed it. (Unfortunately, we don’t seem to have learned. The last 20 years have seen increasingly aggressive restrictions on the production, sale, and consumption of alcohol by local, state, and federal government.)

But the Harrison Act—which fired the first shots of the drug war—was passed even earlier, in 1914. Drug prohibition has marched onward since. Its episodic ratcheting-up and coolings-down have progressed to a particularly aggressive and militaristic incarnation over the last 25 years.

Once we’ve accepted a definition of “public health” expansive enough for government to dictate what we can and can’t put into our bodies, it’s a short leap to seat-belt laws, motorcycle-helmet laws, and prohibitions and restrictions on all sorts of other risky behavior. More

recently we’ve been given “public” smoking bans that extend to private businesses such as bars and restaurants. The Supreme Court recently upheld an Alabama ban on sex toys and marital aids. And parents are all too aware of the myriad regulations on the risks to which they can legally subject their children. Over just the last several years, governments at some level have prohibited motor scooters, “pocket bikes,” all-terrain vehicles, snowmobiles, alcohol vaporizers, and fireworks, to name just a few—all designed to keep people from hurting themselves.

So it shouldn’t be the least bit surprising that “public health” might now come to include the size of our pants and the content of our refrigerators.

The justification for expansions of the government’s power to promote “public health” is typically couched in “the number of lives this will save.” Sometimes, we’re told that a law will add x number of years to the average life. The most-used and easiest tactic is to simply state that the law’s necessary to protect “the children.”

The ad nauseam recitation of the 400,000 figure is a good example, as is a report released in January 2004 stating that being overweight at 40 would cut several years off the typical life. The public-health activists at the Center for Science in the Public Interest have long been fighting for marketing restrictions on junk food, particularly on programs directed “at our children.”

Longevity seems to be an obsession among the public-health crowd. Apparently, there is no limit to the costs they’re willing to endure if some policy promises to lengthen lives. It seems improbable to them that there may be people who’d sacrifice a month or two of their senior years for the lifetime of pleasure some get from cigarettes, a night of hard drinking, or a slice of cherry pie after dinner. It’s as if adding more days to the end of our lives were the only reason for living.

Even then, as British doctor and author Michael Fitzpatrick explains in his book *The Tyranny of Health*, death can’t be prevented. It can only be postponed. And “death can generally be postponed only for a relatively short time by relatively intensive preventative measures,” Fitzpatrick writes. That is, high-cost measures that would typically add just a few days or months to the average life.

There’s certainly nothing wrong with studies or

public-awareness campaigns designed to discover and inform us about how we can make healthier choices. It's that the "advice" rarely stops there. Inevitably, such studies and campaigns lead to calls for government policies aimed at increasing longevity, policies that take options away from people who may value pleasure, convenience, or indulgence more than perfect health or a prolonged geriatric.

In the eloquent polemic *Cigarettes Are Sublime*, Richard Klein writes, "Healthism in America has sought to make longevity the principal measure of a good life. To be a survivor is to acquire moral distinction. But another view, a dandy's perhaps, would say that living, as distinct from surviving, acquires its value from risks and sacrifices that tend to shorten life and hasten dying."

Classical liberals should argue against the ever-expanding "public health" initiatives not only because they're supported by junk science or manipulated data (though that's often the case), but because the freedom to risk, indulge, and "sin" are essential to preserving individual liberty and a free society. Governments of free people aren't authorized to ensure good health. They're charged with securing liberty, which most certainly includes the liberty to have bad habits.

Socialized Medicine

The other chief reason why "public health" has been able to include ridiculous measures like obesity legislation and seat-belt laws is our increasingly collective system of health care. Even private health care has a collective component to it. Today, routine maintenance-oriented doctor visits are typically paid for by employer-provided health insurance, calling to mind the old Milton Friedman axiom about how generous we tend to be with other people's money. Health insurance by definition pools risk. But many states (as well as the general culture of the health-care industry) put restrictions on so-called "medical underwriting"—or allowing health insurers to vary premiums based on risk, the same way auto or life insurers do. All these factors together

create a system of perverse incentives that undermine the notion that we ought to let people take personal responsibility for their own health and well-being. Healthy people subsidize unhealthy people. When the consequences of poor decisions are shared, there's less incentive to make good ones.

And that's just the private sector. At the same time, politicians seem to be falling all over themselves in a rush to expand Medicare and Medicaid benefits for the aging, politically potent Baby Boom generation. The Cato Institute estimates that the new prescription-drug benefit could in the end exceed a trillion dollars. Medicare's noodling with the idea of covering obesity treatments could very well end up costing nearly as much.

This creeping socialization of medicine gives government new license to meddle with our private affairs. It creates a climate where excessive state interference in the most intimate of personal matters—what we put into our mouths—becomes not only acceptable among the electorate, but *desirable*. After all, if that cheeseburger you're eating clogs your arteries and puts you in the hospital, your poor choices will be reflected in my health-

insurance premiums. If you're on Medicare or Medicaid, it'll show up in my taxes.

That's exactly the argument the government put forward in the summer of 2004, when the Department of Health and Human Services (HHS) announced that Medicare would consider covering the costs of obesity treatments, including diet plans, counseling, and gastrobypass surgery, all new frontiers for preventative government intervention. HHS officials insisted that the change would save taxpayers money over the long haul if obesity were prevented or treated before the ill-health effects associated with the condition begin to present themselves.

It isn't difficult to see how this argument could be applied in a larger sense—that we need to tax fatty or sugary foods, for example, to save everyone money on health-insurance premiums and to keep the obesity problem from bankrupting Medicare and Medicaid. In

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fact, that exact argument *has* been made—and by a credentialed *conservative*, no less. On *National Review Online*, David Frum wrote: “And as Americans struggle with an epidemic of obesity—and the ensuing costs to the taxpayer—conservatives who favor (as almost all conservatives do favor) Medicare and Medicaid need to ask themselves whether their easy libertarian attitude to the worst practices of the fast food industry retains its relevance. Big Gulp drinks and super-sized fries are making America sick—and you are paying the bill. A little moderation would cure a lot of medical and fiscal ills; and a little incentive might induce that moderation.”

It’s bad enough hearing that kind of talk from the left. But when it comes from the right, too, it’s a bad har-binger for what might be ahead.

The solution to this is to return some semblance of personal responsibility to the health-care system. Health, or medical, savings accounts (HSA, MSA), for example, enable consumers to roll money not spent on routine medical procedures into a retirement account, tax-free. In contrast to the current system—which if anything encourages poor decisions—HSAs or MSAs encourage consumers to take care of themselves. Money not spent on visits to the doctor’s office is money saved for retirement.

Another suggestion would be to free up health insurers to do medical underwriting. The Bush administration has said it sees no federal barriers to the practice, so to the extent that barriers exist, they’re likely at the state level. Consumers in any state should be free to purchase health insurance from companies in any other state under the laws and regulations of the state where the insurer is incorporated. This would not only free up

health insurers to medically underwrite, it would create a kind of competition between the states to ease regulatory burdens to attract insurers.

The result would unleash market forces on the task of finding the best carrot-and-stick approach to encouraging healthy lifestyles. Insurers would compete for customers, while states would lower regulatory barriers. Currently, there’s much debate over whether the ill-health effects often associated with obesity are from obesity itself or from the sedentary activity levels that often accompany being overweight. Hundreds of insurers competing with one another to both attract consumers and develop plans that reward the healthiest habits among their patrons (which of course benefits the insurers through lower health-care costs) might bring us closer to an answer to such questions. At the very least, if each of us were solely responsible for the consequences of our diet and activity level, the point would be rendered moot from a public-policy perspective.

The bizarre thing about the obesity debate is that less than a decade ago, the very thought of it was often discussed only in parody, or in a *reductio ad absurdum* context. Opponents of the tobacco lawsuits often invoked the idea of trial lawyers suing fast-food restaurants as one example of the “parade of horrors” that might follow should the tobacco suits be allowed to go forward.

Well, we’re here now. This is post-*reductio* America. If the anti-obesity proposals currently up for debate become law, it would be difficult to think of any aspect of our lives that would be out of the reach of the public-health activists. Or, as one advocacy group that represents the food industry has put it, the question will no longer be “what’s next?” . . . but “*what’s left?*” 