

An International Perspective on Battling the Bulge: Japan’s Anti-Obesity Legislation and its Potential Impact on Waistlines Around the World

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In August 2008, Andrew Casana, a spokesperson for the California Restaurant Association, criticized Los Angeles’ year-long moratorium on new fast-food restaurants stating, “What’s next? Security guards at the door saying, ‘You’re overweight—you can’t have a cheeseburger?’”¹ For the overweight and obese citizens of the world, however, Casana’s sarcastic prediction may soon become a reality.²

I. INTRODUCTION

“At no other time in recorded history have human beings been this obese.”³ In the United States, the obesity rate has increased by nearly forty percent since the early 1990s.⁴ However, during the same period

1. Molly Hennessy-Fiske, *Panel Oks Fast-Food Curbs*, L.A. TIMES, July 23, 2008, at B2, available at <http://articles.latimes.com/2008/jul/23/local/me-fastfood23> (noting that “30% of South Los Angeles adults [are] obese, compared with about 21% of adults countywide”); *Back & Forth: Obesity*, TIME, Aug. 11, 2008, at 20.

2. Obesity is generally defined as a “BMI, or body mass index, of 30 kg/m² or greater. “BMI is a measure of weight relative to height: BMI = (weight [in pounds] / height [in inches]² x 703.” Sayward Byrd, Comment, *Civil Rights and the “Twinkie” Tax: The 900-Pound Gorilla in the War on Obesity*, 65 LA. L. REV. 303, 309 (2004).

3. *Id.* at 320; see also David B. Audretsch & Dawne DiOrio, *The Spread of Obesity*, in OBESITY, BUSINESS AND PUBLIC POLICY 15 (Zolton J. Acs & Alan Lyles eds., 2007). Despite popular belief, the United States is not the world’s “fattest country.” The Pacific Island nations of Nauru and Tonga have the highest prevalence of obesity with 90% of the population being overweight or obese. Eric A. FINKELSTEIN & LAURIE ZUCKERMAN, THE FATTENING OF AMERICA: HOW THE ECONOMY MAKES US FAT, IF IT MATTERS, AND WHAT TO DO ABOUT IT 14 (2008). Saudi Arabia’s prevalence of obesity also surpasses that of the United States. *Id.*

4. FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 14.

of time, the rates of obesity in Iceland, Spain, New Zealand, the Czech Republic, and Saudi Arabia have all increased by a greater margin.⁵ Even countries traditionally thought of as relatively “thin,” such as China, have seen significant increases in obesity rates. While only five percent of China’s population as a whole is obese, approximately twenty percent of its urban population is obese, a rate comparable to that of many Western nations.⁶ The International Obesity Task Force (IOTF)⁷ now estimates that more than 1.1 billion people worldwide are overweight or obese, and a staggering 1.7 billion people are at risk for developing weight related illnesses, such as diabetes mellitus, coronary heart disease, hypertension, osteoarthritis, gallbladder disease, and cancer.⁸ In fact, in a number of countries, including the United States, overweight and obesity have become the norm rather than the exception.⁹ If the prevalence of obesity continues to increase at this rate, the World Health Organization (WHO) projects that approximately 2.3 billion people will be overweight and more than 700 million people will be obese by 2015.¹⁰

As a result of the growing obesity epidemic, the number of people worldwide affected by obesity has surpassed the number affected by malnutrition and hunger.¹¹ Thus, while the traditional focus of the

5. *Id.*

6. Seth Mydans, *Clustering in Cities, Asians are Becoming Obese*, N.Y. TIMES, Mar. 13, 2003, at A3, available at <http://query.nytimes.com/gst/fullpage.html?res=9C0CE2DF133EF930A25750C0A9659C8B63>; see also Byrd, *supra* note 2, at 311 (an “alarming” 20% of Chinese city-dwellers are obese).

7. The International Obesity Task Force is a global think-tank and advocacy organization that works with the WHO and other public health groups to “inform the world about the urgency of the [obesity] problem and to persuade governments that the time to act is now.” International Obesity Task Force, What is IOTF?, <http://www.iotf.org/whatisiotf.asp> (last visited Oct. 20, 2009).

8. *Obesity: International Task Force Emphasizes Global Epidemiology*, DIABETES WK., Sept. 15, 2003, at 18; George A. Bray & Jennie Macdiarmid, *The Epidemic of Obesity*, 172 WEST. J. MED. 78 (2000).

9. Maggie Fox, *Obese Americans Now Outweigh the Merely Overweight*, REUTERS, Jan. 9, 2009, <http://www.reuters.com/articlePrint?articleId=USTRE50863H20090109>; FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 14; see also *Epidemiology: Obesity and Overweight Increasing Rapidly in Latin America*, OBESITY, FITNESS & WELLNESS WEEK, Aug. 5, 2000, at 15 (noting that nearly 70 percent of the Paraguay population is overweight or obese, and approximately half of the populations of Brazil, Argentina, Chile, Colombia, Peru and Uruguay are overweight or obese).

10. World Health Organization, Fact Sheet No. 311 on Obesity and Overweight (Sept. 2006), <http://www.who.int/mediacentre/factsheets/fs311/en/index.html>.

11. Bray & Macdiarmid, *supra* note 8, at 78.

international community in respect to nutrition has been to eradicate hunger, as exemplified by the World Food Conference's Universal Declaration on the Eradication of Hunger and Malnutrition,¹² international health organizations are now scrambling to address the opposite problem.¹³ Consequently, IOTF Chairman Phillip James has stated that "[g]overnments throughout the world should be making [obesity] a top priority."¹⁴

Japan recently has emerged as a nation taking this call to arms seriously. Indeed, the issue of obesity and lifestyle-related diseases is particularly salient in Japan. The metabolic time bomb posed by the combination of an increasingly obese and increasingly elderly population presents significant financial problems for Japan. The Japanese government currently spends more than 20 trillion yen per year on social welfare and medical services.¹⁵ However, national healthcare costs are rising by approximately 1 trillion yen annually, ninety percent of which may be attributable to the elderly.¹⁶ Lifestyle-related diseases, including metabolic syndrome, currently account for nearly one-third of the annual healthcare costs and are also expected to rise as the population continues to age.¹⁷ By targeting the waistlines of its citizenry, the government openly acknowledges that it hopes to cut 2 trillion yen in medical costs by 2025.¹⁸

After previous attempts to curb obesity and its related diseases by traditional means were generally unsuccessful, the Japanese Legislature—

12. World Food Conference, Universal Declaration on the Eradication of Hunger and Malnutrition, U.N. Doc. E/CONF. 65/20 (Nov. 16, 1974) *reprinted in* THE RIGHT TO FOOD: GUIDE THROUGH APPLICABLE INTERNATIONAL LAW 3–7 (Katarina Tomasevski ed., 1987). The Declaration recognized that “[t]he elimination of hunger and malnutrition, included as one of the objectives in the United Nations Declaration on Social Progress and Development, and the elimination of the causes that determine this situation are the common objectives of all nations.” *Id.*

13. Some developing countries are facing both problems at the same time. For example, in 2000, approximately 12.5% of children in Ho Chi Minh City, Vietnam were obese, but the government was simultaneously addressing the rate of malnutrition nationwide. *See* Mydans, *supra* note 6. In China, the rates of obesity in urban areas are far greater than those of the country as a whole. *Id.*

14. *Obesity: International Task Force Emphasizes Global Epidemiology*, *supra* note 8, at 18.

15. *Waistline Scrutiny a Midlife Bugbear*, JAPAN TIMES, Sept. 9, 2008, available at 2008 WLNR 17096844.

16. Mayumi Honda, *Government Set to Tackle Lifestyle Diseases*, DAILY YOMIURI (Japan), June 22, 2006, at 4, available at 2006 WLNR 14765084; Naohiro Yashiro et al., *Evaluating Japan's Health Care Reform of the 1990s and Its Efforts to Cope with Population Aging*, in HEALTH CARE ISSUES IN THE UNITED STATES AND JAPAN 19 (David A. Wise & Naohiro Yashiro eds., 2006).

17. Honda, *supra* note 16, at 4.

18. *Id.*

the Diet—adopted a far more compressive and aggressive approach.¹⁹ The resulting “Metabo” legislation went into effect April 1, 2008, and seeks to significantly reduce the rate of metabolic syndrome, a “form of obesity characterized by an excessive accumulation of visceral fat, high blood sugar level and high blood pressure.”²⁰ As this comment will explain, the two components of the program are as innovative as they are controversial. First, the legislation requires annual screening of Japanese adults and provides follow-up counseling and medical treatment for those diagnosed with metabolic syndrome. Second, the legislation imposes fines upon those health insurance providers who show either a low rate of participation in the program or who are unable to adequately reduce the rate of metabolic syndrome amongst their insured patients. The Ministry of Health, Labor and Welfare hopes to reduce the overweight and obese population in Japan by ten percent by 2012, and by twenty-five percent by 2015.²¹

This Comment identifies six factors which may be analyzed to predict the outcome of Japan’s new “Metabo” legislation: (1) the compelling need for anti-obesity legislation; (2) the broad authority vested in Japanese physicians and medical policymakers; (3) the Japanese cultural emphasis on harmony; (4) the structure of the Japanese Constitution; (5) the legislation’s enforcement mechanisms; and (6) the costs of the program. This Comment predicts that although the cost of implementing the program could pose a serious impediment to initiating the anti-obesity campaign on a national scale, the new legislation is likely to succeed in decreasing Japanese obesity.

With these six factors in mind, this Comment also analyzes the possibility of exporting the new “Metabo” legislation to the United States. Because the cultural and structural elements supporting the “Metabo” legislation in Japan are notably absent in the United States, it

19. Since 2000, the government has implemented health-awareness campaigns based on a set of targets But most of the targets have not been met. In fact, figures for some of the targets—such as the number of paces that people are recommended to walk each day, and the proportion of overweight person in their 20s–60s—have generally worsened since the targets were set.

Id.

20. *Most Japanese Know Metabolic Syndrome: Govt Survey*, JIJI PRESS (Japan), May 3, 2008, available at 2008WLNR 8285924; Honda, *supra* note 16, at 4; *Waistline Scrutiny a Midlife Bugbear*, *supra* note 15.

21. Norimitsu Onishi, *Japan, Seeking Trim Waists, Decides to Measure Millions*, N.Y. TIMES, June 13, 2008, at A1, available at <http://www.nytimes.com/2008/06/13/world/asia/13fat.html?em>.

is highly unlikely that the United States will follow Japan's lead in adopting similar legislation. Accordingly, this Comment will show that Japan, rather than the United States, will emerge as a world leader in the anti-obesity movement and is far more likely to come out victorious in the war on obesity.

II. THE SCOPE OF THE "METABO" LEGISLATION—A TWO PRONGED ATTACK ON OBESITY

Before analyzing the six factors that will affect the success of Japan's innovative legislation, it is necessary to introduce the details of the new legislation itself. The aggressive new legislation designed to slim the waistlines of Japanese adults has two components: a mandatory screening and counseling program coupled with a fine system to be imposed on under-performing health insurance providers.²²

A. *Brief Introduction to Japan's Universal Health Insurance System*

The structure of Japan's national healthcare system allows for the mandatory screening process and fine system imposed by the "Metabo" legislation. The Japanese healthcare system already guarantees access to healthcare and an annual exam for all citizens.²³ Under the Universal Health Insurance system, the Japanese government oversees several independently administered health insurance plans that provide coverage to different subdivisions of Japanese citizens.²⁴ The first, the Employee Health Insurance program, provides insurance for all working adults and their dependents by size and type of employer.²⁵ The second, the National Health Insurance program, is organized by local governments and provides services to the self-employed or employees of small businesses.²⁶ Finally, the Health and Medical Services System for the Elderly provides health insurance for citizens aged seventy years and older (or bedridden citizens over the age of sixty-five) from "a national pooling fund in which 'every member of the nation equally shares the burden of paying for geriatric care.'"²⁷ The new "Metabo" legislation has ramifications for the entire healthcare system. As health insurance providers, local governments and employers will both be subject to the

22. Onishi, *supra* note 21, at A1.

23. Aki Yoshikawa et al., *How Does Japan Do It? Doctors and Hospitals in a Universal Health Care System*, 3 STAN. L. & POL'Y REV. 111, 112 (1991).

24. Yashiro et al., *supra* note 16, at 21.

25. Yoshikawa, *supra* note 23, at 116.

26. *Id.*

27. *Id.* (internal citations omitted).

legislation's stringent guidelines, as discussed in greater detail below. Although elderly citizens are not screened for metabolic syndrome under the new legislation, their healthcare is also directly impacted as the burden of paying for the elderly population's care will now fall disproportionately on the health insurance providers who fail to meet these ascribed weight-loss goals.

*B. Mandatory Annual Screening and Counseling:
The "Fat Checks"*²⁸

In accordance with the new legislation, fifty-six million adults between the ages of forty and seventy-four years old will be screened annually for metabolic syndrome.²⁹ Adults who exceed the threshold waistline requirements—set at eighty-five centimeters for men and ninety centimeters for women—are then provided additional care.³⁰ The legislation requires a combination of individualized counseling and medical care, or "lifestyle improvement consultations."³¹ Specially trained nurses will provide "active support" by mapping out a customized diet and exercise plan for overweight patients.³² Although patients are responsible for carrying out the prescribed weight-loss plan on their own, nurses are obligated to check in every three to six months via e-mail or telephone to monitor progress and offer additional advice.³³ Nurses may also refer patients to hospitals or more intensive medical care if necessary.³⁴ For those patients deemed merely "at risk" of developing metabolic syndrome, nurses will provide "motivational

28. David McNeill, *Japan Battles the Bulge with Mandatory Fat Checks*, IRISH TIMES (Ireland), Mar. 27, 2008, at 12, available at 2008 WLNR 5789393.

29. Onishi, *supra* note 21, at A1.

30. Currently the average male waistline in Japan falls nearly an inch below the legislation's cut-off and the average female waistline in Japan falls significantly lower than the legislation's cut-off. By comparison, the average waistline of an American male is thirty-nine inches and the average waistline of an American female is 36.5 inches, both of which exceed the Japanese waistline cut-off point. See Onishi, *supra* note 21, at A1.

31. *85% of Local Govts Offer Free Metabolic Syndrome Checks*, DAILY YOMIURI (Japan), May 13, 2008, at 1, available at 2008 WLNR 8940486.

32. *Govt to Actively Target Metabolic Syndrome*, DAILY YOMIURI (Japan), Aug. 19, 2006, available at 2006 WLNR 14763605.

33. *Anti-Metabolic Syndrome Scheme Needs Rethinking*, NIKKEI WKLY. (Japan), May 12, 2008, available at 2008 WLNR 8937071.

34. Honda, *supra* note 16, at 4.

support” by encouraging diet and exercise.³⁵ However, these motivational plans are optional and do not require any further consultations.³⁶

C. *The Fine System: “Slim Down or Pay”*³⁷

The second component of the new “Metabo” legislation imposes fines for noncompliance. The legislation requires that the results of the screening process and weight-loss counseling services be thoroughly reviewed in 2012.³⁸ At that time, insurance providers who have not had a 65% rate of participation in the weight loss program amongst their insured patients will be fined.³⁹ In addition, insurance providers who have not seen a 25% reduction in their number of patients suffering from metabolic syndrome will face a 10% increase in their required contributions to the nation’s pooled healthcare fund for the elderly.⁴⁰ To the outside observer, the elements of this two-pronged legislation may seem unduly intrusive. However, upon a closer inspection of the Japanese culture, legal system, and healthcare system, the likelihood that this legislation will improve the health of Japan is readily apparent.

III. FACTORS AFFECTING THE WAR ON WAISTLINES— WILL JAPAN TRIM THE FAT?

A. *The Obesity Epidemic in Japan*

The first indication that the new “Metabo” legislation will decrease Japanese obesity is that the nation has a compelling need to lose weight and has grown increasingly obsessed with doing so.⁴¹ In comparison to the United States and most of the Western world, Japan may not appear to have an obesity problem.⁴² In fact, less than five percent of the

35. *Govt to Actively Target Metabolic Syndrome*, *supra* note 32.

36. *Id.*

37. Kimberly Garrison, *Someday Your Choice Could Be Slim Down Or Pay*, PHILADELPHIA DAILY NEWS, Aug. 28, 2008, at 35, *available at* 2008 WLNR 16224992.

38. Hiroaki Takai, *Metabolic Syndrome Sector Swells*, NIKKEI WKLY. (Japan), June 9, 2008, *available at* 2008 WLNR 10870294.

39. Onishi, *supra* note 21, at A12; *see also* Takai, *supra* note 38.

40. Honda, *supra* note 16, at 4.

41. Not surprisingly, Japan also has seen an increase in the number of women suffering from eating disorders. *Eating Disorders on the Rise Among Japanese Women*, DAILY YOMIURI (Japan), Apr. 6, 1996, at 8, *available at* 1996 WLNR 1267025.

42. The comparison between Japan and the Western world is noteworthy because both Japanese and American journalists attribute the rise in Japanese obesity to the country’s adoption of a more Western diet. *See e.g.*, *Waistline Scrutiny a Midlife Bugbear*, *supra* note 15 (“[w]ith little time for exercise and higher consumption of Western food, more Japanese are experiencing metabolic syndrome”); *Waistlines are the Bottom Line: Japan Prods its Workers to Shape Up, Slim Down*, S. FLORIDA SUN-SENTINEL, June 26, 2008, at

Japanese population is obese and the nation has one of the world's lowest rates of obesity.⁴³ Nevertheless, Japan has a compelling need to introduce anti-obesity legislation. The country recently has seen a troublesome increase in the risk factors associated with obesity and metabolic syndrome.⁴⁴ According to the Ministry of Health, Labor and Welfare, 9.4 million adults aged forty through seventy-four suffered from metabolic syndrome in 2006 and millions more were at risk.⁴⁵ Specifically, the average cholesterol count amongst Japanese adults has increased in the past several decades and the number of diabetics has doubled since the mid-1980s.⁴⁶ If left unchecked, some experts fear that one-third of the adult population could suffer from metabolic syndrome by 2010.⁴⁷

Furthermore, Japanese adults are not the only ones gaining weight—obesity is now “striking at an earlier age” than in previous decades.⁴⁸ From 1970 to 1999, the rate of obesity amongst Japanese children increased dramatically, from 2.9% to 9.7% among boys and from 3.4% to 8.0% among girls.⁴⁹ In 2004, the rate of obesity amongst Japanese teens and young adults (fifteen to nineteen years old) was also approximately twice the rate of obesity for the population as a whole.⁵⁰ Studies indicate that obesity is a nationwide problem that affects both rural and urban children alike.⁵¹ These trends are particularly concerning for Japan given the country's disproportionately aged population and the government's obligation to cover healthcare expenses for elderly citizens,

5E, available at 2008 WLNR 11993032 (“eating habits in Japan have been changing, including the acceptance of fast food and Western-style cooking”).

43. FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 15.

44. Rena Singer, *Japan Cracks Down on Waistlines*, U.S. NEWS & WORLD REP., June 4, 2008, available at <http://www.usnews.com/articles/news/world/2008/06/04/japan-cracks-down-on-waistlines.html>.

45. Atsushi Miyazaki & Hidekazu Tanaka, *Japan Turning Into Nation of Fatties*, DAILY YOMIURI (Japan), May 23, 2006, at 3, available at 2006 WLNR 14764614.

46. *Average Cholesterol Count on Rise Among Japanese*, DAILY YOMIURI (Japan), Feb. 5, 1993, at 3, available at WLNR1113442 (noting that the average cholesterol count rose 7.7% from 1980 to 1993); Singer, *supra* note 44.

47. Takai, *supra* note 38.

48. *Young Japanese Men Losing War on Weight*, *supra* note 15.

49. Mydans, *supra* note 6.

50. World Health Organization, Japan: All Data BMI/Overweight/Obesity, <http://www.who.int/infobase/reportviewer.aspx?rptcode=ALL&uncode=392&dm=5&surveycode=102530a1> (last visited Oct. 20, 2009).

51. *Farm Children More Obese than City Kids*, DAILY YOMIURI (Japan), May 25, 1995, at 7, available at 1995 WLNR 1325326.

as previously discussed.⁵² The average life expectancy in Japan has reached eighty-two years—longer than the life expectancy in any other country.⁵³ In 1990, nearly 13% of the Japanese population was age sixty-five years and older, but this proportion is expected to hit a whopping 23% by 2050.⁵⁴ As Japan’s increasingly obese population continues to age, the costs associated with treating obesity and its affiliated diseases will skyrocket.

Accordingly, the Japanese government has grown increasingly concerned with containing the costs of obesity and anti-obesity legislation, which has become a “hot topic” in Japanese politics.⁵⁵ In fact, local municipalities across Japan have been experimenting with anti-obesity campaigns for the past decade. For example, the Hokkaido Police Department called upon the prefecture’s officers “to tighten both their morale and their waists” by issuing them pedometers and launching a “million-step campaign.”⁵⁶ From 2003 to 2005, the city of Sapporo also invited citizens to participate in voluntary exercise sessions organized by the local government.⁵⁷ The Mie Prefecture led a similar weight-loss program dubbed “The Seven Metabo Samurai.”⁵⁸ Thus, while the “Metabo” legislation may seem shocking to the international community, the Japanese have been building up to this point for years. As a result of these previous weight-loss interventions, the Japanese people have grown accustomed to experimenting with government initiatives aimed at their waistlines.

52. See generally MILTON I. ROEMER, NATIONAL HEALTH SYSTEMS OF THE WORLD, VOLUME ONE: THE COUNTRIES 160 (1991) (noting that by 1980 approximately ten percent of the Japanese population lived past age sixty-five). Because the elderly have a “greater prevalence of chronic illness,” they generally require more expensive healthcare services for longer periods of time than the young. *Id.*

53. DAVID A. WISE, *Introduction*, in HEALTH CARE ISSUES IN THE UNITED STATES AND JAPAN 1 (David A. Wise & Naohiro Yashiro eds., 2006). By comparison, the average life expectancy in the United States is seventy-seven years. *Id.*

54. Ryuzo Sato et al., HEALTH CARE SYSTEMS IN JAPAN AND THE UNITED STATES: A SIMULATION STUDY AND POLICY ANALYSIS 7 (1997) (explaining in detail the causes of the change in demographics of the Japanese population). By comparison, the proportion of the United State population age sixty-five and older was nearly 13% in 1990 and “is expected to reach 22.9[%] by 2050.” *Id.*

55. *Waistline Scrutiny a Midlife Bugbear*, *supra* note 15. In fact, metabolic syndrome is so widely debated in Japan that a Cabinet Office survey in 2008 revealed that 87.6% of Japanese were familiar with the meaning of the term. *Most Japanese Know Metabolic Syndrome: Govt Survey*, *supra* note 20.

56. *Hokkaido Police Fight Fat in War Against Crime*, DAILY YOMIURI (Japan), June 7, 1998, at 2, available at 1998 WLNR 1493193.

57. Honda, *supra* note 16, at 4.

58. Onishi, *supra* note 21, at A12. Unfortunately, the “Seven Metabo Samurai” program “ended abruptly after a 47-year-old member with a 39-inch waistline died of a heart attack while jogging.” *Id.*

Japan's increasing fixation on metabo has also been reflected in popular culture. According to a study reported by the Ministry of Education, Science and Technology in 2006, the Japanese people have grown increasingly "aware of their health and their need for exercise" in the past two decades.⁵⁹ Just as Americans have adopted weight-loss icons like Jared Fogle, the Subway spokesman, or the cast members of NBC's weight-loss television show *The Biggest Loser*, the Japanese have adopted their own mega-weight-loss heroes. Toshio Okada, for example, gained national notoriety (and several book deals) after losing 110 pounds.⁶⁰ In addition, from 1997 to 2002, the diet and weight-loss industry more than doubled its sales from 120 billion yen per year to 300 billion yen per year.⁶¹ While these cultural influences have not been enough to reverse obesity trends in the past, they indicate that the Japanese are interested in losing weight and are accustomed to receiving help from the government. Accordingly, the Japanese may be more willing to seize the opportunity presented by the "Metabo" legislation and work to reverse the country's troubling weight gain.

B. The Authority of Japanese Physicians and Medical Policymakers

The second indication that the new "Metabo" legislation will decrease obesity in Japan is the broad authority granted to Japanese physicians. Given the natural imbalance of information and power between medical professionals and their patients, medical paternalism has been a traditional component of many healthcare systems.⁶² Although Americans grew increasingly intolerant of medical paternalism during the civil rights era, the Japanese have only recently, and perhaps tentatively, embraced the general legal concepts of access, accountability, and transparency in healthcare.⁶³

59. *Survey Finds People Feeling Underexercised, More Obese*, DAILY YOMIURI (Japan), Oct. 30, 2006, at 3, available at 2006 WLNR 23436781.

60. *Waistlines Are the Bottom Line: Japan Prods its Workers to Shape Up, Slim Down*, *supra* note 47 (citing Okada's best-selling book, *Sayonara Mr. Fatty: A Diet Memoir*).

61. *Despite Doubts, Sales Expand in the Diet Sector*, ASAHI SHIMBUN (Japan), Mar. 23, 2002, available at 2002 WLNR 7437893.

62. LEANNA DARVALL, *MEDICINE, LAW AND SOCIAL CHANGE: THE IMPACT OF BIOETHICS, FEMINISM AND RIGHTS MOVEMENTS ON MEDICAL DECISION-MAKING* 7 (1993).

63. *Id.* at 8; Harry N. Scheiber, *Introduction* to *EMERGING CONCEPTS OF RIGHTS IN JAPANESE LAW* xiv (Harry N. Scheiber & Laurent Mayali eds., 2007).

Thus, Japanese physicians retain a high degree of control over diagnosis and treatment decisions.⁶⁴ Comparative public health law scholar Eric Feldman summarized the current state of patients' rights in Japan today as follows:

Patients in Japan thus lack a variety of the rights held by their American counterparts. They have no right to examine their medical records. Their right to information about diagnosis and treatment is contingent on physician discretion, which in practice means that many patients are not given an accurate diagnosis. Patients do not have a right to decide which course of treatment to pursue. And in what may be the nation with world's highest rate of prescribed and ingested medication, patients lack the right to know about the intended and unintended effects of what they are consuming.⁶⁵

Given that Japanese patients are not afforded the "right to self-determination or autonomy with respect to the selection of treatment," they may be more willing to blindly accept a mandated diet and exercise program than their American counterparts.⁶⁶

Furthermore, Japanese courts routinely reinforce a physician's authority to withhold diagnosis or treatment information.⁶⁷ For example, in the particularly controversial "Mikano case" in the mid-1990s, a physician informed his patient that she likely suffered from gallstones, yet her symptoms showed a strong likelihood of advanced gall bladder cancer. The patient died months later from cancer and her family filed suit against the physician "claiming that timely disclosure of the cancer diagnosis would have impelled her to seek immediate treatment and could have saved her life."⁶⁸ However, the Supreme Court of Japan affirmed a holding that the doctor had not breached his duty to inform the patient of the consequences of declining treatment.⁶⁹ In response to the "Mikano case," Japanese legal scholars have noted that "the general tendency of the Japanese judiciary to defer to medical practice in matters of information disclosure remains unshaken."⁷⁰ Thus, even if the new "Metabo" legislation were to spawn litigation over undisclosed treatment options for obesity, it is unlikely that the Japanese Courts will interfere with the program. Because of the significant deference afforded to medical professionals by Japanese citizens and the Japanese legal system

64. ERIC A. FELDMAN, *THE RITUAL OF RIGHTS IN JAPAN: LAW, SOCIETY, AND HEALTH POLICY* 44 (2000).

65. *Id.* at 46.

66. *Id.* at 58.

67. Robert B. Leflar, *Informed Consent and Patients' Rights in Japan*, 33 *Hous. L. Rev.* 1, 45 (1996).

68. *Id.* at 53.

69. *Id.*

70. *Id.* at 58.

alike, the “Metabo” weight-loss program should fit seamlessly into the Japanese healthcare system.

C. Japan’s Cultural Emphasis on Harmony

The third factor affecting the likely success of the new “Metabo” legislation in Japan is related to the Japanese value of *wa*, or societal harmony.⁷¹ The Japanese previously have been described as “group-oriented” and “conformist.”⁷² Although the notion of Japanese individualism is often debated, the Japanese emphasis on *wa* is undeniably important to the “Metabo” legislation in two ways.⁷³

First, *wa* is reflected in Japan’s heightened attention to consensus in the legislative process.⁷⁴ According to Japanese legal scholar John Haley:

Lawmaking by consensus gives legislated legal rules an aura of fairness and inherent legitimacy. By consensus legal rules acquire an intrinsic capacity to induce voluntary compliance. Consensus thus fosters public acceptance and obedience to legal rules Even the most controversial legal rules, if enacted after a long period of discussion and debate, can be viewed as an expression of national community agreement.⁷⁵

Because of Japan’s unique emphasis on consensual lawmaking, the Japanese are generally more willing to obey and uphold laws once they have been passed.⁷⁶ Japanese media coverage of the “Metabo” legislation reflects this cultural inclination to accept new legislation. For example, even critics of the “Metabo” legislation have acknowledged that improving the overall health of society is an admirable goal.⁷⁷ In addition, the Japanese media has reported a considerable degree of apathy in response to the anti-obesity campaign. For instance, one citizen told the press, “Japan shouldn’t be making such a fuss about

71. FELDMAN, *supra* note 64, at 144.

72. JOHN OWEN HALEY, *THE SPIRIT OF JAPANESE LAW* 14 (1988).

73. *See, e.g., id.* at 32 (“Although Japan is considerably less homogenous and cohesive than many Japanese and non-Japanese appear to appreciate, no one denies the strength of community”).

74. *Id.* at 35.

75. *Id.* at 17, 36.

76. *Id.*

77. “Nobody disputes the importance of efforts to prevent lifestyle-related diseases like diabetes and high blood pressure in curbing the rapid growth of spending on healthcare.” *Anti-Metabolic Syndrome Scheme Needs Rethinking*, *supra* note 33.

this,” but participated in the waistline screening anyway.⁷⁸ In the apparent absence of open and impassioned opposition to the “Metabo” legislation (or any new legislation in Japan), it seems highly unlikely that the Japanese will reject the new anti-obesity campaign.

The second reason Japan’s emphasis on *wa* is noteworthy in the context of the new “Metabo” legislation is that it complements the goals of public health regulation in general. According to public health experts David L. Kirp and Ronald Bayer:

The ethos of public health and that of civil liberties are radically distinct. At the most fundamental level, the ethos of public health takes the well-being of the community as its highest good and would, to the extent deemed necessary, limit freedom or place restrictions on the realm of privacy in order to prevent morbidity from taking its toll.⁷⁹

Even though public health regulation necessarily infringes upon individual rights, the Japanese seem to openly recognize that a failure to reduce the overall incidence of metabolic syndrome would have “consequences [that] are costly to both individual and society.”⁸⁰ Again, the Japanese media’s reporting is infused with the value of *wa* and denotes that the Japanese may be willing to adhere to the new legislation for the benefit of Japan as a nation, if not for their own personal benefit. For example, an anti-metabo song that made national headlines emphasized communities fighting obesity together with lyrics such as “[L]et’s get our checkups together. Go! Go! Go!”⁸¹ Because Japanese citizens are more willing to act in accordance with the goals of society as a whole, the “Metabo” legislation is more likely to succeed in Japan than perhaps in any other country.

D. The Constitution of Japan

The fourth indication that the “Metabo” legislation will be successful in decreasing Japanese obesity is the judiciary’s relative unwillingness to strike down legislation as unconstitutional.⁸² Instead, the Japanese judiciary has “consistently construed the constitution in ways that reinforce community preferences and practice against claims for protection of individual beliefs.”⁸³ Justification for such a practice is rooted in Japan’s

78. Onishi, *supra* note 21.

79. FELDMAN, *supra* note 64, at 53.

80. Ann Endo, *Supersizing Diabetes in Children*, DAILY YOMIURI (Japan), May 21, 2006, at 21, available at 2006 WLNR 14764740.

81. Onishi, *supra* note 21.

82. Susan Minamizono, Comment, *Japanese Prefectural Scapegoats in the Constitutional Landscape: Protecting Children from Violent Video Games in the Name of “Public Welfare,”* 9 SAN DIEGO INT’L L.J. 135, 142 (2007).

83. HALEY, *supra* note 72, at 179.

traditional “communitarian orientation,” but it may also be inferred from the text of the Japanese constitution itself.⁸⁴ The individual civil rights articulated in Articles 12 and 13 of the Japanese Constitution are not absolute:

The freedoms and rights guaranteed to the people by this Constitution shall be maintained by the constant endeavor of the people, who shall refrain from any abuse of these freedoms and rights and *shall always be responsible for utilizing them for the public welfare.*

All of the people shall be respected as individuals. Their right to life, liberty and the pursuit of happiness shall, *to the extent that it does not interfere with the public welfare*, be the supreme consideration in legislation and in other governmental affairs.⁸⁵

In the context of obesity, an individual’s liberty interests in privacy and self-autonomy are at stake. However, as the Japanese Constitution itself so clearly expresses, the rights of individuals may cede to the welfare of the nation as a whole.

The court’s role in protecting the community rather than recognizing individual rights is apparent in Japanese healthcare jurisprudence in general. First, Japanese patients do not have access to their own medical records unless filing for malpractice.⁸⁶ Second, Japanese medical records are not confidential, as health insurance officials and employers “are often able to obtain detailed information on [patients’] disease and treatment.”⁸⁷ Finally, the Japanese courts previously have allowed policymakers to implement a compulsory screening program in the name of an epidemic. In the mid-1980s, for example, the first draft of Japan’s AIDS legislation called for a revision of the Immigration Act that would “deny entry to foreigners suspected of being HIV-positive.”⁸⁸ Even more recently, the Japanese began to screen the urine of all 12 million primary and middle school students in an effort to detect diabetes.⁸⁹ Thus, while one enraged critic of the “Metabo” legislation argued that his “waistline is none of [his] company’s business,” the law may provide

84. *Id.* at 14.

85. KENPŌ, arts. 12–13 (emphasis added).

86. Leflar, *supra* note 67, at 34.

87. *Id.* at 35.

88. FELDMAN, *supra* note 64, at 75.

89. Endo, *supra* note 80, at 21. As the screening program indicates, the Japanese are also working to decrease childhood obesity even though childhood obesity is not addressed by the new “Metabo” legislation. *Id.*

only limited relief.⁹⁰ That the Japanese courts are unlikely to question the constitutional validity of the new legislation bolsters the likelihood that it will decrease Japanese obesity.

E. The “Metabo” Legislation’s Enforcement Mechanism

The fifth factor affecting the likelihood that the new “Metabo” legislation will effectively reduce obesity in Japan is the legislation’s built-in enforcement mechanism. As previously mentioned, insurance providers that fail to adequately participate in the program or fail to reduce their percentage of patients suffering from metabolic syndrome by 2012 will face serious fines.⁹¹ These fines are hardly an empty threat. Only sixty percent of adults currently attend annual check-ups.⁹² Without full participation, insurance providers may find it difficult to meet the weight-loss goals proscribed by the “Metabo” legislation. However, one local government official acknowledged that it could be “extremely difficult” to increase the number of citizens participating in annual check-ups and the screening process.⁹³ Employers providing health insurance are also feeling the pressure. For example, NEC, a large Japanese employer and manufacturer of personal computers, claimed that if it fails to reach the government’s designated targets it could be fined \$19 million.⁹⁴ Health insurance providers simply cannot risk failure to shape up and slim down, especially in such an unstable economic environment.

With such severe consequences looming, health insurance providers have been apt to support the anti-obesity legislation as much as possible. Thus far, 85% of municipalities have reported to have launched the weight-loss efforts successfully.⁹⁵ Moreover, some employers have gone far beyond what is necessary in supporting the new legislation.⁹⁶ For example, Toyota Motor Corporation invested 4.8 billion yen on exercise and nutrition seminars, a healthcare support center, and other related

90. Singer, *supra* note 44.

91. Onishi, *supra* note 21; *see also* TAKAI, *supra* note 38.

92. Honda, *supra* note 16, at 4.

93. Onishi, *supra* note 21.

94. *Id.*

95. *85% of Local Govts Offer Free Metabolic Syndrome Checks*, *supra* note 31.

96. *Cf.* Takai, *supra* note 38. The support from employers may be in jeopardy with the downturn in the economy. The *Nikkei Weekly* reported in February 2009 that there has been an unexpected drop in corporate gym memberships. “The clubs had anticipated increased demand following a new government mandate that took effect in April 2008 requiring corporate health-care associations to offer special checkups and guidance to prevent or treat obesity. That expected demand, however, has yet to emerge.” *Hit by Drop in Corporate Accounts, Fitness Clubs Begin Scaling Back*, NIKKEI WKLY. (Japan), Feb. 2, 2009, available at 2009 WLNR 1959391.

services before the “Metabo” legislation even went into effect.⁹⁷ Other employers have begun to screen all employees for metabolic syndrome, regardless of their age.⁹⁸ Although the “Metabo” legislation’s built-in enforcement mechanism has motivated many to comply with the program, other employers have preferred to adopt a “wait and see” attitude.⁹⁹ Given the aggressive weight-loss goals set by the “Metabo” legislation, Japan may need more uniform participation for the program to significantly reduce the rate of obesity.

F. The Costs of the “Metabo” Legislation

What appears to be the greatest impediment to the likelihood that the “Metabo” legislation will decrease the rate of Japanese obesity is the cost associated with implementing the program. As previously noted, one of the express purposes behind the “Metabo” legislation is to reduce the cost of healthcare. But because the program costs 15,000 to 20,000 yen per person to implement, critics note that it is unlikely to save the healthcare system enough money to be worthwhile.¹⁰⁰ If those diagnosed with metabolic syndrome resort to quick-fix medications or unhealthy binge diets, the program may ultimately raise healthcare costs.¹⁰¹ Professor Yoichi Ogushi, one outspoken critic and health expert from the Tokai University School of Medicine, has commented that the waistline criteria used to screen patients are far too strict and “could unnecessarily increase the number of patients” in the program.¹⁰² Although all adults

97. *Body Fat Comes Under Broad Attack*, NIKKEI WKLY. (Japan), Feb. 5, 2007, available at 2007 WLNR 2203326. However, critics have also pointed out that employers now have more of a stake in their employee’s weight: “[w]hile this development is seen as an opportunity for Japanese to improve their health, it is also being regarded as a chance for savvy companies to improve their bottom line.” Takai, *supra* note 38.

98. Yuri Kageyama, *Corporate Japan Starts a New Campaign against Obesity, ‘Metaboh’*, CHINA POST, June 9, 2008, <http://www.chinapost.com.tw/health/nutrition%20&%20fitness%20/2008/06/09/160167/p2/Corporate-Japan.htm>.

99. Takai, *supra* note 38.

100. Honda, *supra* note 16, at 4; *see also 85% of Local Govts Offer Free Metabolic Syndrome Checks*, *supra* note 31 (“Observers express concern that the free system will lead to a decline in overall quality of health care and a decrease in other welfare budgets, thereby reducing social services for local residents”).

101. *85% of Local Govts Offer Free Metabolic Syndrome Checks*, *supra* note 31.

102. *Japan Turning Into Nation of Fatties*, *supra* note 45; *see also Anti-Metabolic Syndrome Scheme Needs Rethinking*, *supra* note 33 (“Critics point out that the standard of abdominal obesity used to select people with high risk is not based on solid scientific data”). Most of the criticism of the new legislation seems to focus on the waistline criteria, rather than the adoption of the innovative program in general. In particular, critics are

at risk for developing metabolic syndrome should be included in the program, Ogushi is certainly correct that the long-term costs associated with the “Metabo” legislation will only increase as more patients are included.

In addition to doubts over the long-term efficacy of the “Metabo” legislation, there are immediate cost concerns. The substantial fixed costs of training nurses and opening weight-loss counseling programs has precluded many local governments from initiating the anti-obesity campaign.¹⁰³ While 85% of municipalities have opened their Metabo clinics, another 15% of municipalities have not yet complied with the legislation.¹⁰⁴ The majority of local governments are receiving aid from the federal government to support the program, but certain municipalities have argued that the aid is still not enough.¹⁰⁵ Without more aid from the federal government, “[o]bservers [have expressed] concern that the free system will lead to a decline in overall quality of health care and a decrease in other welfare budgets, thereby reducing social services for local residents.”¹⁰⁶ At this point, however, the Ministry of Health, Labor and Welfare has stated that “[i]t will be difficult to increase state subsidies to municipalities.”¹⁰⁷ The prospect of additional funding seems even less likely as global economic conditions have led the Bank of Japan to project no growth in the national economy for the first time in nearly a decade.¹⁰⁸ Unless these short-term fiscal constraints are resolved, financial impediments could stop the “Metabo” legislation in its tracks.

G. Predictions for the “Metabo” Legislation

Even if the cost associated with implementing the weight loss programs poses a significant impediment to the likelihood that the “Metabo” legislation will decrease Japanese obesity, the new legislation is more likely to improve Japanese health than fail to make a difference. As one health expert noted, it could take several years to discern the full

concerned that waistline cut-offs are stricter for men than they are for women. Hisahiko Yano, *Bloated ‘Metabo’ Market May Have to Slim Down*, NIKKEI WKLY. (Japan), Nov. 4, 2008, available at 2008 WLNR 21057789; *Metabolic Syndrome Criteria ‘Too Strict’*, DAILY YOMIURI (Japan), Oct. 14, 2007, at 2, available at 2007 WLNR 20158492.

103. 85% of Local Govts Offer Free Metabolic Syndrome Checks, *supra* note 31.

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.*

108. *Japan Forecasts No Growth in 2009*, BBC NEWS, Dec. 19, 2008, <http://news.bbc.co.uk/2/hi/business/7791068.stm>.

effect of the program.¹⁰⁹ However, initial reports on the effects of the program have been hopeful. According to the *Nikkei Weekly*,

A survey of male and female consumers aged 20 to 59 found that more than half of respondents were positive about making efforts to prevent developing metabolic syndrome, with 21% saying they were already working on reducing their risk and 35% planning to do so.¹¹⁰

The Japanese have made their reactions to the “Metabo” legislation clear in the private sector as well. Since the adoption of the “Metabo” legislation in April 2008, the “anti-metabolic” industry has seen another surge in sales.¹¹¹ For example, “[p]edometer sales have risen 20% from before April” and high performance underwear for men that allegedly burns fat has been flying off the shelves.¹¹²

Moreover, recent weight-loss research tends to support the prediction that the “Metabo” legislation will decrease obesity in Japan. In general, medical experts agree that coordinated, comprehensive interventions are the best way to fight obesity, both on the individual level and for society as a whole.¹¹³ For example, “the United States Preventive Services Task Force found that education, behavior-oriented counseling, and patient reinforcement and follow-up was the most effective intervention in preventing and treating obesity.”¹¹⁴ The “Metabo” legislation clearly heeds such advice. Although the cost of implementing the anti-obesity program on a national scale poses a serious impediment to the success of the legislation in decreasing obesity, the aforementioned structural and cultural factors of a compelling need for anti-obesity legislation, the broad authority vested in Japanese medical professionals, the emphasis on harmony, the Japanese Constitution, and the legislation’s enforcement mechanisms suggest that the program is more likely to reduce obesity in Japan than fail to make a difference.

109. Takai, *supra* note 38.

110. *Outwitting Metabolic Syndrome*, NIKKEI WKLY. (Japan), June 16, 2008, available at 2008 WLNR 11357379.

111. *Id.*

112. *Id.*

113. Judith G. Dausch, *The Obesity Epidemic: What’s Being Done?*, 102 J. AMER. DIETETIC ASSOC. 638, 639 (May 2002). This is particularly true because there is no one single cause of obesity. David G. Yosifon, *Legal Theoretic Inadequacy and Obesity Epidemic Analysis*, 15 GEO. MASON L. REV. 681, 683 (2008).

114. Byrd, *supra* note 2, at 334.

IV. “METABO” LEGISLATION IN THE UNITED STATES— ARE WE NEXT?

Even though the Japanese view obesity as a grave issue and have responded positively to the new legislation, the international community seems to be amused by Japan’s anti-obesity campaign. For example, the *Irish Times* reported on the legislation in an article replete with sarcastic references to the “fight-the-flab campaign” and the “potbelly police.”¹¹⁵ An African media outlet even comically asked, “[w]here will all the Japanese sumo wrestlers go now?”¹¹⁶ The response in the United States, however, has been far more critical. An editorialist for the *Philadelphia Daily News* likened the Japanese government to Big Brother and the *Washington Post* referred to the Japanese legislation as “draconian.”¹¹⁷ An ABC News report summarized the American media’s response to the “Metabo” legislation when stating that “a program like Japan’s has no place in the U.S.”¹¹⁸

Ironically, however, some Japanese health experts believe that the “Metabo” legislation is more appropriate for the United States given the severity of the American obesity epidemic and prevalence of metabolic syndrome in the United States.¹¹⁹ Japanese health expert Yoichi Ogushi commented, “[I]f you did this in the United States, there would be benefits, since there are many Americans who weigh more than 100 kilograms.”¹²⁰ In reference to American obesity, the *Asahi Shimbun* newspaper also reported that in the United States, “[y]ou see people who are amazingly corpulent—often as fat as former sumo wrestler Konishiki.”¹²¹

Despite international opinion, the United States is unlikely to find a place for “Metabo” legislation any time soon. Several of the elements supporting the legislation in Japan, including a universal healthcare

115. McNeill, *supra* note 28, at 12.

116. Opiyo Oloya, *Uganda: ‘Waistline Police’ on the Lookout for Obese Japanese*, ALLAFRICA GLOBAL MEDIA (ALLAFRICA.COM), June 25, 2008, <http://allafrica.com/stories/200806250044.html>.

117. Garrison, *supra* note 37; Patrick Basham & John Luik, *Fat risks? Sumo, Some Less*, WASH. TIMES, July 11, 2008, at A20, available at <http://www.washingtontimes.com/news/2008/jul/11/fat-risks-sumo-some-less/>.

118. Radha Chitale, *Fat Fines: Could Japan Plan Work in U.S.?*, ABC NEWS, June 27, 2008, <http://abcnews.go.com/Health/story?id=5254825&page=1>.

119. For example, according to the International Obesity Task Force, the number of children “affected by the metabolic syndrome doubled from 910,000 to two million in less than 10 years.” An IOTF spokesperson noted that these statistics were “more than just a warning signal—[they’re a] red light.” *Metabolic Syndrome Affects Half a Million European Children*, AM. HEALTH LINE, June 3, 2005.

120. Onishi, *supra* note 21 (100 kilograms is approximately 220 pounds).

121. *Haste Makes “Waist” in Expanding Americans*, ASAHI SHIMBUN (Japan), Jan. 25, 2003, available at 2003 WLNR 8971870.

system and a cultural emphasis on national harmony, are notably absent in the United States. Instead, “Metabo” legislation in the United States would be undermined by a disjointed healthcare system and a culture of individualism and autonomy. While the United States also has a compelling need for anti-obesity legislation and *should* adopt an innovative and comprehensive attack on obesity, it is highly unlikely to adopt legislation on par with Japan’s “Metabo” legislation.

A. Disjointed Structure of the American Healthcare System

Perhaps the most obvious impediment to adopting “Metabo” legislation in the United States is the structure of the healthcare system. The structure of the American healthcare system prevents the adoption of “Metabo” legislation in two ways. First, Americans are not guaranteed access to healthcare on an annual basis, and 47 million Americans are uninsured.¹²² Thus, unlike Japan, the United States does not have a comprehensive nationwide healthcare system to use as a foundation for implementing an aggressive screening and counseling program. Even if the United States were able to adopt “Metabo” legislation for those who do receive annual health exams, it is unlikely that the program would significantly impact the health of the nation as a whole. Thus, adopting a nationwide anti-obesity program would first require the United States to address the seemingly impossible task of guaranteed access to healthcare.

Second, the American healthcare system is unable to enforce anti-obesity legislation with its current structure. As previously discussed, the “Metabo” legislation in Japan has garnered a tremendous amount of support from health insurance providers in part because of the possible financial penalties. Conversely, American health insurance providers are not obligated to contribute directly to a nationally pooled healthcare fund for the elderly. Although beyond the scope of this Comment, “fat taxes” and financial penalties imposed on health insurance providers have also been extremely controversial and widely rejected in the United States.¹²³ Although President Obama is calling for sweeping reforms to

122. *47 Million Uninsured Americans 'Is a Traveesty,' Says the APHA*, MED. NEWS TODAY, Aug. 29, 2007, <http://www.medicalnewstoday.com/articles/80891.php>.

123. See generally Erin E. Patrick, *Lose Weight or Lose Out: The Legality of State Medicaid Programs that Make Overweight Beneficiaries' Receipt of Funds Contingent Upon Healthy Lifestyle Choices*, 58 Emory L.J. 249, 284–85 (2008) (arguing that obesity-related penalties should not be implemented to reduce healthcare costs); Chris L. Winstanley, Comment, *A Healthy Food Tax Credit: Moving Away From the Fat Tax and*

the American healthcare system, the current structure prevents the adoption of Japan's "Metabo" legislation to fight obesity in the United States.¹²⁴

B. American Individualism and Regulating Healthcare

The second factor undermining the likelihood of the United States adopting Japan's "Metabo" legislation is the American aversion to the "nanny state." Healthcare regulation in the United States "reveals some of the most salient tensions in American political theory: Under what circumstances can government limit individual freedoms to protect citizens from the consequences of their personal and lifestyle choices?"¹²⁵ In the United States, those circumstances are rare indeed. Unlike their Japanese counterparts, Americans are overwhelmingly anti-paternalistic and oppose government "interference with people's liberty for their own good" or for the good of society as a whole.¹²⁶ Because "personal choice, individualism, and autonomy are core American values," many Americans have adopted the viewpoint that government regulations have no place in their home, let alone in their kitchen.¹²⁷ If Japan's "Metabo" legislation were ever seriously considered in the United States, it would have to overcome our government's procedural safeguards against state interference on privacy.¹²⁸ Pursuant to Executive Order 12866, government regulation is permitted only when targeting a market failure or compelling public need.¹²⁹ Anti-obesity legislation is unlikely to pass

Its Fault Based Paradigm, 86 OR. L. REV. 1151, 1170–83 (2007) (discussing Stanford Law Professor Jeff Strnad's "food tax" imposed through the insurance system).

124. A national healthcare program may soon be a reality in America. President Obama has called for sweeping changes in the American healthcare system. See, e.g., Dan Lothian & Suzanne Malveaux, *Obama Calls for Overhaul of U.S. Health Care System*, CNN, <http://www.cnn.com/2009/POLITICS/03/05/health.care.summit/index.html#cnnSTCText> (last visited Oct. 20, 2009). On February 4, 2009, the Obama administration took the first step to a more comprehensive healthcare system by signing the Children's Health Insurance Bill, which extends insurance to impoverished children. Robert Pear, *Obama Signs Children's Health Insurance Bill*, N.Y. TIMES, Feb. 4, 2009, at A4, available at http://www.nytimes.com/2009/02/05/us/politics/05health.html?_r=3&scp=1&sq=obama%20children's%20healthcare&st=cse.

125. Thaddeus Mason Pope, *Balancing Public Health against Individual Liberty: The Ethics of Smoking Regulations*, 61 U. PITT. L. REV. 419, 424 (2000).

126. Winstanley, *supra* note 123, at 1174.

127. *Id.* As Justice Benjamin Cardozo has said in regards to medical paternalism: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." Ben A. Rich, *Medical Paternalism v. Respect for Patient Autonomy: The More Things Change the More They Remain the Same*, 10 MICH. ST. J. MED. & L. 87, 91 (2006).

128. David Burnett, *Fast-Food Lawsuits and the Cheeseburger Bill: Critiquing Congress's Response to the Obesity Epidemic*, 14 VA. J. SOC. POL'Y & L. 357, 417 (2007).

129. Exec. Order No. 12,866, 3. C.F.R. 638 (1993).

muster from an economic point of view; however, Americans should reconsider the value of addressing obesity as a “compelling public need.”

*1. Anti-Obesity Legislation Is Unlikely to Rest on a
Market Failure Theory*

According to general economic theory, government regulation “should be limited to addressing those areas where private markets fail to reach the optimal allocation of resources.”¹³⁰ However, the private market may be unable to reach the optimal allocation of resources and the maximization of social welfare when hindered by a “market failure.” Two commonly debated market failures that may be used to justify anti-obesity legislation include: (1) negative externalities and (2) asymmetric information. Where there is evidence of a market failure, it may be necessary for the government to step in and rectify the problem with appropriate legislation. Yet in the context of obesity, American scholars and politicians are divided on the validity of these alleged market failures and whether it is appropriate to justify anti-obesity legislation with such theories. Given the controversy of the debate in the United States, it is unlikely that sufficient consensus will be reached to adopt an anti-obesity campaign similar to Japan’s “Metabo” legislation on such grounds.

*a. Negative Externalities—The Cost of Obesity on
Society as a Whole*

Some law and economics theorists contend that obesity imposes negative externalities upon society, thus constituting a market failure and providing an appropriate justification for anti-obesity legislation. In general, externalities are defined as the “side effects of a market that spill over into society at large.”¹³¹ For example, while cigarette smoking causes obvious harm to the individual smoker, it may also cause harm to society as non-smokers may suffer from second-hand smoke and contract life-threatening illnesses through no fault of their own.¹³² This

130. See FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 102.

131. *Id.* at 104.

132. See, e.g., Joseph P. McMenamin & Andrea D. Tiglio, *Not the Next Tobacco: Defenses to Obesity Claims*, 61 FOOD & DRUG L.J. 445, 465 (2006) (discussing second-hand smoke as an externality).

particular market failure, the negative externalities smokers pose to society through the dangers of second-hand smoke, was necessary to justify many of the smoking regulations of the 1990s.¹³³ Given that obesity closely follows tobacco consumption as the second largest cause of preventable death in the United States, aggressive regulation of obesity seems like the natural next step in public health regulation.¹³⁴ However, the possible externalities posed by the obesity epidemic are far more obscure and more controversial than those associated with smoking. According to one skeptical scholar, “[T]he self-destructive dietary habits of even the most corpulent overeater pose no threat to those seated at the same table.”¹³⁵

As the costs of the obesity epidemic to society are exposed, it is becoming increasingly clear that there are other externalities to consider. First, the debilitating diseases stemming from obesity pose costs on the healthcare system that have increased exponentially with the corresponding rise in the rate of obesity. Medicaid and Medicare now spend an additional \$45 billion dollars a year on obesity-related matters and taxpayers are footing the bill at an additional \$175 per person per year.¹³⁶ Second, because obesity causes increased risks of absence from work and even premature death, the decreased productivity of the work force must also be considered.¹³⁷ Finally, commentators have noted other surprising costs, such as increased fuel costs to the airline industry.¹³⁸ Overall, the Surgeon General estimated in 2000 that the aggregate costs of obesity had reached \$117 billion dollars.¹³⁹ As the costs of obesity on society become more apparent, they may be used to justify more aggressive anti-obesity intervention.¹⁴⁰ However, at this point it is

133. See, e.g., The California Smoke Free Workplace Act, CAL. LAB. CODE § 6404.5 (1995).

134. Kristian Bolin & John Cawley, *Introduction* to THE ECONOMICS OF OBESITY xvii (Kristian Bolin & John Cawley eds., 2007).

135. MCMENAMIN & TIGLIO, *supra* note 132, at 466. Although interesting new research suggests that a communicable virus may cause obesity in some people, it is still generally accepted that the health consequences of overeating are internalized. *Id.* at 486; see also Saul Levmore, *Taxing Obesity—Or Perhaps the Opposite*, 53 CLEV. ST. L. REV. 575, 576 (2005–06) (comparing negative externalities posed by smoking to those possibly posed by obesity).

136. FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 132.

137. Brooke Courtney, *Is Obesity Really the Next Tobacco? Lessons Learned from Tobacco for Obesity Litigation*, 15 ANNALS HEALTH L. 61, 67 (2006).

138. *Id.* at 69.

139. U.S. Dept. of Health & Human Services, THE SURGEON GENERAL’S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY 2001, <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>.

140. Negative externalities are difficult to ascertain and in other areas of government regulation evidence of externalities grew over time. For example, in the context of motorcycle helmet laws, many originally argued that the costs of failure to wear a helmet were borne

doubtful that debatable assertions of economic harm as a negative externality will justify an anti-obesity campaign as controversial as Japan's "Metabo" legislation.

*b. Asymmetric Information—Do We Really Know
What We're Eating?*

The second market failure that has been used to justify anti-obesity legislation in the United States is the asymmetric information theory. According to Nobel Prize winning economist George Akerlof, asymmetric information situations, or those in which one party in a transaction has better information to make an informed decision than the other party, can create market failures "even though there are some prices where sellers would like to sell and buyers would like to buy."¹⁴¹ This market failure would be particularly relevant to the obesity epidemic if consumers continued to purchase unhealthy foods while unaware of the consequences of such a diet. Government intervention may be required to level the informational playing field and create better informed consumers.¹⁴²

The market failure resulting from asymmetrical information between food consumers and producers underlies several recent pieces of American legislation targeting obesity. For example, in 2008, California became the first state to require information labels on restaurant menus

only by the motorcyclist himself and that helmet laws infringed upon the personal liberties of motorcyclists. POPE, *supra* note 125, at 435–44. Eventually, however, the government,

[E]xpanded [its] notion of harm to others, perceiving that the risks that riders and drivers posed to themselves translated into a drain on medical resources. 'Indeed, the conduct proscribed by so-called 'victimless' crimes is, upon further reflection, not at all victimless The accident victim's injuries impose a burden on the entire community.'

Id.

Regulations requiring motorcyclists to wear helmets are now universally upheld. The same evolution took place in the context of anti-smoking regulations. It was not until 1986 when the Surgeon General first "identified the dangers of secondhand or environmental tobacco smoke" that negative externalities were used to justify anti-smoking legislation. However, today, "[p]rotecting the nonsmoker from the direct adverse health effects of tobacco smoke is now the cited basis for most existing private, local, state, and federal regulation of tobacco." *Id.* Perhaps in time the negative externalities of obesity will also become more widely accepted and serve as a justification for anti-obesity regulation.

141. FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 111.

142. *Id.* at 112–13.

to provide consumers with the caloric value of their meals.¹⁴³ The market failure resulting from asymmetrical information has also been used to justify anti-obesity programs for children on the basis that children are too immature and lack the requisite knowledge to make their own informed decisions about diet and exercise.¹⁴⁴ For example, many states have prevented or restricted access to vending machines on school campuses.¹⁴⁵ Marketing and advertising to children have also been regulated on the grounds that “many children do not understand the difference between advertising and television programming.”¹⁴⁶ While the asymmetrical market failure justification could be used to implement a program similar to Japan’s “Metabo” legislation for American children, the justification would be limited to a school setting.

c. The Negative Externalities of Obesity and Asymmetric Information Between Food Producers and Consumers Do Not Provide Sufficient Justification for Anti-Obesity Legislation

Given the debatable existence and effects of these market failures on the obesity epidemic in the United States, prominent law and economics scholars have argued that market failures are not to blame for the rise in obesity rates and, therefore, government intervention in the supposed “problem” is unwarranted. Nobel Prize winning economist Gary Becker has summarized the argument as follows:

[Government intervention] measures are from an economic standpoint justifiable only if the growth in obesity represents a market failure. It is possible that being fatter than doctors think healthy is optimal. People trade off health costs for benefits in other currencies; food high in calories tend to be both delicious and cheap. The health effects of being overweight are highly publicized. In addition, in our society fat people are generally considered much less attractive than thin people, and there is a considerable premium in the job market for attractive people. Given all these negatives of being overweight, it is difficult to believe that obese people have underestimated the costs of being overweight.¹⁴⁷

Richard Posner, Seventh Circuit Judge and distinguished legal theorist, has agreed that obesity is not a “problem,” stating that “in a model of human behavior in which people are assumed to be rational actors, there

143. California Menu Labeling Bill, SB 1420, CAL. CODE HEALTH & SAFETY § 114094 (West Supp. 2009) (effective July 1, 2009).

144. Pope, *supra* note 125, at 464–65.

145. Breighanne Aileen Fisher, Comment, *Community-Based Efforts At Reducing America’s Childhood Obesity Epidemic: Federal Lawmakers Must Weigh In*, 55 DEPAUL L. REV. 711, 717 (2006).

146. *Id.* at 730–31.

147. Yosifon, *supra* note 113, at 693. For additional evidence suggesting overweight individuals make conscious decisions to accept a shorter life span in return for experiencing other preferences, see FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 86–87.

is no such thing as being overweight.”¹⁴⁸ Accordingly, Posner concludes that because the benefits of being overweight or obese must outweigh the burdens to these individuals, there is no such thing as an obesity “problem” and no sound justification for government intervention.¹⁴⁹

The underlying assumption to Posner’s analysis that consumers are rational actors is not without criticism.¹⁵⁰ For example, recent scientific research has defined clear links between genetics and a propensity towards obesity.¹⁵¹ International obesity statistics also show that obesity is highly correlated with ethnicity.¹⁵² However, when evaluating the adoption of any anti-obesity legislation, the respected theories of Posner and Becker undermine the justification of intervention in the name of a market failure. In fact, Congressional records indicate that many elected officials are also of the opinion that government intervention in obesity is unwarranted. Congressman Steve Chabot of Ohio has stated that obesity “is really pretty simple. If you eat too much, you get fat. It is your fault. Do not try to blame someone else.”¹⁵³ Congressman Robin Hayes of North Carolina has also stated, that the “simple fact is that responsibility for obesity here in America rests with the individual choices made by each citizen.”¹⁵⁴ While resolving the market failure debate amongst scholars and politicians is far beyond the scope of this comment, these diverging opinions on the existence of market failures and whether obesity should be regulated on such grounds serve as a significant impediment to adopting any obesity legislation in the United States. Without a consensus on the need to regulate obesity as a market failure, the United States’ adoption of laws similar to Japan’s “Metabo” legislation necessarily relies upon a showing of a “compelling public need.”

148. Yosifon, *supra* note 113, at 692.

149. *Id.*

150. *Id.* at 696; *see also* McMenamin & Tiglio, *supra* note 146, at 506–08 (discussing the notion of food addiction).

151. Amanda Spake, *Rethinking Weight*, U.S. NEWS & WORLD REPORT, Feb. 1, 2004, at 50, available at <http://health.usnews.com/usnews/health/articles/040209/9obesity.htm>.

152. FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 52–55 (posing the example of Polynesian women in New Zealand who are far more likely to be overweight than their neighbors of European descent despite similarities in diet and exercise).

153. Burnett, *supra* note 128, at 396.

154. *Id.* (citing 150 Cong. Rec. H952 (Mar. 10, 2004)).

2. *Compelling Public Need*

Because of the hotly debated market failure justifications for regulating obesity, legislation on the obesity epidemic in the United States is far more likely to succeed when justified as a “compelling public need.” Although the “compelling public need” standard is inherently amorphous, obesity regulation may fall under its scope in several different ways. First, it is undeniable that obesity currently is a “hot topic” in American culture. In the federal government alone, the following departments recently have introduced obesity related initiatives: the Department of Health and Human Services, the Office of the Surgeon General, the National Recreation and Park Association, the Center for Disease Control, the United States Department of Agriculture, Indian Health Services, the Federal Trade Commission, and the Internal Revenue Service.¹⁵⁵ Improving healthcare consistently has been reported as a top concern of Americans for decades, but Americans recently have started to cite obesity as one of the nation’s top public healthcare issues.¹⁵⁶

Indeed, if any nation truly needs obesity intervention, then the United States is a prime target. Just two decades ago, only 47% of Americans were overweight and 15% were obese.¹⁵⁷ Today, the majority of Americans are now overweight or obese, and the number of severely obese Americans is growing twice as fast as the rate of obesity in general.¹⁵⁸ Americans too have reason to worry about the future of obesity as the rate of obesity in children has more than doubled in the past twenty years.¹⁵⁹ Moreover, 15% of American children and teens are overweight, but “among some groups—such as Mexican–American boys

155. Dausch, *supra* note 113, at 639.

156. Adrian M. Viens, *Quality of Life as a Paradigm for Health in a Developed Society*, 1 INTERNET J. L., HEALTHCARE & ETHICS 1, 2 (2002); Michael D. Lemonick, *How We Grew So Big*, TIME, June 7, 2004, at 58, available at http://www.time.com/time/subscriber/covers/1101040607/article/how_we_grew_so_big_diet01a.html.

157. Yosifon, *supra* note 113, at 682.

158. Spake, *supra* note 151.

159. *Future of Fatness*, U.S. NEWS & WORLD REP., Feb. 1, 2004, at 56, available at <http://health.usnews.com/usnews/health/articles/040209/9obesity.b2>. Despite the rapid increase of childhood obesity in the United States throughout the 1980s and 1990s, some studies suggest that the rate of childhood obesity has leveled out in recent years. For example, the United States Center for Disease Control and Prevention (CDC) has reported that the obesity rate among children “hovered at about 16% between 2002 and 2006.” Carl Bialik, *The Slimming Figures of Childhood Obesity*, THE WALL STREET JOURNAL, July 22, 2009, at A11, available at http://online.wsj.com/article_email/SB124821547930269995-1MyQjAxMDI5NDI4MTIyMTE1Wj.html. Even so, CDC Director William Dietz remains convinced that childhood obesity is a serious problem in the United States and has stated that “this is no time for complacency.” *Id.*

and African-American girls—the numbers are nearly double that.”¹⁶⁰ Like Japan, the United States has not seen concrete results from the government’s previous attempts to curb obesity.¹⁶¹ Finally, the costs of obesity in the United States are staggering. The United States expends approximately \$93 billion annually on obesity-related healthcare, “half of which is accounted for by publicly funded health care programs, such as Medicare and Medicaid.”¹⁶²

Secondly, Americans have indicated that they *want* the federal government to more aggressively respond to obesity. In 2004, a TIME/ABC News poll reported that 53% of Americans felt that the federal government is doing too little to address obesity, whereas only 8% felt that the government already was taking too much action.¹⁶³ Overweight and obese Americans in particular have also indicated that they need help addressing their condition. At any given time, 40% of American women and 20% of American men are on a diet, and Americans spend a whopping \$49 billion per year on weight-loss products.¹⁶⁴ Now that the majority of Americans are either obese or overweight, their needs may eclipse those of the rest of the population.

Even if Japan will emerge as the world leader in the war on waistlines, the United States need not be left behind entirely. The United States has reached the point where obesity presents at least an equally strong basis for “compelling public need” intervention as the nation’s other notable public health and safety regulations. Americans should urge lawmakers to recognize that obesity qualifies as a “compelling public need” and warrants government regulation on an unprecedented scale.

V. CONCLUSION

On April 1, 2008, Japan launched its internationally controversial “Metabo” legislation aimed at significantly reducing the rate of obesity in the country over the next several years. Although the outcome of Japan’s innovative approach to curbing obesity will not be fully understood for years to come, there are several factors working in its

160. *Id.*

161. Dausch, *supra* note 113, at 638.

162. Yosifon, *supra* note 113, at 683.

163. Lemonick, *supra* note 156.

164. Steven M. Suranovic & Robert S. Goldfarb, *A Behavioral Model of Cyclical Dieting*, in *THE ECONOMICS OF OBESITY*, *supra* note 134, at 50; FINKELSTEIN & ZUCKERMAN, *supra* note 3, at 204.

favor. First, despite its reputation as a relatively “thin” nation, Japan has a compelling need to adopt anti-obesity legislation. Because the Japanese are aware of the metabolic time bomb facing the increasingly aging and obese society, they are less likely to dismiss the “Metabo” program as unnecessary and arbitrary. Second, the nation’s traditional paternalistic healthcare system affords physicians and healthcare policymakers substantial authority. Because the Japanese are accustomed to blindly accepting diagnosis and treatment information from their physicians without seeking a “second opinion,” they are also likely to accept the “Metabo” program and the mandated weight-loss counseling proscribed by their physicians. Third, Japanese society in general places great emphasis on *wa*, or community harmony. This value is applicable to the new “Metabo” legislation in two ways: the Japanese are unlikely to resist controversial legislation once passed, and they are unlikely to object to public health care measures that benefit the nation as a whole at the expense of individual rights. Fourth, the Japanese Constitution and healthcare jurisprudence lends little relief for disgruntled citizens under the new “Metabo” program. Because the individual rights afforded to the Japanese in Articles 12 and 13 of the Constitution are not absolute and the Japanese courts routinely defer to physicians’ authority on matters of healthcare policy, any legal challenge to the new legislation is unlikely to succeed.

Despite the factors indicating that the “Metabo” legislation will be successful in reducing the prevalence of obesity in Japan, there are two factors that may impede the success of the program. First, the legislation’s built-in enforcement mechanism of fines has spurred some health insurance providers into action. However, there are still those who have adopted a “wait and see” attitude that could be detrimental to the program as whole. Without participation from all of the nation’s health insurance providers, the scope of the program is far less expansive, and the likelihood for success in reducing the overall rate of obesity in Japan becomes less certain. Second, the costs of the “Metabo” legislation’s mandatory screening process and weight-loss counseling pose serious challenges, especially during these difficult economic times. Given the high cost of administering the program, some health insurance providers have had difficulty launching the program, while others contend that the net cost of the program overtime will exceed the benefits to society.

Although the success of the new “Metabo” legislation in decreasing Japanese obesity is uncertain at this point, it is clear that Japan will emerge as the world leader in the war on waistlines ahead of the United States. Despite the United States’ arguably greater need for anti-obesity intervention, the cultural and structural factors that serve to support the

program in Japan are notably absent in the United States. Not only does the fragmented American health insurance system pose a substantial challenge to administering similar legislation in the United States, but the culture of anti-paternalism in the United States is also naturally opposed to any state regulation of public health. While Americans may find such legislation less palatable than the Japanese, they should recognize that there is a compelling need to regulate obesity on a national scale. Although it is unlikely that Americans will adopt anti-obesity legislation on par with Japan's "Metabo" legislation any time soon, Americans should look at their waistlines intently and consider the possibility of it.

