The Constitutional Right to Health within the Mercosur: Obesity and Bisphenol A in Perspective

By *Alberto Krayyem Arbex*, Rio de Janeiro*

A. Introduction

The right to health is a major landmark in the constitutions of Brazil and Argentina. In the Brazilian Constitution, it is discussed in Article 6, which defines health as a fundamental right, and also in Articles 196 to 200, which affirm that 'health is everyone's right, a duty of the State, and must be guaranteed by means of social and economic policies'.[1] The breadth of this definition has strengthened the identity and the reach of health law in Latin America, as important commentators on the issue have recognized.[2] [3] Similarly, the right to health is clearly recognized in the Constitution of the Province of Buenos Aires (Article 36, paragraph 8).[4] The Argentine Constitution assures the right to health in trade relations, as described in Article 42.[5] In its jurisprudence, the Supreme Court of Argentina itself affirms and guarantees 'the right to health, and for such purposes, ensures to all of its inhabitants access to health in the aspects of prevention, care and treatment'.[6] Similarly, the legislature assumes that the public health service must function under appropriate conditions, as demonstrated by a recent law (No. 26529) of 2009.[7] [8] This spectrum of debate raises the two essential issues, which are examined in this paper. They merit further and wider discussion in both countries: The rising

* *Alberto Krayyem Arbex*, Medical Doctor and Jurist, Associate Professor and Chief Coordinator of a post-graduation course in Medicine and Endocrinology at the Medical Institute for Teaching and Research - IPEMED, Brazil; holds a Master in Medicine of the Federal University of Rio de Janeiro. E-mail: albertoarbex@gmail.com
This paper is the product of research under way at the University of Buenos Aires (UBA), Argentina as part of the Juris Doctor Degree in Health Law. I have adopted an interdisciplinary approach to the theme. I am especially grateful to Professor Dr M.S. Ciruzzi and Professor Dr M. Aizenberg for their constant academic support for this approach to the subject, that is, working in a parallel way with Brazilian and Argentinian laws. Both countries should benefit from a bilateral debate.

1 *Brazil*, Constitution of the Federative Republic of Brazil. Brasília, 1988.

2 *Sueli Gandolfi Dallari,* A new discipline: the Health Law, Revista de Saúde 22 (2004), pp. 327-334.

3 *Luiz Carlos Romero and Maria Celia Delduque,* Health Law Studies. The rule making in Health, Brasília 2011, 214 p.

4 *Argentina*, Provincial Constitution of Buenos Aires 1994.

5 *Argentina*, Federal Constitution of 1853. Constitución de la nación Argentina: official text of 1853, organized by the Law No. 24.430, Buenos Aires 1995.

6 *Wilson Ruiz Orejuela.* State's Medical Responsibility, Âmbito Jurídico 2011.

7 *Argentina*, Law No. 26529 of 2009. It regulates the rights of patients and their relationships with health institutions.

8 Arnaldo Sampaio de Moraes Godoy, Introduction to the constitutional law of Argentina, Jus Navigandi 2007 (at: www.jus.com.br).

prevalence of obesity and the commercial regulation of products containing the chemical substance bisphenol A.

B. Regulation of current health issues in Mercosur

The astonishing way new health issues arise and become established is consistent with the observations of Esther Diaz's description of modern science.[9] The specialized knowledge bound up with contemporary global health technology expands so rapidly that it outstrips the legal consequences entailed by it; this phenomenon profoundly affects current approaches to new diseases and are evocative of Habermas' discussion of law and democracy in modern societies.[10]

Paralleling these innovative technological achievements, health problems arise that did not exist before. 'Repetitive strain injury', which in the past was virtually unknown, has increased, for example, with the propagation of computers. Depression related to the work environment and so-called 'bullying' at work are also consequences of a new model of labour organization that requires greater job dedication that in previous decades. The same may be said of obesity and the use of bisphenol A, which may also be termed 'new health issues', since neither existed only a few years ago. The WHO, for example, classified obesity as a disease only in 1985.[11] The substance bisphenol A has been studied in depth only in the last decade, and its harmful biological effects were unknown until recently. Its ubiquity in the environment, as waste, was neglected or ignored.[12]

In such a small time lapse, our societies have not yet managed to build adequate laws to address these two problems, and most of the populations in Brazil and Argentina are unaware of the risks associated with obesity and bisphenol A.

I. Obesity as a major public health problem in Brazil and Argentina

Obesity is a broad and vital health problem, affecting an alarming percentage of the populations of both Brazil and Argentina.[13][14] Moreover, it is a medical condition that has become much more prevalent. Like other western countries, excess weight currently affects about 50%

9 *Esther Díaz*, Posmodernidad, Buenos Aires 2005, pp. 53-70.

10 *Jürgen Habermas,* Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy, Cambridge (Mass.), 1996. v. 2, 354 p.

11 *World Health Organization*, Obesity and Overweight, Geneva. Updated March 2011 (at http://www.who.int/mediacentre/factsheets/fs311/en/).

12 *Fernando Fabrizi Sodré, Cassiana Carolina Raimundo Montagne, Marco Antonio Fernandes Locatelli, Wilson Jardim*. Occurrence of endocrine disruptors and pharmaceuticals in surface waters in the region of Campinas, Journal of the Brazilian Society of Ecotoxicology 2 (2007), pp.187-96.

13 *Alberto Krayyem Arbex*, Obesity and Public Health Policies in Brazil and Argentina, in: Marco Antonio Tayah (Org.), Reflections on Latin American Law, Buenos Aires, 2011, pp.36-49.

14 *Ana Dâmaso* (Org), Obesity, Rio de Janeiro 2009, 336 pp.

of the population of Brazil and Argentina. ,[1516] Brazil, as other developing nations, is experiencing a nutritional transition,,[1718] in which its citizens have experienced a drop in their levels of malnutrition since the 1970 s, concomitant with a rise in their obesity rates.[19] In Brazil, research published in 2011 by the Ministry of Health[20] reveals that 48.1% of all Brazilians carry excess weight; in 2006, this figure was 42.7%. A survey in Argentina[21] shows that 50.5% of Argentinians are overweight.

The increased availability of food and, hence, calories—the extrinsic factor—combined with a human biological structure that stores excess calories as body fat—the intrinsic factor—are important aspects of the genesis of this global epidemic. According to the WHO, the incidence of obesity has doubled worldwide since 1980.[11] Excess weight is associated with several health disorders, including cancers—cancers of the colon, the breast, and other organs—pregnancy complications, arthritis of the joints, and especially with diabetes and heart diseases. This association is strengthened by the time of exposure, meaning that overweight young people may be at greater risk.[22]

1.) Obesity in Brazil

In Brazil, the legal regulation of obesity is discrete and incipient. The current focus of the federal government, which continues the bias of previous administrations, is the eradication of poverty and not obesity.[23] Although Brazil has taken some initial steps, which have been praised by the 'International Obesity Task Force', and President Dilma has declared early in 2011 her interest in a 'National Plan for the Reduction of Obesity', no effective measures have

15 *Roseli Sichieri, Moura, Erly Catarina de Moura*. A multilevel analysis of variations in body mass index among adults, Brazil, 2006. Revista de Saúde Pública 43 (2009), pp. 90-97.

16 *World Health Organization*, Obesity and Overweight, note 11.

17 *Malaquias Batista-Filho, Anete Rissin*, Nutritional transition in Brazil: geographic and temporal trends, Cadernos de Saúde Pública 19 (2003), pp. S181-S191.

18 *Luciana Pedrosa Leal, Malaquias Batista-Filho*, *Pedro Israel Cabral Lira et al*. Prevalence of anemia and associated factors in children six to 59 months of Pernambuco, Revista de Saúde Pública 45 (2011), pp.457-461.

19 RC *Oliveira,* The nutrition transition in the context of demographic and epidemiological transition, Revista Mineira de Saúde Pública 3 (2004), pp.16-23.

20 *Ministry of Health of Brazil*, Brasília, 2011.

21 *Jorge Elgart, Guillermina Pfirter, Lorena Gonzalez et al.* Obesity in Argentina: epidemiology, economic impact and morbimortalidad. Argentinean Journal of Public Health 1 (2010), pp. 6-12.

22 *Shlomo Melmed, Kenneth S. Polonsky, P. Reed Larsen, and Henry M. Kronenberg*, Williams Textbook of Endocrinology, Philadelphia 2011, 1920 pp. This is the most influential textbook on the medical endocrinology field in the world.

23 *Malaquias Batista-Filho, Anete Rissin,* Nutritional transition in Brazil: geographic and temporal trends, Cadernos de Saúde Pública (Papers on Public Health) 19 (2003), pp. S181-S191.

been taken in support of this pledge to broaden the focus on excess weight.[24] [25] In March 2012, the Brazilian Health Ministry initiated a task force on childhood obesity prevention, holding debates about healthy foods and habits for parents in public schools throughout the country.[26] To date, no remarkable changes have been seen in the views of parents on this matter. In fact, excess weight is increasing among the young in Brazil: government research released in 2009 shows that the number of overweight young Brazilians increased from 3.7% (1970) to 21.9% (2009); one of three children between five to nine years of age carry excess weight.

2.) Obesity in Argentina

In contrast to Brazil, the regulation of obesity in Argentina is robust and is on its way to reaching maturity. The Argentine law No. 26396 of 2008, the so-called 'Ley de Obesidad', establishes a national policy for the disease, which is associated with prevention. In addition, the presidential decree No. 1395, also of 2008, sanctioned the cited law and established a committee of experts to regulate and enforce its application.[27] Recent decisions of the Supreme Court of the Nation, from 2009 and 2010, already reflect this new reality. Argentinian society itself, three years after the validation of the new law, shows greater consciousness of the importance of this scourge and is relying more on the protection provided by legislation.

II. Bisphenol A presents health risks to children and adults

Article 42 of the Argentine Constitution states that 'consumers have the right . . . in the trade relationship, to have their health protected'. The Brazilian Consumer Law (Article 4) assures health protection to consumers, and Article 6 goes further by defining 'the protection of life, health and [guarantees of] safety against risks posed by . . . products and services considered hazardous or harmful'.[28]

Therefore, the question of health risk is posed by the exposure to the substance bisphenol A, or simply BPA, which is present in plastic baby bottles, possessing an activity similar to

24 *ABESO,* President Dilma Roussef: We are developing the National Plan for the Reduction of Obesity, Journal of the Brazilian Association for the Study of Obesity and the Metabolic Syndrome 11 (2011), pp. 10-11. The president was elected one year ago, in 2010, and still could not implement all her projects for the land.

25 *Francisco José Roma Paumgarten*, Pharmacological treatment of obesity: a public health perspective, Revista de Saúde Pública 27 (2011), pp. 404-405.

26 *Ministry of Health,* http://portalsaude.saude.gov.br/portalsaude /mobile/visualizarNoticia.cfm?cod=4052&tipo=noticia.

27 *Argentina*, Law No.. 26396 of 3rd September 2008. It approves Argentina's health policies toward obesity.

28 *Brazil,* Law no. 8078, September 11th 1990, Consumer´s Code. This is considered to be one of the most modern and consumer-oriented codes in Latin America, taking into consideration current trade and business and a proper defence of the consumer.

that of the female human hormone, although it is not a hormone at all. Specifically, it binds to oestrogen receptors with the same efficiency as the female hormone oestradiol. Studies suggest the association of such exposure with breast cancer and infertility, when humans are regularly exposed to BPA.[29] When a plastic bottle is heated in a microwave oven—a common procedure for caregivers when preparing baby milk—this substance is released from the plastic and passes into the milk. The child becomes a helpless victim, and parents are unaware of the danger to which they routinely expose their offspring. Studies reveal that 92% of Americans have detectable BPA in their urine, mainly children and adolescents. It is more highly concentrated in the placenta, amniotic fluid, and breast milk, posing potential hazards to newborns and children. Thus, BPA presents risks for reproductive, immune, and neurological disorders, as well as cancers, attention deficits, and memory lapses.[30]

The applicable principles for the restriction of BPA are the following:

1. Precautionary Principle: the lack of full scientific certainty should not delay measures to prevent risk;
2. Vulnerability Principle (in Brazil, guaranteed by the Consumer Code, Article 4, item 1): the consumer does not possess all the necessary information about a product or service that he or she purchases. The supplier is responsible for this information;
3. The Right to Information (in Brazil, Consumer´s Code, Article 6, Paragraph III; in Argentina, Buenos Aires Constitution, Article 42): the consumer has the right to adequate and clear information about the risks that products may pose.

BPA has been banned in Canada, Denmark, Costa Rica, France, and two American states (Minnesota and Chicago) in children's products. Since March 2011, Germany prohibits the production of baby bottles with this substance (The demand for this prohibition was first made by a non-governmental organization in October 2009.)

1) Legal situation of bisphenol A in Brazil

At the main scientific conference of the Brazilian Society of Endocrinology and Metabolism in 2011, the three years of mobilization of this organization against BPA intensified.[31] The discussion of the subject, which expanded over time, has finally reached the attention of the Brazilian health authorities. The National Health Surveillance Agency (ANVISA) issued Resolution No. 41 on 16 September 2011, which bans the manufacture and importation of

29 *Evanthia Diamanti-Kandarakis, Jean-Pierre Bourguignon, Linda C Giudici et al,.* Endocrine-Disrupting Chemicals: An Endocrine Society Scientific Statement, Endocrine Reviews 30 (2009), pp. 293-342. This is an extensive review of the theme from a major journal of endocrinology.

30 *Paloma Alonso-Magdalena, Ivan Quesada, Angel Nadal*, Endocrine disrupters in the etiology of type 2 diabetes mellitus, Nature Reviews Endocrinology 7 (2011), pp. 346-353. This is another important journal with a recent technical analysis of this theme.

31 *SBEM - Brazilian Society of Endocrinology and Metabolism,* Working Group on Endocrine Disruptors of SBEM- Chapter São Paulo, (at: www.desreguladoresendocrinos.com.br), Updated 10th October 2011.

baby bottles containing bisphenol A. As of January 2012, it has also barred for sale in Brazil baby bottles containing the substance.[32] The Brazilian press has disclosed, however, that industries are working towards obtaining a longer term to withdraw their products from the market, searching for more flexible regulation.

Some similar projects are under analysis by specific committees of the Brazilian Congress: for example, PLS 159/2010 prohibits the sale of baby bottles, pacifiers, and other plastic bottles with BPA in their formulation, and PL 5831/2009 proscribes the production, sale, and importation of packages equipment, and goods for infants and young children that contain it.

2) Legal Situation of Bisphenol A in Argentina

The Argentine press has discussed the ban of baby bottles with bisphenol A by the European Community (June 2011) and Brazil (September 2011). A debate on this subject theme occurred in the Mercosur Parliament in early 2012. During an interview in 2010, Dr Lilian Corra, president of the Argentine Association of Doctors for the Environment, declared that 'We need a law that permanently controls the content of these substances. We ought to work with the precautionary principle. If a substance is potentially harmful, we must avoid it and not wait for the day when it will be proved that it impacted negatively on the lives of thousands of people'.[33] This discussion is still in its nascent phase in Argentina and has not been addressed on an on-going basis by legislators. However, it seems reasonable to expect that the health sector will probably demand regulation, as in Brazil. In 2008, four hospitals—the Rivadavia, the Fernandez, Garrahan, and Austral hospitals (three of which are in Buenos Aires)—began a campaign called 'Health Care without Harm' and changed from plastic to glass bottles. The Argentinean legislature has yet to take action. As suggested by Dr Corra, a new law to control effectively this product´s sale and prevent future hazards must still be created.

3) Similarities in these bi-national issues

a) The significant effect on children, a vulnerable population, in both countries

Children are less able to understand health hazards; consequently, they defend themselves more poorly against risks. The approach towards them should be preventive, as suggested by paediatric scientific societies. In the matter of obesity, a child follows the eating habits of his or her family and thus consumes an excess of calories in the home environment. The attempt to change such habits, far from being merely an objective and technical matter, touches on powerful cultural forces. It requires a dietary re-education of the whole family, together with the mobilization of specialists, such as dieticians and endocrinologists; thus, such change is

32 *ANVISA*, National Health Surveillance Agency, Board Resolution nr. 41, of 16th September 2011. It decided for the ban of produces containing bisphenol A in baby bottles for infants.

33 *Diário Perfil*, Babies at Risk. Here baby bottles are sold that are forbidden in other countries as toxic products, Perfil.com, Buenos Aires, December 5, 2010.

difficult to implement and of low efficacy because of the obesogenic environment in which we live.[34][35]

As for bisphenol A, new-borns, infants up to two years old, and children are especially affected. Among the most widespread daily techniques for cleaning baby bottles, boiling in water is the most common one and the microwave oven the most practical. Both techniques produce the release of BPA when the plastic is heated.

b) The insufficient public awareness of risks

In Brazil and Argentina, democratic logic assumes free trade and the respect for consumer rights (Brazilian Constitution, Article 170; Argentine Constitution, Article 42). Both involve the right to an adequate knowledge of commodities, including any risks that they may present (Brazilian Consumer´s Code, Article 6). However, risk warnings in both countries are too technical, written in small script, and of little practical application.

Warnings on high-calorie products are covered by Argentina's 'Ley de Obesidad' but have yet to be applied and face stiff resistance from the country's food industry. In Brazil, the most successful cases involve the disclosure of risks in products containing gluten, which have been properly labelled to great effect, but these involve a very small subset of the population, those with gluten intolerance. More recently (mid 2010), the mandatory disclosure of 'trans fat' in food content has begun. Whilst appropriate, such measures are still timid and not sufficiently effective, for the food industry has already found ways to circumvent the loss of market share prompted by such disclosures. In the case of 'trans fat', for example, the withdrawal of that ingredient has led to its replacement by palm oil, which has high levels of saturated fats that are also harmful to health and, like 'trans fat', increases the risk of atherosclerotic and cardiovascular diseases.

aa) The conflict between the market (the food industry) and the health interests of citizens

The health risks of foods are poorly disclosed because domestic industries fear that they will be harmed in international and domestic trade. In Brazil and Argentina, laws to regulate food have always been vulnerable to such commercial interests. In 2007 and 2008, when discussing the content of the 'Ley de Obesidad', the lobby of the sugar-producing industry in Argentina employed notorious efforts to prevent the restriction of high sugar products. Such purely commercial interests impact the formation of sound national health policies.

34 *World Health Organization*, Population-based prevention strategies for childhood obesity – Report of the WHO forum and technical meeting, Geneva 2010. This is an international meeting on obesity and possible worldwide solutions to it. Specialists from around the globe are worried about the future, since many adults are already obese and children are becoming overweight sooner.

35 *Fábio Rodrigues* Suñe, *Juvenal Soares* Dias-da-Costa, Prevalence and associated factors for overweight and obesity among schoolchildren in a city in southern Brazil, Cadernos de Saúde Pública 23 (2007), pp. 1361-1371.

The general population's limited knowledge of the hazardous effects of BPA is, in theory, a quite modifiable reality. The substance's biological effects are, however, a complex technical issue, which have been the subject of several lab studies and not without scientific disagreement. (Remember the 'climate change' debate, which evinced a similar pattern, until the reality of climatic warming gained essentially full acceptance in the scientific community.) The nefarious health impact of BPA is, thus, not unanimously accepted by researchers. It may, therefore, be difficult to disseminate information about its harms to the masses. Even among health experts, one still observes a lack of awareness, since BPA is a new subject.

bb) Socially motivated political and legal mobilization

Popular pressure is the source of governmental action to combat obesity and BPA in both Brazil and Argentina. In Brazil, ANVISA's recent BPA regulation emerged from a movement within the medical community over the course of three years, which later generated social and health consequences; however, the time between the onset of this movement and the discovery of the risks of BPA to consumers and the environment was long. In Argentina, social mobilization against excess weight started with the 'Cuestion de peso' program in 2007, which led to the 'Ley de Obesidad'. Considering the historical examples, it appears as if the creation of laws is the surest, although not the most rapid way, to protect the health of citizens in both countries.

III. Bioethics and Population Health

Every citizen has the right to understand choices that he or she makes each day as a consumer. Logic suggests, consequently, that knowledge has direct positive impact on life and health. It is wrong for governments, therefore, to not initiate and promote appropriate and healthier choices for their citizens because of arguments that these will harm economic growth.[36] After all, health and virtue are bound together as ethical terms in the human psyche.[37] Today's commercial choices are intimately connected to self-reward and self-awareness.

Current laws usually do not provide adequate public health education. Food labels are not clear or are clear only to experts and health specialists. Specifically, they do not specify what should or should not be consumed in terms of health risks. Products are classified as 'light' or 'diet', for example, not to protect consumers but rather often as a marketing strategy. The motivation for labelling is thus not the protection of consumer health.

In our societies, sick individuals face scorn and discrimination each day. The ethical consequences of this situation are difficult to estimate, both individually and socially. Legal decisions involving health issues demand better training and more sustainable technical argu-

36 *Alberto Pellegrini Filho*, Public Policy and the social determinants of health: the challenge of the production and the use of scientific evidence, Cadernos de Saúde Pública 27 (2011), pp.135-S140.

37 *John N Burry*, Obesity and virtue - Is staying lean a matter of ethics?, Medical Journal of Australia 171 (1999), pp. 609-610.

ments. In the combined analysis of law and health, expertise is necessary to assess current issues, including appropriate public policies for social integration and the expansion of the rights of those affected by health hazards that are consequences of economic development.[38] The vulnerable social groups—children, women and low-income individuals—harmed by bisphenol A must be addressed by specific public policies.

IV. Discussion—viable solutions to obesity and bisphenol A

Ideas, perspectives, and solutions come from various sources and places. A penalty on products with excessive fat, based on the 'polluter pays' principle of environmental law, is a possible solution. In a recent decision (2011), Denmark targeted food high in saturated fats. (Denmark already imposes higher taxes on foods with excess sugar, such as chocolate and soft drinks.) In Hungary, the government taxes soft drinks, sweets, snacks, and artificial flavours.[39] A second option is to lower taxes on healthier products. However, governments resist lowering their revenue from taxes, despite the future benefits that may derive from such action, such as lower health care costs. It has also been suggested that governments should lead the effort to protect public health, as they have done in tobacco control, a landmark in disease prevention. Taxing unhealthy foods, especially sugar-sweetened beverages, may reduce their consumption. After all, governments pay the highest percentage of the costs that the consumption of such foods entails, the treatment of illnesses caused by them. Finally, some suggest that food products be appropriately labelled, which is a democratic means to help consumers make healthier choices. Although already implemented in some places, this solution has is neither rigorous enough nor effective in raising the public's awareness of food risks. Better labels, containing clearer and more precise information would greatly benefit the consumer. The debate is still open on the creation of adequate laws and the establishment of viable solutions to the health issues raised by obesity and bisphenol A.

C. Conclusions

In both Brazil and Argentina, the two health issues discussed here, obesity and bisphenol A have followed parallel paths. Greater scientific knowledge and expertise have led to legislative changes that apply the legal and constitutional principles guaranteeing the right to health. These changes are more marked in Brazil with regard to bisphenol A and more in Argentina with regard to obesity. As the above discussion suggest, effective solutions can be shared and pursued by countries with similar cultures in the same economic bloc.

Although one can change laws, bringing more formal protections to citizens, the threats to public health continue to appear and multiply, particularly for the most vulnerable populations and environments. This situation will be radically altered only if public policy delib-

38 *Silvia Badim Marques*, The right to universal access to medicines in Brazil: dialogues between law, politics and medical technology, Thesis (Doctor of Law), São Paulo: USP, 2011, 396 pp.

39 *Itamaraty—Ministry of Foreign Affairs of Brazil,* Denmark surcharges fatty foods, 04th October 2011.

erately acts to prevent risks and not just to react to known hazards. It is strictly necessary to respect and actively protect the constitutional principle of the right to health.