



2013

## Bloomberg's Health Legacy: Urban Innovator or Meddling Nanny?

Lawrence O. Gostin

*Georgetown University Law Center*, [gostin@law.georgetown.edu](mailto:gostin@law.georgetown.edu)

A graphic categorizing his major health policies appears [here](#).

This paper can be downloaded free of charge from:


<https://scholarship.law.georgetown.edu/facpub/1285>

<http://ssrn.com/abstract=2334823>

---

43 Hastings Center Rep. 19-25 (2013)

This open-access article is brought to you by the Georgetown Law Library. Posted with permission of the author.  
Follow this and additional works at: <https://scholarship.law.georgetown.edu/facpub>

 Part of the [Health Law and Policy Commons](#), [Health Policy Commons](#), [Human Rights Law Commons](#), [Public Health Commons](#), and the [Public Policy Commons](#)

similarities across the four specialty areas include a normative approach, that is, a desire to elucidate what ought to be done; respect for those served, whether individuals, communities, or both; and the need for a decision-making process that considers questions with unclear ethical solutions by using an established framework steeped in a common set of principles that guide the decision-makers through evidence, ethical considerations, and scenario shifts to arrive at a path forward.

We developed pedagogical materials with these various bioethics specialties in mind. The materials are designed to lead students through an exploration of foundational concepts, applied to contemporary bioethical concerns. The focus is on skill building, decision-making, and incorporation of an ethical perspective into daily work, all of which apply in each specialty area. Some materials might lend themselves more to one area than another, but the intent is to develop tools that will be useful in all four areas.

All bioethics commission materials are available for free downloading at [bioethics.gov](http://bioethics.gov). Feedback, including success stories instructors are willing to share with others, is welcomed at [education@bioethics.gov](mailto:education@bioethics.gov).

#### Disclaimer

The findings and conclusions in this paper are those of the authors and do not necessarily represent the official position of the Presidential Commission for the Study of Bioethical Issues or the Department of Health and Human Services.

1. Executive Order no. 13,521, *Establishing the Presidential Commission for the Study of Bioethical Issues*, *Federal Register* 74, no. 228 (November 24, 2009): 62671.

2. Presidential Commission for the Study of Bioethical Issues, *New Directions: The Ethics of Synthetic Biology and Emerging Technologies* (Washington, D.C.: PCSBI, December 2010), 134.

3. A. M. Peiffer, C. E. Hugenschmidt, and P. J. Laurienti, "Ethics in 15 Min per Week," *Science and Engineering Ethics* 17 (2011): 289-97.

4. National Institutes of Health. *Update on the Requirement for Instruction in the Responsible Conduct of Research*, Notice No.: NOT-OD-10-019, <http://grants.nih.gov/grants/guide/notice-files/NOT-OD-10-019.html>.

5. L. C. Kaldjian et al., "Do Medical Students Recall and Use the Language of Ethics They Are Taught Preclinically Once They Are in the Clinical Training Environment? An Empirical Study in Ethics Education," *American Journal of Bioethics Primary Research* 4, no. 2 (2013): 23-30, at 27.

6. Presidential Commission for the Study of Bioethical Issues, *Moral Science: Protecting Participants in Human Subjects Research* (Washington, D.C.: PCSBI, December 2011), 73.

7. Presidential Commission for the Study of Bioethical Issues, *New Directions: The Ethics of Synthetic Biology and Emerging Technologies*, 134.

8. Presidential Commission for the Study of Bioethical Issues, *Moral Science*, 72.

9. Presidential Commission for the Study of Bioethical Issues, *Moral Science*, 71; *ibid.*, *Privacy and Progress in Whole Genome Sequencing* (Washington, D.C.: PCSBI, October 2012), 82.

10. Presidential Commission for the Study of Bioethical Issues, "Ethically Impossible" *STD Research in Guatemala from 1946 to 1948* (Washington, D.C.: PCSBI, September 2011), 1-51.

# Bloomberg's Health Legacy: *Urban Innovator or Meddling Nanny?*

BY LAWRENCE O. GOSTIN

Michael Bloomberg assumed office as the 108th mayor of New York City on January 1, 2002. As he leaves the mayoralty—having won re-election twice—his public health legacy is bitterly contested. The public health community views him as an urban innovator—a rare political and business leader willing to fight for a built environment conducive to healthier, safer lifestyles. To his detractors, Bloomberg epitomizes a meddling nanny—an elitist dictating to largely poor and working-class people about how they ought to lead their lives. His policies have sparked intense public, corporate, and political ire—critical of sweeping mayoral power to socially engineer the city and its inhabitants.

Here, I seek to show how Bloomberg has fundamentally changed public health policy and discourse. He has used the engine of government to make New York City a laboratory for innovation—raising the visibility of public health, testing policy effectiveness, and probing the boundaries of state power. Even though the courts have blocked some of his boldest initiatives, he has offered a paradigm for the "new public health"—reaching beyond infectious diseases to upstream risk factors in everyday life and the human habitat. I also critically probe various arguments designed to derail his policies, along with the overarching charge of unjustified paternalism. (A graphic categorizing his major health policies appears in the online version of *HCR* and on the O'Neill Institute website.)

Lawrence O. Gostin, "Bloomberg's Health Legacy: Urban Innovator or Meddling Nanny?" *Hastings Center Report* 43, no. 5 (2013): 19-25. DOI: 10.1002/hast.208

## Diet and Nutrition: Addressing the Root Causes of Obesity

Mirroring national trends, being overweight or obese is now the norm in New York City (58 percent of adults across the city), with black, Latino, and low-income communities the most heavily affected and obesity rates reaching 70 percent in the poorest neighborhoods.<sup>1</sup> Perhaps more disturbing is that 40 percent of the city's youth are overweight or obese, compared to 33.2 percent nationally.<sup>2</sup> If the trend is not reversed, today's generation could live shorter lives than their parents. This stark reality forces society to face critical questions: does government have an obligation to reduce obesity, what combination of interventions work, and at what cost to personal freedom?

**Trans fat ban.** Are some products so hazardous to health that they should be removed from the market? Artificial trans fatty acids provide no health benefit and are unsafe at any consumption level.<sup>3</sup> In 2006, the city required that any food served to customers (unless in a sealed package) contain less than 0.5 grams of trans fat per serving, and many cities have followed suit—notice, however, that even half a gram of trans fat per serving is unhealthy, especially if consumers eat multiple servings during the course of a day.

Although the trans fat limit received a warmer public response than other diet-related policies, it still met opposition from restaurants and civil libertarians. Economic interests drove much of the debate, with claims it would raise food prices, thus affecting employment and consumers. Consumers feared the ban would affect the taste of baked goods and argued that the state should not dictate what people eat. But after a half-decade of experience, the fears proved unfounded, with no attributable rise in food prices or noticeable difference in taste. The lesson may be that if products change in ways that make people healthier (less trans fat, sugar, or sodium), public tastes will often adapt. Sites in the United States and globally have followed the New York model, and low trans fat has now become a widely accepted norm.

**Menu labeling.** The Board of Health in 2006 required restaurants that voluntarily disclosed calorie information to post calories in standard form. The New York State Restaurant Association challenged the regulation, alleging that federal law preempted the board's action. The court agreed, but only because the statute did not apply uniformly to all chain restaurants.<sup>4</sup> A revised regulation, enacted in 2008, addressed the court's concerns by requiring all chain restaurants to disclose calories on menus and menu boards. The NYSRA then challenged the amended regulation under the First Amendment, but the Second Circuit found that compelled disclosure of truthful, objective information did not violate the commercial speech doctrine.<sup>5</sup>

Menu labeling facilitates informed decision-making. Individuals underestimate the caloric content of food and, on average, consume more than one-third of their calories away from home.<sup>6</sup> Most studies, however, show that posting calories has little effect on aggregate purchasing decisions.<sup>7</sup> This

may be attributable, in part, to the failure to provide context. Researchers suggest that providing a physical activity equivalent (for example, 450 calories = 80 minutes of running) would be more effective.<sup>8</sup>

Despite the scientific uncertainty, many cities have followed New York's model. Nationally, the Affordable Care Act will require all chains with more than twenty locations to post calorie counts and recommended daily intake. The U.S. Food and Drug Administration's proposed rule is less rigorous than New York's—for example, it applies only to food services, excluding those in movie theaters and amusement parks; worse still, the ACA may preempt more stringent local requirements.

**National Salt Reduction Initiative.** New York launched the NSRI—a public-private partnership of over ninety health agencies and associations—in 2009. Companies voluntarily pledged to reduce sodium by 20 percent in overall sales within a given food category (canned soup, for example) by 2014. This left ample room for high-sodium foods provided the producer offset these with low-sodium alternatives within the category. Many companies have joined the NSRI, with twenty-one meeting the 2012 sodium goals.<sup>9</sup>

Americans consume over twice the daily-recommended 1,500 mg of sodium, increasing blood pressure. Excess salt intake is associated with 136,000 deaths per year, and a small reduction could prevent many of these deaths, saving \$10-24 billion annually in medical costs.<sup>10</sup> Little of the sodium excess comes from the shaker—80 percent is added to prepared or packaged foods. The problem, then, is not primarily behavioral but, rather, lies in food manufacturing and marketing. Gradually reducing sodium content early in the supply chain could alter eating habits, with major health benefits. The NSRI offers an illustration of a public-private partnership to tackle a health problem. Self-regulation may be a useful way to improve health, but only if government is prepared to regulate if voluntary approaches prove unsuccessful.

**Sugary drink portion limits.** Soft drink portion sizes have grown dramatically, along with Americans' waistlines. A twelve-ounce soda that was "king-size" in 1950 is now marketed as a child portion. A "large" Coca-Cola at McDonald's is thirty-two ounces, while 7-Eleven's Double Gulp contains fifty ounces, six hundred calories, and no nutritional value. Sugar-sweetened drinks account for a substantial portion of increased caloric intake.<sup>11</sup> Children are particularly vulnerable—for every sweetened beverage a child drinks daily, her odds of becoming obese increase by 60 percent.<sup>12</sup> To curb consumption, the Board of Health proscribed serving sizes of more than sixteen ounces for sweetened beverages that contain over twenty-five calories per eight ounces. The rule excluded beverages containing alcohol or more than 50 percent milk, and it did not cover state-regulated businesses—including 7-Eleven.

The beverage size limit has come to represent Bloomberg's so-called Nanny State. Amid intense publicity, polls registered disapproval both within the city and nationally. Mississippi—the most obese state—prohibited local communities

from mandating calorie counts or portion size caps. However, it was a legal challenge rather than a political one that delayed (and perhaps blocked) implementation of the rule. A trial judge ruled that the Board of Health lacked the power to enact the rule, which properly resided with the elected City Council. Characterizing the policy as an “administrative Leviathan,” the court also deemed it “arbitrary and capricious” and laden with exceptions.<sup>13</sup> On July 30, 2013, the appellate division upheld the decision, ruling that the Board of Health had the power to ban “inherently harmful” foods but that sweetened beverages did not fall into that category.<sup>14</sup> Although the city appealed, its prospects for success appear dim.

*Disease surveillance.* Striking a balance between surveillance and privacy has proved a perennial challenge for public health. Historically, surveillance efforts have primarily tracked infectious diseases, but public health agencies now seek to extend monitoring to chronic diseases. Critics of the policy have voiced misgivings about whether citizens’ privacy may be invaded to alter primarily self-regarding behavior.

Bloomberg introduced two contentious surveillance programs, for HIV and diabetes, respectively. The diabetes initiative, discussed here, was the first of its kind. Diabetes prevalence in New York leapt from 3.7 percent to 9.2 percent between 1994 and 2004.<sup>15</sup> In response, the city declared diabetes an epidemic, requiring laboratories to report hemoglobin A1C test results to the health department, which then informed treating physicians and patients with elevated blood sugar. Civil libertarians objected to the system’s opt-out structure—any patient who did not actively object would receive the data. Yet 43 percent of patients stated they would use the data, with many scheduling medical appointments.<sup>16</sup> The city’s intent was also to advise physicians about better diabetes management. The program is one of the first uses of surveillance that not only tracks a chronic, noncommunicable disease but also links the data to concrete interventions. It bridges the historic divide between public health and medicine, thus offering pathways for future programs.

## Physical Activity: Transforming the Built Environment

Living a sedentary lifestyle is a powerful contributor to chronic disease and early death, and physical activity in the United States has declined by 40 percent since 1965.<sup>17</sup> In New York City, 75 percent of adults fail to meet the recommended minimums for exercise.<sup>18</sup> Bloomberg has sought to structure the built environment to encourage active lifestyles, making it easier to walk, play, and recreate.

*Facilitating bicycle use.* New York City has added 386 miles of bicycle lanes since 2006, making residents more active. Bicycle riding has risen dramatically, doubling between 2007 and 2011.<sup>19</sup> In May 2013, the city partnered with a private company to launch its bike share program, Citi Bike, providing 6,000 bicycles at 330 stations throughout Manhattan and Brooklyn. Within a month, the system attracted about 450,000 total trips and 46,840 annual members; 72 percent of City residents support bike sharing.<sup>20</sup> Bicycle riding poses a tradeoff between improved fitness and higher injury rates, but safety im-

proves as cycling reaches a critical mass. At the same time, many motorists bristle at the perceived preference given to bicyclists, together with their propensity to ignore traffic rules. Making cities bicycle friendly flies in the face of the historical governmental preference given to cars and roads. Yet, it signals that recreation and alternative transportation are integral to active urban lifestyles.

*Pedestrian paths and parks.* Even casual observers cannot fail to see the flow of walkers, joggers, and skaters milling around the city. The increase in physical movement occurred partly by design through expansion of public spaces and pedestrian accessibility—parks, green spaces, and integrated pedestrian walkways. The High Line—a lively, attractive walkway built on an abandoned elevated rail line on Manhattan’s West Side—attracts millions of users, revitalizing neighborhoods. Security is a significant factor in encouraging activity. The major reduction in crime, together with safety programs (such as Safe Routes to Schools and Safe Streets for Seniors) has worked wonders. Higher curbs, safer bus stop locations, and pedestrian-only streets make residents feel more

---

*Bloomberg’s contentious diabetes program is one of the first uses of surveillance that not only tracks a chronic, noncommunicable disease but also links the data to concrete interventions.*

---



secure. The city's progress continues, with plans to convert the Fresh Kills Landfill into a park three times larger than Central Park; the city intends to have a park within a ten-minute walk of every resident by 2030.

### **Tobacco Control: Curbing the Largest Preventable Cause of Premature Mortality**

At the turn of the millennium, smoking took nearly 9,000 lives annually in New York City, and it remains the leading cause of preventable death. Half of the city's 1.3 million smokers were expected to die prematurely from tobacco-related diseases. The toll fell disproportionately on minorities and the poor. These grim facts motivated the mayor's office to develop a suite of tobacco control policies, and the results have been remarkable. Between 2002 and 2011, the rate of smoking fell from 21.5 percent to 14.8 percent among adults, and from 17.5 percent to 8.5 percent among youth.<sup>21</sup>

**Smoke-free laws.** Smoke-filled rooms were the norm when Bloomberg took office. In 2002, 57 percent of city food workers spent most of their waking hours inhaling second-hand smoke, increasing their cancer risk by 50 percent. That year, New York City banned smoking in all restaurants and bars. The environmental effects were powerful: just one year later, cotinine concentrations—a biomarker to detect nicotine exposure—decreased by 83 percent, and tobacco-related symptoms decreased from 88 percent to 38 percent.<sup>22</sup> Vociferous protests by businesses that the ban would drive customers away proved unfounded; patrons welcomed the change. The city's Smoke-Free Act changed norms nationwide. At the time, only California and a few cities had smoke-free laws, but now over 80 percent of Americans are protected by such statutes.

The mayor went further in 2011 by extending the smoking ban to parks, beaches, and pedestrian plazas. Side-stream smoke poses a much lower risk in outdoor spaces, and banning cigarettes outdoors is highly paternalistic. But even though the ban is not rigorously enforced, it has reinforced the culture of a smoke-free environment. Smoking has become culturally unacceptable, and the regulation has wide public support.<sup>23</sup>

**Cigarette taxes.** Raising cigarette prices reduces smoking, especially among young people: for every 10 percent rise in price, youth smoke 7 percent less.<sup>24</sup> In 2002, New York City increased the tax per pack from \$0.08 to \$1.50. At first, many smokers avoided the tax by buying in adjacent jurisdictions, but over time the avoidance behavior subsided. The tax is regressive, since smokers are disproportionately poor and working class. Yet the resulting benefits of reduced smoking are distributed progressively—a tradeoff between economic justice and health justice.

**Marketing restrictions.** In 2009, the city required retailers to display graphic warnings with images of cancerous lungs, decayed teeth, or stroke-damaged brains. The regulation never went into effect, however; the Second Circuit ruled that federal law preempted the local regulation.<sup>25</sup> Fast-forward to

2013: the United States and other countries have proposed graphic labeling. These proposals, too, are bitterly contested; Big Tobacco claims that they violate commercial speech rights and take property without just compensation.

Undaunted by the setback, Bloomberg sought other ways to discourage tobacco purchases at the point of sale. In March 2013, citing continuing youth smoking, he proposed a ban on openly displaying cigarettes in stores, although retailers could still advertise products and price information. The next month, Bloomberg proposed an increase in the minimum age for buying tobacco from eighteen to twenty-one, which would give New York City the strictest age limits in the nation. Both proposals are awaiting City Council endorsement.

### **Probing the Critiques of Bloomberg's Policies**

A familiar litany of critiques shadows any novel public health policy: the science is inconclusive, freedom of choice is constrained, the executive is exercising unilateral power, beware slippery slopes, corporations have rights, and justice demands protecting the vulnerable against state interference. These might be framed as general justifications for governmental restraint. They are the antithesis of the public health approach, which urges government to act in the face of enduring injury and disease.

**Inconclusive science.** Critics invariably challenge chronic disease policies as lacking sufficient evidence of effectiveness. At the most extreme, they demand conclusive proof—charging, for example, that the science behind the trans fat ban is “not indubitable.”<sup>26</sup> Science seldom reaches universal agreement, of course, least of all on the causation of complex, multifactorial diseases. Rarely are policy-makers in other domains expected to demonstrate a certainty, or even a high probability, of “success.” In most policy spheres, such as economic policy, we understand that causal relationships are difficult to demonstrate, but critics often demand it of public health.

Yet, a reasonable level of logic and research guides all of Bloomberg's interventions. Even with the soda portion limit (perhaps the hardest case), the mayor relied on science to support a creative, untested strategy: sugary drinks deliver empty calories, with a direct relationship to obesity, while portion sizes have grown exponentially. Society cannot know what works until commonsense ideas are tested.

Related to the demand for scientific certainty is the demand for consistency, illustrated by the criticism that the soda portion limit applies to McDonald's supersized drinks but not to 7-Eleven's Big Gulps. In fact, few policies are perfectly consistent; rather, they are crafted as political compromises, and politics is the art of the possible, not the perfect. Essentially, critics are saying, “We hate the portion size ban for its nanny intrusiveness, but it won't work because it's riddled with exceptions.” The implication is that critics would accept the limit if it applied more broadly, which clearly is not their intent. A direct tax on sugary drinks would have been a more logical intervention than portion control, but

New York State has been unwilling to institute one, despite Bloomberg's requests.

Finally, critics demand that each intervention be proven in isolation, but the more rational question is whether a suite of policies has a reasonable chance of working. Tobacco policies, for example, have dramatically reduced smoking over several decades. But we have great difficulty measuring the efficacy of any single intervention. Rather, a range of policies (taxes, labeling, smoke-free laws, and advertising restrictions) worked in combination over time to denormalize smoking.

**Paternalism.** The societal discomfort with Bloomberg's agenda is grounded, at its core, in distrust of government influence on how autonomous adults conduct their lives. The city's health policies intrude on personal space. Many believe that the state should not assume responsibility for self-regarding decisions, whether by shaping individual dietary preferences (trans fats and portion sizes) or monitoring individuals' health status (disease surveillance).

American antipathy toward paternalism drives policy-makers to try to justify interventions under the harm principle—to argue, for example, that secondhand smoke, increased medical costs, and lost productivity amount to harm to others and so are not purely self-regarding. Third-party harms are not imaginary, but the real policy intent is simply to ease the grave burdens of diabetes, heart disease, cancer, and emphysema. Health officials genuinely believe it is unwise for individuals to smoke, overeat, live sedentary lives, or do myriad other things that cause them suffering and early death.

More importantly, Bloomberg's policies are not all that intrusive, and certainly not as burdensome as the underlying diseases. Policies to promote good nutrition and physical activity and control the use of tobacco are not morally equivalent to quarantines or forced treatment. Often, they represent nothing more than a return to the social norms of the recent past—such as smaller food portions and more livable spaces. Other interventions, such as limiting advertising to children or the reduction of trans fat, sodium, and sugar, actively create a “new normal.” Once implemented, many interventions are embraced; few of us are nostalgic for the days of smoke-filled restaurants and workplaces.

The underlying point here is that personal choice is always conditioned by social circumstances in various ways. The public health approach rejects the idea that there is such a thing as unfettered free will, recognizing instead that the built environment, social networks, marketing, and a range

of situational cues drive complex behaviors. There are reasons, beyond personal responsibility, that health outcomes skew drastically by socioeconomic status. The job of public health is to make healthy living the easier choice.

The real burden is on industry, not on consumers. One can see this vividly in New York City, where food makers funded public opposition to the soda portion ban.

**Corporate rights.** The corporate sector tries to conflate the public's interests with its own economic interests. Businesses claim that consumers have a right to smoke, eat, or drink their products, however unhealthy the products may be. This defense of consumer rights may wrongly imply that corporations are being socially responsible. Where their posturing as champions of consumer rights fails, companies invoke their own liberties. When government tells corporations what they must or must not say (through labeling requirements or marketing restrictions, for example), businesses clothe themselves in the First Amendment. The menu labeling challenges have thus far failed, with the Second Circuit reasoning that New York City does not force restaurants to take any position or prevent them from contesting the city's views.

Big Tobacco repeatedly asserts the right to market hazardous products. In 2012, the industry challenged a city requirement to place graphic images on cigarette packages. The court never reached a decision on the merits, however, holding that federal law preempted the city's action.<sup>27</sup> At the national level, the courts are split over the constitutionality of graphic warning labels. In response, the FDA withdrew its rule, promising to reissue a revised version.

The mayor's most recent tobacco initiative—forcing retailers to keep tobacco products hidden from the public's view—will provoke another First Amendment challenge. Bloomberg's intent was to shield children from marketing and to prevent impulse buying by former smokers. The Convenience Store Association called the bill “patently absurd,” stating that “no other retail business licensed to sell legal products is required to hide them from its customers.” Big Tobacco earlier sued Haverstraw in Rockland County, New York, over a similar display ban, but the village could not afford a defense, so it simply repealed the ordinance. New York City will certainly defend the rule, forcing a judicial process about the clash of values between health and the First Amendment.

**Unilateral executive power.** It takes a great deal of political capital to enact legislation affecting personal lifestyles. Never

---

*Policies to promote good nutrition and physical activity and to control the use of tobacco are not morally equivalent to quarantines or forced treatment.*

---

known as a patient man, Bloomberg has tested the limits of mayoral authority. The trial court in the soda portion case remarked that, by bypassing the elected city council, he had “eviscerated” the separation of powers. Courts blocked several other Bloomberg initiatives (such as limits on vehicle emissions) due to questions of procedure and authority. He has issued more executive orders than mayors Koch and Giuliani combined. His design changes in the city streetscape (pedestrian plazas and bike lanes) began as pilot projects, with no public hearings.

Some regard Bloomberg as an urban innovator for overcoming political paralysis, but others see a failure of transparency and accountability. The Board of Health (which adopted policies such as the soda portion ban) has greater expertise, but its members are unelected and answerable primarily to the mayor. Those concerned with procedural regularity condemn the exercise of unilateral power, while those seeking health improvements welcome strong leadership. Undoubtedly, checks and balances are valuable elements of a robust democracy. The question is whether a chief executive has a duty to cut through political logjams to achieve collective goods or whether working within the legislative structure is always required.

**Slippery slopes.** Critics often worry that if a particular policy is implemented, it will lead to ever more invasive policies in the future. For example, banning trans fats or restricting sugary drink sizes opens the door to regulating any unhealthy food. A host of vested corporate interests—the sugar, alcohol, and tobacco industries, along with restaurants and advertisers—can make common cause around slippery slope concerns. All of these groups stand to lose if health is placed at the center of public policy.

Slippery slope arguments should be approached with suspicion, as they force a speculative analysis without any specifics about the policy feared to lie downslope, or the likelihood of its being manifest. The task of policy-makers is to delineate which policies are acceptable and which are not. Their adoption of any given policy does not suggest that they will extend the same reasoning in other realms. It should not be necessary to win a debate today about policies that may, or may not, be proposed in the future.<sup>28</sup>

Slippery slope arguments, moreover, lack normative force because all sides in a debate can level them. A move in the direction of antipaternalism, for example, could set government on a slippery slope toward neglecting acute health problems. Policy-making is about striking a reasonable balance based on available evidence.

**Dueling conceptions of justice.** Because obesity- and tobacco-related diseases fall primarily on African Americans, Latinos, and the working class, interventions necessarily apply disproportionately to those groups. This means, of course, that any intrusion on autonomy or privacy will fall primarily on the vulnerable. Diabetes registers, for example, mostly keep track of lower-income patients, raising a concern about justice. Tobacco taxes are regressive, which liberals normally oppose. Industry and civil libertarians have joined together

to decry the injustice of health measures that tread disproportionately on the liberty of the poor and minorities.

This is a curious conception of justice, however, because it focuses solely on the fair distribution of the downsides of obesity or tobacco policies—that is, limits on liberty. The justice argument fails miserably in weighing the corresponding health benefits to the poor. Government’s *failure* to act to reduce the suffering and early death visited mostly in poor neighborhoods is the far greater injustice. Suppose that the ban on trans fats or soda portions facilitates healthier diets, that cigarette taxes reduce smoking, or that surveillance results in better diabetes management. If those policies work, a negligible limit on personal choice seems a very small price to pay for ameliorating the devastation to the individual and families from chronic diseases. The opportunity for a healthy life is the primary freedom, as it underwrites so many of life’s options.

### The “New” Public Health

The “new” public health—focusing on upstream risk factors in everyday life—is not a passing fad or the preoccupation of a lone politician. It is rather a sober and necessary response to an epidemiological transition to lifestyle-related diseases. If Bloomberg’s passion inspires and accelerates innovative public health throughout the nation and globally, he will leave office with an enviable legacy.

With the deep challenges posed by complex multifactorial diseases, there are simply no tried and tested solutions. The new public health requires experimentation based on available science—with all of the attendant uncertainties and missteps. If American culture cannot escape from its reflexive antipathy to any form of paternalism, the criticisms leveled against Bloomberg will persist in our political discourse.

It is no accident that these critiques are so often bundled. Once a measure has been tarred as “paternalistic,” it is subjected to intensified scrutiny. The easy course is to watch idly while devastating diseases rob people, particularly the poor, of healthy years. The harder course is to adopt novel (sometimes unpopular) policies to encourage healthier choices.

Governments should be held accountable for the health of their inhabitants. Those who disrupt the status quo, however, are not the only ones who must shoulder the burden of accountability. Public officials have largely stood by as obesity rates have skyrocketed. While the mayor has drawn fierce criticism and legal challenges, there has been scant accountability for government inaction.

Progress will be piecemeal, through experiments and incremental steps that are embraced gradually. This can be uninviting work for politicians, who fixate on the next election cycle. The public health community should take time to recognize and defend its champions—and Mayor Bloomberg undoubtedly is among our most courageous and creative advocates for a healthier and safer population.

## Acknowledgments

Daniel Hougendobler, Bryan Thomas, Suneel Jain, and Xi Lu provided valuable research and writing assistance for this essay.

1. Office of the Mayor, "Reversing the Epidemic: The New York City Obesity Task Force Plan to Prevent and Control Obesity," May 2012, [http://www.nyc.gov/html/om/pdf/2012/otf\\_report.pdf](http://www.nyc.gov/html/om/pdf/2012/otf_report.pdf).
2. C. L. Ogden and M. D. Carroll, "Prevalence of Obesity and Trends in Body Mass Index Among U.S. Children and Adolescents, 1999-2010," *Journal of the American Medical Association* 307 (2012): 483-90.
3. W. H. Dietz and K. S. Scanlon, "Eliminating the Use of Partially Hydrogenated Oil in Food Production," *Journal of the American Medical Association* 308 (2012): 143-44.
4. *New York State Rest. Ass'n v. New York City Bd. of Health*, 509 F. Supp. 2d 351 (S.D.N.Y. 2007).
5. *New York State Rest. Ass'n v. New York City Bd. of Health*, 556 F.3d 114 (2d Cir. 2009).
6. L. R. Young and M. Nestle, "Portion Sizes and Obesity: Responses of Fast-Food Companies," *Journal of Public Health Policy* 28, no. 2 (2007): 238-48.
7. T. Dumanovsky et al., "Changes in Energy Content of Lunchtime Purchases from Fast Food Restaurants after Introduction of Calorie Labeling: Cross Sectional Customer Surveys," *British Medical Journal* 343 (2011): d4464.
8. S. N. Bleich and L. Rutkow, "Improving Obesity Prevention at the Local Level: Emerging Opportunities," *New England Journal of Medicine* 368 (2013): 1761-62.
9. National Salt Reduction Initiative Corporate Commitments, <http://www.nyc.gov/html/doh/downloads/pdf/cardio/nsri-corporate-achievements.pdf> (accessed August 8, 2013.).
10. K. Bibbins-Domingo et al., "Projected Effect of Dietary Salt Reductions on Future Cardiovascular Disease," *New England Journal of Medicine* 362 (2010): 590-99.
11. V. S. Malik, M. B. Schulze, and F. B. Hu, "Intake of Sugar-sweetened Beverages and Weight Gain: A Systematic Review," *The American Journal of Clinical Nutrition* 84, no. 2 (2006): 274-88.
12. D. S. Ludwig, K. E. Peterson, and S. L. Gortmaker, "Relation between Consumption of Sugar-Sweetened Drinks and Childhood Obesity: A Prospective, Observational Analysis," *Lancet* 357 (2001): 505-08.
13. *NY Statewide Coalition of Hispanic Chambers of Commerce v. NYC Board of Health*, Supreme Court of New York, New York County, WL 1343607 (N.Y. Sup. March 11, 2013).
14. *New York Statewide Coalition of Hispanic Chambers of Commerce v. New York City Dep't of Health and Mental Hygiene*, N.Y.S.2d (N.Y. App. Div. 2013).
15. B. P. Tabaei et al., "Incidence of Self-Reported Diabetes in New York City, 2002, 2004, and 2008," *Preventing Chronic Disease* 9 (2012): 110320.
16. S. Chamany et al., "Tracking Diabetes: New York City's A1C Registry," *Milbank Quarterly* 87, no. 3 (2009): 547-70.
17. S. Reddy, "Hard Math: Adding Up Just How Little We Actually Move," *Wall Street Journal*, March 11, 2013.
18. New York City Department of Health and Mental Hygiene, "3.2 Million New Yorkers Are Overweight or Obese," November 2005, <http://www.nyc.gov/html/doh/html/pr/pr115-05.shtml>.
19. New York City Department of Transportation, "Network and Statistics," <http://www.nyc.gov/html/dot/html/bicyclists/bikestats.shtml> (accessed August 8, 2013).
20. CBS New York, "Poll: NYC's Planned Bicycle Sharing Program Enjoying Wide Support," October 2011, <http://newyork.cbslocal.com/2011/10/20/poll-nycs-planned-bicycle-sharing-program-enjoying-wide-support/>.
21. New York City Global Partners, "Best Practice: Tobacco Control Program," July 12, 2011, [http://www.nyc.gov/html/uncpp/gprb/downloads/pdf/NYC\\_Health\\_TobaccoControl.pdf](http://www.nyc.gov/html/uncpp/gprb/downloads/pdf/NYC_Health_TobaccoControl.pdf) (accessed August 8, 2013).
22. American Cancer Society, "The Effects of Secondhand Smoke on Worker Health," September 2008, <http://action.acscan.org/site/DocServer/Effects-Secondhand-Smoke.pdf?docID=5161> (accessed August 8, 2013).
23. Marist College Institute for Public Opinion, "Good in Theory, But Not Necessarily in Practice," August 8, 2011, <http://maristpoll.marist.edu/88-nyc-percentE2-percent80-percent99s-smoking-ban-good-in-theory-but-not-necessarily-in-practice/>.
24. J. A. Tauras et al., "State Tobacco Control Spending and Youth Smoking," *American Journal of Public Health* 95, no. 2 (2005): 338-44.
25. *23-34 94th St. Grocery Corp. v. New York City Bd. of Health*, 685 F.3d 174, 185-186 (2d Cir. 2012).
26. D. Resnik, "Trans Fat Bans and Human Freedom," *American Journal of Bioethics* 10, no. 3 (2010): 27-32.
27. *23-34 94th St. Grocery Corp.*, 685 F.3d at 185-86.
28. L. Gostin, "Trans Fat Bans and the Human Freedom: A Refutation," *American Journal of Bioethics* 10, no. 3 (2010): 33-34.