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Personal Health in the Public Domain: Reconciling Individual Rights with Collective Responsibilities

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This Article defends a more robust conception of public health paternalism than that proposed by Professor Friedman, one that goes beyond the use of "soft" paternalism or nudges. Public health, and the government in general, help influence the choices people make in their daily lives through a multitude of mechanisms. Whenever possible, public health professionals should strive to make the healthy choice the easy choice. However, many population health problems, including obesity, require a more active governmental response, as these challenges are not solely or even primarily attributable to individual behavioral choices. Combating obesity, or other complex health problems, requires direct and indirect use of government powers—through both "hard" and "soft" paternalism—to shape the environment in which individuals live and to impact individual choices. Embracing behavioral, social, cultural, and structural changes that reflect both shared benefits and shared sacrifices requires communal effort. Public health cannot act alone in the public sphere by simply ignoring counter arguments or resistance from individual or corporate stakeholders. Instead, public health must draw on an existing (if sometimes dormant) strain of civic responsibility, recognition of the common good as well as common dangers, and awareness of the necessity to protect "the commons" from the tragedy of overuse. Public health has both the right and the obligation to initiate policies and practices that enhance the health and well-being of our citizenry.

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I. INTRODUCTION

Professor Friedman's topic—the regulatory power of the state to protect public health and the public's response to those efforts[1]—deserves attention. Yet his article's focus on questioning the limits of "paternalism," whether expressed as "hard" or "soft" intervention in the self-regarding judgment of individuals, remains constrained within the parameters of "philosophical liberalism"[2] and is far too narrow. Instead, we choose to expand this dialogue by contextualizing regulations aimed at reducing obesity within the broader public health spectrum of disease determinants, feasible interventions, and the ethical underpinnings of public health's power and obligation to act to protect the public's health, even where that entails limiting individual rights.

II. AGREEMENTS WITH FRIEDMAN

We begin where our thoughts on public health regulation differ least from Professor Friedman's, including the acknowledged power of the state to act, the gravity of the obesity problem, and the existence of some interventions, whether called "soft paternalism"[3] or "nudges,"[4] that can

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[1] David Adam Friedman, *Public Health Regulation and the Limits of Paternalism*, 46 CONN. L. REV. 1687, 1691–94 (2014).

[2] *See* Bruce Jennings, *Public Health and Civic Republicanism: Toward an Alternative Framework for Public Health Ethics*, *in* ETHICS, PREVENTION, AND PUBLIC HEALTH 30, 31 (Angus Dawson & Marcel Verweij eds., 2007) ("During the time of modern public health in the industrialized West . . . the predominant framework of normative justification for state action has been provided by the tradition of philosophical liberalism.").

[3] Friedman, *supra* note 1, at 1690–91 (defining "soft paternalism" as the "careful construction of the decision-making environment [that] can lead people to make better choices without eliminating less socially desirable choices outright").

[4] *See* RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS 6 (2009) (defining the term "nudge" as "any aspect of the choice

shape the public health environment and thus, individuals' choices.

That Professor Friedman's article invokes relatively little dialogue on legal rights or issues is instructive. We presume he has no issue regarding the state's authority to act on behalf of the public's health,[5] and on that we can agree. Even in instances where the efficacy of population-based interventions is debatable, challenges over time to the state's authority across a range of topics and concerns have bolstered rather than constrained that authority. One needs only to look at the untoward consequences of the Eighteenth Amendment,[6] the suboptimal marketing of the human papillomavirus (HPV) vaccine,[7] and ongoing debate over "excess" use of cancer screening technologies[8] to acknowledge that the

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architecture that alters people's behavior in a predictable way without forbidding any options or significantly changing their economic incentives").

[5] *See* Jacobson v. Massachusetts, 197 U.S. 11, 25–31, 39 (1905) (upholding Cambridge, Massachusetts' smallpox vaccination requirement based on the police power); Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 203 (1824) ("[Inspection laws] form a portion of that immense mass of legislation, which embraces every thing within the territory of a State, not surrendered to the general government . . . . Inspection laws, quarantine laws, [and] health laws of every description . . . are component parts of this mass."); LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 91–92 (2d ed. 2008) ("[Police power is the inherent authority of the state (and, through delegation, local government) to enact laws and promulgate regulations to protect, preserve, and promote the health, safety, morals, and general welfare of the people. To achieve these communal benefits, the state retains the power to restrict, within federal and state constitutional limits, private interests—including personal interests in autonomy, privacy, association, and liberty, as well as economic interests in freedom to contract and uses of property."); WILLIAM J. NOVAK, THE PEOPLE'S WELFARE: LAW AND REGULATION IN NINETEENTH-CENTURY AMERICA 14 (1996) (providing that in early America the acceptance of the state's police power was part of a well-regulated society as it encompassed a "science and mode of governance where the polity assumed control over, and became implicated in, the basic conduct of social life").

[6] *See* U.S. CONST. amend. XVIII (establishing the prohibition of alcoholic beverages in the United States), *repealed by* U.S. CONST. amend. XXI; Laurence H. Tribe, *How to Violate the Constitution Without Really Trying: Lessons from the Repeal of Prohibition to the Balanced Budget Amendment*, *in* CONSTITUTIONAL STUPIDITIES, CONSTITUTIONAL TRAGEDIES 98 (William N. Eskridge, Jr. & Sanford Levinson eds., 1998) ("The Eighteenth Amendment, it should be said, is nearly everybody's prime example of a constitutionally dumb idea.").

[7] The recommendation to vaccinate adolescents ten to fifteen years of age, based on the necessity of immunizing them before HPV exposure, prompted outcries that the practice would increase sexual activity among these teens and served to seriously suppress vaccine uptake. Kristin Davis et al., *Human Papillomavirus Vaccine Acceptability Among Parents of 10- to 15-Year-Old Adolescents*, 8 J. LOWER GENITAL TRACT DISEASE 188, 189, 193 (2004); *see also* Robert A. Bednarczyk et al., *Sexual Activity-Related Outcomes After Human Papillomavirus Vaccination of 11- to 12-Year-Olds*, 130 PEDIATRICS 798, 799 (2012) ("In 2006, the Advisory Committee on Immunization Practices recommended that all US girls aged 11 to 12 receive the human papillomavirus (HPV) vaccine . . . and [the] administration [was] permitted [for patients] as young as 9 years. . . . A frequently discussed concern, both in peer-reviewed literature and mass media, about vaccinating preteenage girls against HPV is that vaccination against an STI could lead to increased promiscuity through risk compensation or behavioral disinhibition." (citations omitted)).

[8] *See* Archie Bleyer & H. Gilbert Welch, *Effect of Three Decades of Screening Mammography on Breast-Cancer Incidence*, 367 NEW ENG. J. MED. 1998, 2004 (2012) ("Our study raises serious questions about the value of screening mammography."); Andrew Coldman & Norm Phillips,

state is occasionally responsible for non- or counterproductive health interventions. These examples do not, however, undermine the state's right to act in those or other instances. Similarly, the impact of graduated licenses on reducing teen motor fatalities,[9] the near eradication of life threatening communicable diseases through mass public immunization efforts[10] (many of which mandate action that allows but does not require exemption for religious, philosophical, or other grounds),[11] the impact of occupational safety standards in reducing worker-related injuries,[12] or the risk reduction achieved through food and product safety standards[13] do not confer additional power to the state by virtue of their acknowledged success to protect the public's health. As such, our disagreement with Professor Friedman over the particular effort to prohibit sale of large, sugared beverages should not rest upon the right of the state to do so, but on the merit of taking that specific action to reduce health burdens for individuals and society.

Second, we concur with Professor Friedman that the health-related burdens of obesity on society are substantial[14] and may be greater than generally thought.[15] Our disagreement with Professor Friedman on the

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Incidence of Breast Cancer and Estimates of Overdiagnosis After the Initiation of a Population-Based Mammography Screening Program, 185 CANADIAN MED. ASS'N J. E492, E492 (2013) ("There is growing interest in the overdiagnosis of breast cancer resulting from mammography screening.").

[9] *See* Robert D. Foss et al., *Initial Effects of Graduated Driver Licensing on 16-Year-Old Driver Crashes in North Carolina*, 286 JAMA 1588, 1588, 1590 (2001) (discussing graduated driver licensing programs and that in North Carolina, one such program resulted in a "substantial" decline in vehicle accidents for sixteen-year-olds).

[10] *See* CDC, *Achievements in Public Health, 1990–1999: Impact of Vaccines Universally Recommended for Children—United States, 1900–1998*, 48 MORBIDITY & MORTALITY WKLY. REP. 243, 245–46 (1999) (discussing the decline in morbidity from nine vaccine-preventable diseases and, in the case of smallpox, complete eradication in the twentieth century).

[11] Kevin M. Malone & Alan R. Hinman, *Vaccination Mandates: The Public Health Imperative and Individual Rights*, *in* LAW IN PUBLIC HEALTH PRACTICE 262, 273–74, 280 (Richard A. Goodman et al. eds., 2003).

[12] *See* CDC, *Achievements in Public Health, 1900–1999: Improvements in Workplace Safety, United States, 1900–1999*, 48 MORBIDITY & MORTALITY WKLY. REP. 461, 466–67 (1999) (describing the decline in occupational injuries and fatalities in light of enacted safety regulations).

[13] *See, e.g.*, Eric K. Sauber-Schatz et al., CDC, *Vital Signs: Restraint Use and Motor Vehicle Occupant Death Rates Among Children Aged 0–12 Years—United States 2002–2011*, 63 MORBIDITY & MORTALITY WKLY. REP. 113, 113 (2014) (describing the reduction of death rates of children due to mandated car seats); William W. Walton, *An Evaluation of the Poison Prevention Packaging Act*, 69 PEDIATRICS 363, 366–67, 369 (1982) (describing the reduction of death rates of children due to regulations involving mandated packaging standards); CDC, *Achievements in Public Health, 1900–1999: Safer and Healthier Foods*, 48 MORBIDITY & MORTALITY WKLY. REP. 905, 905–12 (1999) (describing the history of government regulations in the food industry).

[14] *See* Friedman, *supra* note 1, at 1712 (noting a study which ranked obesity as the leading risk factor for preventable death).

[15] *See* Ryan K. Masters et al., *The Impact of Obesity on U.S. Mortality Levels: The Importance of Age and Cohort Factors in Population Estimates*, 103 AM. J. PUB. HEALTH 1895, 1900 (2013) ("[C]ontrary to prevailing wisdom regarding the effect of the obesity epidemic on US longevity, our findings revealed that obesity accounted for a large share of US adult mortality in recent decades—

issue of whether soft drink consumption contributes to the nation's obesity problem is largely a matter of degree. A recent study has estimated that the 20% increase in per capita consumption of soft drinks between 1997 and 2010 (9.5 to 11.4 gallons per person per year) is associated with a 4.8% increase in overweight adults and 2.3% increase in obese adults worldwide,[16] a threat sufficient in our minds to call for global action.

Presently, childhood obesity in the United States affects 16.9% of children and adolescents, three times the prevalence observed thirty years ago.[17] At a minimum, adult obesity affects roughly 31% of the population with an additional 34% classified as overweight, and obesity prevalence is markedly higher within vulnerable population groups (e.g., African Americans, the poor, and the elderly).[18] Although genetic prenatal and postnatal growth patterns have been identified as important markers for childhood and adult obesity,[19] recognition of "obesogenic environments"—settings that promote weight gain and impede weight loss—are essential to understanding the multifactorial scope and depth of this problem.[20] Taken together, approximately 365,000 deaths are attributed to obesity and inactivity in the United States each year.[21] The economic consequences of obesity are equally daunting. Americans spend more than $190 billion to care for obesity-related conditions.[22] Obesity-related costs of under-

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about 18% of all deaths between ages 40 and 85 years during the time period 1986 to 2006." (footnotes omitted)). Controlling for confounding factors that were previously overlooked, the study estimated adult mortality attributable to being overweight or obese was, for black and white men, 5.0% and 15.6%, and for black and white women, 26.8% and 21.7%, respectively. *Id.*

[16] Sanjay Basu et al., *Relationship of Soft Drink Consumption to Global Overweight, Obesity and Diabetes: A Cross-National Analysis of 75 Countries*, 103 AM. J. PUB. HEALTH 2071, 2073, 2075 (2013).

[17] CYNTHIA OGDEN & MARGARET CARROLL, CDC, PREVALENCE OF OBESITY AMONG CHILDREN AND ADOLESCENTS: US TRENDS 1963–1965 THROUGH 2007–2008, at 1, 5 (2010), *available at* http://www.cdc.gov/nchs/data/hestat/obesity _child_07_08/obesity_child_07_08.htm.

[18] Adam Drewnowski & SE Specter, *Poverty and Obesity: The Role of Energy Density and Energy Costs*, 79 AM. J. CLINICAL NUTRITION 6, 7 fig.1 (2004); Katherine M. Flegal et al., *Prevalence and Trends in Obesity Among US Adults, 1999–2000*, 288 JAMA 1723, 1724 tbl.1, 1725 tbl.2, 1726 tbl.4 (2002).

[19] *See* Debbie A. Lawlor et al., *Exploring the Developmental Overnutrition Hypothesis Using Parental–Offspring Associations and* FTO *as an Instrumental Variable*, 5 PLOS MEDICINE 484, 485 (2008) ("According to the developmental overnutrition hypothesis, high maternal glucose and high free fatty acid and amino acid plasma concentrations result in permanent changes in appetite control, neuroendocrine functioning, or energy metabolism in the developing fetus and thus lead to greater adiposity and risk of obesity in later life.").

[20] Boyd Swinburn et al., *Dissecting Obesogenic Environments: The Development and Application of a Framework for Identifying and Prioritizing Environmental Interventions for Obesity*, 29 PREVENTIVE MED. 563, 564 (1999).

[21] *See* Rosie Mestel, *Obesity's Estimated Death Toll Reduced*, CHI. TRIB., Jan. 19, 2005, at 12 (noting that the obesity death toll was reduced from 400,000 per year to 365,000 per year according to the Centers for Disease Control & Prevention).

[22] John Cawley & Chad Meyerhoefer, *The Medical Care Costs of Obesity: An Instrumental Variables Approach*, 31 J. HEALTH ECON. 219, 226 (2012).

productivity and underemployment have not been estimated, but can be presumed to be substantial.

What is undeniable, but unstated in Professor Friedman's analysis, is the extent to which market practices contribute to this problem. A cross-national analysis of the fast food industry over the prior decade reveals a significant, independent effect of market deregulation on body mass index (BMI) levels.[23] This independent effect is attributable to soft drink consumption, not animal fat or total caloric intake, in twenty-five high-income countries.[24] This association between market-liberal policies and obesity has also been reported by others.[25]

Third, Friedman is not alone in suggesting that the state works best and most efficiently when it shapes the choices available to individuals without ultimately depriving them of choice.[26] Thaler and Sunstein argue that government and private actors shape individuals' choices in virtually every facet of our daily lives, from which retirement plan we choose (if any at all) to what we put on our trays for lunch.[27] They argue that the government and private institutions *should* try to shape individuals' choices in ways that will improve their lives and make them better off,[28] calling this "*libertarian paternalism*."[29] From this perspective, government influence on individual choice is not only inevitable, but it is also the government's responsibility. They freely acknowledge, however, that libertarian paternalism "is a relatively weak, soft, and nonintrusive type of paternalism because choices are not blocked, fenced off, or significantly burdened."[30] If an individual is determined to ride a motorcycle without a helmet, forgo saving for retirement, or live on fast food, libertarian paternalism would not prevent him from doing so.

We take Thaler and Sunstein's assertion a step further. Public health (and the rest of government) are critical choice architects in people's daily

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[23] *See* Robert De Vogli et al., *The Influence of Market Deregulation on Fast Food Consumption and Body Mass Index: A Cross-National Time Series Analysis*, 92 BULL. WORLD HEALTH ORG. 99, 101 (2014).

[24] *Id.*

[25] *See, e.g.*, David M. Cutler et al., *Why Have Americans Become More Obese?*, 17 J. ECON. PERSP. 93, 111–12 (2003) ("More regulated countries are 7 percent less obese than are less regulated countries."); Avner Offer et al., *Obesity Under Affluence Varies by Welfare Regimes: The Effect of Fast Food, Insecurity, and Inequality*, 8 ECON. & HUM. BIOLOGY 297, 301 (2010) ("There is something about market-liberal countries that causes obesity to increase faster than elsewhere.").

[26] *See* THALER & SUNSTEIN, *supra* note 4, at 8 (explaining that "nudges" from the government can help solve problems in society and this can be done without infringing on people's freedom of choice).

[27] *See id.* at 10–11 (noting that both government and private actors can be "choice architects" who, knowingly or not, shape individuals' choices both for better or worse).

[28] *See id.* at 5 ("[W]e argue for self-conscious efforts, by institutions in the private sector and also by government, to steer people's choices in directions that will improve their lives.").

[29] *Id.*

[30] *Id.*

lives in a multitude of health-related ways, and we, as public health professionals, should step up to the plate by doing our best to make the healthy choice the easy choice. Yet, we still reject the notion that there is no role for government action that forces individuals to forgo some actions that they find pleasurable, rewarding, or convenient.

At best, health promotion initiatives for changing behavior that concentrate on education about risk reduction yield modest effects,[31] in part because the mechanisms by which individuals undertake health promoting behaviors are complex and not fully articulated.[32] Changing behavior to avoid health risks is difficult to establish and sustain due to the inherent optimistic biases of decision makers who routinely underestimate risky practices[33] and the corrosive effects of decision fatigue,[34] which acknowledges that choice is an effortful action that depletes resources necessary for vigilant self-regarding decisions.[35] Given time and redundancy of options, individuals increasingly will elect paths that require lesser commitments.[36]

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[31] *See* Glorian Sorensen et al., *The Effects of a Health Promotion-Health Protection Intervention on Behavior Change: The WellWorks Study*, 88 AM. J. PUB. HEALTH 1685, 1689 (1998) (noting that the results of the study analyzing the effectiveness of health promotion-health intervention programs in the workplace were "modest"); *Research: Using Insufficient Evidence Findings*, COMMUNITY GUIDE, http://www.thecommunityguide.org/uses/research.html (last updated Mar. 29, 2012) (explaining, for example, the innumerable initiatives that, as yet, lack sufficient evidence of efficacy to recommend their widespread use).

[32] *See* Mauri A. Ziff et al., *The Relative Effects of Perceived Personal Control and Responsibility on Health and Health-Related Behaviors in Young and Middle-Aged Adults*, 22 HEALTH EDUC. Q. 127, 128, 133 (1995) ("The mechanisms that mediate the relationship between control and health are unknown, although a growing literature suggests that the immune system and lifestyle behaviors play a large role." (footnotes omitted)). For a discussion of the limitations surrounding empirical studies that examine personal control and health related behaviors, see K.R. Allison, *Theoretical Issues Concerning the Relationship Between Perceived Control and Preventive Health Behaviour*, 6 HEALTH EDUC. RES. 141 (1991); Daniel S. Bailis et al., *Perceived Control in Relation to Socioeconomic and Behavioral Resources for Health*, 52 SOC. SCI. & MED. 1661 (2001). *But see* Christopher J. Armitage, *Can the Theory of Planned Behavior Predict the Maintenance of Physical Activity?* 24 HEALTH PSYCHOL. 235 (2005) (finding that an individual's perceived control was predictive of the individual's engagement in physical activities).

[33] *See* TALI SHAROT, THE OPTIMISM BIAS: A TOUR OF THE IRRATIONALLY POSITIVE BRAIN 189 (2011) (arguing that people have an optimistic bias which makes them believe that they are less likely to suffer from misfortune). *See generally* DAN ARIELY, PREDICTABLY IRRATIONAL: THE HIDDEN FORCES THAT SHAPE OUR DECISIONS 102 (2008) (discussing how teenagers often underestimate the risk of driving while distracted by other people or loud music).

[34] *See* ROY F. BAUMEISTER ET AL., LOSING CONTROL: HOW AND WHY PEOPLE FAIL AT SELF-REGULATION 17, 19 (1994) (noting that people fail at self-regulation because fatigue prevents them from overriding bad habits or impulses).

[35] *Id.* at 9.

[36] *See* Kathleen D. Vohs & Todd F. Heatherton, *Self-Regulatory Failure: A Resource-Depletion Approach*, 11 PSYCHOL. SCI. 249, 249–54 (2000) (displaying the results of three studies of dieters and concluding that "the active effort required to control behavior in one domain leads to diminished capacity for self-regulation in other domains," resulting in less effort and commitment devoted towards harder tasks).

III. SHIFTING THE CONVERSATION: JUSTIFYING PUBLIC HEALTH PATERNALISM THROUGH THE EYE OF SOCIAL JUSTICE

Next, we challenge some of the apparent premises of Friedman's argument while presenting an ethical justification for a robust public health response to serious health problems.

Foremost among these issues is the premise that personal autonomy is the defining personal ethic of American society. While one is hard-pressed to overstate the importance of self-regarding behavior in our nation's history, socio-political writings, or modern commercial imagery, we nonetheless take issue with ascribing preeminent value, as Professor Friedman does, to an individual's right to act in self-interest to the exclusion of other personal or public considerations.[37] Recognizing that the right of self-regulated behavior of individuals is not absolute, we see elements of our social contract defining the limits and responsibilities of "civil action" as necessary for meaningful, productive encounters.[38]

Second, the contemporary discourse about food preferences and lifestyle is significantly skewed by an industry that benefits from the sale of items, regardless of the nutritional peril consumption poses to individuals—sometimes referred to as privatizing benefits and socializing costs.[39] The autonomous right to act is rarely combined with an autonomous responsibility to bear the cost of adverse outcomes. The burdens of poor diets visited upon individuals, households, or communities are negligibly borne by the parties who encourage such consumption practices. Individuality does not extend to the delivery or finance of health care for "bad choices."[40] The problem with blaming poor diet solely on

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[37] *See* Friedman, *supra* note 1, at 1769–70 (proposing that legislators and regulators should consider both personal autonomy and public health considerations to arrive at "[a]n integrated response that accounts for the potential to improve public health along with the popular tolerance or appetite for regulatory interventions [as this] will produce the best possible social outcomes").

[38] *See* Richard Boyd, *"The Value of Civility?,"* 43 URB. STUD. 863, 874–75 (2006) ("Rather than simply being a negative or aversive disposition like tolerance, moderation or peacefulness—which ask nothing more from us than to leave other people alone—civility presupposes an active and affirmative moral relationship between persons."); *infra* note 72 and accompanying text (discussing civility as an ethical framework for public health).

[39] *See Privatizing Profits and Socializing Losses*, INVESTOPEDIA, http://www.investopedia.com/terms/p/privatizing-profits-and-socializing-losses.asp (last visited Feb. 27, 2014) (defining the term as "[a] phrase describing how businesses and individuals can successfully benefit from any and all profits related to their line of business, but avoid losses by having those losses paid for by society").

[40] Health plans, with few exceptions, are not actuarially based. We expect payment for care regardless of the conditions that precipitate the health problem. Note that the individual insurance market prior to the Patient Protection and Affordable Care Act—where insurers used aggressive underwriting to make individual premiums reflect the projected future costs of health care—was an example where companies have tried to make insurance actuarially based. *See On Their Own*, CONSUMER REP., Jan. 2008, at 22, 25 (profiling the insurance industry prior to the Act and quoting Janet Trautwein, the CEO of the National Association of Health Underwriters, as saying that

consumers is that it only deals with the consumer's side of the equation. Due to all our present-centered biases, individuals are demonstrably "bad choosers" when they are left to make health-related choices in a "market" that is essentially structured to sell more food and generate higher profits for food companies. An individual's "right" to choose to consume sugared soft drinks is debatable in light of substantial evidence demonstrating the addictive properties of sugar consumption.[41]

Counterarguments about diet and well-being by health and lifestyle advocates have had limited impact in light of the financial and conceptual difficulties of putting forth persuasive messages that resonate with target audiences. Similarly, the fifty-year impact of health promoting messages since the Surgeon General's first report[42] has been dwarfed by the effectiveness of system changes to limit the distribution and use of tobacco in public.[43] Indeed, the impact of system changes on reducing smoking

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"insurance is an actuarial science that looks at the likelihood of something happening and what the cost will be" (internal quotation marks omitted)).

[41] *See* Nicole M. Avena et al., *Evidence for Sugar Addiction: Behavioral and Neurochemical Effects of Intermittent, Excessive Sugar Intake*, 32 NEUROSCIENCE & BIOBEHAVIORAL REV. 20, 30–32 (2008) (providing a comprehensive analysis of the addictive properties of dietary sugar intake); *see also* DAVID A. KESSLER, THE END OF OVEREATING: TAKING CONTROL OF THE INSATIABLE AMERICAN APPETITE 14–15 (2009) (discussing the addictive nature of sugar and its effect on an individual's choice in diet); *cf.* BRIAN M. WANSINK, MINDLESS EATING: WHY WE EAT MORE THAN WE THINK 180–82 (2006) (offering additional commentary on this topic, particularly how some consumers see companies as "manipulative" and "fill[ing] fast food with fat, salt, and sugar because they know we will eat it, love it and come back again and again").

[42] *See* U.S. DEP'T OF HEALTH, EDUC. & WELFARE, SMOKING AND HEALTH: REPORT OF THE ADVISORY COMMITTEE TO THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE, at v (1964) (describing the formative experimental research on tobacco as a "complicated" subject that "require[es] evaluations and judgments from many different professional and technical points of view").

[43] *See* Melanie S. Dove et al., *The Impact of Massachusetts' Smoke-Free Workplace Laws on Acute Myocardial Infarction Deaths*, 100 AM. J. PUB. HEALTH 2206, 2211 (2010) (displaying results of a study indicating that approximately one year after enactment of a smoke-free law "there was a substantial decrease in AMI [acute myocardial infarction] mortality in Massachusetts, resulting in approximately 270 fewer deaths from AMI than expected"); Patricia M. Herman & Michele E. Walsh, *Hospital Admissions for Acute Myocardial Infarction, Angina, Stroke, and Asthma After Implementation of Arizona's Comprehensive Statewide Smoking Ban*, 101 AM. J. PUB. HEALTH 491, 494–96 (2011) (describing the results of studies that have shown a reduction in hospital admissions for AMI, resulting from or related to smoking bans); David T. Levy et al., *The Effects of Tobacco Control Policies on Smoking Rates: A Tobacco Control Scorecard*, 10 J. PUB. HEALTH MGMT. & PRAC. 338, 346–49, tbl.1 (2004) (displaying an international comparison of a range of policies and finding that education, school bans, and limitations on retail sales have limited impact, but can be helpful in combination); Frank A. Sloan & Justin G. Trogdon, *The Impact of the Master Settlement Agreement on Cigarette Consumption*, 23 J. POL'Y ANALYSIS & MGMT. 843, 852 (2004) (concluding that price increases, not education, have been the primary mechanism through which the Settlement has led to a decrease in smoking prevalence); Mark W. Vander Weg et al., *Smoking Bans Linked to Lower Hospitalizations for Heart Attacks and Lung Disease Among Medicare Beneficiaries*, 31 HEALTH AFF. 2699, 2704 (2012) ("[W]e found that smoke-free legislation was associated with a significant reduction in hospitalizations for acute myocardial infarctions and that the rate of decline increased over time."). For a discussion of the more limited impact of advertising bans alone (a cross-national perspective), see Wilm Quentin et al., *Advertising Bans as a Means of Tobacco Control Policy: A Systematic Literature*

prevalence rates has occurred despite assertions of dubious financial "benefit" of the Tobacco Master Settlement Agreement on health.[44]

Within the context of New York City's portion-cap rule for sugar-sweetened beverages, Professor Friedman's critique of hard paternalism is misplaced. While the intent to reduce personal consumption of a high caloric, low nutrition food item was clear,[45] former Mayor Michael Bloomberg's proposal prohibited neither possession nor consumption of said beverages.[46] The effort to limit the size of beverage containers more accurately constituted a "nudge" toward healthy behavior—changes that make the healthy choice the easier choice. Arguably, it was opposition by entities entitled to distribute and sell such items,[47] rather than consumer consternation, that doomed the initiative. It would be more accurate to posit that the regulation of the sale and distribution of a "dangerous product," in this case super-size sweetened beverages, produced wholly predictable resistance from those who directly profit from such sales—manufacturers and sellers.

The typical ethical framework proposed for public health ethics, as described by Bruce Jennings, rests solidly within the liberal tradition. It includes "natural rights contractarianism, economic and civil

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Review of Time-Series Analyses, 52 INT'L J. PUB. HEALTH 295, 304–05 (2007).

[44] See Walter J. Jones & Gerard A. Silvestri, *The Master Settlement Agreement and Its Impact on Tobacco Use 10 Years Later*, 137 CHEST 692, 700 (2010) ("It is clear that the MSA has not resulted in a clear and straightforward intensification of state tobacco control efforts, because of the impact of interest group activity and changing economic situations at the state level. MSA resources have been significantly diverted from tobacco control and treatment into other state policy activities.").

[45] *See* Kara Marcello, Note, *The New York City Sugar-Sweetened Beverage Portion Cap Rule: Lawfully Regulating Public Enemy Number One in the Obesity Epidemic*, 46 CONN. L. REV. 807, 820–22 (2013) (outlining the Board of Health's reasoning in adopting the regulation).

[46] Section 81.53 of title 24 of Rules of the City of New York limited sale of "sugary drinks" to containers that were no larger than sixteen ounces. The notes accompanying the definitions under the rule state:

> §81.53 was added to Article 81 by resolution adopted September 13, 2012 to establish maximum sizes for sugary drinks and service beverage cups sold and offered in FSEs. People tend to consume more calories at meals that include large beverage sizes. Its intent is to address the supersize trend and reacquaint New Yorkers with smaller portion sizes, leading to a reduction in consumption of sugary drinks among New York City residents.

Bd. of Health, *Notice of Adoption of an Amendment (§ 81.53) to Article 81 of the New York City Health Code*, N.Y.C. DEP'T HEALTH & MENTAL HYGIENE 6, *available at* http://www.nyc.gov/html/doh/downloads/pdf/notice/2012/notice-adoption-amend-article81.pdf.

[47] *See* N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, 110 A.D.3d 1, 6 n.2 (N.Y. App. Div. 2013) (showing that the parties challenging the soda ban included numerous business interests, "namely, the New York Statewide Coalition of Hispanic Chambers of Commerce, The New York Korean-American Grocers Association, Soft Drink and Brewery Workers Union, Local 812, International Brotherhood of Teamsters, The National Restaurant Association, The National Association of Theatre Owners of New York State, and The American Beverage Association"), *aff'd*, 23 N.Y.3d 681 (2014).

libertarianism, and utilitarianism or welfarist liberalism."[48] Friedman's focus on autonomy and paternalism fits comfortably within the liberal dialogue. While each of these strains within the liberal tradition remains important and frequently animates the scholarly and public discussion of such issues as anti-obesity efforts, this framework falls short of a robust ethics for public health that can address current challenges faced within our society. As Jennings observes, "The liberal framing of public health ethics is useful up to a point, but it is ultimately too narrow to provide normative justification for—or adequate moral insight about—the kinds of social change public health must strive to bring about."[49]

Notably, even in bioethics—which focuses on individual rights and duties—ethical theory continues to value autonomy no more than other principles (e.g., "beneficence, non-maleficence, and justice").[50] Lisa Lee and her colleagues conclude that "[t]he dominance of individual autonomy despite prima facie equivalence in clinical ethics is incompatible with the population-centered focus of public health."[51]

We defend paternalism in part by critiquing the assumptions that underlie the claim that individuals can always make informed choices that lead to their net benefit.[52] As Friedman notes,[53] and copious social science literature supports, individuals often have limited capacity to evaluate choices—whether due to inherent biases in human decision-making, lack of individual capacity to understand and accurately weigh scientific data on risks and benefits, or the absence of full information in many settings requiring choice. Additionally, cultural and social constraints also influence individual behavior, sometimes in ways that are not health reinforcing. An adolescent's decision to try tobacco is shaped by a complex web of peer behavior, relationships with parents, and the social meaning ascribed to smoking.[54] Of course, that same decision is also

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[48] Jennings, *supra* note 2, at 31.

[49] *Id.*

[50] *See* THOMAS L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 99 (6th ed. 2009) ("Respect for the autonomous choices of persons runs as deep in common morality as any principle . . . ."); Lisa M. Lee et al., *Ethical Justification for Conducting Public Health Surveillance Without Patient Consent*, 102 AM. J. PUB. HEALTH 38, 39 (2012) (stating that even though autonomy is on the rise compared to other ethical values, biomedical ethics still holds it as equivalent with the other major values).

[51] Lee et al., *supra* note 50, at 40.

[52] *See* L.O. Gostin & K.G. Gostin, *A Broader Liberty: J.S. Mill, Paternalism and the Public's Health*, 123 PUB. HEALTH 214, 215 (2009) (outlining Mill's theory of liberty, which argues that a state should be limited in its attempts to prevent harms that individuals inflict upon themselves, and noting four assumptions that underlie Mill's argument).

[53] *See* Friedman, *supra* note 1, at 1726–27 (noting that many people hold biases that interfere with decisions, which leads them "to make suboptimal or harmful choices").

[54] *See* Cheryl S. Alexander et al., *Taking a First Puff: Cigarette Smoking Experiences Among Ethnically Diverse Adolescents*, 4 ETHNICITY & HEALTH 245, 253–55 (1999) (stating that all three of these factors influence whether an individual will smoke).

demonstrably shaped by paternalistic state action—e.g., age limits for cigarette purchases, restrictions on advertising aimed at youth, banning smoking in public places, and substantial taxes on tobacco products.[55] Thus, even the notion of truly autonomous action is flawed at its basic assumptions.

It bears noting that a paternalistic responsibility of our society is not necessarily in conflict with a rigorous defense of self-regarding behavior. Consider a hypothetical disease that causes significant annual morbidity (e.g., 400,000+ cases) and mortality (150,000 deaths), for which conservative care is known to yield an acceptable five year disease-free survival rate of 70%, whereas more aggressive therapy, with associated discomforts and cost, promises to boost the five-year survival rate to 77% (i.e., a 10% improvement in care).[56] For any individual facing the choice of how to be treated for his or her disease, the likelihood of benefitting from aggressive therapy would be relatively low.[57] Moreover, should even infrequent "treatment-induced morbidity" occur (e.g., 5% of aggressively treated patients exhibiting severe cardiotoxicity), the aggressive treatment of every twenty patients could yield a life limiting, and perhaps life threatening, complication for one individual. As such, a patient's right to choose preferred treatment for the disease would be understood and that right to self-regarding behavior should be protected by society. Nonetheless, the public-at-large has great reason to define standards of care, issue clinical score cards, offer tort relief, and incentivize physician compensation in the interest of compelling physicians and patients to accept aggressive therapy so as to achieve the highest possible cure rate for the disease.[58] Overlooking that responsibility not only "denies" benefit to

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[55] *See* Sloan & Trogdon, *supra* note 43, at 852–54 (finding that increases in the price of cigarettes and changes in advertising reduce the probability that young adults would smoke and suggesting that prevention methods were likely to lead to larger effects on young adults); *see also Information by Topic, Legislation, Smoking & Tobacco Use*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/tobacco/data_statistics/by_topic/policy/legislation/ (last visited Apr. 14, 2014) (listing various federal laws affecting tobacco products).

[56] This hypothetical is based roughly on the historical reality of breast cancer care in the 1980s. Bernard Fisher et al., *A Randomized Clinical Trial Evaluating Sequential Methotrexate and Fluorouracil in the Treatment of Patients with Node-Negative Breast Cancer Who Have Estrogen-Receptor-Negative Tumors*, 320 NEW ENG. J. MED. 473, 473 (1989) (stating that chemotherapeutic treatment of women with high risk of disease recurrence increased five-year survival from 71% to 80%).

[57] According to this scenario, fourteen aggressively treated cases are needed to achieve the successful five-year survival of one additional patient.

[58] Numerous studies demonstrate that physicians exert significant influence on treatment choice for patients undergoing care. *See, e.g.*, L.A. Siminoff & J. H. Fetting, *Factors Affecting Treatment Decisions for a Life-Threatening Illness: The Case of Medical Treatment of Breast Cancer*, 32 SOC. SCI. & MED. 813, 816 (1991) (finding that four-fifths of patients surveyed reported that they abided by a decision of their physician as to how they should be treated for their disease). Experimental evidence in support of this finding is provided by Andrea D. Gurmankin, Jonathan Baron, and John C. Hershey.

large numbers of individuals but undermines the return on investment in health care innovation and system infrastructure.[59]

For a more robust argument for paternalism in public health we begin with an emphasis on the "public" in public health. As others have noted, the focus of public health is on population health, rather than the health of specific individuals.[60] Public health policy, practices, and interventions embody public health responsibility for the collective as well as the individual. Chronic diseases, many linked to behavior, pose some of the most pressing health threats today;[61] diet, inactivity, and smoking, while

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See Andrea D. Gurmankin et al., *The Role of Physicians' Recommendations in Medical Treatment Decisions*, 22 MED. DECISION MAKING 262, 263–71 (2002) (performing an experiment to test the degree to which patients are influenced by their physicians, and finding that physician decisions are very influential). Physicians making those "decisions" on behalf of their patients, in turn, are known to respond to the relative reimbursement available for some preference-sensitive therapies. *See, e.g.*, Thomas G. McGuire, *Physician Agency*, *in* 1A HANDBOOK OF HEALTH ECONOMICS 461, 522–26 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (discussing the health economics theory that a physician's desire to maintain a certain income offers a partial explanation for his or her behavior when treating patients); Mireille Jacobson et al., *How Medicare's Payments Cuts for Cancer Chemotherapy Drugs Changed Patterns of Treatment*, 29 HEALTH AFF. 1391, 1394 (2010) (finding that the implementation of a new payment system was linked to an increase in chemotherapy treatment, particularly from physicians' offices); Mireille Jacobson & Joseph P. Newhouse, *Expect the Unexpected? Physicians' Responses to Payment Changes*, EXPERT VOICES 1–2 (2010), http://www.nihcm.org/pdf/EV-JacobsonNewhouseFINAL.pdf (finding that Medicare fee cuts can lead to changes in physicians' behavior); Diane Alexander, *Does Physician Compensation Impact Procedure Choice and Patient Health?* 2 (Princeton Univ., Woodrow Wilson Sch. of Pub. & Int'l Affairs, Ctr. for Health & Wellbeing, Working Paper No. 1475, 2013), *available at* wws-roxen.princeton.edu/chwpapers/papers/ALEXANDER_D_Jul13.pdf (finding that the rate of C-sections varies according to compensation structure).

[59] *See* Stephen F. Jencks et al., *Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001*, 289 JAMA 305, 310–11 (2003) ("Growing national alarm over unrealized opportunities to improve care has been accompanied by a significant improvement in care, although far more remains to be done than has been accomplished. The improvement reported herein is consistent with the goals of the Medicare QIO program, which has performance-based contracts with QIOs to achieve precisely these kinds of improvements."); Stephen F. Jencks et al., *Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels*, 284 JAMA 1670, 1675 (2000) ("This study provides strong evidence of a substantial opportunity to improve the care delivered to Medicare beneficiaries. Available data suggest that providing the services measured here could each save hundreds to thousands of lives a year . . . .").

[60] *See* GOSTIN, *supra* note 5, at 16–17 ("[P]ublic health's abiding interest is in the well-being and security of populations, not individual patients."); Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, *in* NEW ETHICS FOR THE PUBLIC'S HEALTH 57, 58–67 (Dan E. Beauchamp & Bonnie Steinbock eds., 1999) (discussing the historical concepts of public health in the United States and noting that it is largely focused on the common good and on the public, as opposed to on specific individuals); Gostin & Gostin, *supra* note 52, at 217–18 (discussing public health paternalism's concern with welfare of the entire population rather than individuals).

[61] *See* J. Michael McGinnis & William H. Foege, *Actual Causes of Death in the United States*, 270 JAMA 2207, 2207–11 (1993) ("[T]he three leading causes of death—tobacco, diet and activity patterns, and alcohol—are all rooted in behavioral choices."); Ali H. Mokdad et al., *Actual Causes of Death in the United States, 2000*, 291 JAMA 1238, 1238–43 (2004) (finding that one-third of all deaths in the United States were attributable to smoking or poor diet and physical inactivity); *cf.* Ali H. Mokdad et al., *Correction: Actual Causes of Death in the United States, 2000*, 293 JAMA, 293, 293

behaviors undertaken by individuals, create risks to populations[62] and burdens to society. If the state, through public health, fails to respond vigorously, it shirks its responsibility to protect the public and squanders resources that could be used elsewhere.

Additionally, the motivating values of public health include social justice, which suggests both that public health has a special duty to protect the most marginalized and to address and reduce health disparities across populations.[63] The poor, racial, and ethnic minorities experience disproportionate burdens of many chronic diseases linked to obesity, inactivity, and smoking.[64] The burden of disease, in turn, may negatively impact educational, employment, and practical opportunities for those affected and increase persistent socio-economic disparities.[65] This cycle is self-reinforcing. The well-off have time and resources to join gyms; live in safe neighborhoods; pay for after-school sports for their children; shop for fresh, varied, and healthful food; and avoid fast food outlets.[66] The poor,

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(2005) (reporting that an error in calculations caused the writers to overestimate the number of deaths attributable to poor diet and physical activity, but maintaining that their principal conclusion, that tobacco and poor diet and physical activity contribute to a large number of deaths).

[62] *See* Geoffrey Rose, *Sick Individuals and Sick Populations*, 14 INT'L J. EPIDEMIOLOGY 32, 32 (1985) ("We might achieve a complete understanding of why individuals vary, and yet quite miss the most important public health question, namely, 'Why is hypertension absent in the Kenyans and common in London?'. The answer to that question has to do with the determinants of the population mean; for what distinguishes the two groups is nothing to do with the characteristics of individuals, it is rather a shift of the whole distribution—a mass influence acting on the population as a whole.").

[63] *See* GOSTIN, *supra* note 5, at 21–23 ("These two aspects of justice—health improvement for the population and fair treatment of the disadvantaged—create a richer understanding of public health. Seen through the lens of social justice, the central mission of the public health system is to engage in systematic action to ensure the conditions for improved health for all members of the population, and to redress persistent patterns of systematic disadvantage."); Gostin & Gostin, *supra* note 52, at 218 (offering a social justice perspective to view the problem of paternalism); *see also* Dan E. Beauchamp, *Public Health as Social Justice*, *in* NEW ETHICS FOR THE PUBLIC'S HEALTH, *supra* note 57, at 101–09 ("[P]ublic health is ultimately and essentially an ethical enterprise committed to the notion that all persons are entitled to protection against the hazards of this world and to the minimization of death and disability in society.").

[64] Ashleigh L. May et al., CDC, *Obesity—United States, 1999–2010*, 62 MORBIDITY & MORTALITY WKLY. REP. 120, 121 (Supp. 2013) ("The prevalence of obesity differed substantially across categories of various demographic characteristics . . . . [A]mong women, the overall (1999–2010) prevalence among non-Hispanic blacks (51%) was 10 percentage points higher than that among Mexican-Americans and 20 percentage points higher than that among non-Hispanic white women.").

[65] *See* Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, 21 HEALTH AFF. 60, 65–70 (2002) (describing the indirect relationship between "income, education, and occupation" and health).

[66] *See* GOSTIN, *supra* note 5, at 22 (highlighting, at the other end of the self-reinforcing cycle, "poverty, substandard housing, poor education, unhygienic and polluted environments, and social disintegration" as agents that lead to "systematic disadvantage not only in health but also in nearly every aspect of social, economic, and political life"); Gostin & Gostin, *supra* note 52, at 218 ("The most disadvantaged . . . are bombarded with commercial messages about unhealthy products; their communities are inundated with stores selling fast food, tobacco, alcoholic beverages and firearms; their neighbourhoods do not have playgrounds and fields for recreation; and they live in poorly lit,

by contrast, often lack every facilitator of healthier choices, from income and time to proximity of full-service supermarkets, playgrounds, and sports fields.[67] From this perspective, failure to act on the part of public health is not merely neutral, it disproportionately harms those with the least resources to make healthy choices on their own; frankly, it discriminates insidiously.

Gostin points out that good health, in and of itself, represents a social good or "utility" that often goes unconsidered.[68] As individuals, most of us know that good health is necessary to be full-functioning, but, due to the inherent biases of human decision-making, the immediate benefits of a sugary drink, a fast-food meal, or time on the couch may outweigh the longer term, health-focused goals of lowering our BMI, building more aerobic capacity, and avoiding tobacco products—even though these activities might enable us to be more productive at work, experience less disability during our lives, and avoid early mortality. From the population perspective, however, "[p]opulation health becomes a transcendent value because a certain level of human functioning is a prerequisite for [engaging in] activities that are critical to the public's welfare—social, political, and economic."[69]

Finally, we do not think that public health can "go it alone" in the public sphere by simply ignoring counter arguments or resistance from individual or corporate stakeholders. Instead, we believe that public health must draw on an existing (if sometimes dormant) strain of civic responsibility,[70] recognition of the common good as well as common dangers, and awareness of the necessity to protect "the commons" from the tragedy of overuse.[71] Along those lines we note at least two positive

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violent areas that discourage outside activity. The poor cannot afford the whole foods, health clubs and leisure time that make it so much easier for the prosperous to live a healthy lifestyle.").

[67] *See* GOSTIN, *supra* note 5, at 22 ("A core insight of social justice is that there are multiple causal pathways to numerous dimensions of disadvantage. The causal pathways to disadvantage include poverty, substandard housing, poor education, unhygienic and polluted environments, and social disintegration. These, and many other causal agents, lead to systematic disadvantage not only in health but also in nearly every aspect of social, economic, and political life. Inequalities of one kind beget other inequalities, and existing inequalities compound, sustain, and reproduce a multitude of deprivations in well-being. Taken in their totality, multiple disadvantages add up to markedly unequal life prospects.").

[68] *See id.* at xxi ("Good health is fundamentally important because it is essential to happiness, livelihood, political participation, and many of the other elements necessary for a life full of contentment and achievement.").

[69] *Id.* at 8.

[70] *See* Jennings, *supra* note 2, at 33, 39–41 (describing a system of "civic republicanism" that places emphasis on "equity, reciprocity, mutuality, solidarity, and balance" in a society that categorizes the field of public health as a public service).

[71] Garrett Hardin, *The Tragedy of the Commons*, 162 SCIENCE 1243, 1244–45 (1968) (explaining that individuals are inclined to maximize their utility by consuming common resources because the consumption of those resources is borne across the entire population).

models—"civility" and "civic republicanism"—and suggest that public health draw on this discourse as it engages policy-makers and the public to find solutions to problems, such as obesity, that threaten our whole society, even though they seem to turn on individual, self-regarding behaviors.

Civility, through its "rules of engagement," defines minimal criteria for "legitimate" social action by increasing our capacity to resolve disagreements and by maximizing overall efficiencies within our pluralistic system.[72] Collective discourse is needed to define what lays within and outside the bounds of civic engagement so that intrinsic rights, privileges, and responsibilities of individuals can be assured.[73] To advocate autonomy above civility is to champion might over minds in the public square. The embrace of civility does not simply permit, but requires us to act to support or build the social capital of communities. Because obesity and its associated health concerns hinder productivity and engagement of individuals in our social order,[74] the collective effort to minimize health risks (e.g., by inhibiting soft drink consumption) is warranted despite the impact on personal choice. The absence of limitations on an individual may have measurable and meaningful social, economic, and moral consequences for the community at large.

The notion of civic republicanism provides another foundation for public health regulation. Although the last two centuries have been dominated by the liberal discourse of rights, liberties, and interests,[75] a more communitarian and collectively focused approach animated many of the debates that shaped early American government[76] and has never really left us. "Civic pride," mutual responsibility, and voluntarism in times of public need are themes familiar to almost any community in the United States, and through each, we recognize that there is something special about the communal good that makes it greater than the interests of an

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[72] Boyd, *supra* note 38, at 864–68 (discussing the necessities of civility as "functionally necessary as the minimal condition for social and political life").

[73] *See id*. at 874–76 (discussing the value of civility's role in "keeping the peace and preserving the *status quo*").

[74] *See* Elizabeth Mendes, *Six in 10 Overweight or Obese in U.S., More in '09 Than in '08*, GALLUP (Feb. 9, 2010), www.gallup.com/poll/125741/six-overweight-obese.aspx (stating that obese Americans are more likely to be "unable to engage in normal activities because of poor health" resulting in the "lost productivity and economic implications [which] may be negative for the country as a whole").

[75] *See* Jennings, *supra* note 2, at 31–33 (discussing the patterns of "behavior and institutions" that govern the parameters of normative behavior); *cf.* NOVAK, *supra* note 5, at 14 (discussing the idea that "[n]o aspect of human intercourse remained outside the purview of police science"); Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267, 285–86 (1993) (describing the range and richness of government regulation to promote health and welfare in colonial and federalist society).

[76] For a discussion of the relevance of these ideals to the American Revolution, see generally BERNARD BAILYN, THE IDEOLOGICAL ORIGINS OF THE AMERICAN REVOLUTION (1967); GORDON S. WOOD, THE CREATION OF THE AMERICAN REPUBLIC 1776–1787 (1969).

aggregate of individuals. Jennings dubs this "civic republicanism," emphasizing that it draws on notions of citizenship, stewardship for the common good, and an engaged populace's willingness to be governed.[77] Public health ethics and our justification for our actions should adopt "the vocabulary of solidarity, mutuality, interdependency, social justice, community, and the common good."[78] As one of the civic professions, we rely on public health, along with public administration, policy analysis, planning, the military, and law enforcement or public safety[79] to use power and authority wisely and provide us with justifications for why we should voluntarily comply with (sometimes burdensome) rules. As such, public health can play an important role—providing balance to the information environment around health issues, identifying and removing unacceptable risks from our daily lives, and negotiating with the rest of government to prioritize health among many important public issues. In the practical sense, we move toward civic republicanism when we shift from seeing problems (health or otherwise) as "personal trouble" to seeing them as "public issues."[80] The obesity epidemic illustrates a similar dynamic. In recent decades it has gone from being discussed as a purely personal problem related to behavior (a result of personal choices and lack of will-power), or individual determinants (genetics and metabolism) to being considered an epidemic, with society-wide implications for health, finance, urban planning, agricultural, and energy policies, among many others.[81] Current data related to health costs alone amply demonstrate that we can no longer afford to regard obesity as merely a personal problem.[82] The question remains whether we can imagine and then embrace behavioral, social, cultural, and structural changes[83] that reflect both shared benefits and shared sacrifices.

Public health, and perhaps the state in the larger sense, needs to feed and foster the sense of connection, interrelatedness, and political engagement that characterizes these broader ethical frameworks for public health, so that public health can create a "bubble of civic virtue and a small

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[77] *See* Jennings, *supra* note 2, at 38–44 (discussing the tenets of civic republicanism).

[78] *Id.* at 37.

[79] *Id.* at 33.

[80] *Id.* at 32.

[81] *See* Benjamin Caballero, *The Global Epidemic of Obesity: An Overview*, 29 EPIDEMIOLOGIC REVS. 1, 3–4 (2007) (discussing the shift from focusing on obesity as an individualized problem to the focus on "external developments of energy balance").

[82] *See* Youfa Wang et al., *Will All Americans Become Overweight or Obese? Estimating the Progression and Cost of the US Obesity Epidemic*, 16 OBESITY 2323, 2329 (2008) ("By 2030, health-care costs attributable to obesity and overweight could range from $860 to $956 billion . . . .").

[83] *See, e.g.*, Scott Burris et al., *Integrating Law and Social Epidemiology*, 30 J.L. MED. & ETHICS 510, 510 (2002) (describing law as a key structural determinant of health as well as a tool for intervention).

space for the political imagination and the common good."[84] Within that space, public health can work with individuals and communities to improve the long-term health of both our children and ourselves. Public health has the right and the obligation to initiate policies and practices that enhance the health and well-being of our citizenry. Obesity is not a health risk but a morbid state with definable and predictable sequelae that shortens life expectancy and limits functional activity of affected individuals.[85] It is more akin to heart disease than smoking or stress, as it is a health state and not an exposure via behavior or the environment. As such, society must weigh the collective benefits versus personal autonomy when taking action to prevent its onset and minimize its consequences.

[84] Jennings, *supra* note 2, at 58.

[85] *See* Christine L. Himes, *Obesity, Disease, and Functional Limitation in Later Life*, 37 DEMOGRAPHY 73, 73–74 (2000) (discussing the link between body size and decreased functional activity later in life).