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Public Health Regulation and the Limits of Paternalism Lead Article

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Public Health Regulation and the Limits of Paternalism

DAVID ADAM FRIEDMAN

This Article explores the role of paternalism in regulatory efforts to improve public health, focusing mostly on obesity, but also accounting for recent developments in other public health arenas. First, the Article describes a spectrum of interventions that regulators can implement in the public health zone, ranging from soft paternalism to hard paternalism. Second, the Article discusses the limits of these paternalistic interventions in addressing the problem of high obesity rates in America. The analysis shows that the underlying scientific and socioeconomic factors driving obesity prove difficult to confront—a difficulty further complicated by the lower tolerance that the public has expressed for regulatory interventions that diminish individual autonomy. That is, soft paternalism may be too weak to address obesity, and hard paternalism may prove socially unpalatable to deploy. Third, the Article reinforces the notion that a larger pattern may have emerged with respect to the limitations of paternalistic approaches, and addresses recent attitudinal shifts against marijuana prohibition and water fluoridation, as well as a wave of activism combating the refusal of food producers to enable people to make choices about consuming genetically-modified foods. The analysis concludes that the negativity associated with the reduction of personal autonomy has constrained the options of regulators already charged with solving difficult problems. Ultimately, however, narrow opportunities for intervention still exist. If regulators invest heavily in the soft paternalistic initiatives that prove effective, and the hard paternalistic opportunities that prove inoffensive, then the aggregate impact on public health, though limited, may prove positive.

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Public Health Regulation and the Limits of Paternalism

DAVID ADAM FRIEDMAN*

*“The nice thing about [New York City’s attempt to enforce a 16-ounce container size limit on sweetened drinks] is it’s really just a suggestion. So, if you want to buy 32 ounces, you just have to carry it back to your seat in two cups. And maybe that would convince you to only take one, but if you want two you can do it. I think government’s job . . . is to give you advice, not to force you [to] do things. . . . Although . . . I think some of these other things—calorie counts we’ve done in chain restaurants so you can see what you’re eating—[are okay]. But when it comes to forcing you, . . . the only thing the government can do practically—and I think should do—is education. Exercise is great for you, but how do you convince people to do it? And should you force them to do it? Probably not.”*¹

—Michael Bloomberg, New York City Mayor

I. INTRODUCTION

New York City Mayor Michael Bloomberg, who was famously and perhaps appropriately caricatured as “Nanny Bloomberg,”² conceded that practical limits to paternalism exist in public health, even in the obesity sphere.³ Though his leadership on instituting a trans fats ban in New York

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¹ Colin Campbell, *Bloomberg Says Government “Probably” Shouldn’t Force People to Exercise*, N.Y. OBSERVER (Mar. 8, 2013), <http://observer.com/2013/03/bloomberg-says-government-probably-shouldnt-force-people-to-exercise/>.

² This label does not seem to bother the mayor. After the *New York Post* ran a front-page cartoon of him as Mary Poppins, he responded: “I take that as a great badge of honor. I can’t think of anything I like [more]. It says we’re trying to do something—save lives.” David Seifman, *Say You’ll Mary Me!*, N.Y. POST, Mar. 19, 2013, at 3 (alteration in original).

³ See Campbell, *supra* note 1 (reflecting Bloomberg’s cognizance of the limits on paternalism).

City presented a ripe and fruitful opportunity for hard paternalism,⁴ his other, more notorious effort to limit the container sizes of sugar-sweetened drinks fell flat with the public.⁵ Indeed, the portion-cap initiative (the “Big Gulp ban”)⁶ arguably had fewer paternalistic attributes than the trans fats ban. The trans fats ban compelled restaurants to change their offerings and removed a choice from consumers, albeit on a less-detectable basis.⁷ On the other hand, with the Big Gulp ban, New York City consumers were free to imbibe as much sugar as they wanted—though they were obstructed or “insulated”⁸ from making the choice to drink more. But despite the ultimate freedom to drink up, a broad segment of the population objected to this kind of paternalism, even though the regular consumption of large sweetened drinks was limited to a small subset of consumers.⁹

Debates about the appropriateness of regulating personal behavior have ancient roots,¹⁰ but are opening on new fronts. Pure, traditional paternalism, labeled “hard” paternalism by some,¹¹ has been critiqued by those who believe that the same regulatory outcomes can be achieved while preserving autonomy. Those who advocate “soft” or “libertarian” paternalism argue that a careful construction of the decision-making environment can lead people to make better choices without eliminating

⁴ See Sonia Y. Angell et al., *Change in Trans Fatty Acid Content of Fast-Food Purchases Associated with New York City’s Restaurant Regulation: A Pre-Post Study*, 157 ANNALS INTERNAL MED. 81, 84 (2012) (concluding that the initiative to restrict trans fats use by restaurants resulted in decreased trans fats consumption).

⁵ See Michael M. Grynbaum & Marjorie Connelly, *60% in City Oppose Soda Ban, Calling It an Overreach by Bloomberg, a Poll Finds*, N.Y. TIMES, Aug. 22, 2012, at A19 (reporting poll results that showed sixty percent of New York City residents opposed the ban).

⁶ Though this term, derived from an offering at 7-Eleven stores, has been used in common parlance to describe the initiative, Bloomberg’s regulation did not apply to convenience stores, or to the actual Big Gulp product. Glenn Blain, *7-Eleven’s Big Gulps Safe from Bloomberg’s Soda Ban*, N.Y. DAILY NEWS (Feb. 27, 2013), <http://www.nydailynews.com/new-york/big-gulps-safe-bloomberg-soda-ban-article-1.1275438#ixzz2XMal5U3Q>.

⁷ See Corby Kummer, *The Trans-Fat Ban as a Model of Slow Health Policy*, THE ATLANTIC (Nov. 8, 2013), <http://www.theatlantic.com/health/archive/2013/11/the-trans-fat-ban-as-a-model-of-slow-health-policy/281299/2/> (describing the reach of the trans fats ban, and observing that “consumers didn’t mind retooled fats”).

⁸ For a discussion of insulation methods, see *infra* Part II.B.4.

⁹ See Grynbaum & Connelly, *supra* note 5 (reporting that, while sixty percent of New Yorkers opposed the ban, two-thirds of them had one or fewer sodas per week).

¹⁰ See NICKOLAS PAPPAS, THE ROUTLEDGE GUIDEBOOK TO PLATO’S REPUBLIC 229–39 (2013) (discussing the Platonic and Socratic views of paternalism).

¹¹ According to Sarah Conly, “hard paternalism . . . advocates making some actions impossible, and soft paternalism merely recommends incentivizing certain preferable options.” SARAH CONLY, AGAINST AUTONOMY: JUSTIFYING COERCIVE PATERNALISM 5–6 (2013). Cass Sunstein and Richard Thaler define paternalism as having “the goal of influencing the choices of affected parties in a way that will make those parties better off.” Richard H. Thaler & Cass R. Sunstein, *Libertarian Paternalism*, 93 AM. ECON. REV. 175, 175 (2003). They distinguish soft paternalism from hard paternalism by stating that the former lacks coercion. *Id.*

less socially desirable choices outright.¹² Richard Thaler and Cass Sunstein brought the concept of deploying soft paternalism to the forefront with the publication of their book, *Nudge*, which drew upon much of the literature about paternalism and behavioral economics.¹³ One critique of the soft approach contends that the costs of permitting people to continue to make bad choices are not justifiable when a hard approach would simply eliminate the bad choice.¹⁴ Still others argue that libertarian paternalism and state-guided efforts to enhance social welfare cannot be reconciled with a libertarian point of view.¹⁵

Recently, paternalism's modern role in regulation has surfaced at the centerpiece of several high-profile clashes about public health, most notably in policy debates about the prevalence of obesity.¹⁶ Despite recent advances in slowing the growth of the obesity rate in the United States,¹⁷ it appears that there are some limits to the types and degrees of regulatory intervention that the public is willing to accept.

I explore this important topic in public health by way of examples, with particular attention being given to obesity, but also to marijuana

¹² Soft paternalism has been used to encompass a broad family of concepts—each of which have quirks. Among these concepts are anti-anti-paternalism, asymmetric paternalism, libertarian paternalism, and light paternalism. See, e.g., Colin F. Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for "Asymmetric Paternalism,"* 151 U. PA. L. REV. 1211, 1212 (2003) (defining asymmetric paternalism as a regulatory approach that "creates large benefits for those who make errors, while imposing little or no harm on those who are fully rational"); Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1541 (1998) (describing anti-anti-paternalism as "a skepticism about antipaternalism, but not an affirmative defense of paternalism"); George Loewenstein & Emily Haisley, *The Economist as Therapist: Methodological Ramifications of "Light" Paternalism*, in THE FOUNDATIONS OF POSITIVE AND NORMATIVE ECONOMICS: A HANDBOOK 210, 213 (Andrew Caplin & Andrew Schotter eds., 2008) (explaining that "[l]ight paternalism aims to enhance decision making without restricting it"); Cass Sunstein & Richard Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1201 (2003) (identifying libertarian paternalism as "an approach that preserves freedom of choice but that encourages both private and public institutions to steer people in directions that will promote their own welfare"). Russell Korobkin assembled this conceptual inventory. Russell Korobkin, *Libertarian Welfarism*, 97 CALIF. L. REV. 1651, 1652–53 (2009). In his article, Korobkin offers a theory of "libertarian welfarism," which advocates using the same tools as libertarian paternalism, but to serve collective social welfare ends, rather than just individual ends. *Id.* at 1653.

¹³ CASS R. SUNSTEIN & RICHARD H. THALER, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008).

¹⁴ See generally ONLY, *supra* note 11 (arguing that soft paternalism is ineffective).

¹⁵ See generally Gregory A. Mitchell, *Libertarian Paternalism Is an Oxymoron*, 99 NW. U. L. REV. 1245 (2005) (contending, inter alia, that the redistributive effects of libertarian paternalism are inconsistent with libertarian values).

¹⁶ See, e.g., Robert Creighton, *Cheeseburgers, Race, and Paternalism: Los Angeles' Ban on Fast Food Restaurants*, 30 J. LEGAL MED. 249, 266 (2009) (discussing opposition to a fast food ban in Los Angeles, which was rooted in anti-paternalism). See generally Colin Hector, *Nudging Towards Nutrition? Soft Paternalism and Obesity-Related Reform*, 67 FOOD & DRUG L.J. 103 (2012) (discussing both sides of the paternalism debate regarding obesity policy).

¹⁷ See, e.g., Betsy McKay, *U.S. News: Obesity in Young Children Falls Sharply*, WALL ST. J., Feb. 26, 2014, at A4 (describing a forty percent drop in preschool-age obesity over the past decade).

legalization, water-supply fluoridation, and efforts to label foods with genetically-modified organisms (GMOs). These flashpoint zones show a general rejection of paternalism—especially visible, hard paternalism. This leaves regulators with the more limited toolkit of soft paternalism to attack some of the more difficult public health problems. In fact, a rejection of hard paternalism can lead regulators either to use strategies that preserve autonomy, or simply to do nothing to regulate personal choices.

Assessing whether paternalism has reached its limits of effectiveness in public health raises a number of questions, namely: Which types of paternalistic initiatives have potential, and which have been exhausted? If these questions can be answered practically, they might guide policymakers more effectively. For example, according to a 2010 Centers for Disease Control and Prevention (CDC) study, the obesity problem may have peaked.¹⁸ This might mean that in spite of certain public rejections of paternalism, regulators may be justified in continuing with some of the anti-obesity strategies. But, in light of the public attitude, having a framework for deciding which strategies to pursue further may prove helpful.

Though common wisdom holds that “[d]ata is not the plural of anecdote,”¹⁹ truthful anecdotes provide an invitation to test certain hypotheses and spark dialogue about their meaning. A cursory view of the obesity problem alone demonstrates inconsistencies in scientific and epidemiological viewpoints. Public attitudes toward paternalism can be similarly inconsistent. Positing that paternalism has reached its limits can be challenging to prove or disprove, but nowhere has the debate about paternalism been sharper than in public health. Though I focus on various components of the obesity problem and other public health issues, I

¹⁸ See Katherine M. Flegal et al., *Prevalence and Trends in Obesity Among U.S. Adults, 1999–2008*, 303 JAMA 235, 240 (2010) (“These data suggest that the increase in the prevalence of obesity previously observed . . . may not be continuing at a similar level over the period 1999–2008, particularly for women but possibly for men.”).

¹⁹ E-mail from Fred Shapiro, Assoc. Librarian for Collections and Access and Lecturer in Legal Research, Yale Law Sch. to American Dialect Society (July 6, 2004, 11:21 PM), available at <http://listserv.linguistlist.org/cgi-bin/wa?A2=ind0407a&L=ads-l&P=8874>. Ironically, this common saying appears to be a complete reversal of the original sentiment expressed by the original declarant, noted political scientist Raymond Wolfinger. *Id.* Fred Shapiro, the author of the Yale Dictionary of Quotations, emailed Wolfinger in 2004 for clarification about this aphorism. Wolfinger wrote:

I said “The plural of anecdote is data” some time in the 1969–70 academic year while teaching a graduate seminar at Stanford. The occasion was a student’s dismissal of a simple factual statement—by another student or me—as a mere anecdote. The quotation was my rejoinder. Since then I have missed few opportunities to quote myself.

Id. As Shapiro observed, “What is interesting about this saying is that it seems to have morphed into its opposite—‘Data is not the plural of anecdote’—in some people’s minds.” *Id.*

composed this narrative to show that paternalism may have reached the natural limits of effectiveness. I also show, however, that paternalism and public health intersect in different ways—and that neither term is monolithic.

Generalizations, of course, invite the presentation of exceptions and, though anecdotes can always be countered by anecdotes, discussing recent reactions to public health regulation in a few other spheres provides a starting point for answering the question of whether paternalism has peaked. For example, the legalization of recreational marijuana use in Washington and Colorado may embody a new movement away from paternalism in the public health sphere.²⁰ The successful challenges in recent years to efforts to fluoridate drinking water in Portland, Oregon, and a growing list of other locales may also reflect rejection of hard paternalism.²¹ Moreover, the recent reaction to GMOs in the food supply presents a question about who plays the paternalist.²² The grassroots concerns about GMO ingredients, particularly activist efforts seeking food labeling, could be viewed as a rejection of the paternalism led by corporate interests and government complicity with those interests.²³ With all of these issues in controversy, I argue that a general pushback on the advancement of paternalism reflects an overarching public attitude across these quite different debates and movements in public health.

Will hard paternalism play a viable and significant role in public health in the future? Predicting the future can prove humbling, even *with* a set definition of a standard and a robust and consistent data set about past patterns.²⁴ Moreover, recent developments in public health regulation indicate that regulators may have a more limited range of tools going forward. In particular, when looking at obesity—which is the most significant problem I will explore in terms of scale—finding viable opportunities to change consumption and physical activity patterns through

²⁰ See *infra* text accompanying notes 379–81.

²¹ See *infra* Part III.C.2.

²² See *infra* Part III.C.3. Connecticut became the first state to require labeling of genetically-modified foods. More than twenty states are considering taking similar action. Stephanie Strom, *Connecticut Approves Genetic Labeling*, N.Y. TIMES, June 4, 2013, at B4.

²³ Michele Simon, *How Grassroots Advocates Beat the Biotech and Food Lobbies*, HUFFINGTON POST (June 5, 2013), http://www.huffingtonpost.com/michele-simon/gmo-labeling-connecticut_b_3386010.html. This would reflect Gerald Dworkin's definition of broad paternalism, which concerns "any paternalistic action: state, institutional . . . or individual." Gerald Dworkin, *Paternalism*, STAN. ENCYCLOPEDIA PHIL. (June 1, 2010), <http://plato.stanford.edu/entries/paternalism/>.

²⁴ Snowfall accumulation prediction provides an example. Even armed with mountains of historical data and multiple predictive models, the task proves daunting. See generally Tyler McCandless et al., *Statistical Guidance Methods for Predicting Snowfall Accumulation in the Northeast United States*, 35 NAT'L WEATHER DIG. 149, 150, 152, 156 (2011) (detailing the difficulty of accurately forecasting snowfall, despite technological advances in meteorology). Meanwhile, degrees of paternalism are impossible to measure with precision. "How much" paternalism and "what type" of paternalism can be directionally discerned at best.

hard paternalism proves difficult, and soft paternalism can prove ineffective.

In Part II of this Article, I describe the paternalism at issue in public health in broad strokes, from traditional viewpoints about non-intervention to soft paternalism and hard paternalism. I also discuss the application of the different modes of paternalistic intervention in general terms. In Part III, I discuss how paternalism in general may have met the limits of its reach in public health, focusing substantially on obesity, but also looking at other public health areas that may illuminate the trend. Obesity initiatives, state-level efforts to decriminalize marijuana use, fluoridation initiatives, and grassroots efforts to label GMOs all have different contours but share an anti-paternalistic thread. Part IV argues that the limits of paternalism and the challenges of public health should affirmatively focus regulators on identifying and selecting opportunities that respect both the attitudinal limits toward paternalism and the real scientific challenges to public health. The limits of paternalism do not present an end to the gains in public health regulation, but they do require regulators to prioritize their efforts in light of those limits. Part V briefly concludes with an exhortation to public health regulators, urging them to use a framework that incorporates both policy efficacy and the true limits of paternalism into regulatory decision making.

II. PATERNALISM

Paternalism has peaked, for now, in the realm of public health regulation. Before providing support for that claim, I must first define the forms of paternalism to which I refer. Forests have been felled in the name of understanding and applying theories of paternalism,²⁵ so for the purposes of this Article, I adopt Gerald Dworkin's broad definition of paternalism because it comports with the other "flavors" of paternalism

²⁵ Over the past few years, a large body of literature has emerged in the general sphere of public health and paternalism, even when "health-care" policy is excluded. See, e.g., David R. Buchanan, *Autonomy, Paternalism, and Justice: Ethical Priorities in Public Health*, 98 AM. J. PUB. HEALTH 15, 15 (2008) ("On empirical and ethical grounds, public health should seek instead to expand individual autonomy to improve population health."); Thomas R.V. Nys, *Paternalism in Public Health Care*, 1 PUB. HEALTH ETHICS 64, 64 (2008) (challenging the "charges" of paternalism in public health); Robert A. Skipper, *Obesity: Towards a System of Libertarian Paternalistic Public Health Interventions*, 5 PUB. HEALTH ETHICS 181, 181 (2012) (advocating deployment of libertarian paternalism to reduce obesity); Lindsay F. Wiley et al., *Who's Your Nanny?: Choice, Paternalism and Public Health in the Age of Personal Responsibility*, 41 J.L. MED. & ETHICS 88, 88–89 (2013) (briefly exploring "the forces behind the cultural and political resonance of concerns about public health paternalism, 'personal responsibility,' and the 'nanny state'"). For recent examples in the legal and regulatory literature, see Rebecca L. Goldberg, *No Such Thing as a Free Lunch: Paternalism, Poverty, and Food Justice*, 24 STAN. L. & POL'Y REV. 35 (2013), and Lindsay F. Wiley, *Rethinking the New Public Health*, 69 WASH. & LEE L. REV. 207 (2012).

that will be described.²⁶ Dworkin described paternalism as the “interference with a person’s liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person being coerced.”²⁷ Dworkin also recognized the distinction between narrow and broad paternalism, with narrow paternalism describing state action, and broad paternalism further including private actors.²⁸

Paternalism in public health sprawls beyond the context of public regulation to include the private domain. It thus encompasses action by the Food and Drug Administration (FDA) to remove a person’s favored medication from the market,²⁹ as well as a wife physically blockading the path of her husband’s car to prevent him from driving, rather than walking, to buy unhealthy ice cream.³⁰ Examples of private paternalism abound, and oftentimes public paternalism has a secondary private effect. For instance, the FDA has promulgated marketing restrictions for smokeless tobacco,³¹ with the intention of protecting young consumers.³² But actors other than the government can certainly influence young consumers. Consider the behavioral changes that can result from such things as privately-imposed bans and restrictions on the public use of chewing tobacco in professional sports.³³ In this case, paternalistically-motivated and self-imposed, private restrictions reduce the glorification of individually harmful behavior, while also limiting exposure to audiences prone to engaging in the behavior.³⁴

²⁶ Gerald Dworkin, *Paternalism*, 56 THE MONIST 64, 65 (1972).

²⁷ *Id.*

²⁸ Dworkin, *supra* note 23.

²⁹ See, e.g., Katherine Hobson, *Without Darvon and Darvocet, What’s a Pain Sufferer to Do?*, WALL ST. J. HEALTH BLOG (Nov. 24, 2010, 5:04 PM), <http://blogs.wsj.com/health/2010/11/24/without-darvon-and-darvocet-whats-a-pain-sufferer-to-do/> (noting that many patients objected when the FDA removed an established painkiller from the market because of cardiac risks).

³⁰ See, e.g., Jenna Karvunidis, *Policing Your Spouse’s Diet—NO ICE CREAM FOR YOU!*, HIGH GLOSS & SAUCE BLOG (June 11, 2012, 1:27 PM), <http://www.chicagonow.com/high-gloss-and-sauce/2012/06/policing-your-spouses-diet-no-ice-cream-for-you/> (“Run that house, ladies. Don’t think you’re being nice by letting everyone get chubby! My unpopular opinion is if you really love someone, you don’t let them make poor choices.”) Karvunidis’s actions and philosophy comport nicely with broader definitions of paternalism that recognize paternal actions of private actors.

³¹ 21 C.F.R. § 1140.10–1140.34 (2013).

³² 75 Fed. Reg. 13225 (Mar. 19, 2010).

³³ In 1993, Major League Baseball banned the use of chewing tobacco by minor league players. *Tobacco Ban in Minors*, N.Y. TIMES (June 3, 1993), <http://www.nytimes.com/1993/06/03/sports/tobacco-ban-in-minors.html>. In 2011, Major League Baseball, after negotiations with the players’ union, did not ban the use of chewing tobacco during play, but did restrict the carrying of pouches and use of tins on the field, and also use during pre- and post-game interviews and at team functions. Bob Young, “*Giant*” 1st Step, ARIZ. REPUBLIC, Nov. 23, 2011, at C2.

³⁴ Before the formal restrictions came into effect, baseball phenom Stephen Strasburg announced that part of his motivation for quitting was that he “[did not] want kids who want to be like him to see him with a packed lower lip.” Adam Kilgore, *Strasburg Attempting to Shut Out Tobacco*, WASH. POST,

Paternalism broadly describes an approach to regulation, but understanding the various dimensions of paternalism requires nuance. Recently, soft paternalism has been offered as a broad alternative to hard paternalism. Hard paternalism “advocates making some actions impossible, and soft paternalism merely recommends incentivizing certain preferable options.”³⁵ Sarah Conly recently offered a strong defense of hard, coercive paternalism, concluding that regulators have a stark choice: “[They] can leave people to suffer the effects of their errors, errors that can ruin their lives, or [they] can intervene. Coercive paternalism is humanitarian . . . and . . . reflects the value of human choice, since it helps individual[s] to reach the goals they have set for themselves.”³⁶

Soft paternalism values personal autonomy over coercion, seeking opportunities to preserve choice and engender improved decision making. Richard Thaler and Cass Sunstein describe their brand of soft paternalism, libertarian paternalism, as “preserv[ing] freedom of choice but . . . authoriz[ing] both private and public institutions to steer people in directions that will promote their welfare.”³⁷ Though various definitions of hard and soft paternalism circulate, I embrace the definitions offered by Conly, Thaler, and Sunstein as current and concise.³⁸

My analysis does not require exploration of the historical development of thought about paternalism,³⁹ but it does require this narrowing of the

Jan. 31, 2011, at A1.

³⁵ CONLY, *supra* note 11, at 5.

³⁶ *Id.* at 194.

³⁷ Sunstein & Thaler, *supra* note 11, at 175, 179.

³⁸ It is important to clarify terminology. Joel Feinberg used the term soft paternalism to describe paternalism directed at someone who lacks voluntary choices, and hard paternalism to be directed at those whose choices and actions are voluntary. JOEL FEINBERG, HARM TO SELF 12 (1986). Here, I use soft paternalism to describe regulatory efforts that attempt to improve individual welfare by enhancing decision making while preserving autonomy, and hard paternalism to describe regulatory efforts that mandate the action that improves welfare, while removing discretion. One scholar, Thaddeus Pope, has emphasized that the moral debate about deploying hard paternalism can only begin with a more explicit, “honest[] and transparen[t]” definition of hard paternalism than that offered by Feinberg. Thaddeus Mason Pope, *Is Public Health Paternalism Really Never Justified? A Response to Joel Feinberg*, 30 OKLA. CITY U. L. REV. 121, 121–22 (2005). Pope argues that Feinberg dismisses the necessity of deploying hard paternalism by stretching the boundaries of soft paternalism to encompass interventions that would be classified as hard paternalism. *Id.* at 122. Elsewhere, Pope further articulated the need to better define the boundaries of hard paternalism in order to clarify debates about the justification for deployment. Thaddeus Mason Pope, *Counting the Dragon’s Teeth and Claws: The Definition of Hard Paternalism*, 20 GA. ST. U. L. REV. 659, 660–62 (2004).

³⁹ Theories of paternalism and their merits have been debated since the time of Plato and Socrates, through the Enlightenment, and into the modern era—where the current scholarly debate has been one that weighs libertarian approaches against paternalism and, within paternalism, soft paternalism versus hard paternalism. *See, e.g.*, JOHN LOCKE, TWO TREATISES OF GOVERNMENT 10–16 (Thomas I. Cook ed., Hafner Pub. Co. 1965) (1690) (presenting Locke’s argument against paternal and regal power and authority through his critique of the divine right of kings); PAPPAS, *supra* note 10, at 229–39 (discussing the Platonic and Socratic views of paternalism); F.M. Barnard, *Will and Political*

working definitions of paternalism. Indeed, public health regulators today intervene at various points along a spectrum, exploiting both “soft,” libertarian paternalism, and “hard,” traditional paternalism.

In Part II.A, I briefly describe some of the contours of paternalism, using this most recent framing and focusing on points along the spectrum of paternalistic interventions. In Part II.B, I illustrate the points through various applications.

A. *Flavors of Paternalistic Intervention*

Paternalism might be justified if the prescribed action corrects people from making so-called bad choices or wrong choices.⁴⁰ Take the example of a lifeguard at a public beach, who has the ability to help directly with the health and welfare of people in her territory.⁴¹ Assume that the lifeguard knows that broken glass has presented hazards on her beach, leaving several beachgoers to suffer cuts to their feet. As the lifeguard watches people pass by her tower, plodding through the sand in bare feet, she has several options. The first option is to do nothing and permit people to make their own assessments about the pleasure of walking barefoot against the risk of getting cut and the costs of gathering information about beach safety. This non-intervention appears to respect the default, natural preferences of people. There is no certainty that people will get cut, but there is a certainty that permitting people to choose to go barefoot respects their preferences. People can choose to ask the lifeguard about hazards, but often the prospective costs of retrieving and processing information exceed the expected potential benefits.

The lifeguard’s other options all involve layers of intervention to correct the information problem or to simply prevent harm. All may be justifiable, but they do involve changing the decision-making process and some deprivation of autonomy. The lifeguard can shout, “Sharp glass is hidden in the sand!” This would be the provision of pure, true information. It might not change behavior—but personal decisions about the risk/pleasure return would be of a higher, more informed quality. The lifeguard can also shout, “Put on your sandals! Yesterday, two people cut their feet on the glass in this sand and were taken by ambulance to the

Rationality in Rousseau, 32 POL. STUD. 369, 376–79 (1984) (discussing “Rousseau’s principled opposition to paternalism”).

⁴⁰ I note that moral justifications can be offered for different levels of paternalistic intervention, but I do not make normative prescriptions based on morality. I advise using restraint and expecting modest results from regulatory intervention in public health, based on the reality of public attitudes toward paternalism and the complexity of the problem being addressed.

⁴¹ One popular encyclopedia uses a different lifeguard illustration, for a lifeguard presents a natural example of an omniscient, benevolent decision maker responsible for public and individual welfare. *Paternalism*, NEW WORLD ENCYCLOPEDIA, http://www.newworldencyclopedia.org/entry/Paternalism#Soft_vs._hard_paternalism (last updated Apr. 2, 2008).

hospital!” This truthful narrative of harm adds a degree of intervention beyond pure information about the presence of the glass. The beach regulator tells a salient story. Beyond that, the lifeguard could require all beach walkers to don footwear—permitting people to enjoy the beach, but with less autonomy about the way they can do it. The lifeguard insulates the beachgoers from harm. At the most extreme, the lifeguard could announce that the beach will be closed until it is made completely safe, depriving the decision makers of all autonomy about judging risk.

Substitution of regulatory judgment for personal judgment about health and safety would be fairly controllable in the well-defined beach environment, which is a narrow zone where control can be exercised over a narrow set of behaviors. Additionally, the values behind preserving autonomy might be stronger in some circumstances than others. Preventing people from taking a certain chance of drowning or from high-risk exposure to shark attacks might justify hard paternalism. Letting people take the risk of cutting their feet might only warrant a softer paternalism because the risk and magnitude of harm would be lower.

I structure the discussion of paternalistic intervention in public health in a manner similar to that of the lifeguard example. Paternalistic interventions can be framed to address knowledge or information errors in decision making, or other biases. At their extreme, they simply prohibit actors from making a harmful choice.

I present below a five-level spectrum of interventional efforts that I derived from the work of Cass Sunstein and Christine Jolls.⁴² This spectrum has been used in different contexts. For example, Daniel Young further crystallized my approach in the context of regulating intervention in health care markets.⁴³ I have previously applied this framework in the contexts of sugary drink container size limits⁴⁴ and regulations of peer endorsements in advertising.⁴⁵ The five levels are arrayed accordingly:

- (1) *Libertarian or apaternalistic*: government allows a fully free market and relies on consumers to accurately process relevant information;
- (2) *Weak-form debiasing*: government provides raw statistical and factual information to consumers in an attempt to make them aware of relevant data;⁴⁶

⁴² Christine Jolls & Cass R. Sunstein, *Debiasing Through Law*, 35 J. LEGAL STUD. 199 (2006).

⁴³ Daniel Young, *Curing What Ails Us: How the Lessons of Behavioral Economics Can Improve Health Care Markets*, 30 YALE L. & POL'Y REV. 461, 480–81 (2012).

⁴⁴ David Adam Friedman, *Micropaternalism*, 88 TUL. L. REV. 75, 90–109 (2013).

⁴⁵ David Adam Friedman, *Debiasing Advertising: Balancing Risk, Hope, and Social Welfare*, 19 J.L. & POL'Y 539, 556–59 (2011).

⁴⁶ Jolls and Sunstein focus their article on the concept of using regulation to “debias” consumers. Jolls & Sunstein, *supra* note 42, at 199–202. Debiasing describes regulatory efforts to improve welfare

- (3) *Strong-form debiasing*: government makes available a “concrete instance of the occurrence” or “truthful narratives of harm” in order to illustrate the downside effects of various biases, although consumer choice remains unrestrained;⁴⁷
- (4) *Insulating strategies*: government protects consumers by creating barriers to entry or hard-to-satisfy standards;⁴⁸ and
- (5) *Outright bans and mandates*: government bars or prevents consumers from choosing certain options in the marketplace, or dictates mandatory practices.⁴⁹

All across this intervention spectrum, obesity-reducing efforts or other public health initiatives are at work. Even in the non-intervention sphere, markets work to resolve obesity in some ways, even if by selfish means to selfish ends.⁵⁰ At the softer end of the spectrum, regulators attempt to address cognitive biases through the presentation of more information to improve the quality of decision making. At the other end of the intervention spectrum, outright bans, reflecting hard paternalism, have been in place.

B. *Application of Paternalistic Interventions*

To illustrate the paternalistic intervention spectrum described in Part II.A, I apply it to domains that include but extend beyond public health. Understanding the intervention tactics across the spectrum, their effectiveness, and their implications for preserving autonomy facilitates a full assessment of different approaches.

1. *Apaternalism*

The apaternalistic approach toward regulation does not necessarily equate to indifference to social problems, but rather to a contention or belief that markets naturally solve problems. A further extension of this argument is that even regulators with good intentions can injure social welfare through the unintended or undesirable consequences of their direct

without depriving the regulated subjects of autonomy or choice. People have natural biases, and the premise of debiasing is that if you expose people to these biases or restructure their choices, they will make superior decisions for their own welfare and welfare at large. See Friedman, *supra* note 45, at 543–44 (“Debiasing through law purports to bring attractive features to the regulatory arena, achieving welfare-enhancing outcomes without paternalism.”).

⁴⁷ Jolls & Sunstein, *supra* note 42, at 210, 215.

⁴⁸ See *id.* at 225–27 (proposing that in some situations, “insulating” strategies will be preferable options to “strategies for debiasing through law” or “refusing to respond at all”).

⁴⁹ *Id.* at 207.

⁵⁰ Certainly, markets have worked to generate obesity. Overconsumption of unhealthy foods results from market-driven transactions, even if some of those transactions reflect information failures.

intervention.⁵¹ Negative externalities from private behavior might justify intervention,⁵² but the argument about whether markets or regulation would best solve the externality issue remains.⁵³

In the public health arena, externalities might reflect the public cost of private decisions about consumption or the choice to remain sedentary.⁵⁴ Redistributing this social cost out of fairness and out of a desire to reduce the regulated activity is one pursuit. The other, which libertarians might reject, is the paternalism that attempts solely to protect people from self-harm. This could be described as counter to John Stuart Mill's harm principal.⁵⁵ Market enthusiasts might endorse an externality-related tax, not for the primary purpose of displacing personal choice, but to ensure that an actor's choice is not distorted by making behavior less expensive to the actor than it would be if internalized. In other words, if the tax internalizes the externality of the behavior, balance would be restored to

⁵¹ For example, some nutrition scientists argue that agricultural subsidies may lead to excessive production of unhealthy products. See James E. Tillotson, *America's Obesity: Conflicting Public Policies, Industrial Economic Development, and Unintended Consequence*, 24 ANN. REV. NUTRITION 617, 630–35 (2004) (arguing that agricultural policies in the United States are related to the prevalence of obesity); David Wallinga, *Agricultural Policy And Childhood Obesity: A Food Systems and Public Health Commentary*, 29 HEALTH AFF. 405, 407–09 (2010) (discussing how agricultural policies help to determine what people eat, and ultimately are contributing to childhood obesity). But see Julian M. Alston et al., *Farm Subsidies and Obesity in the United States: National Evidence and International Comparisons*, 33 FOOD POL'Y 470, 473–74 (2008) (arguing that farm subsidies have generally small and inconsistent effects on farm commodity prices, and that the resulting food prices of more- and less-fattening foods are similarly inconsistent); Bradley J. Rickard et al., *How Have Agricultural Policies Influenced Caloric Consumption in the United States?*, 22 HEALTH ECON. 316, 329–35 (2013) (minimizing the link between agricultural subsidies and the increasing availability of fattening foods).

⁵² See M. Todd Henderson, *The Nanny Corporation*, 76 U. CHI. L. REV. 1517, 1522–23 (2009) (“[I]f those imposing costs on others are forced to pay for these costs, society will get the socially optimal amount of the activity generating the costs.”). If regulators compel manufacturers to compensate others for pollution, the manufacturers will internalize the costs. *Id.*

⁵³ See Henry I. Miller, *The Right Way to Fight Obesity*, DEFINING IDEAS (June 19, 2013), <http://www.hoover.org/publications/defining-ideas/article/149881> (arguing that nanny-state activism will be less effective than market-based reforms).

⁵⁴ I discuss externalities resulting from individual choices in the context of Pigouvian consumption taxes, *infra* Part II.B.4.b, under the category of insulation tactics.

⁵⁵ Mill's harm principle justified coercion only in the event of external harm to others, regarding the protection of solely individual welfare beyond that of the rest of mankind. JOHN STUART MILL, ON LIBERTY ¶ 1.9 (4th ed. 1869). In theory, this justification would mesh with Korobkin's model of libertarian welfarism, which proffers the notion that “nudging” interventions can substitute for coercion. Korobkin, *supra* note 12, at 1653. As Mill wrote:

[T]he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can rightfully be exercised over any member of a civilised community against his will is to prevent harm to others. His own good, whether physical or moral, is not a sufficient warrant.

MILL, *supra*, ¶ 1.9.

the market.⁵⁶

The apaternalistic approach defers to the preferences of the individual. Individuals make choices based on what they think will maximize their own happiness, and tampering with such subjectivity will interfere with that goal.⁵⁷ One behavioral critique of this approach is that such decisions are made with imperfect information and hard-wired cognitive errors. The debiasing approaches discussed next attempt to preserve choice and autonomy.⁵⁸ The insulation approaches attempt to make certain choices more costly, while bans completely substitute the regulator's judgment for that of the consumer.⁵⁹

One other practice that apaternalists might tolerate would be voluntary actions by producers to alter offerings in a way that might lead to better choices. For example, if tastes change, consumers might start to care about safety over other features when purchasing an automobile.⁶⁰ The categorization of the behavior as libertine becomes trickier if regulators induced the preference or demand for the desirable feature. If consumers were even slightly nudged toward this choice, then autonomy was slightly reduced. This kind of problem clarifies why these categories must appear on a spectrum. I use the spectrum to illuminate regulatory phenomena, not to trap every regulatory effort into a box.

2. *Weak-Form Debiasing*

Weak-form debiasing describes the first and least-intrusive step into the regulatory sphere. In this form of soft paternalism, regulators simply provide decision-makers with information to make better decisions. No choices are surrendered and personal autonomy is preserved. Objections to weak-form debiasing tactics come from advocates of hard paternalism, who contend that weak approaches will not yield the right decisions.

Today, the regulatory-commercial atmosphere bombards consumers with more disclosures about public health and consumer products than any other time in the history of industrial consumerism. Educational public health initiatives in certain spheres have never been more robust.⁶¹ In other

⁵⁶ See William J. Baumol, *On Taxation and the Control of Externalities*, 62 AM. ECON. REV. 307, 307, 312 (1972) (“[A] Pigouvian tax, without compensation to those affected by an externality” “is compatible with optimal resource allocation”).

⁵⁷ See Yofi Tirosh, *The Right to Be Fat*, 12 YALE J. HEALTH POL'Y L. & ETHICS 264, 266–67 (2012) (“American law should recognize a new realm of liberty: the realm of body size.”).

⁵⁸ See *infra* Part II.B.2–3.

⁵⁹ See *infra* Part II.B.4–5.

⁶⁰ Volvo, for example, has built a strong brand around the centerpiece of safety. See Lois Geller, *Why a Brand Matters*, FORBES (May 23, 2012), <http://www.forbes.com/sites/loisgeller/2012/05/23/a-brand-is-a-specialized/> (“Think of Volvo, for instance, and your first thoughts are probably going to be something like ‘well built, comfortable, Swedish’ and, most of all, ‘safety.’”).

⁶¹ See, e.g., DEP'T OF HEALTH & HUMAN SERVS., ENDING THE TOBACCO EPIDEMIC: A TOBACCO CONTROL STRATEGIC ACTION PLAN FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

consumer domains like the financial sector, mandatory disclosure seems to be accelerating.⁶² Seldom do we see examples where regulators have rolled back disclosure requirements.

Some commentators argue that this weaker form of debiasing may have extremely limited effects,⁶³ while others still warn of the disproportionate or distortive effects of adding or removing information from the decision-making atmosphere. Regarding the latter concern, the availability heuristic describes the phenomenon where people use information most readily available to them to extrapolate to a broader picture.⁶⁴ Weak-form debiasing can resequence information in ways that can unpredictably distort decisions.⁶⁵ For example, oversaturating people with information about terrorist attacks leads them to believe that the associated risk is greater than that for sunbathing, which actually poses a greater threat.⁶⁶ Similarly, because homicides are featured more heavily in news reports, people are prone to believe that such killings are more prevalent than suicides.⁶⁷ Elsewhere, I have argued that boldfaced disclosures on peanut butter jars about the acceptable amount of rat hairs therein—per regulators—might make people shy away from a purchase more than they ordinarily should.⁶⁸

Weak- and strong-form debiasing strategies both carry the risk of “overshooting.”⁶⁹ Too much disclosure might distort risk assessment.

14–18, 43–57 (2010) (outlining federal, state, and local initiatives for tobacco prevention and control). Relatedly, the Consumer Product Safety Commission provides readily available “Safety Guides” and “Safety Education Centers” for consumer products ranging from ATVs to household items. *Safety Education*, U.S. CONSUMER PRODUCT SAFETY COMM’N, <http://www.cpsc.gov/en/Safety-Education/> (last visited Oct. 12, 2014).

⁶² See, e.g., Kenneth J. Benton, *Consumer Compliance Outlook: An Overview of the Regulation Z Rules Implementing the CARD Act*, PHILA. FED. RES. BANK, <http://www.philadelphiafed.org/bank-resources/publications/consumer-compliance-outlook/2010/first-quarter/regulation-z-rules.cfm> (last visited July 15, 2014) (providing examples of the disclosures required by the Credit Card Accountability Responsibility and Disclosure Act of 2009).

⁶³ One school of thought convincingly argues that information disclosures do not enhance decision making. See, e.g., Omri Ben-Shahar & Carl E. Schneider, *The Failure of Mandated Disclosure*, 159 U. PA. L. REV. 647, 650–51 (2011) (arguing mandatory disclosure has failed to achieve desirable results for consumers); Howard Latin, “Good” Warnings, *Bad Products, and Cognitive Limitations*, 41 UCLA L. REV. 1193, 1230–32 (1994) (arguing that overcoming consumer optimism bias requires more than marginal informational disclosures).

⁶⁴ See Timur Kuran & Cass R. Sunstein, *Availability Cascades and Risk Regulation*, 51 STAN. L. REV. 683, 685 (1999) (describing the availability heuristic as “a pervasive mental shortcut whereby the perceived likelihood of any given event is tied to the ease with which its occurrence can be brought to mind”).

⁶⁵ See SUNSTEIN & THALER, *supra* note 13, at 24–26; Friedman, *supra* note 45, at 590.

⁶⁶ SUNSTEIN & THALER, *supra* note 13, at 24–26.

⁶⁷ *Id.*

⁶⁸ Friedman, *supra* note 45, at 570.

⁶⁹ See Jolls & Sunstein, *supra* note 42, at 230–31 (providing an example of overshooting where truthful narratives are used in the context of consumer safety law, and consumers may be led to “exaggerate the risks of consumer products”).

Consumers may misapply information or develop false confidence from having it.⁷⁰ In public health, consumers are making complex sets of personal choices and transactions—and one set of decisions might lead to an inadvertently more harmful set of decisions. If disclosure unduly pushes consumers to eschew more sugar, for example, which leads to consumption of more salt, the net effect might not be desirable.⁷¹

Nonetheless, the premise that more information preserves choice while providing information to make better decisions can have credibility in the right contexts—and I discuss those contexts in Part III.

3. *Strong-Form Debiasing*

Strong-form debiasing describes an information-based strategy for improving decision making, just as weak-form debiasing does. The regulatory construction of “truthful narratives of harm” about certain identified behaviors separates strong-form debiasing from weak-form debiasing.⁷² To maximize effectiveness, these truthful narratives, assembled from raw facts, must be designed to be compelling to the target audience and must reference *concrete* examples of harm.⁷³ The concreteness of the examples taps directly into the availability heuristic.⁷⁴ By making an example of harm more “available” and “vivid,” the information may be riper for absorption.⁷⁵ The narrative must be truthful to be effective because if the narrative stretches credibility, then the target of the narrative might write it off as a worst-case scenario.⁷⁶

Narratives involving compelling harm are slightly harder on the paternalism spectrum because instead of merely providing information, the regulator deploys an *argument*. Regulators have deployed these arguments most notably in efforts to curb drug abuse⁷⁷ and cigarette smoking.⁷⁸ The

⁷⁰ See Lauren E. Willis, *Against Financial-Literacy Education*, 94 IOWA L. REV. 197, 235–36 (2008) (suggesting that improving consumer financial literacy can lead to overconfidence, which can lead to poorer decisions than the status ante).

⁷¹ As I will discuss, *infra* Part III.B.2.c.ii, the effect of sugar taxes on public health may prove ambiguous. Therefore, an extrapolation that the lighter intervention techniques of disclosure and education might have unpredictable effects is within reason. At least one study suggests that the effects of an aggressive tax strategy on sugary soda might modestly reduce child-adolescent consumption, but that the calories forgone would be replaced with calories from the consumption of other sugary beverages. Jason M. Fletcher et al., *The Effects of Soft Drink Taxes on Child and Adolescent Consumption and Weight Outcomes*, 94 J. PUB. ECON. 967, 972–73 (2010). For a robust discussion of the nuances and challenges associated with the taxation approach, see Katherine Pratt, *A Constructive Critique of Public Health Arguments for Anti-Obesity Soda Taxes and Food Taxes*, 87 TUL. L. REV. 73, 111–35 (2012).

⁷² Jolls & Sunstein, *supra* note 42, at 210, 212, 215.

⁷³ *Id.* at 210.

⁷⁴ *Id.* at 212–17.

⁷⁵ *Id.* at 212–13.

⁷⁶ *Id.* at 214.

⁷⁷ This makes the recent trend toward decriminalization of marijuana, discussed *infra* Part III.C.1,

anti-tobacco advertising campaign sponsored by the American Legacy Foundation published letters depicting dying mothers apologizing to their families for the damage they had inflicted due to their impending tobacco-related demises.⁷⁹ In a well-known public service advertisement, famous stage actor Yul Brynner appeared posthumously to warn people about the deadly risks of smoking:

[The ad] opened with an image of Brynner's tombstone, with the inscription "Yul Brynner, 1920–1985." An announcer intoned, "Ladies and gentlemen, the late Yul Brynner."

Next, Brynner appeared on the . . . video clip. His antismoking advice was followed by another statement he had made on the program: "If I could take back that smoking, we wouldn't be talking about any cancer. I'm convinced of that." With that, the 30-second spot ended.⁸⁰

A private non-profit organization receiving only a small amount of public funding, the American Cancer Society, paid for the Brynner ad.⁸¹

For obesity, some of the most interesting narratives have come from the private sphere in long-form documentaries about the ills of fast food. A notable example is Morgan Spurlock's *Super Size Me*, in which he demonstrated severe ill effects on his health from consuming nothing but McDonald's food for thirty days.⁸² Spurlock's film could be classified as a market-driven, apaternalistic venture in that it was not financed by the

somewhat ironic. In 1987, the Partnership for a Drug-Free America launched its famous "This is Your Brain on Drugs" commercial, which made *Time*'s top-ten list of public service advertisements. See *There Goes My Appetite, Top-10 Public-Service Announcements*, TIME (Sept. 4, 2009), http://content.time.com/time/specials/packages/article/0,28804,1920454_1920455_1920449,00.html ("[T]his iconic PSA makes use of everyday household items—namely, an egg and a frying pan—to illustrate how narcotics affect the body.").

⁷⁸ See Jolls & Sunstein, *supra* note 42, at 214–15 (displaying graphic pictures and warnings about the harms of cigarettes).

⁷⁹ An example of a simple anti-smoking narrative devised by the American Legacy Foundation: "Dearest Jon, I am so sorry my smoking will cheat us out of 20 or 30 more years together. Remember the fun we had every year at the lake. I will ALWAYS love and treasure you. Linda." *Women*, AM. LEGACY FOUND., <http://women.americanlegacy.org/includes/pdfs/ad2.pdf> (last visited July 15, 2014).

⁸⁰ Barron H. Lerner, *In Unforgettable Final Act, a King Got Revenge on His Killers*, N.Y. TIMES, Jan. 25, 2005, at F5.

⁸¹ Lerner, *supra* note 80. The American Legacy Foundation is funded by tobacco settlement money procured by state attorneys general, rendering it more accountable to regulators. Jolls & Sunstein, *supra* note 42, at 215.

⁸² SUPER SIZE ME (Samuel Goldwyn Films 2004). The Spurlock narrative, along with other fast food documentaries, has so pervaded the public consciousness that they have been parodied. See *New Documentary to Finally Shed Light on Nation's Fast Food Chains*, THE ONION (June 19, 2013), <http://www.theonion.com/articles/new-documentary-to-finally-shed-light-on-nations-f,32887/> (claiming, sarcastically, that America is in desperate need of a documentary to show the realities of the fast food industry because no such movie exists). For further discussion of Spurlock's narrative approach, see *infra* Part III.B.2.b.

government or produced by regulators: the movie was privately produced for profit.⁸³ Of course, one can envision how regulators *could* use similar tactics to tap the power of a truthful narrative of harm.

4. *Insulation Strategies*

Moving further toward the hard end of the paternalism spectrum, some regulation aims to insulate people from harm, while still preserving the choice to engage in the core activity. I divide insulation strategies into two categories: (1) mandates that make activities safer, while still permitting engagement in the activities; and (2) taxes imposed with the purpose of curbing a behavior, even if that behavioral goal does not constitute the entire purpose. The taxes could be collected to compensate others or the general public for negative externalities, thereby compelling actors to internalize the costs of their behavior and incentivizing reduction of that behavior.⁸⁴ I outline each category in turn.

a. Conditional Mandates

Conditional mandates only require restriction in specific contexts that still leave the actor free to choose. These restrictions often surface in the product safety realm. For example, mandates that make riding in an automobile safer are not absolute; technically, riders are still free to select an alternate means of transportation. The air bag installation mandate provides an illustration—albeit a controversial one in some circles, because air bag deployments have both saved lives and taken them.⁸⁵ Automobile manufacturers are required to install airbags and consumers are compelled to absorb some of the associated costs through the price of the automobile. Every intervention can potentially redistribute risk in unanticipated ways. This mandate does remove a degree of choice, seeing as a consumer must buy airbags when buying a car. But beyond raising the consumer cost of the car slightly, the mandate hardly interferes with the ability to drive.

Motorcycle helmet laws provide another example of an insulation regulatory strategy.⁸⁶ In the name of safety, these laws permit people to

⁸³ See *Super Size Me: Company Credits*, IMDB.COM, <http://www.imdb.com/title/tt0390521/companycredits> (last visited July 15, 2014) (showing that the movie was privately produced by The Con, Kathbur Pictures, and Studio on the Hudson).

⁸⁴ See A.C. PIGOU, *THE ECONOMICS OF WELFARE* 168–79 (1920) (describing how taxes can be used to internalize externalities); see also Baumol, *supra* note 56, at 307 (bolstering the “impeccable” “Pigouvian tradition” by demonstrating applications on top of “theoretical nicet[ies]”).

⁸⁵ See David J. Houston & Lilliard E. Richardson, Jr., *The Politics of Air Bag Safety: A Competition Among Problem Definitions*, 28 POL’Y STUD. J. 485, 487 (2000) (discussing the contours of the air bag safety policy debate).

⁸⁶ According to the Insurance Institute for Highway Safety, nineteen states and the District of Columbia require the use of motorcycle helmets. *Motorcycle Helmet Use*, INS. INST. FOR HIGHWAY SAFETY, <http://www.iihs.org/iihs/topics/laws/helmetuse?topicName=motorcycles> (last visited July 15, 2014).

ride motorcycles subject to the conditional mandate that they wear helmets. The choice to ride the motorcycle is preserved, but some degree of freedom has been removed in the interest of individual and social welfare.⁸⁷ The Big Gulp ban, as Bloomberg noted, would not have removed the consumer option to ingest large amounts of sugary beverages—it would merely slow the consumer down.⁸⁸ Thus, it would constitute insulation. But this Big Gulp paternalism, though not of the hardest variety, was visible enough to draw notable public ire from those who felt the New York City Board of Health overreached with this deprivation of autonomy.⁸⁹

b. Taxation

Taxation of harmful goods, when enacted with the intent to change behavior or curb consumption, can also be a form of insulation.⁹⁰ The mandatory nature of taxation places it on the hard paternalism end of the regulatory spectrum, but it is not the “hardest” tactic. With taxation, the choice to smoke or drink has not been eliminated—it has merely been impeded by compelling the consumer to internalize the social cost of consumption. Yet again, though, this type of intervention can lead to counterintuitive results.⁹¹

If revenues compensate the appropriate parties for external costs, taxation still advances individual welfare because individual decisions will

⁸⁷ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-42, MOTORCYCLE SAFETY: INCREASING FEDERAL FUNDING FLEXIBILITY AND IDENTIFYING RESEARCH PRIORITIES WOULD HELP SUPPORT STATES' SAFETY EFFORTS 1 (2012) (explaining how social welfare is affected by motorcycle crashes, as “society bears about three-quarters of the measurable costs of *all* motor vehicle crashes.”). Costs associated with motorcycle accidents were estimated to be \$16 billion in 2010, though this study did not account for “longer-term medical costs.” *Id.*

⁸⁸ See Campbell, *supra* note 1 (quoting Bloomberg as stating “if you want to buy 32 ounces, you just have to carry it back to your seat in two cups”).

⁸⁹ See Michael Grynbaum, *At Movie Theatres and Beaches, the Soda Industry Makes Its Case*, N.Y. TIMES, July 6, 2012, at A19 (citing instances of public backlash against the ban).

⁹⁰ See Kelly D. Brownell et al., *The Public Health and Economic Benefits of Taxing Sugar-Sweetened Beverages*, 361 NEW ENG. J. MED. 1599, 1604 (2009) (arguing that sugary beverage taxes will reduce consumption); Jennifer Cantrell et al., *Purchasing Patterns and Smoking Behaviors After a Large Tobacco Tax Increase: A Study of Chinese Americans Living in New York City*, 123 PUB. HEALTH REP. 135, 136 (2008) (describing the impact of taxes on reducing cigarette consumption); Frank J. Chaloupka et al., *The Effects of Price on Alcohol Consumption and Alcohol-Related Problems*, NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM (Aug. 2002), <http://pubs.niaaa.nih.gov/publications/arh26-1/22-34.htm> (describing how increased alcohol prices, such as those achieved through taxation, reduce drinking as well the consequences of alcohol abuse). For a brief discussion of sugar-related taxes, see also *infra* Part III.B.2.c.ii.

⁹¹ See Pratt, *supra* note 71, at 112 (“Consumers may or may not substitute equally caloritic or more caloritic untaxed foods or drinks for the foods or drinks that are subject to the tax.”). Katherine Pratt describes the literature that argues that tobacco taxes might not prove to conform to the Pigouvian model. *Id.* at 79. The reasoning is that smokers have higher mortality rates, which effectively leads to an earlier transfer of their pension, social security, and elder care costs to non-smokers. *Id.* Slowing down smoking with taxes decelerates this transfer. *Id.*

factor in the true costs of the transaction. The tax maximizes social welfare because non-participants no longer absorb the external costs of the behavior of others, and yet transactions may continue, unlike with a ban. Since transactions may continue, with the actors absorbing the true costs, welfare stands to be enhanced. In theory, a smoker can still choose to smoke, provided that the tax transfers resources in a way where non-smokers are not injured, enhancing social welfare.⁹²

Next on the spectrum, the regulators remove all choice and autonomy from decisions. Rube Goldberg methods involving cognitive psychology and negative incentives are eschewed in favor of directly ensuring that the behavior leading to the harm is prohibited.⁹³ This next approach is the hardest form of paternalism.

5. *Outright Bans and Mandates*

Regulatory bans on behavior, consumption, and transactions eliminate choice and autonomy. Mandated behavior inherently coerces compliance. Paternalism, when deployed in these hard, most absolute forms, substitutes the wisdom of regulators for the wisdom of individuals in making decisions about individual and collective welfare. Historical bans on marijuana fall into this category,⁹⁴ as do bans on certain consumer financial transactional activities.⁹⁵ In such instances, the regulator implicitly weighed the harm as being great enough to warrant deprivation of autonomy. The measure of a given ban or mandate's sustainability would be the level of public toleration for the autonomy loss.

The 1978 ban on the use of lead as a paint ingredient provides a

⁹² *But see* Pratt, *supra* note 71, at 131 (noting the disproportionate effect taxes on tobacco have on the poor).

⁹³ *See* CONLY, *supra* note 11, at 16 (“[S]ociety . . . should . . . make people do what is good for them.”).

⁹⁴ *See* Gerald Caplan, *Medical Marijuana: A Study of Unintended Consequences*, 43 MCGEORGE L. REV. 127, 128 (2012) (providing a general overview of the Drug Enforcement Agency (DEA) and FDA's paternalistic justification for such a sweeping ban). Some inferences can be drawn from the federal ban, namely, that lawmakers intended not merely to protect the immediate user, but to blunt societal problems that would affect others. A 2009 study by neuroscientists concluded that chronic marijuana smoking would lead to “negative consequences” associated with deteriorated decision making. Staci A. Gruber et al., *Altered Affective Response in Marijuana Smokers: An FMRI Study*, 105 DRUG & ALCOHOL DEPENDENCE 139, 151 (2009). The study cited other findings that marijuana users tend to be impulsive and underperform in the workplace. *Id.* at 140. In addition to the user absorbing this cost, others do, too. This is not to say that legalization of medical marijuana is without a plethora of benefits and justifications. In fact, it is difficult to find a recent law review article written by academics that opposes the legalization of medical marijuana.

⁹⁵ Lending transactions that amount to usury would fit into this “absolute” ban category. *See* Christopher L. Peterson, *Usury Law, Payday Loans, and Statutory Sleight of Hand: Salience Distortion in American Credit Pricing Limits*, 92 MINN. L. REV. 1110, 1114 (2008) (providing a discussion of usury laws and presenting “an empirical analysis of all fifty states’ usury laws in two time periods: 1965 and the present”).

remarkable example of a major industrial change mandated by the government in the interest of public health.⁹⁶ Despite demonstrable dangers, the national ban took fifty years to implement because of aggressive political tactics employed by the paint manufacturing industry.⁹⁷ But public opposition to the lead ban after thirty-six years proves to be low, possibly because the end product essentially *appeared* unchanged when lead was removed.⁹⁸ In fact, over the past thirty-six years, efforts to address lead paint dangers became even more aggressive.⁹⁹ One set of commentators even analogized the dynamics of regulating lead paint, including the obstructionary tactics used by its producers, to that of regulating soda, noting that “[d]emanding that all scientific questions be answered and all aspects of a rule be completely consistent before regulations are put in place is a frightening requirement.”¹⁰⁰

Analogizing the regulation of lead paint to the regulation of soda, though provocative, has flaws. Lead paint had long been known to present serious health risks, but those risks were attributable to just one ingredient—albeit an important one—in the product line.¹⁰¹ Ultimately, paint manufacturers satisfactorily replaced the lead ingredient with titanium dioxide, which had little impact or visibility to the consumer.¹⁰² Limiting soda production or changing the composition of soda directly affects consumer choice and autonomy *daily*. And rather than regulating one ingredient in one product, food regulators need to consider myriad, constantly-consumed ingredients and other causes beyond the composition of food. A ban on soda would not address the web of other problems that contribute to obesity; it might just shift unhealthy consumption around to

⁹⁶ Press Release, U.S. Consumer Prod. Safety Comm’n, CPSC Announces Final Ban On Lead-Containing Paint (Sept. 2, 1977), *available at* <http://www.cpsc.gov/en/Recalls/1977/CPSC-Announces-Final-Ban-On-Lead-Containing-Paint/>.

⁹⁷ See David Rosner & Gerald Markowitz, *Why It Took Decades of Blaming Parents Before We Banned Lead Paint*, THE ATLANTIC (Apr. 22, 2013), <http://www.theatlantic.com/health/archive/2013/04/why-it-took-decades-of-blaming-parents-before-we-banned-lead-paint/275169/> (describing how the paint manufacturing industry had “fought every attempt at regulation” since the 1920s).

⁹⁸ Authorities warn that lead paint cannot be visually identified. See, e.g., *True/False Questions on Lead*, N.Y. STATE DEP’T HEALTH, <http://www.health.ny.gov/environmental/lead/exposure/childhood/leadq.htm> (last visited July 15, 2014).

⁹⁹ See 40 C.F.R. § 745(E) (2013) (regulating lead-based paint poisoning prevention in residential property renovation). This regulation took effect primarily in 2010. *Id.* § 745.81.

¹⁰⁰ Rosner & Markowitz, *supra* note 97.

¹⁰¹ See Tristan Fowler, *A Brief History of Lead Regulation*, SCI. PROGRESS (Oct. 21, 2008), <http://scienceprogress.org/2008/10/a-brief-history-of-lead-regulation/> (providing a background on lead paint regulation and a brief historical summary of the known health hazards caused by lead-based products). Lead lends pigmentation and durability attributes to paint. James Mitchell Crow, *Why Use Lead in Paint?*, ROYAL SOC’Y CHEMISTRY (Aug. 21, 2007), <http://www.rsc.org/chemistryworld/News/2007/August/21080701.asp>.

¹⁰² See Crow, *supra* note 101 (observing that the lead pigments were replaced by titanium dioxide, “which is so safe it’s also used in food colourings as well as in sunscreen”).

other substitute products.¹⁰³

Trans fats bans, however, much more closely resemble lead paint bans.¹⁰⁴ Though the trans fats have been removed, consumers have accepted their substitutes with little protest or notice.¹⁰⁵ In fact, since local bans began proliferating, many national companies have voluntarily reduced or eliminated trans fats in their products.¹⁰⁶ When a paternalistic move does not visibly reduce choice but enhances individual welfare, the ban may prove to be a practical and effective prescription for a problem, even if a narrow one.

If the ethos of soft paternalism is to protect autonomy but push the actor toward the better choice, the hidden ban functions the same way. The forgone autonomy is invisible or simply has no value. If opportunities to deploy hidden paternalism emerge, they can be valuable for regulators to exploit. However, not all bans can be as narrow in scope, deep in effect, and stealthy in implementation as the trans fats ban. The limits of hard paternalism begin to emerge when autonomy disappears. Practical limits to hard bans, in the form of consumer substitution, also emerge.¹⁰⁷

* * *

Sarah Conly views the avoidance of hard paternalism in favor of autonomy as morally questionable.¹⁰⁸ Such hard-paternalists argue that, if the welfare answer is known and harm can be prevented, the state should act directly, instead of implementing a strategy to merely influence people to make the right choices.¹⁰⁹ The resilience of the permissibility of known dangers speaks to the difficulties that paternalistic strategies encounter. For example, though the complete elimination of consumer fireworks sales would make people safer,¹¹⁰ those sales will likely continue. After all, what is more popularly associated with celebrating autonomy and liberty

¹⁰³ See Pratt, *supra* note 71, at 109, 112.

¹⁰⁴ For a more in-depth discussion of trans fat bans, see *infra* Part III.B.2.d.ii.

¹⁰⁵ See *infra* notes 366–69.

¹⁰⁶ See *infra* note 200.

¹⁰⁷ Some studies suggest that raising the minimum legal age for alcohol consumption (a ban) led those affected to substitute to marijuana use. See Benjamin Crost & Santiago Guerrero, *The Effect of Alcohol Availability on Marijuana Use: Evidence from the Minimum Legal Drinking Age*, 31 J. HEALTH ECON. 112 (2012); John Dinardo & Thomas Limieux, *Alcohol, Marijuana, and American Youth: The Unintended Consequences of Government Regulation*, 20 J. HEALTH ECON. 991 (2001).

¹⁰⁸ CONLY, *supra* note 11, at 176.

¹⁰⁹ Pope, *supra* note 38, at 683–84.

¹¹⁰ See, e.g., John R. Hall, Jr., *Fireworks*, NAT'L FIRE PROT. ASS'N, <http://www.nfpa.org/research/reports-and-statistics/fire-causes/fireworks> (last visited July 15, 2014) (offering statistics regarding the 9600 fireworks-related injuries that required emergency-room treatment in the United States during 2011).

than fireworks?¹¹¹

Consumer fireworks provide an appropriate vehicle for concluding this broad overview of the paternalistic-intervention spectrum. Public efforts have been initiated on all places of the paternalism spectrum to make consumer fireworks safer. Weak-form debiasing appears in the form of basic disclosures about dangers.¹¹² Strong-form debiasing emerges in narratives of harm about fireworks-related injuries, often promoted by local officials during the days leading up to the Fourth of July.¹¹³ Most regulation of consumer fireworks reflects insulating strategies relating to conditions of fireworks sales and restrictions on their explosive content.¹¹⁴ Some of the regulatory approaches to fireworks can be categorized as absolute bans on a wide range of consumer fireworks.¹¹⁵

As Part III will demonstrate, the same spectrum of options for addressing fireworks has been deployed against the more complex and layered Gordian knot of obesity. As will be shown, some of the keys to reducing obesity—like decreasing the heavy consumption of processed grains or increasing physical activity levels—may prove at once critical for advancement of public health and resistant to regulatory intervention.

III. PATERNALISM AND PUBLIC HEALTH

The overall purpose of this Article is to assess the role of paternalism in public health and whether paternalism, particularly paternalism in its harder forms, has reached natural limits in terms of popular viability and practical effectiveness. Obesity provides perhaps the most logical starting point for this exercise. Arguably, obesity presents perhaps the biggest and most complex public health challenge facing regulators. Yet, as the

¹¹¹ Even the U.S. Consumer Product Safety Commission concedes as much. “Fireworks are synonymous with our celebration of Independence Day. Yet, the thrill of fireworks can also bring pain. 200 people on average go [to] the emergency room every day with fireworks-related injuries in the month around the July 4th holiday.” *Fireworks Information Center: Fireworks Injuries*, CONSUMER PROD. SAFETY COMM’N, <http://www.cpsc.gov/Safety-Education/Safety-Education-Centers/Fireworks/> (last visited July 15, 2014).

¹¹² *See id.* (diagramming the body parts most often injured by fireworks and issuing a stern warning).

¹¹³ *See, e.g.,* Sarah Cody, *It’s the Time of Year for a Grill and Fireworks Safety Refresher*, HARTFORD COURANT, July 1, 2013, at B8 (weaving in a dramatic story involving burn injuries to ESPN television reporter Hannah Storm); Shawne K. Wickham, *A Fireworks “Nightmare,”* UNION LEADER, June 30, 2013, at A1 (summarizing a fire chief’s recounting of a fireworks mishap that resulted in a major house fire and “burns and puncture injuries” to eight adults and five children).

¹¹⁴ *See, e.g.,* CONN. GEN. STAT. § 29-357(a) (2013) (restricting the weight of “pyrotechnic mixture” per item of consumer fireworks); WASH. REV. CODE § 70.77.395 (2011) (specifying in detail the days and hours when fireworks may be legally sold).

¹¹⁵ In Maine, for example, localities have banned fireworks in the wake of the repeal of a statewide ban. *See* David Harry, *Police in Maine Wary of Fireworks Use, Despite Local Bans*, FORECASTER (June 26, 2012), <http://www.theforecaster.net/news/print/2012/06/26/police-maine-wary-fireworks-use-despite-local-bans/127972>.

obesity problem looms large, public reactions to other public health initiatives can inform the broader understanding of the trend. To help discern patterns, it is worthwhile to look beyond obesity at public attitudes toward the legalization of marijuana at the state level, local water fluoridation initiatives, and GMO food labeling battles.

Part III.A describes the basic drivers of the obesity problem. I emphasize the term “basic,” because the obesity problem presents complexities and controversies from medical, epidemiological, and regulatory perspectives beyond the scope of any one article. Part III.B proceeds by exploring efforts to regulate obesity along the paternalism spectrum, including efforts that have emerged or are reflected in the marketplace. Then, in Part III.C, I assess the limits of paternalism’s potential in light of developments in marijuana legalization, mandatory fluoridation, and the GMO disclosure movement.

A. *Defining the Obesity Problem and Its Drivers*

Obesity remains at the forefront of a national, if not global, debate about public health. According to the CDC, more than thirty-five percent of the American population falls into the “obese” category.¹¹⁶ Though a consensus has formed about the basic drivers of obesity in the United States, it can be difficult to discern where and how regulatory efforts can be deployed most efficiently and effectively to mitigate this public health issue. It also appears that certain factors driving obesity rates may prove difficult for regulators to change.

In June 2013, the American Medical Association (AMA) House of Delegates voted to recognize obesity as a disease.¹¹⁷ Like many contours of the debate about obesity, this vote was not without controversy. The vote of the House of Delegates overrode the specific recommendation of the AMA’s own Council on Science and Public Health, which, after a year-long study, expressed concerns about labeling obesity as a disease when the phenomenon lacked reliable means of diagnosis.¹¹⁸

Within the medical community, agreement prevails about the seriousness of the broader obesity problem, but disagreement reigns about the epidemiological classification problem. AMA board member Dr. Patrice Harris endorsed the delegate vote, arguing that “[r]ecognizing obesity as a disease will help change the way the medical community

¹¹⁶ CYNTHIA L. OGDEN ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 82, PREVALENCE OF OBESITY IN THE UNITED STATES, 2009–2010, at 2 (2012).

¹¹⁷ Melissa Healy & Anna Gorman, *Obesity to Be Viewed as a Disease; The AMA Decision Is Likely to Alter Insurers’ and Doctors’ Approach to the U.S. Epidemic*, L.A. TIMES, June 19, 2013, at AA1.

¹¹⁸ Andrew Pollack, *A.M.A. Recognizes Obesity as a Disease*, N.Y. TIMES, June 19, 2013, at B1. The council eschewed the body-mass index (BMI) diagnostic metric as “simplistic and flawed.” *Id.*

tackles this complex issue that affects approximately one in three Americans.”¹¹⁹ Dr. David Katz of the Yale University Prevention Research Center rejected the disease label “because disease occurs when the body is malfunctioning. . . . Turning surplus calories into a fat reserve is not malfunction, it is normal physiology.”¹²⁰ Katz labeled obesity as “largely a societal problem” resulting from societal changes.¹²¹ He stressed, “Obesity is rampant in the modern world not because of changes in our bodies, but because of changes in the modern world. We are drowning in excess calories and labor-saving technologies.”¹²²

Without serious dispute, obesity presents a grave public health issue, whether categorized as a disease or not. Even a cursory examination of the data reveals that such a label is well deserved. An extensive 2009 study revealed that dietary and physical activity factors collectively comprise the leading risk factor for preventable deaths in the United States.¹²³ The study ranks “overweight-obesity” as the third leading stand-alone risk factor (216,000 deaths per year), right behind high blood pressure (395,000 deaths), and smoking (467,000 deaths).¹²⁴ It is notable that many of the other leading preventable risk factors are related to dietary or lifestyle habits that drive obesity.¹²⁵ Without a doubt, basic theories of both soft and hard paternalism would support interventions like that

¹¹⁹ *Id.* Advocates for the obese recognized the potential impact of the disease designation. Morgan Downey, publisher of an obesity report, believes the label will lead the medical community to “tak[e] obesity more seriously [and] counsel[] patients about it.” *Id.*

¹²⁰ Steven Reinberg, *U.S. Doctors’ Group Labels Obesity a Disease*, HEALTHDAY NEWS (June 19, 2013), <http://consumer.healthday.com/vitamins-and-nutritional-information-27/obesity-health-news-505/u-s-doctors-group-labels-obesity-a-disease-677526.html>.

¹²¹ *Id.*

¹²² *Id.*

¹²³ Goodarz Danaei et al., *The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors*, PLOS MED., Apr. 2009, at 15 tbl.8, 19 [hereinafter *Harvard School of Public Health Study*].

¹²⁴ *Id.* at 10, 14, 15 tbl.8.

¹²⁵ As summarized by the *Harvard School of Public Health Study*:

- Inadequate physical activity and inactivity (191,000 deaths)
- High blood sugar (190,000 deaths)
- High LDL cholesterol (113,000 deaths)
- High dietary salt (102,000 deaths)
- Low dietary omega-3 fatty acids (84,000 deaths)
- High dietary trans fatty acids (82,000 deaths)
- Alcohol use (64,000 deaths) (alcohol use averted a balance of 26,000 deaths from heart disease, stroke and diabetes, because moderate drinking reduces risk of these diseases. But these deaths were outweighed by 90,000 alcohol-related deaths from traffic and other injuries, violence, cancers and a range of other diseases).
- Low intake of fruits and vegetables (58,000 deaths)
- Low dietary poly-unsaturated fatty acids (15,000 deaths)

Id. at 15 tbl.8.

suggested by the study's senior author: "[t]he government should . . . use regulatory, pricing, and health information mechanisms to substantially reduce salt and trans fats in prepared and packaged foods and to support research that can find effective strategies for modifying the other dietary, lifestyle, and metabolic risk factors that cause large numbers of premature deaths."¹²⁶

Despite the significant resources and broad public campaigns that have been deployed to address obesity, the CDC recently classified 35.7% of all adults as obese.¹²⁷ Obesity rates were highest among older adults, particularly females over sixty years old.¹²⁸ The obesity rates for children ranging from two to nineteen years old were approximately 17%.¹²⁹ Moreover, "[a]lthough national, state, and local governments and many private employers and payers have increased their efforts to address obesity since 1998, data from the [CDC] . . . reveal[ed] that obesity rates increased by 37[%] between 1998 and 2006."¹³⁰

Though the prevalence of obesity increased over the past few decades, obesity rates appear to have stabilized recently.¹³¹ Whether this stabilization is attributable to obesity efforts, or some natural epidemiological limit, is difficult to discern.¹³² One medical association casually speculated that the saturation of health-oriented media or a "biological limit on obesity" could be causing this slowdown.¹³³ Dr. David Ludwig¹³⁴ has speculated that some people are genetically impermeable to obesity, and implies that the epidemic may be halted by the presence of these genes.¹³⁵ Further, he offers reasoning as to why certain individuals

¹²⁶ *Smoking, High Blood Pressure and Being Overweight Top Three Preventable Causes of Death in the U.S.*, HARV. SCH. PUB. HEALTH (Apr. 27, 2009), <http://www.hsph.harvard.edu/news/press-releases/smoking-high-blood-pressure-overweight-preventable-causes-death-us/>.

¹²⁷ OGDEN ET AL., *supra* note 116, at 1 fig.1.

¹²⁸ *Id.*

¹²⁹ *Id.* at 5–6.

¹³⁰ Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates*, 28 HEALTH AFF. w822, w823 (2009).

¹³¹ OGDEN ET AL., *supra* note 116, at 1.

¹³² See B. Rokholm et al., *The Levelling Off of the Obesity Epidemic Since the Year 1999—A Review of Evidence and Perspectives*, 11 OBESITY REVS. 835, 842 (2010) (suggesting that "[a]lthough intuitively appealing, clear evidence, beyond parallel correlations" between ecological factors and obesity "is lacking" and that the plateauing of the obesity epidemic may not be a "result of public health campaigns . . . influencing food and exercise habits").

¹³³ *Obesity*, CEU UPDATE (Nat'l Ass'n of Health Profs., Gardner, KS), June 2012, at 1, available at <http://www.nahpusa.com/userfiles/file/CEU/0612%20CEU.pdf>.

¹³⁴ David Ludwig, M.D., Ph.D. is the Director of the Optimal Weight for Life Program at Boston Children's Hospital. *David Ludwig, MD, PhD*, BOS. CHILD. HOSP., <http://www.childrenshospital.org/researchers/david-ludwig> (last visited July 14, 2014).

¹³⁵ See Pam Belluck, *After a Longtime Rise, Obesity Rates in U.S. Level Off, Data Suggest*, N.Y. TIMES, Jan. 14, 2010, at A20 (indicating that Dr. Ludwig suggests that the stabilization of obesity rates "could be that most of the people who are genetically susceptible, or susceptible for psychological or behavioral reasons, have already become obese").

encounter a natural limit on just how obese they can get, which prevents the total population from getting heavier indefinitely.¹³⁶ Nonetheless, stability does not mean that the epidemic has been reversed, and Dr. Ludwig appears to agree with Dr. William Dietz, who stated that “we [do not] have in place the kind of policy or environmental changes needed to reverse this epidemic just yet.”¹³⁷

In terms of the financial impact to society, one study estimated that the medical costs attributable to obesity rose from \$78.5 billion in 1998 to \$147 billion by 2008.¹³⁸ Therefore, in addition to concerns about individual health, the external costs of obesity are pressing, and perhaps justify harder paternalism—or at least rendering the label of paternalism less pejorative when justifying certain initiatives. For comparison, costs related to violent deaths in 2005, which include homicide and suicide, were \$47.2 billion.¹³⁹

High obesity levels in the United States can be attributed to many reinforcing root causes. Some of these root causes may prove challenging to address individually, never mind together. According to the National Heart, Lung and Blood Institute, obesity can be caused by energy imbalance (i.e., greater energy intake than expenditure), inactive lifestyle, environment, genes, family history, health conditions, medication, emotional factors, cessation of smoking, age, pregnancy, and lack of sleep.¹⁴⁰ Though some may quibble with this list, or reorder the causes in terms of importance, consensus emerges around the primacy of nutrition, energy intake, and inactivity in contributing to the obesity problem. This Article will therefore discuss that trio of obesity drivers before briefly remarking on a few others.

American nutrition and energy intake patterns have changed over the past forty years.¹⁴¹ The composition of the American diet, both in sources and number of calories, presents a prodigious challenge for those who wish to address the intake portion of the obesity problem. According to the U.S. Department of Agriculture (USDA), the population’s average daily calorie intake increased by nearly 25% between 1970 and 2000.¹⁴² The biggest contributor to that intake gain was an increase in refined grain products

¹³⁶ See *id.* (relaying Dr. Ludwig’s explanation that “[w]hen people eat more . . . at first they gain weight; then a growing share of the calories go ‘into maintaining and moving around that excess tissue,’ . . . so that ‘a population doesn’t keep getting heavier and heavier indefinitely’”).

¹³⁷ *Id.*

¹³⁸ Finkelstein et al., *supra* note 130, at w822.

¹³⁹ *Cost of Violent Deaths in the United States, 2005*, CDC, <http://www.cdc.gov/violenceprevention/violentdeaths/index.html> (last updated Feb. 24, 2011).

¹⁴⁰ *What Causes Overweight and Obesity?*, NAT’L HEART, LUNG & BLOOD INST. (July 13, 2012), <http://www.nhlbi.nih.gov/health/health-topics/topics/obe/causes.html>.

¹⁴¹ U.S. DEP’T OF AGRIC., *AGRICULTURE FACT BOOK 2001–2002*, at 14 (2003).

¹⁴² *Id.*

(9.5%), followed closely by added fats and oils (9.0%).¹⁴³ Added sugars (4.7%) also drove the intake gain,¹⁴⁴ but seem to attract a disproportionate share of the policymaking frenzy.¹⁴⁵ A focus on regulating specific products or categories may prove effective, but golden opportunities like the trans fats ban do not present themselves readily. Addressing the caloric intake gain from refined grain products¹⁴⁶ seems to be an obvious potential area of focus, but the roster of popular foods that fall into this category would prove daunting to attack.¹⁴⁷

Data linking energy intake to obesity can prove counterintuitive though. One study based on CDC data revealed that total average daily caloric intake spiked 16% between 1971–1975 to 2003–2004.¹⁴⁸ Then, average caloric intake dropped three percent between 2003–2004 and 2009–2010.¹⁴⁹ During this period, obesity rates held the same for women and increased for men.¹⁵⁰ Dr. Dietz, a co-author of this caloric study, observed that it is “hard to reconcile what these data show, and what is happening with the prevalence of obesity [The caloric intake drop is] a lot, and . . . we would expect to see a measurable impact on obesity.”¹⁵¹

One might deduce that the stubbornness of obesity in this circumstance is attributable to lack of energy expenditure or physical activity. But the data supporting that thesis is surprisingly ambiguous. A study conducted on the county level revealed widespread increases in individual physical

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ See Mark Bittman, *What Is Food?*, N.Y. TIMES OPINIONATOR (June 5, 2012, 9:00), http://opinionator.blogs.nytimes.com/2012/06/05/what-is-food/?_php=true&_type=blogs&_r=0 (“Added sugar, as will be obvious when we look back in 20 or 50 years, is the tobacco of the 21st century.”). Note that sugary sodas are but one component of these added sugars. See Anahad O’Connor, *The Claim: Most of the Added Sugar in Our Diets Comes from Sugar Drinks.*, N.Y. TIMES, May 7, 2013, at D5 (asserting that nearly 70% of calories from added sugars come from processed foods).

¹⁴⁶ “Refined grains have been milled, a process that removes the bran and germ. This is done to give grains a finer texture and improve their shelf life, but it also removes dietary fiber, iron, and many B vitamins.” U.S. Dep’t of Agric., *What Foods Are in the Grains Group?*, CHOOSEMYPLATE.GOV, <http://www.choosemyplate.gov/food-groups/grains.html> (last visited July 15, 2014).

¹⁴⁷ The USDA includes the following in the refined grain category: cornbread, corn tortillas, couscous, crackers, flour tortillas, grits, noodles, pitas, pretzels, white bread, white sandwich buns and rolls, white rice, spaghetti, macaroni, and corn flakes. *Id.*

¹⁴⁸ Earl S. Ford & William H. Dietz, *Trends in Energy Intake Among Adults in the United States: Findings from NHANES*, 97 AM. J. CLINICAL NUTRITION 849, 849 (2013). The National Health and Nutrition Examination Survey (“NHANES”), assembled by the CDC, estimated adjusted mean energy intake at 1955 kcal/d over the 1971–1975 period, which increased 16% to 2269 kcal/d in 2003–2004. *Id.*

¹⁴⁹ *Id.* NHANES estimated adjusted mean energy intake at 2196 kcal/d in 2009–2010, a reduction of 3% since 2003–2004. *Id.*

¹⁵⁰ *Id.* at 849.

¹⁵¹ Kathryn Doyle, *Despite Obesity Rise, U.S. Calories Trending Downwards*, CHI. TRIB. (Mar. 6, 2013), http://articles.chicagotribune.com/2013-03-06/news/sns-rt-health-obesityus14n0bz0go-20130306_1_obesity-rise-calorie-intake-activity-and-obesity.

activity, but a low correlation between increased activity and obesity rates.¹⁵² This study still heralded the benefits of increased physical activity, but, ironically, pointed back toward lowering caloric intake as the key to reducing obesity.¹⁵³ Of course, one may be able to sort through various studies and find contradictions.¹⁵⁴ It may nonetheless be possible to reconcile certain studies, e.g., perhaps in this case it matters *who* has been reducing calories and increasing physical activity—the obese may be getting more obese, the healthy may be getting healthier. Either way, while there tends to be agreement about the dangers of obesity, consensus about cutting into the problem may not be as clear as one would expect at first glance. For the purposes of this Article, I will assume that an attack on the sedentary lifestyle might reduce obesity rates and have other salutary effects.

A relationship between socioeconomic status and obesity has also been identified.¹⁵⁵ Aggregate data collected by the CDC presents guidance about where obesity prevalence lies, and some of it is not intuitive. Most obese people are *not* of low-income status,¹⁵⁶ which would mean that regulators have to view this problem not as one that could be addressed with simply a paternalistic focus on low-income households. Obesity indeed has grown more aggressively within low-income segments, but the data shows that in absolute numbers, obesity persists across income levels.¹⁵⁷

Nonetheless, it is worth asking whether obesity rates are higher within certain socioeconomic groups because it may indicate that targeted efforts might help these groups. According to the CDC, between 1988–1994 and 2007–2008, obesity prevalence increased across *all* income groups and *all*

¹⁵² Laura Dwyer-Lindgren et al., *Prevalence of Physical Activity and Obesity in US Counties, 2001–2011: A Road Map for Action*, POPULATION HEALTH METRICS, July 2013, at 4, 6.

¹⁵³ *Id.* at 10.

¹⁵⁴ Cf. Ann Smith Barnes, *Obesity and Sedentary Lifestyles: Risk for Cardiovascular Disease in Women*, 39 TEX. HEART INST. J. 224, 226 figs.1 & 2 (2012) (making connections between sedentary lifestyle, obesity and mortality through comparisons of maps).

¹⁵⁵ See, e.g., Paul A. Diller, *Combating Obesity with a Right to Nutrition*, 101 GEO. L.J. 969, 982 (2013) (“Although obesity was mainly a ‘disease of affluence’ for centuries after the beginning of civilization, it is now more prevalent among poorer segments of the population in developed countries like the United States, a trend that is particularly pronounced among children.” (footnote omitted)); Wendy C. Perdue, *Obesity, Poverty, and the Built Environment: Challenges and Opportunities*, 15 GEO. J. ON POVERTY L. & POL’Y 821, 821 (2008) (“Not only are obesity rates *generally* higher among those with lower socioeconomic status, but the chronic conditions caused by obesity may present a particular challenge for the poor who often lack access to necessary ongoing medical supervision.” (emphasis added) (footnote omitted)); Trenton G. Smith et al., *Why the Poor Get Fat: Weight Gain and Economic Insecurity*, 12 F. FOR HEALTH ECON. & POL’Y 1, 16 (2009) (explaining obesity as an optimal response to economic insecurity).

¹⁵⁶ CYNTHIA L. OGDEN ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 50, OBESITY AND SOCIOECONOMIC STATUS IN ADULTS: UNITED STATES, 2005–2008, at 2 (2010).

¹⁵⁷ *Id.*

attained levels of education.¹⁵⁸ Among men, obesity rates tend to be slightly higher at *higher* income levels.¹⁵⁹ Among women, however, obesity rates tend to be higher in *lower* income households.¹⁶⁰ Also, among women, lower education levels correlate with higher obesity prevalence—a phenomenon that is not exhibited among men.¹⁶¹

Further, race and ethnicity intersect with the obesity phenomenon. According to the Kaiser Family Foundation, in 2011, studied groups had the following “overweight/obesity” rates: Whites (62.5%), Blacks (71.7%), Hispanics (68.2%), American Indian/Alaskan Native (68.9%), and Asian/Pacific Islanders (40.9%).¹⁶² Neighborhood effects also emerge. New York City obesity rates vary widely by neighborhood, from as low as 6.8% up to 31.7%, with one study isolating the “availability of supermarkets, restaurants, fast food outlets, beverage and snack food stores, fitness facilities, and commercial land use” as the driving factors.¹⁶³ The study’s authors regarded its findings as consistent with prior studies showing that area income, food availability, and physical activity resources are related to obesity.¹⁶⁴

Further demonstrating that the matrix of demographics and intake patterns can present complexities, consider the consumption patterns of fast food. A 2013 study of eight fast food chains revealed an increase in the nutritional quality of the menus since the late 1990s, but observed that room for further improvement exists.¹⁶⁵ One can speculate about the difficulty of achieving incremental improvements in this area.

Fast food consumption has been linked to hectic lifestyles that would naturally lead to putting “quick availability” and “takeout” at a premium in dietary choices.¹⁶⁶ The most notable finding from a recent National Health and Nutrition Examination Survey might be that among all adults, the fraction of daily caloric intake attributable to fast food did not vary by

¹⁵⁸ *Id.* at 4–5.

¹⁵⁹ *Id.* at 1.

¹⁶⁰ *Id.* at 2. “Upper income” households are considered to be above 350% of the poverty level and “lower income” households are below 130% of the poverty level. *Id.*

¹⁶¹ *Id.* at 3.

¹⁶² *Overweight and Obesity Rates for Adults by Race/Ethnicity*, HENRY J. KAISER FAM. FOUND., <http://kff.org/other/state-indicator/adult-overweightobesity-rate-by-re/> (last visited July 15, 2014).

¹⁶³ Jennifer L. Black et al., *Neighborhoods and Obesity in New York City*, 16 HEALTH & PLACE 489, 495 (2010).

¹⁶⁴ *Id.* at 496–97.

¹⁶⁵ See Mary O. Hearst et al., *Nutritional Quality at Eight U.S. Fast-Food Chains*, 44 AM. J. PREVENTIVE MED. 589, 591–92 (2013) (stating that the results of the study showed an increase in nutritional scores in areas such as meat, saturated fat, and calories from solid fats, but no change or a decrease in scores in other areas).

¹⁶⁶ CHERYL D. FRYAR & R. BETHENE ERVIN, U.S. DEP’T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 114, CALORIC INTAKE FROM FAST FOOD AMONG ADULTS: UNITED STATES, 2007–2010, at 1 (2013).

income.¹⁶⁷ Among adults between the ages of twenty and thirty-nine, the average caloric intake did exhibit a slight negative correlation with income level.¹⁶⁸ Overall, age seemed to be a primary differentiator for fast food consumption, with those under age forty taking in almost two-and-a-half times the amount of fast food calories than those over age sixty.¹⁶⁹ Also, differences in consumption patterns emerge among race and ethnicity dimensions. The survey found that non-Hispanic Black adults received a significantly higher percentage of calories from fast food than Hispanics and non-Hispanic white adults.¹⁷⁰ Within this category, non-Hispanic Black adults under age forty received nearly twice their portion of daily calories from fast food as the total adult average.¹⁷¹

Counterintuitive to some, groups traditionally aligned with social justice issues prioritized other concerns during the litigation over New York City's Big Gulp ban.¹⁷² Both the NAACP and the Hispanic Federation, for example, sided against the New York Department of Public Health.¹⁷³ Though some argue that these groups were influenced by the well-established philanthropy of "Big Soda,"¹⁷⁴ the core arguments made in their joint amicus brief stand as an example of the expression of competing social interests that emerge when paternalism is introduced.¹⁷⁵

Childhood obesity presents an entirely separate layer of complication to the obesity problem. As the CDC noted, in a thirty-year period leading to 2012, obesity rates skyrocketed for young people—more than doubling for all children, and quadrupling in the adolescent age group.¹⁷⁶ Remarkably, however, in a new study of trends between the years 2008 and 2011, rates of childhood obesity appear to have stabilized or reversed

¹⁶⁷ *Id.* at 3.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at 1 fig.1.

¹⁷⁰ *Id.* at 2.

¹⁷¹ *Id.* at 2 fig.2.

¹⁷² *E.g.*, Nancy Huehnergath, *How Big Soda Co-Opted the NAACP and Hispanic Federation*, HUFFINGTON POST (Jan. 25, 2013), http://www.huffingtonpost.com/nancy-huehnergath/minorities-soda-lobby_b_2541121.html.

¹⁷³ Memorandum of Law of Amici Curiae the New York State Conference of the NAACP and the Hispanic Federation in Support of Plaintiffs-Petitioners' Verified Article 78 & Declaratory Judgment Petition, *N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene*, 970 N.Y.S.2d 200 (2013) (No. 653584-2012) [hereinafter Memorandum of Law].

¹⁷⁴ Huehnergath, *supra* note 172.

¹⁷⁵ See Memorandum of Law, *supra* note 173, at 2–3, 8–9 (expressing concern about the ban's interference with personal choice and freedom, especially in predominantly minority communities). The potential negative impact of Big Gulp Regulation on African-American and Hispanic-owned small businesses was one factor. *Id.* at 3, 8.

¹⁷⁶ *Childhood Obesity Facts*, CDC, <http://www.cdc.gov/healthyyouth/obesity/facts.htm> (last visited July 15, 2014); see also Cynthia L. Ogden et al., *Prevalence of Obesity and Trends in Body Mass Index Among US Children and Adolescents, 1999–2010*, 307 JAMA 483, 483 (2012) (stating that there has been a significant increase in childhood obesity since the 1980s).

course.¹⁷⁷ Paternalism meshes a bit more effectively with childhood problems,¹⁷⁸ because the regulatory apparatus has means for controlling children's access to food and encouraging physical activity (i.e., public schools).¹⁷⁹ The reduction has been attributed to myriad factors, such as: increases in breastfeeding, improvements to the Supplemental Nutrition Program for Women, Infants and Children (WIC), school lunch and nutrition improvements, restaurant changes to child menus, and increases in physical activity generated by programs like "Let's Move!"¹⁸⁰ Some health scientists believe that a combination of these factors working together contributed to the advancement.¹⁸¹ But again, there remains the contention that this reversal, along with others, merely reflects that obesity levels have a natural limit, driven by factors like environment and genetics, not regulatory interventions.¹⁸²

B. Addressing Obesity Along the Paternalism Spectrum

Even this broad, but not fully complete, description of the obesity problem makes plain that the causes of obesity are intertwined and difficult to address. The only real way to solve the obesity problem in the United States, if one accepts that regulators are capable, would be to press forward with solutions on every dimension of the problem. Regulators could target certain categories of foods or delivery outlets for foods. Specific groups could be selected for messaging about nutrition and activity—like African American men under the age of forty, or all females over the age of sixty—or certain geographic regions of the country. Campaigns to convince people to eat less and more nutritiously could be launched and certain ingredients could be banned. The promotion of physical activity could continue to be pursued beyond the public schools.

In a full-court press against obesity, regulators would encounter political resistance to paternalistic endeavors, at least if recent responses to autonomy loss can be thought to constitute a trend. Anything less than a full-court press, however, might result in minimal returns. Obesity

¹⁷⁷ See Ashleigh L. May et al., *Vital Signs: Obesity Among Low-Income, Preschool-Aged Children—United States, 2008–2011*, 62 MORBIDITY & MORTALITY WKLY. REP. 629, 630 (2013) (“[A] total of 19 states/territories reported significant downward trends in obesity prevalence among low-income preschoolers . . . [a]n additional 21 states/territories experienced no significant trend in obesity prevalence. Three states experienced a significant upward trend in obesity prevalence.”).

¹⁷⁸ Not without irony, consider the root of the word “paternal”—“father.” MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 908 (11th ed. 2003).

¹⁷⁹ See *infra* Part III.B.2.d.i.

¹⁸⁰ Cathy Payne & Michelle Healy, *A Closer Look at Why Child Obesity Rates May Be Falling*, USA TODAY, Aug. 7, 2013, at ARC. In the early wake of this study, root cause analysis for this specific reversal has not been well developed in formal literature. For a more detailed discussion of the “Let's Move!” initiative, see *infra* text accompanying notes 202–16.

¹⁸¹ *Id.*

¹⁸² *Id.*

reduction on a massive scale involves changing the way people of different ages, ethnic and racial backgrounds, and socioeconomic strata behave when they eat or drink—and whether they elect to pursue physical activity. Changing such inherently personal habits involves broad strategies, targeted strategies—and certainly a dose of paternalism. The regulators would be substituting their choices for the current choices of the population.

Consider how comparatively simple it has been to address the epidemiological challenge of smoking. With smoking, regulators could hone in on an unnecessary habit involving one controlling substance. They deployed a laser-like focus on tobacco—through public education,¹⁸³ label mandates,¹⁸⁴ and sales restrictions.¹⁸⁵ Locations for public smoking could be restricted one step at a time.¹⁸⁶ A narrow set of products could be taxed.¹⁸⁷ The success enjoyed by those who targeted tobacco use will be much harder to achieve in this field. With obesity, the inputs are required for everyday living. The tools are fewer, the public appetite for hard paternalism in many spheres can be uneasy, and the theaters of “battle,” ranging from public schools to the corner food market are various, plenty, and fraught with complexity.

For the purposes of determining whether and which paternalistic strategies could be effective or have remaining potential for addressing obesity, the analysis must focus on the strategies that the public will support, or at least not aggressively oppose. If regulators fail to employ rigorous criteria to choose initiatives, a full-court-press could be a waste of regulatory capital and public resources. The complexity of a comprehensive solution only seems to increase upon close scrutiny.

Before assessing the limits of current efforts regulators have deployed to combat obesity—using the paternalism spectrum—I will discuss the nature of the apaternalistic or free market workings against this public problem. I will then discuss the primary cognitive bias that obesity regulators must combat—the present bias—and assess the impact and limitations of such efforts.

¹⁸³ See, e.g., *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, 43 MORBIDITY & MORTALITY WKLY. REP. 1, 1 (1994) (outlining the CDC’s guidelines for school health programs to prevent tobacco use).

¹⁸⁴ 15 U.S.C. § 1333 (2012).

¹⁸⁵ See, e.g., CONN. GEN. STAT. § 53-344(b) (2013) (prohibiting the sale of tobacco to minors).

¹⁸⁶ See Patrick Kabat, Note, “*Til Naught but Ash is Left to See*”: *Statewide Smoking Bans, Ballot Initiatives, and the Public Sphere*, 9 YALE J. HEALTH POL’Y L. & ETHICS 128, 138–45 (2009) (outlining different levels of smoking bans in public places across several states).

¹⁸⁷ See U.S. DEP’T OF HEALTH & HUMAN SERVS., PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS: A REPORT OF THE SURGEON GENERAL 698–701 (2012) (demonstrating the effects of federal, state, and local excise taxes on cigarette sales to minors).

1. *Free Market Approaches*

The most powerful solution available that eschews all paternalism in favor of autonomy would be a natural collective preference to engage in proper caloric intake and energy discharge. Though other factors like genetics might play into obesity, if these preferences, which would lead to better health and longer life expectancy, were dominant, free choice would lead to healthier decisions.

Social norms can prove immensely powerful in influencing preferences.¹⁸⁸ The literature on social norms has grown deep,¹⁸⁹ but Richard McAdams's view that people adhere to social norms to appeal to the "esteem of others"¹⁹⁰ appears to be on trial in the obesity arena. Stigma about obesity already exists, which incidentally, was a concern expressed by physicians who opposed the AMA's disease label.¹⁹¹ Beyond a doubt, society puts a premium on looking healthy:

Weight bias translates into inequities in employment settings, health-care facilities, and educational institutions, often due to widespread negative stereotypes that overweight and obese persons are lazy, unmotivated, lacking in self-discipline, less competent, noncompliant, and sloppy. These stereotypes are prevalent and are rarely challenged in Western society, leaving overweight and obese persons vulnerable to social injustice, unfair treatment, and impaired quality of life as a result of substantial disadvantages and stigma.¹⁹²

Yet, despite these individual costs, the behavior and choices that drive high obesity rates persist. If the McAdams theory of social norms worked here, the expected obesity rate would be lower. Or, perhaps, people's preferences for their consumption and physical activity levels simply trump the value of the esteem. The norms within individual social networks in which people travel may also overpower broader societal

¹⁸⁸ Korobkin, *supra* note 12, at 1659. As Korobkin notes, there are different theories about the power of social norms. *See id.* at 1659 n.43 (explaining that Robert Cooter believes the source of the power of norms comes from "internalization" of external influencers, while Eric Posner believes norms are followed because of their value as a signal of responsibility and willingness to cooperate with other people).

¹⁸⁹ *See* Cass R. Sunstein, *Empirically Informed Regulation*, 78 U. CHI. L. REV. 1349, 1408 n.262 (2011) (citing to recent social norm literature).

¹⁹⁰ Richard H. McAdams, *The Origin, Development, and Regulation of Norms*, 96 MICH. L. REV. 338, 342 (1997) (emphasis omitted).

¹⁹¹ Dr. Daniel H. Bessesen, an obesity specialist at the University of Colorado, noted that "the term disease is stigmatizing, and people who are obese don't need more stigmatizing." Healy & Gorman, *supra* note 117.

¹⁹² Rebecca M. Puhl & Chelsea A. Heuer, *The Stigma of Obesity: A Review and Update*, 17 OBESITY 941, 941 (2009) (citations omitted).

values.¹⁹³ Another notion, which I discuss below, is that present bias reveals its power here. The instant rewards from current choices are valued disproportionately and, perhaps irrationally, higher than collective costs in the future.

Unsurprisingly, the marketplace taps into this norm, either serving the segment that prefers health or those who aspire to improve their health. Natural preferences and aspirations have enabled the emergence of a substantial weight-loss and exercise industry. Though market forces might already be influenced by regulation, private solutions to the obesity problem may already be at work. One Wall Street firm recognized that the obesity fight presents a significant investment opportunity over the next twenty-five to fifty years, recommending scrutiny of fifty companies as long-term investment opportunities.¹⁹⁴ Estimates vary but one private group measured the size of the global weight loss and diet management products and services market at \$390 billion in 2010, growing at an annual rate of 11.5% to \$672 billion by 2015.¹⁹⁵

Voluntarism has also emerged in the food industry in the form of disclosing calorie counts¹⁹⁶ or reducing portion-size offerings.¹⁹⁷ Voluntarism might emerge out of sheer private paternal goodwill, may simply be good for business, or might be designed to preempt regulation.¹⁹⁸ Some businesses, like McDonald's, were publicly shamed for their business practices with respect to nutrition.¹⁹⁹ With trans fats, several restaurant chains and food manufacturers followed a regulatory trend and voluntarily eliminated the substance as an ingredient in their food offerings.²⁰⁰ Nonetheless, industry voluntarism appears vastly outsized by

¹⁹³ See Jean K. Langlie, *Social Networks, Health Beliefs, and Preventive Health Behavior*, 18 J. HEALTH & SOC. BEHAV. 244, 244–45 (1977) (discussing the Social Network Model and its incorporation of social-psychological characteristics).

¹⁹⁴ *Fight Against Obesity Is Major Investment Trend—BofA*, REUTERS INDIA (July 17, 2012), <http://in.reuters.com/article/2012/07/16/obesity-report-merrillynch-idINL6E8IGG1020120716>.

¹⁹⁵ Press Release, MarketResearch.com, *Weight Loss Market to Reach \$672 Billion by 2015* (Sept. 27, 2011), available at <http://www.marketwired.com/press-release/weight-loss-market-to-reach-672-billion-by-2015-1565973.htm>.

¹⁹⁶ For example, Starbucks, Panera Bread, and Subway have all voluntarily disclosed calorie counts. Atossa Araxia Abrahamian, *Starbucks to Post Calorie Counts in Stores Nationwide*, REUTERS (June 18, 2013), <http://www.reuters.com/article/2013/06/18/us-starbucks-calories-idUSBRE95H0KD20130618>.

¹⁹⁷ See *infra* note 199.

¹⁹⁸ Public endorsement of voluntarism can be traced back to the era of Herbert Hoover. See JOAN HOFF WILSON, *HERBERT HOOVER: FORGOTTEN PROGRESSIVE* 38 (Oscar Handlin ed., 1975).

¹⁹⁹ See SUPER SIZE ME, *supra* note 82 (chronicling the health effects of eating McDonald's for one month). Though McDonald's disavows a link to the negative movie publicity, it eliminated super-sizes after the release. Associated Press, *McDonald's Phasing out Supersize Fries, Drinks*, NBC NEWS.COM (Mar. 3, 2004), http://www.nbcnews.com/id/4433307/ns/business-us_business/t/mcdonalds-phasing-out-supersize-fries-drinks/#.UwFPfldWBJ.

²⁰⁰ For example, within a relatively short timeframe, McDonald's, Burger King, KFC, Wendy's, Disney (theme parks), and the Girl Scouts (cookies) all made voluntary commitments to reduce or

the scope of the obesity problem, even if it does address a small piece.²⁰¹ The diverse elements of the problem—including food manufacturing, consumption patterns, household income and structure, and physical activity—present difficulty beyond addressing one product, place, or behavior through voluntarism.

Characterizing government efforts to induce voluntarism can prove challenging, for it is difficult to observe exactly how much the government pressures the industry to resolve its own problems (under an implied threat of heavier regulation). Because such industry actions are considered voluntary, I place them at the very edge of apaternalistic regulation.

For example, consider high-profile government initiatives like the White House’s “Let’s Move!” campaign, which is led by First Lady Michelle Obama.²⁰² The campaign nudges people toward better nutrition choices and moves the industry toward voluntarily adopting healthier production practices.²⁰³ Mrs. Obama, upon launching the campaign, declared that “[t]he physical and emotional health of an entire generation and the economic health and security of our nation is at stake.”²⁰⁴ Even with these self-declared high stakes, “Let’s Move!” ultimately relies on people to make the right choices after educating them about exercise and diet, rather than dictating choices.²⁰⁵

From the industry side of the equation, “Let’s Move!” claims some

eliminate trans fats from their foods. Robert Niles, *Disney Plans to Dump Trans Fat at U.S. Theme Parks*, THEME PARK INSIDER (Oct. 16, 2006), <http://www.themeparkinsider.com/flume/200610/212/>; Adrian Sainz, *Burger King to Use Trans-fat-free Oil*, ASSOCIATED PRESS (July 6, 2007), <http://phys.org/news102934980.html>; *KFC Announces Switch to Zero Trans Fat Cooking Oil Following Two-Year Test for Same Great Taste*, KFC.COM (Oct. 30, 2006), <http://web.archive.org/web/20070119110204/http://www.kfc.com/about/pressreleases/103006.asp>; *McDonald’s Finally Picks Trans-fat-free Oil*, NBCNEWS.COM (Jan. 30, 2007), <http://www.nbcnews.com/id/16873869/#.UwvLPPldWBJ>; *Statement from GSUSA CEO Kathy Cloninger: Girl Scout Cookies Now Have Zero Trans Fats*, GIRL SCOUTS (Nov. 13, 2006), http://www.girlscouts.org/news/news_releases/2006/gsc_cookies_now_have_zero_trans_fats.asp; *Wendy’s Significantly Cuts Trans Fats—Switch to New Cooking Oil Under Way*, WENDY’S (June 8, 2006), http://web.archive.org/web/20061109131923/http://www.wendys.com/about_us/news/index.jsp?news=5.

²⁰¹ Voluntarism in other contexts, like reducing on-screen smoking, has been simpler. Movies reach a large volume of people, and the industry was small and tightly knit through its trade association. See William Triplett, *Smoking in Movies to Affect Ratings*, VARIETY (May 10, 2007), <http://variety.com/2007/film/news/smoking-in-movies-to-affect-ratings-1117964655/> (reporting that pervasive smoking in movies will negatively affect ratings).

²⁰² *White House Task Force on Childhood Obesity*, LET’S MOVE!, <http://www.letsmove.gov/white-house-task-force-childhood-obesity-report-president> (last visited July 15, 2014).

²⁰³ I distinguish these voluntary efforts, which are the product of a government nudge, from the voluntarism emanating from purely market-driven reasons.

²⁰⁴ *First Lady Michelle Obama Launches Let’s Move: America’s Move to Raise a Healthier Generation of Kids*, THE WHITE HOUSE (Feb. 9, 2010), <http://www.whitehouse.gov/the-press-office/first-lady-michelle-obama-launches-lets-move-americas-move-raise-a-healthier-genera>.

²⁰⁵ See *id.* (discussing how “Let’s Move!” educates families to make healthy choices).

advancement, most notably, Wal-Mart's voluntary commitment to lower the cost of fruits and vegetables, to help food producers reduce added sugars by ten percent by 2015, and to provide healthy labeling for customers.²⁰⁶ The largest restaurant company in the country, Darden Restaurants,²⁰⁷ voluntarily improved the nutrition content of its children's menu, at the urging of Mrs. Obama.²⁰⁸ Further, in 2010, a coalition of producers and retailers agreed to eliminate 1.5 trillion calories from their sales within five years.²⁰⁹ Though these moves have been voluntary, they were made with the encouragement of the White House. One can speculate as to just how voluntary these moves really were, but they were not openly compelled.

Even this light level of intervention drew political fire from activists who thought that the "Let's Move!" effort was too light or timid,²¹⁰ and others who expressed an anti-paternalistic reaction, essentially arguing that

²⁰⁶ *First Lady Michelle Obama Announces Collaboration with Walmart in Support of Let's Move! Campaign*, THE WHITE HOUSE (Jan. 20, 2011), <http://www.whitehouse.gov/the-press-office/2011/01/20/first-lady-michelle-obama-announces-collaboration-walmart-support-let-s-> Wal-Mart, the largest retailer and grocer in the United States, maintains roughly a twenty percent share of the dry grocery market and fifteen percent of the fresh groceries. Stephanie Clifford, *Walmart Strains to Keep Aisles Stocked Fresh*, N.Y. TIMES, Apr. 4, 2013, at A1.

²⁰⁷ *Our Brands*, DARDEN, <http://www.darden.com/restuarants/> (last visited July 15, 2014). Darden owns "Olive Garden, Red Lobster, LongHorn Steakhouse, the Capital Grille, Bahama Breeze, and Seasons 52." Marion Nestle, *Michelle Obama Gets Darden's to Promise Healthier Kids' Meals*, THE ATLANTIC (Sept. 17, 2011), <http://www.theatlantic.com/health/archive/2011/09/michelle-obama-gets-dardens-to-promise-healthier-kids-meals/245211/>.

²⁰⁸ Nestle, *supra* note 207.

²⁰⁹ Mary Clare Jalonick, *Food Makers to Trim 1.5 Trillion Calories*, NBC NEWS (May 17, 2010), http://www.nbcnews.com/id/37195646/ns/health-diet_and_nutrition/t/food-makers-trim-trillion-calories/#.UxDch_IdWBJ.

²¹⁰ E.g., Bridget Huber, *Michelle Obama's Moves: Has the First Lady's Anti-Obesity Campaign Been too Accommodating Toward the Food Industry?*, THE NATION (Oct. 10, 2012), <http://www.thenation.com/article/170485/michelles-moves#>. Dr. Yoni Freedhoff of the University of Ottawa has been a leading advocate of stronger interventions with food manufacturers. As the non-interventionist advocate Jeff Stier noted in an op-ed:

[R]egulation-hungry activist[. . . Dr. Yoni Freedhoff]'s . . . fiery YouTube video last month drew more than 200,000 views, was the basis of headlines in the *Los Angeles Times*, and rallied the food police to renew their campaign for more government regulation against his sole stated cause of obesity: under-regulated corporate peddlers of inexpensive calories. In his screed, Freedhoff lays the blame for obesity on public health officials for not doing more to pressure people to "legislate change." He says governments are also to blame, since they have not issued enough regulations, changed enough laws, spent enough money, or instituted enough fat taxes. He says we need government and public health officials to intervene, since industry isn't to blame for doing [its] job, which he says is to "misinform consumers" in their quest to sell as many cheap calories as possible.

Jeff Stier, *The Food Police Lay the Groundwork for a 2013 Food Fight*, FORBES (Jan. 3, 2013), <http://www.forbes.com/sites/realspin/2013/01/03/the-food-police-lay-the-groundwork-for-a-2013-food-fight/>.

the whole of “Let’s Move!” reflected regulatory overreach in the spirit of Big Brother.²¹¹ *Defining Ideas*, a libertarian-leaning online journal maintained by the Hoover Institution, posted an article that took the middle ground, lauding “Let’s Move!” for endorsing the “major role that *voluntary* choices play in weight control” and recognizing the initiative’s “modest successes” in working with industry.²¹²

Some looked at the whole of the “Let’s Move!” display, despite its relative respect for personal autonomy, with hostility.²¹³ Much of the anti-“Let’s Move!” rhetoric focused on hypocrisy, noting that the First Lady was not setting an example that was consistent with her own behavior,²¹⁴ though some of the rhetoric could be discounted as having partisan motivation. For example, “some conservatives even suggested that [Mrs.] Obama was endangering people, blaming an increase in pedestrian deaths on the first lady’s campaign by saying that Americans were putting themselves at risk by walking more.”²¹⁵

The point of describing “Let’s Move!” is to illustrate an initiative that straddles voluntarism and the very edge of paternalism, and show that even a light amount of intervention sparks a debate about *any* intervention. Is this slight intervention intended to be a “buy off” of the food industry—or is the collaboration with Big Food a beachhead for tyranny? “Let’s Move!” shows that the politics of paternalism prove challenging in environments where some people favor drastically more state intervention and others want less. In this sense, “Let’s Move!” shares certain commonalities with the Big Gulp effort. Meanwhile, the voluntary calorie disclosures made by Starbucks, Panera Bread, and Subway did not provoke a great deal of controversy—perhaps because the government stood apart from the move.²¹⁶

With obesity, the spectrum of apaternalism ranges from the purest forms of unfettered market phenomena to the influenced voluntarism embodied by “Let’s Move!” Regulatory interventions in the larger food

²¹¹ E.g., James Oliphant, *Conservatives Dish Out Criticism of Michelle Obama’s Anti-Obesity Campaign*, CHI. TRIB., Feb. 26, 2011.

²¹² Henry I. Miller & Jeff Stier, *The Right Way to Fight Obesity*, DEFINING IDEAS (June 19, 2013), <http://www.hoover.org/research/right-way-fight-obesity>.

²¹³ See Oliphant, *supra* note 211 (“Former First Ladies Barbara and Laura Bush worked to end illiteracy. Nancy Reagan famously took on teenage drug use. Lady Bird Johnson planted flowers. But none of them have been seared for something as seemingly benign as calling for kids to eat more vegetables, as Michelle Obama has.”).

²¹⁴ Radio-talk-show host Rush Limbaugh, after noting that Michelle Obama had been observed in public eating unhealthy foods said, “If we are supposed to eat roots, berries and tree bark, show us how.” *Id.* Such comments could be characterized as social and political satire, and though many may find difficulty placing Rush Limbaugh in the same category as Mark Twain and Will Rogers, the permeation of his comments into cornerstone media outlets like the *Los Angeles Times* warrants notice.

²¹⁵ *Id.*

²¹⁶ See Abrahamian, *supra* note 196.

arena emerge from all quarters, local and federal, and can pull in different directions.²¹⁷ As noted throughout this Article, the government subsidizes the production of certain foods that contribute to an unhealthy diet, yet also deploys a variety of interventions to combat obesity. Though the comparison is not nearly as stark, this tension is reminiscent of how the federal government subsidizes tobacco farming,²¹⁸ while simultaneously taxing tobacco consumption.²¹⁹

Indeed, the same marketplace that lures an estimated one hundred million Americans into dieting of some sort each year²²⁰ also generates substantial sales of unhealthy food at the hands of food marketers.²²¹ Individual preferences differ and overlap. The market pulls in different directions. The evidence overwhelmingly indicates that the obesity problem has not been resolved by the combination of market forces and reactive intervention.

The ensuing Subsections describe points along the spectrum of regulatory intervention, with each point presenting tradeoffs in terms of ease and effectiveness. But before the paternalism spectrum is applied in detail, I will briefly describe the cognitive error that regulators may be attempting to correct in obesity: the present bias.

2. Paternalistic Approaches

Regulatory strategies can be designed to address a bias or error that interferes with decisions, leading people to make suboptimal or harmful

²¹⁷ See Sunstein, *supra* note 189, at 1362–63 (discussing short term versus long term benefits of regulation).

²¹⁸ See, e.g., Ramsey Cox, *Senate Rejects Amendment to End Tobacco Farm Subsidies*, THE HILL (May 23, 2013, 6:54 PM), <http://thehill.com/blogs/floor-action/senate/301645-senate-rejects-amendment-to-end-tobacco-farm-subsidies> (discussing the U.S. Senate's rejection of an amendment that would have ended crop insurance subsidies for tobacco farmers).

²¹⁹ See *Tax and Fee Rates*, TTB.GOV, http://www.ttb.gov/tax_audit/atftaxes.shtml (last updated Nov. 6, 2013) (listing the federal tax rates for various tobacco products).

²²⁰ *100 Million Dieters, \$20 Billion: The Weight-Loss Industry by the Numbers*, ABC NEWS (May 8, 2012), <http://abcnews.go.com/Health/100-million-dieters-20-billion-weight-loss-industry/story?id=16297197>.

²²¹ The Federal Trade Commission estimated that in 2006, food and beverage companies spent over \$1.6 billion marketing their goods to just children and adolescents. FED. TRADE COMM'N, *MARKETING FOOD TO CHILDREN AND ADOLESCENTS: A REVIEW OF INDUSTRY EXPENDITURES, ACTIVITIES, AND SELF REGULATION* ES 11 (2008), <http://www.ftc.gov/sites/default/files/documents/reports/marketing-food-children-and-adolescents-review-industry-expenditures-activities-and-self-regulation/p064504foodmktngreport.pdf>. Note, though, that the market creates room for upscale, healthy food retailers like Whole Foods—which address a demographic not in the obesity target zone. As one potential competitor put it: “As long as Whole Foods stays in the higher income areas, they will do well . . . They wouldn't last two weeks in my area, as customers can not afford the higher prices, and there are many towns just like ours.” Tom Ryan, *Whole Foods Market Aims for 1,000 Stores in the U.S.*, FORBES (July 5, 2011), <http://www.forbes.com/sites/retailwire/2011/07/05/whole-foods-market-aims-for-1000-stores-in-the-u-s/>.

choices.²²² Logically, identifying appropriate interventions first requires isolating the biases that lead people to make harmful choices. Regulators can then use appropriate tools across the paternalism spectrum to remove the bias and prevent it from impacting the behavior of the individual. But before delving into this process, a normative value judgment must be made about whether wrong or harmful decisions exist that people should be nudged away from or forbidden to make.²²³ After all, the regulation of caloric intake and expenditure stands to interfere with some deeply personal trade-offs that individuals must make about their health, appearance, and instant enjoyment of life.

The first question to pose is whether an individual's decisions over time to consume certain foods and remain sedentary comprise a harm that should be corrected. Though the medical community seems to be largely unified around the consensus that obesity presents a social problem,²²⁴ other points of view about "fatness" and identity have been expressed. As Yofi Tirosh observed, "Recognizing the expressive role of the law enables us to realize the importance of the message sent by contemporary law—a message that life as a fat person is less valuable in many respects and merits less effort to create conditions for full realization of its potential."²²⁵ One spillover from making a normative decision to attack the obesity problem is the social cost it may have for people who have affirmatively made a legitimate lifestyle choice. Law reinforces norms,²²⁶ and those who live outside those norms may suffer unwarranted individually-borne costs.²²⁷

The notion that these highly personal decisions about consumption or physical activity are irrational or poor would have to incorporate the idea that people willfully act against their own objective interests or that a cognitive distortion drives their behavior. Is eating a carton of ice cream in one sitting irrational? Is empty pleasure-seeking or instant gratification irrational? Is never exercising irrational? The answers to these questions rest upon a tangled intersection of utility curves and personal discount rates. The answers also depend upon whether regulators should be concerned with the aggregate social problem as opposed to individual personal choice. Nonetheless, regulators frequently attempt to improve

²²² See Jolls & Sunstein, *supra* note 42, at 206–07 (describing the Truth in Lending Act, which requires that credit-seeking consumers be given certain information that counters optimism biases).

²²³ I have noted elsewhere in the context of advertising regulation that debiasing decisions always have a normative root. Friedman, *supra* note 45, at 606.

²²⁴ *Addressing Overweight and Obesity: Evolving to a Medical Consensus*, 108 J. AM. OSTEOPATHIC ASS'N 52, 52 (2008).

²²⁵ Tirosh, *supra* note 57, at 283.

²²⁶ See McAdams, *supra* note 190, at 397–98 (discussing how law can strengthen a norm merely by expressing it).

²²⁷ See *supra* note 192 and accompanying text.

decision making or, quite often, to guide people to make the right decisions and develop the right habits.

In the obesity arena, regulators are mostly attempting to provide people with data to make better decisions that can incorporate that extra information. The major cognitive bias that they may be trying to counter, among many, is present bias.²²⁸ For regulators attempting to debias people to make better long-run decisions about consumption, the present bias emerges as a formidable obstacle.

Put simply, a large segment of the population values instant gratification over future consequences,²²⁹ whether the consequences are a benefit or a detriment. This discounting is natural and perhaps appropriate. Therefore, the first question that regulators seeking to deploy soft paternalism through debiasing must address is what the appropriate discount rate might be. The second question such regulators must address is how to effectively move that rate, so that people are making the correct temporal valuations on their own.

Economists Ted O'Donoghue and Matthew Rabin describe present bias as a human tendency toward impatience.²³⁰ People "like to experience rewards soon and to delay costs until later."²³¹ As a basic model, present bias explains such inter-temporal, behavioral-finance social challenges as short-sighted retirement planning²³² and the over-accumulation of consumer debt.²³³ But it could also explain consumption behavior that leads to obesity.²³⁴ When people "consider[] trade-offs between two future moments, present-biased preferences give stronger relative weight to the earlier moment as it gets closer."²³⁵ That is, people may disproportionately prefer the pleasure of eating something obesogenic now over diffusing

²²⁸ See Andrew S. Hanks et al., *Healthy Convenience: Nudging Students Toward Healthier Choices in the Lunchroom*, 34 J. PUB. HEALTH 370, 370–71 (2012) (explaining that present-bias motivates students to repeat the same familiar, unhealthy food choices).

²²⁹ See Joel Stein, *Instant Gratification*, TIME (May 7, 2012), <http://content.time.com/time/magazine/article/0,9171,2113162,00.html> ("[M]ost obesity isn't caused by a lack of access to affordable produce or time to cook. It's the result of short-term over long-term thinking.").

²³⁰ Ted O'Donoghue & Matthew Rabin, *Doing It Now or Later*, 89 AM. ECON. REV. 103, 103 (1999).

²³¹ *Id.*; see also Jess Benhabib et al., *Present-Bias, Quasi-Hyperbolic Discounting, and Fixed Costs*, 69 GAMES & ECON. BEHAV. 205, 222 (2009) (finding "clear experimental evidence against exponential discounting in that it exhibits a present bias").

²³² Richard Thaler & Shlomo Benartzi, *Save More Tomorrow™: Using Behavioral Economics to Increase Employee Saving*, 112 J. POL. ECON. S164, S167–68 (2004).

²³³ Stephen Meier & Charles Sprenger, *Present-Biased Preferences and Credit Card Borrowing*, 2 AM. ECON. J.: APPLIED ECON. 193, 195 (2010).

²³⁴ See Charles J. Courtmanche et al., *Impatience, Incentives, and Obesity* 26 (Andrew Young Sch. of Pol'y Stud. Res. Paper Series, Working Paper No. 2012-7-4, 2012), available at <http://ssrn.com/abstract=2139065> (demonstrating that "present-bias and long-run patience are statistically significant and negatively associated with BMI").

²³⁵ O'Donoghue & Rabin, *supra* note 230, at 103, 106.

potentially negative impact later.

Humorist Erma Bombeck less famously, but more recently, wrote: “Seize the moment. Remember all those women on the Titanic who waved off the dessert cart.”²³⁶ Bombeck was merely sliding the discount rate around on present bias, encouraging people to discount the unknown future and revel in the consumption of today. Is this normatively wrong? The enjoyment of food, whether consumed in a fancy bistro or casually, has true value as a soothing part of everyday life. Regulators attempt to address caloric intake despite this obvious fact that people tend to enjoy eating—it is in the biological nature of the species to do so, and occasionally and sometimes regularly, to excess.²³⁷

Note that in the subsequent discussion of weak-form and strong-form debiasing, the debiasing efforts focus on providing information or narratives that enhance decision making, but take on the present bias somewhat indirectly. Disclosing caloric information, for example, may help the discounter in valuing the present pleasure of eating a bran muffin for breakfast against the long-term costs, but it does not directly confront the consumer with the dynamics behind the intertemporal tradeoff.

Harder paternalism, on the other hand, may put a thumb on the scale to mitigate present bias by making certain harmful choices more difficult or impossible. The hardest forms of paternalism eliminate the discounting dilemma entirely, with the regulator making the decision for the consumer that consuming a certain item, e.g., trans fats or sugary drinks, does not provide an appropriate present value.

a. Weak-Form Debiasing

Weak-form debiasing describes regulatory efforts to present consumers with information that should fill gaps and enhance decision making, with the notion that better decisions will be made.²³⁸ Again, this premise already rests on one compound assumption—that the possession of more information will benefit the recipient and that the recipient will use it.

Debiasing efforts through mandatory information disclosure should improve people’s ability to value or discount future costs more accurately. Further, decision making may prove to be more conscious or current if, for example, every time a consumption purchase is made, consumers are not only confronted with the price, but also with the associated caloric intake.²³⁹ Caloric disclosures have long been in place on product

²³⁶ SHEILA ELLISON, *IF WOMEN RULED THE WORLD* 26 (2004) (emphasis omitted).

²³⁷ J.R.R. Tolkien celebrated this truth: “If more of us valued food and cheer and song above hoarded gold, it would be a merrier world.” J.R.R. TOLKIEN, *THE HOBBIT* 290 (1937).

²³⁸ See *supra* Part II.B.2.

²³⁹ See Brian Elbel et al., *Calorie Labeling and Food Choices: A First Look at the Effects on Low-Income People in New York City*, 28 *HEALTH AFFAIRS* w1110, w1115–16 (2009)

packaging, but are increasingly entering fast food and service environments and other education campaigns.²⁴⁰

These mandates encounter a few natural limits. One boundary is that the disclosures are often only made at the point of sale, rather than a context where consumption is most likely to occur, such as in the home. Only thirty-five percent of average daily energy intake traces to food purchased in restaurants.²⁴¹ Another boundary presents through cognitive overexposure, because consumers might become desensitized to disclosures.²⁴² Moreover, mandating caloric disclosures in fast food restaurants may cause people to shift their patronage to contexts where there will not be an interference with the instant enjoyment of their consumption.²⁴³

This is not to say that the effect of disclosures will necessarily prove harmful, but if disclosures (and weak-form debiasing) become a symbolic substitute for all regulatory action, they may crowd out public support or backing for other measures. As I will discuss below in the exceptional case of Mississippi,²⁴⁴ these initiatives can draw fire not just from those who think that they are insufficient, like the hard-paternalist critics of “Let’s Move!,” but also from those who think they go too far.

Here, in further describing weak-form debiasing, I focus on the actual experiences with implementing calorie-count disclosures in public food service settings. Again, though these mandates compel producers to disclose, consumers remain free to choose, and if they absorb and process the additional information, in theory, they become more equipped to make accurate decisions about the transaction and consumption.

In 2008, New York City led the way on caloric disclosure²⁴⁵ by

(“[A]pproximately 88 percent [of individuals who noticed labeling] indicated that they purchased fewer calories in response to labeling.”).

²⁴⁰ See *id.* (discussing the increasing popularity of menu labeling).

²⁴¹ Lorien E. Urban et al., *Accuracy of Stated Energy Contents of Restaurant Foods*, 306 JAMA 287, 291 (2011). This Article critiques the accuracy of restaurant disclosures, which should be calibrated as carefully as possible if consumer faith in the system is to be preserved. *Id.* at 287.

²⁴² Ben-Shahar & Schneider, *supra* note 63, at 687–88.

²⁴³ See Christian Turner, *The Burden of Knowledge*, 43 GA. L. REV. 297, 346–47 (2009) (noting how knowledge can affect conduct). One prominent behavioralist, George Loewenstein, points out that caloric disclosures could potentially be used as a proxy for value by some, which would have the opposite desired consumption effect. George Loewenstein, Editorial, *Confronting Reality: Pitfalls of Calorie Posting*, 93 AM. J. CLINICAL NUTRITION 679, 680 (2011) (“When comparing a \$3 Big Mac at 540 calories with a similarly priced chicken sandwich with 360 calories, the financially strapped consumer (who is also often the overweight consumer) may well conclude that the Big Mac is a better deal in terms of calories per dollar.”).

²⁴⁴ See *infra* text accompanying notes 260–65.

²⁴⁵ See Elbel et al., *supra* note 239, at w1111 (“New York City became the first U.S. jurisdiction to implement this legislation, on 19 July 2008.”). National regulation will soon follow, but state and local governments can play a large role in supplementing the federal requirements, should they choose. See Sara N. Bleich & Lainie Rutkow, *Improving Obesity Prevention at the Local Level—Emerging*

commencing enforcement of a rule that required chain restaurants to conspicuously display the caloric content of food and beverage offerings.²⁴⁶ The 2010 Patient Protection and Affordable Care Act (“ACA”)²⁴⁷ mandated similar requirements at the federal level, but as of late 2013, the FDA had not yet implemented this provision of the law.²⁴⁸

Early evidence regarding the efficacy of caloric disclosure appears rickety. A major research foray into the New York City calorie disclosure mandate’s effect on the low-income population indicated that the information provision did not affect calories purchased.²⁴⁹ Although nearly twenty-eight percent of the surveyed population that noticed the calorie labeling indicated that it factored into purchasing decisions, the net impact was apparently negligible.²⁵⁰ Another study also saw uneven results in consumption patterns after the regulation.²⁵¹ Further contributing to an array of questions about disclosure efficacy, another survey revealed that supplying recommended caloric intake benchmarks along with the caloric disclosures had no behavioral impact.²⁵² The additional disclosure did not “moderate the impact of calorie labels on food purchases [and] appeared to promote a slight *increase* in calorie intake.”²⁵³

However, some data emerging from mandatory caloric disclosures support the notion that such programs may prove mildly effective in some zones.²⁵⁴ A study of consumer behavior in Starbucks after disclosure revealed that the caloric content of the average transaction declined by six percent after the regulatory change, with no measurable impact on

Opportunities, 368 NEW ENG. J. MED. 1761, 1762–63 (2013) (“Because it is estimated that the ACA provisions will affect less than half of U.S. restaurants—and restaurants with fewer than 20 locations will not necessarily volunteer to comply—state and local menu-labeling regulations remain important.”).

²⁴⁶ N.Y.C., N.Y., HEALTH CODE tit. 24, § 81.50(a)–(c) (2013).

²⁴⁷ Patient Protection and Affordable Care Act, Pub. L. 111-148, § 4205, 124 Stat. 119, 573–76 (2010) (codified as amended at 21 U.S.C. § 343(q)(5) (2012)).

²⁴⁸ For an overview of the FDA’s potential promulgation, see *Overview of FDA Proposed Labeling Requirements for Restaurants, Similar Retail Food Establishments and Vending Machines*, FOOD & DRUG ADMIN., <http://www.fda.gov/Food/IngredientsPackagingLabeling/LabelingNutrition/ucm248732.htm> (last updated Apr. 24, 2013).

²⁴⁹ Elbel et al., *supra* note 239, at w1115–16.

²⁵⁰ *Id.* at w1114–15.

²⁵¹ See Tamara Dumanovsky et al., *Changes in Energy Content of Lunchtime Purchases from Fast Food Restaurants after Introduction of Calorie Labelling: Cross Sectional Customer Surveys*, 343 BRIT. MED. J. 4464, 4464 (2011) (“Although no overall decline in calories purchased was observed for the full sample, several major chains saw significant reductions. After regulation, one in six lunchtime customers used the calorie information provided, and these customers made lower calorie choices.”).

²⁵² Julie S. Downs et al., *Supplementing Menu Labeling With Calorie Recommendations to Test for Facilitation Effects*, 103 AM. J. PUB. HEALTH 1604, 1606 (2013).

²⁵³ *Id.* at 1604 (emphasis added).

²⁵⁴ See Bryan Bollinger et al., *Calorie Posting in Chain Restaurants*, 3 AM. ECON. J.: ECON. POL’Y 91, 99–105 (2011) (indicating that posting calorie information may decrease consumers’ intake).

Starbucks' profitability.²⁵⁵ In fact, it even appeared that the calorie counts may have driven revenue away from Dunkin' Donuts and toward Starbucks in areas where they competed closely.²⁵⁶

Weak-form debiasing efforts are still being made on the caloric disclosure front. Even though efficacy of these efforts may be in doubt, only five years of data exists with respect to New York City's mandate. Perhaps pressing forward with provisions of consumer information may, at the very least, convey important expressive value. No sweeping argument has been made that disclosure is unambiguously harmful, though the FDA estimates that compliance costs of the ACA disclosure regulation will be substantial.²⁵⁷

Disclosure may also prove to be a less intrusive means of regulatory recourse when harder paternalistic endeavors fail. In the wake of the Big Gulp ban's legal and political fallout, the New York City Board of Health planned to spend \$1.4 million on advertising to "urg[e] people to reduce consumption of these drinks given the risk of obesity-related illnesses."²⁵⁸ Though it may be unclear whether this fallback will be more of a weak-form or strong-form narrative method of debiasing, it is clear that the City is retreating to the less controversial strategy of providing information.

The political reaction to the federal mandates of disclosure may prove difficult to assess, as the regulation may be viewed through the lens of general support for or hostility toward the ACA. It is possible that people will disaggregate the federal mandatory calorie disclosure and evaluate that piece of the ACA on its own terms, especially once it rolls out to jurisdictions without local calorie disclosure. There is, however, at least one notable local example of strong resistance to weak-form debiasing.

In Mississippi, on the heels of a New York trial court's decision to strike down the Big Gulp ban,²⁵⁹ the legislature passed a law banning localities from requiring food service businesses to disclose calorie counts.²⁶⁰ Mississippi also holds the ignominious distinction of having the

²⁵⁵ *Id.* at 112–14.

²⁵⁶ *Id.* at 113–14.

²⁵⁷ CTR. FOR FOOD SAFETY & APPLIED NUTRITION, FOOD & DRUG ADMIN., DOCKET NO. FDA-2011-F-0172, FOOD LABELING: NUTRITION LABELING OF STANDARD MENU ITEMS IN RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS NOTICE OF PROPOSED RULEMAKING 9–12 (2011).

²⁵⁸ Matthew Mientka, *Cola Wars Refreshed: New York City Launches Attack Against Sugary Beverages Via TV and Bus Ads*, MED. DAILY (June 4, 2013), <http://www.medicaldaily.com/articles/16171/20130604/nyc-health-department-advertising-campaign-sugary-beverages-sweetened-drinks-obesity-diabetes.htm#Yc0aGVHCOwU3pVGe.99>.

²⁵⁹ *N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene*, No. 653584/2012, 2013 WL 1343607, at *20 (N.Y. Sup. Ct. Mar. 11, 2013), *aff'd*, 23 N.Y.3d 681 (2014).

²⁶⁰ S.B. 2687, 2013 Leg., Reg. Sess. (Miss. 2013); *see also* Liz Neporent, *Mississippi Governor Signs "Anti-Bloomberg" Bill*, ABC NEWS (Mar. 19, 2013), <http://abcnews.go.com/Health/mississippi-governor-signs-anti-bloomberg-bill/story?id=18731896> (describing the legislation).

second highest adult obesity rate²⁶¹ and lowest life expectancy²⁶² of any state in the country. Yet, even with public health concerns at the forefront, Mississippi, in a rare display of bipartisanship, passed a law to dampen the enactment of the mildest of paternalistic mandates—the requirement to disclose raw information.²⁶³

Mississippi Governor Phil Bryant, after signing the bill into law, proclaimed: “It is simply not the role of government to micro-regulate citizens’ dietary decisions The responsibility for one’s personal health depends on individual choices about a proper diet and appropriate exercise [I]t is a personal priority of mine to educate Mississippians on the importance of making good health decisions.”²⁶⁴ One might puzzle about exactly how this law would help the governor meet this priority. Indeed, passage of the Mississippi law surfaced the notion that business interests solidly supported and promoted the legislation²⁶⁵ and that any public reaction to paternalism may have only played a partial role.

With the exception of Mississippi, the positive reaction to the soft paternalism of mandatory calorie disclosure has not been overwhelmed by any noticeable popular backlash,²⁶⁶ even in the aftermath of Bloomberg’s unpopular Big Gulp effort. If public attitudes toward paternalistic efforts are positive, it could indicate an appetite for more interventions on that particular regulatory plane. Even if the effort does not carry a significant direct impact, the indirect cultural signals could be beneficial.

The political feasibility of disclosure may indeed tempt policymakers. But many are still skeptical about whether this easier form of regulation, which preserves political autonomy, will prove effective.²⁶⁷ It is not

²⁶¹ See *Adult Obesity Facts*, CDC, <http://www.cdc.gov/obesity/data/adult.html> (last updated Aug. 13, 2013) (estimating Mississippi’s obesity rate as 34.6%; only Louisiana rates higher at 34.7%).

²⁶² See Rong Wei et al., *U.S. Decennial Life Tables for 1999–2001: State Life Tables*, NAT’L VITAL STAT. REP., Sept. 14, 2012, at 1, 4 tbl.A (estimating Mississippi’s overall life expectancy as 73.88 years, while the national average is 76.83 years).

²⁶³ Even one prominent medical community opponent of the Big Gulp ban balked at the Mississippi approach: “[T]his bill goes too far If we refuse to engage in any attempts at all, we will fail to learn what works and what doesn’t It’s an effort to shut down all attempts.” Aaron Carroll, *JAMA Forum: Tackling Obesity and Learning What Works*, NEWS@JAMA (Mar. 20, 2013), <http://newsatjama.jama.com/2013/03/20/jama-forum-tackling-obesity-and-learning-what-works/>.

²⁶⁴ Emily Wagster Pettus, *Phil Bryant, Mississippi Gov., Signs Law Banning Restrictions on Food Portions*, HUFFINGTON POST (Mar. 19, 2013), http://www.huffingtonpost.com/2013/03/19/phil-bryant-mississippi_n_2908804.html.

²⁶⁵ The president of the Mississippi Poultry Association put it simply: “Don’t mess with the buffet.” *Id.*

²⁶⁶ The Mississippi law has been characterized as a “backlash” to Bloomberg. Jeffrey Hess, *Soda Wars Backlash: Mississippi Passes “Anti-Bloomberg” Bill*, NPR (Mar. 12, 2013, 3:58 AM), <http://www.npr.org/blogs/thesalt/2013/03/12/174048623/mississippi-passes-anti-bloomberg-bill>.

²⁶⁷ As noted, Sarah Conly argues that such measures are too weak to have any effect on public behavior and that hard paternalism is the most effective policy option. See *supra* text accompanying note 14. Behavioral science researchers George Loewenstein and Peter O’Donoghue observed: “[T]he [behavioral-economics] field has its limits. . . . Indeed, it seems in some cases that behavioral

necessarily a question of whether hard paternalism is more *justifiable* in scenarios where regulators know that they can prevent harm. The question in this instance is how far weak-form debiasing can advance public interests in the obesity realm, and in public health at large.

Whether one heeds the following exhortations of George Loewenstein or not, they are worth considering not just for evaluating obesity interventions, but also for assessing all seemingly clever interventions:

“Never let the truth get in the way of a good story” provides an apt description of the rush to calorie labeling at fast-food establishments Calorie labeling, in effect, puts the onus of weight reduction on consumers, but consumers have not grown fat because they have stopped paying attention to what they eat; they have grown fat because processed food has become cheaper (both in terms of money and time), whereas fresh food has become more expensive. The most serious risk associated with calorie labeling, therefore, is not its effect on consumers themselves, which is likely to be minimal; the real danger is that it will substitute for, or delay, more substantive policies that get at the root cause of the problem.²⁶⁸

When experimenting with weak-form debiasing and other behavioral tools, policymakers should move beyond pure intuition and measure the effectiveness of the results. There are some who may confuse an effort with a solution. In every intervention involving debiasing, research will be required to ensure that the desired consequences are realized and to monitor unintended outcomes as well.

b. Strong-Form Debiasing

Regulatory efforts to improve decision making by stringing data together into truthful narratives of harm appear infrequently. Vast, narrative driven communication campaigns about obesity, whether publicly or philanthropically funded, have not been broadcast widely to the public—and certainly not in the volume of anti-smoking campaign efforts.²⁶⁹

However, powerful and truthful narratives about harms to health, particularly as they relate to weight gain from overconsuming certain foods, have been told. Over the past decade or so, the private sector

economics is being used as a political expedient, allowing policymakers to avoid painful but more effective solutions rooted in traditional economics. . . . Behavioral economics should complement, not substitute for, more substantive economic interventions.” George Loewenstein & Peter Ubel, *Economics Behaving Badly*, N.Y. TIMES, July 15, 2010, at A31.

²⁶⁸ Loewenstein, *supra* note 243, at 679.

²⁶⁹ For examples of particularly vivid anti-smoking campaign efforts, see *supra* notes 78–81.

produced at least one movie and one notable book franchise that provided truthful narratives of harm about obesity. The 2004 film *Super Size Me* told a compelling, salient narrative about the harms of fast food through the truthful tale of a thirty-day journey of consuming nothing but McDonald's food offerings.²⁷⁰ This movie followed on the heels of a successful book, *Fast Food Nation*, which described the evolution of the fast food industry, both in terms of marketing and production.²⁷¹ *Fast Food Nation* has even been compared to Upton Sinclair's *The Jungle*.²⁷² The market for private storytelling has limits, but public regulators also have the opportunity and means to string together compelling truthful stories out of data for the purpose of improving choices.

One study found that showing Morgan Spurlock's movie, *Super Size Me*, to young adults had an impact on their attitudes toward fast food.²⁷³ Specifically, the study's authors found, "[T]he experimental group advanced to a significantly higher stage [for reducing fast food intake] at the posttest than the control group. This significant difference was maintained at the follow-up test."²⁷⁴ The study concluded that this particular film alone "may substantially affect individual client outcomes, and may ultimately lessen the impact of the obesity epidemic"²⁷⁵ and suggested that "[f]ood and nutrition professionals practicing in the field of weight management could benefit patients by incorporating this film into behavioral counseling sessions or utilizing it as a consciousness-raising and emotional arousal adjunct to counseling."²⁷⁶

Compelling and entertaining stories like the one of Morgan Spurlock literally putting his body on the line for science might be put to more regular use. Such narratives could be assembled more frequently. Captive audiences who have not yet attained more general autonomy, like adolescents and young adults, could benefit especially. But so would broader audiences, given the commercial appeal of some of these endeavors. Storytelling is powerful, but underused. Stories could be narrowed and targeted toward the audiences that are most at risk. For example, if poorer women have a disproportionate problem with obesity,²⁷⁷ a narrative could be tailored and delivered to them through appropriate

²⁷⁰ SUPER SIZE ME, *supra* note 82.

²⁷¹ ERIC SCHLOSSER, FAST FOOD NATION: THE DARK SIDE OF THE ALL-AMERICAN MEAL (2001). The book was also turned into a feature film. FAST FOOD NATION (Fox Searchlight 2006). In theory, a documentary like *Super Size Me* preserves the purity of truthfulness more than an artistic depiction.

²⁷² CECILIA TICH, EXPOSÉS AND EXCESS: MUCKRAKING IN AMERICA, 1900/2000, at 2 (2004).

²⁷³ Ellen Cottone & Carol Byrd-Bredbenner, *Knowledge and Psychosocial Effects of the Film Super Size Me on Young Adults*, 107 J. AM. DIETETIC ASS'N 1197, 1201 (2007).

²⁷⁴ *Id.* at 1200.

²⁷⁵ *Id.* at 1202.

²⁷⁶ *Id.*

²⁷⁷ See *supra* text accompanying note 160.

communication channels.

The point of telling a narrative about fast food consumption is to link the causes and effects of obesity and show how choices can have consequences over time. Ideally, this will lead people to overcome present bias. The behavioral science about narratives and present bias has been developing, not as much in public health, but more so in the field of personal finance and the emerging crisis from collective underfunding of personal retirement.²⁷⁸ In that realm, researchers sought to identify ways to neutralize the present bias and get people “to think about their future selves more concretely and vividly.”²⁷⁹ Decision theorist Dale Griffin summarized recent research, noting that the “quick answer [to present bias problems] is that we need to imagine our future self just as concretely and vividly, and take the time to imagine in detail the problems that our future self will encounter. In other words, we need to force ourselves to plan for that far off future in detail.”²⁸⁰

One particular experimental effort to improve consumer decision making warrants brief description, if only to suggest that there still remains untapped potential to create narratives for influencing consumption, physical activity, and other health issues, especially with expanded accessibility to certain technologies. A recent cross-disciplinary study revealed that “people can be encouraged to make more future-oriented choices by having them interact with age-progressed renderings of their own likenesses.”²⁸¹ The authors understatedly deemed this approach “a new kind of intervention.”²⁸² Though the results should be treated as preliminary because of the strikingly novel technique, it appears that experimental “exposure to visual representations of one’s future self leads to lower discounting of future rewards.”²⁸³ The study showed that these results arose not because subjects were “thinking about aging per se,” but “simply from direct exposure to renderings of the future self.”²⁸⁴

These findings may have emerged from a novel experimental setting in a different zone of personal decision making, but one wonders what might emerge from exposing visual representations of self to people, cross-temporally, reflecting different decisions about caloric intake and

²⁷⁸ See Kelly Greene & Vipal Monga, *Workers Saving Too Little to Retire*, WALL. ST. J., Mar. 19, 2013, at A1 (noting that more people report having less money saved for retirement and less confidence in their ability to retire comfortably than in previous years).

²⁷⁹ Dale Griffin, *Planning for the Future: On the Behavioral Economics of Living Longer*, SLATE, http://www.slate.com/articles/health_and_science/prudential/2013/08/_planning_for_the_future_is_sca ry_but_why_is_that.html?wpisrc=slate_embeddedtap3 (last visited July 15, 2014).

²⁸⁰ *Id.*

²⁸¹ Hal E. Hirschfield et al., *Increasing Saving Behavior Through Age-Progressed Renderings of the Future Self*, 48 J. MARKETING RES. S23, S33 (2011).

²⁸² *Id.*

²⁸³ *Id.* In this study, it is in the form of higher theoretical contributions to savings. *Id.* at S32.

²⁸⁴ *Id.* at S33.

expenditure. Perhaps regulators should pursue more experimentation along this direction to see if personalized visual narratives of harm can lead people to make better decisions about discounting on matters of personal health.

If a narrative device works, whether it takes the form of a series of documentaries or the next innovative technology, obstacles still emerge. Even with personal finance, it may prove difficult to compel people to go through a de-biasing—or some might pejoratively say brainwashing—exercise. A sustained campaign, particularly on film, could be viewed as propaganda. Though placing narratives of harm in the public sphere might prove simple if dropped into powerful public service advertisements, like the Yul Brynner smoking ad,²⁸⁵ more complicated narratives involving longer stories or the personal construction of narratives through sit-down exercises become logistically difficult. Schoolchildren can certainly be compelled to do these exercises as a form of hard paternalism, but would it be too intrusive (or even lawful) to require public-assistance recipients to sit through such exercises? Would the outrage from the autonomic deprivation be greater than any outrage from the Big Gulp ban? These questions warrant further thought.

Without doubt, these delivery mechanisms for new and different types of narratives have yet to be exploited. It is difficult to assess their potential power in the absence of a real effort, but it may behoove regulators to invest more in uncovering the raw cognitive science and in finding avenues to deploy these intervention vehicles. Note that this strong-form debiasing should not dramatically diminish autonomy and should still reflect a low level of intervention and paternalism. Telling stories also follows an old tradition dating back to the morality tales embedded in Aesop's fables—but, in this instance, where one tells the stories could prove to be the most serious challenge. Also, regulators would need to exercise restraint, or else they run the risk of appearing to propagandize, which could raise public hackles about paternalism.

If markets and voluntarism fail to influence behavior, and if soft paternalism fails to influence choices, regulators can also pursue harder forms of paternalism.²⁸⁶ Insulation strategies, which permit more limited autonomy and make consumption safer, can be deployed. The true autonomy-depriving bans and mandates associated with hardest manifestation of paternalism require more political capital, unless the regulators shield the public from experiencing the autonomy deprivation.

²⁸⁵ See *supra* text accompanying note 80.

²⁸⁶ Of course, regulators need not pursue strategies in this order. In fact, Sarah Conly's work might suggest the opposite. See CONLY, *supra* note 11, at 5 (recommending hard paternalism over soft paternalism). I order the interventions in this way because putting them on a spectrum helps to contextualize them.

c. Insulation

Insulation strategies can appear in various forms. Product use can be made safer, or harmful choices can be made more costly. In the obesity context, I discuss two traditional insulation strategies for the purpose of showing how difficult they can be to implement with the intended effect. I focus first on the attempted Big Gulp ban in New York City, and then I turn to a brief review of the efficacy of consumption taxes.

I follow this with a brief discussion of consumption subsidies. Subsidies are a regulatory intervention often designed to *encourage* the consumption or use of selected goods or services that are deemed socially desirable.²⁸⁷ Consumption taxes can be engineered with the opposite intent, to *discourage* socially undesirable consumption or usage.

Though the lens of pure microeconomics, these strategies mirror each other, but taxation tends to carry a more paternalistic flavor because it presents a barrier to choice, thereby reducing autonomy. Subsidies, though they mirror taxation, appear to promote more choice and encourage certain choices, likely surfacing fewer autonomy objections. Subsidies may not feel like insulation, but I discuss them in this section to demonstrate how two closely aligned approaches may appear different to the public.

i. Conditional Mandates: The Big Gulp Ban

The failed New York City Big Gulp ban provides the most current example of an insulation strategy in regulatory efforts to address obesity.²⁸⁸ Mayor Bloomberg, in the quote that opens this Article, maintained that the portion cap did not really stop potential consumption. He effectively characterized the Big Gulp ban as a debiasing effort, since manipulating available container sizes would put a speed bump in consumption. Again, as Bloomberg directly put it:

The nice thing about the soda thing is it's really just a *suggestion*. So, if you want to buy 32 ounces, you just have to carry it back to your seat in two cups. *And maybe that would convince you to only take one, but if you want two you can do it. I think government's job . . . is to give you advice, not to force you [to] do things.*²⁸⁹

Bloomberg perhaps attempted to do two things with this particular effort. By raising transaction costs and perhaps providing pause for

²⁸⁷ Sometimes subsidies are designed to keep producers afloat—agriculture and automobile manufacturing serve as examples.

²⁸⁸ I discussed this regulatory effort extensively in a prior article, from which I draw heavily within this Subsection. Friedman, *supra* note 44, at 101–04.

²⁸⁹ Campbell, *supra* note 1 (emphasis added).

consumer's remorse,²⁹⁰ Bloomberg hoped to slow down or diminish the amount of sugary drink consumption. That is, not to eliminate sugary drink consumption, but to insulate consumers from the effects of over-imbibing. The facts, however, did not support the notion that this regulation would have any concrete effect, and Judge Melvin Tingling struck down the portion-cap regulation partially on grounds that the regulation was arbitrary and capricious, exacting a burden without a reasonable basis.²⁹¹

The Harvard School of Public Health offers facts supporting the premise that soda consumption has indisputably increased in the United States.²⁹² The standard serving size for soda shifted from twelve ounces to twenty ounces between the 1960s and 1990s.²⁹³ Nonetheless, targeting sugary drinks alone would only have a limited impact, which one might not expect given the political efforts that Bloomberg invested in the Big Gulp ban.

The percentage of aggregate caloric intake that is attributable to sugary drinks expanded at a robust rate from the 1970s to 2001, from about 4% to about 9%.²⁹⁴ The latter number, however, demands further attention.²⁹⁵ As noted previously, during this same era, total average caloric intake increased by nearly 25%, with much of the increase accounted for by the heavier consumption of refined grains.²⁹⁶ The Center for Science in the Public Interest complicates the picture, presenting data showing that the consumption of carbonated sugary drinks, omitting diet drinks, has already declined by 24% since 1998 on a per capita basis,²⁹⁷ leaving speculation about how much further decline could be realized.

A recent CDC survey found that half of the population consumes a sugary drink daily.²⁹⁸ But it also found that only 5% of the population

²⁹⁰ Because refills of drinks can be free, I do not use the phrase "buyer's remorse."

²⁹¹ *N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene*, No. 653584/2012, 2013 WL 1343607, at *19–20 (N.Y. Sup. Ct. Mar. 11, 2013), *aff'd*, 23 N.Y.3d 681 (2014).

²⁹² HARVARD SCH. OF PUB. HEALTH, FACT SHEET: SUGARY DRINK SUPERSIZING AND THE OBESITY EPIDEMIC 1 (2012), available at <http://cdn1.sph.harvard.edu/wp-content/uploads/sites/30/2012/10/sugary-drinks-and-obesity-fact-sheet-june-2012-the-nutrition-source.pdf>.

²⁹³ *Id.*

²⁹⁴ *Id.* at 1.

²⁹⁵ Of course, not all calories are equal. Some may accompany more nutrition than others. See *What Are Empty Calories?*, U.S. DEP'T AGRIC., <http://www.choosemyplate.gov/weight-management-calories/calories/empty-calories.html> (last visited July 15, 2014) ("Solid fats and added sugars add calories to . . . food[,] but few or no nutrients.").

²⁹⁶ See *supra* text accompanying note 142.

²⁹⁷ Michael J. Jacobson, *Good News!*, NUTRITION ACTION HEALTHLETTER, <https://www.cspinet.org/nah/memo/JUN2012.html> (last visited July 15, 2014).

²⁹⁸ CYNTHIA L. OGDEN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 71, CONSUMPTION OF SUGAR DRINKS IN THE UNITED STATES 2005–2008, at 2 (2011).

consumes more than 567 calories in sugary drinks daily—equating to roughly four cans of soda.²⁹⁹ Sixteen ounces of Coca Cola contain approximately 187 calories,³⁰⁰ which means that any effective marginal discouragement would only remove a small fraction of calories from the daily diet of consumers who fall into the heavy-drinker category.

This Big Gulp ban may have been bounded by its potential impact on the aggregate diet, but the other obstacles that the initiative encountered are worth noting. The New York City Board of Health could only regulate portion sizes within its jurisdiction, which is limited to restaurants, delis, food carts, movie theaters, stadiums, and arenas.³⁰¹ Therefore, a consumer who wanted to have a larger drink could still patronize a supermarket, a convenience store, a vending machine, or a newsstand—all of which are unregulated by the Board of Health.³⁰² Thus, had the ban been enacted, large servings of sugary drinks still would have been readily accessible to the public.

Again, this attempted regulation did not prohibit the consumption of sugary drinks—it merely limited container size. Nothing except a minor additional expense or inconvenience would have prevented a consumer from drinking as much sugar as she wanted. Within the realm of consumption, regulating the purchase of sugary drinks in units above sixteen ounces could have an impact, but only a narrow impact.

This high-profile effort to insulate, stymied by the courts, would likely have had minimal impact on sugary drink consumption, sugar consumption, and obesity—if one accepts the notion that sugary drinks are a smaller part of the problem that proves stubborn to regulate. Perhaps the expressive value of the regulation would have influenced people to be more health conscious. But it turned out that the public overwhelmingly opposed this autonomy deprivation,³⁰³ even though the excessive consumption habit in question was only engaged in by a small part of the public.³⁰⁴

I have argued elsewhere that Bloomberg may merely have wanted the battle over soda to lead to a public dialogue about its consumption.³⁰⁵ But note that this public dialogue only emerged because the public had a low

²⁹⁹ *Id.*

³⁰⁰ Elisabeth Dahl, *Calories from 16 Ounces of Coke*, LIVESTRONG.COM (Aug. 16, 2013), <http://www.livestrong.com/article/295932-calories-from-16-ounces-of-coke/>.

³⁰¹ Michael M. Grynbaum, *Mayor Planning a Ban on Big Sizes of Sugary Drinks*, N.Y. TIMES, May 31, 2012, at A1.

³⁰² *Id.*

³⁰³ *E.g.*, Grynbaum & Connelly, *supra* note 5.

³⁰⁴ *See supra* text accompanying note 299.

³⁰⁵ *See* Friedman, *supra* note 44, at 78 (“[Michael Bloomberg] has repeatedly deployed paternalistic regulatory strategies in narrow spheres to spark a colorful and controversial public dialogue.”).

tolerance for paternalism—even though the paternalism was mostly directed at others and targeted at a narrow category and manner of consumption. If Bloomberg did indeed receive his desired public dialogue about soda, he needs to hope that the residual legacy will be the public inculcation of a truthful narrative of harm about overconsumption—because the insulation function evaporated.

ii. Consumption Taxes

Taxes can insulate by making certain transactions more expensive, leading consumers to recalculate present-bias influenced decisions.³⁰⁶ The concept of levying taxes on sugar or obesogenic products³⁰⁷ has been promoted recently in the popular sphere,³⁰⁸ but, as Katherine Pratt observes, empirical evidence that such taxes will achieve their desired effects on public health can be difficult to find.³⁰⁹ She notes that “public health advocates often make empirical assumptions, which are consistent with their common sense but may turn out to be erroneous, about the consequences of their proposals.”³¹⁰ For example, the taxation of sweetened beverages might reduce consumption, but could lead consumers to substitute other, untaxed obesogenic food and beverages in their place.³¹¹

Some studies conclude that no evidence supports the notion that soda taxes affect obesity,³¹² while one even predicts that these taxes could *increase* obesity.³¹³ I offer an excerpt from the conclusion of the latter study, conducted by a trio of economists, to offer a window into one view

³⁰⁶ See Rachele Holmes Perkins, *Salience and Sin: Designing Taxes in the New Sin Era*, 2014 BYU L. REV. 143, 157–58 (discussing policymakers’ commonly proffered justifications for sin taxes).

³⁰⁷ For a developed proposal from public health scientists, see generally Brownell et al., *supra* note 90.

³⁰⁸ See, e.g., Patrick McGreevy, *Oil and Soda Taxes Advance in California Legislature*, L.A. TIMES (May 1, 2013), <http://articles.latimes.com/2013/may/01/local/la-me-pc-tax-votes-20130501> (discussing a California bill that would institute a “tax on sweetened beverages, including sodas, in hopes of reducing obesity among young people”).

³⁰⁹ Pratt, *supra* note 71, at 113.

³¹⁰ *Id.* at 111–12.

³¹¹ *Id.* at 112; see also Eric A. Finkelstein et al., *Impact of Targeted Beverage Taxes on Higher- and Lower-Income Households*, 170 ARCHIVES INTERNAL MED. 2028, 2033 (2010) (suggesting that taxation just leads individuals to substitute one high-calorie food for another).

³¹² E.g., Finkelstein et al., *Pros and Cons of Proposed Interventions to Promote Healthy Eating*, 27 AM. J. PREVENTIVE MED. 163, 169 (2003).

³¹³ Gideon Yaniv et al., *Junk-Food Home Cooking, Physical Activity and Obesity: The Effect of the Fat Tax and the Thin Subsidy*, 93 J. PUB. ECON. 823 (2009). Some findings, however, have predicted some promise for potential weight loss from these taxes. See, e.g., TRAVIS A. SMITH ET AL., U.S. DEP’T OF AGRIC., TAXING CALORIC SWEETENED BEVERAGES: POTENTIAL EFFECTS ON BEVERAGE CONSUMPTION, CALORIE INTAKE, AND OBESITY, at iii–iv (2010) (explaining study results showing that “[t]he weight loss induced by the tax could reduce the . . . prevalence of obesity from 33.4 to 30.4 percent”). The general point here is that there may be more for empiricists to uncover on this front, just as there is more to uncover about the effectiveness of disclosure.

of the complexity of using taxation as an insulation strategy:

[S]ome adverse possible consequences . . . might have been overlooked by [fat tax] advocates [W]hile a fat tax will unambiguously reduce the obesity level of a non-weight conscious individual, it will not necessarily do so for a weight-conscious individual. In particular, if the individual is physically active, a fat tax will unambiguously *increase* obesity if a certain relationship between the parameters of the model holds. The reason for this is that weight is gained when calorie intake exceeds calorie-use through physical activity. A fat tax, when reducing junk-food consumption, encourages the preparation of healthy meals which necessitates time for cooking and health-ingredient shopping, at the expense of physical activity. Consequently, obesity might rise in spite of the fall in junk-food consumption, exacerbating the problem the fat tax proposal intended to eliminate.³¹⁴

This ambiguous dynamic, where unintended consequences emerge from intervention into decision making, echoes the surprising outcomes in calorie disclosure efforts.³¹⁵ Thus, deploying this particular taxation strategy, an insulation strategy on the harder paternalistic edge of the spectrum, might not address the obesity problem.

* * *

Insulation tools can be difficult to identify and deploy. As with other interventions in decision making, consequences of actions can be unproductive or even counterproductive. Further, the political cry from autonomic deprivation can present obstacles and make the public weary—although, a good fight always draws a crowd. If that crowd can be influenced by a cultural debate about obesity, it may make even a failed intervention somewhat productive.

iii. Subsidies

Paul Diller and Samantha Graff offer a number of examples of localities exercising their authority to issue mandates that in effect constitute hidden paternalism because the paternalism is difficult for the public to detect.³¹⁶ Though these initiatives have been made on a smaller

³¹⁴ Yaniv et al., *supra* note 313, at 829.

³¹⁵ See *supra* note 243 and accompanying text.

³¹⁶ See Paul A. Diller & Samantha Graff, *Regulating Food Retail for Obesity Prevention: How Far Can Cities Go?*, 39 J.L. MED. & ETHICS 89, 89–90 (2011) (describing local efforts using police

scale, should they prove effective, they exemplify the types of efforts that may not set off the autonomy-deprivation warning alarm. The interventions identified take the form of seemingly benign subsidies that promote healthy food options by directly expanding the set of choices for consumers.³¹⁷ Many of the local initiatives Diller and Graff identify appear laudable, pragmatic, and aligned with providing healthy choices, but they may be incremental and indirect compared to more paternalistic endeavors. For example, facilitating zoning for farmers markets and community gardens³¹⁸ may only marginally help a group of people already inclined to make healthy choices.

These strategies extend beyond mere provision of information, pushing them further along the spectrum toward hard paternalism, but consumers are not compelled to make the healthier choices. Though the fit may not be perfect, insulation can include the creation of entirely new choices because more options equate to more protection from making the less desirable choice. Arguably, a case could be made for putting this paternalism in the softer category because subsidies expand choices with a positive intervention, in contrast to the seemingly punitive intervention associated with taxation of choices.

To the extent that these subsidy initiatives are tested to ensure that they actually work—and give the taxpayers return on their tax dollar—they can be encouraged to proliferate both in variety and geographic scope. If subsidizing new supermarkets in low-income zones proves to have no impact, perhaps local tax monies should be deployed elsewhere within those neighborhoods. If it proves to have a measurably net positive impact, more such initiative should be pursued.

d. Hard Paternalism, Bans, and Mandates

Hard paternalism can be crisply illustrated through the lens of parental paternalism. Parents often substitute their own judgments and choices for those of their children. Ideally, children can be trained to make the right choices without constant interference and monitoring from parents—because parents will find monitoring costs too expensive to sustain, especially as children grow and confront more choices outside parental presence. Teenagers desire autonomy, while parents prefer the comfort of the certainty that their children will only make safe choices. Squelched desire for autonomy can lead to complaints about fairness and, potentially,

power). The other interventions Diller and Graff offer tend to fall into zones of control described in the section on hard paternalism and bans. They also cite Chicago's soda taxes. *Id.* at 92 tbl.2.

³¹⁷ *Id.* at 91 tbl.1. Examples include issuance of permits to "green cart" vendors to operate in communities that need more access to fresh produce, grocery store produce-carrying requirements, and tax incentives for developers who open new full-service groceries. *Id.*

³¹⁸ *Id.*

rebellion.³¹⁹

The reaction to the Big Gulp ban indicates that the public attitude toward paternalism in contexts involving private consumption decisions may be trending negative. That said, hard paternalism can still be deployed effectively under the right circumstances—for example, in zones where a degree of government control already exists, and in contexts where the paternalism proves intangible or difficult for people to see or notice. Hard paternalism in the form of mandates, though, may prove especially challenging to implement because mandates do not just remove a choice—they force action.

i. Zones of Control

Regulators have control over consumption when they literally dictate the menu choices. These zones of control seem to emerge in areas where income is lower and the population depends more heavily on public school meals and the Supplemental Nutrition Assistance Program (“SNAP”).³²⁰ Though paternalism directed at the low-income population has proved controversial at times,³²¹ regulators have already staked out the territory for general intervention. Importantly, this particular zone of control might encompass a significant sector of the population facing obesity. As noted, obesity and other public health problems may be more pronounced in low-income communities, and yet, in the childhood population, obesity may already be in decline.³²²

Childhood obesity, besides constituting an instant problem, carries negative consequences forward because the social, emotional, and physical impact of childhood obesity can extend well into adulthood.³²³ After some

³¹⁹ The legislative “anti-Bloomberg” flurry in Mississippi, see *supra* text accompanying notes 259–62, typifies an adolescent rebellion of sorts. See Kim Severson, “*Anti-Bloomberg Bill*” in *Mississippi Bars Local Restrictions on Food and Drink*, N.Y. TIMES, Mar. 14, 2013, at A16 (describing the legislation as “the latest and most sweeping expression of a nationwide battle”).

³²⁰ SNAP administers what people commonly refer to as food stamps. *Supplemental Nutrition Assistance Program (SNAP)*, U.S. DEP’T AGRIC., <http://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap> (last visited July 15, 2014).

³²¹ For example, the debate about House Budget Chairman Representative Paul Ryan’s 2014 antipoverty plan has focused on paternalism. See Jamelle Bouie, *The Poor Don’t Need a Life Coach*, SLATE (July 25, 2014), http://www.slate.com/articles/news_and_politics/politics/2014/07/paul_ryan_s_anti_poverty_plan_the_house_budget_chairman_s_paternalistic.html (offering a paternalism-based critique); Reihan Salam, *Paul Ryan’s Anti-Poverty Plan Is Paternalistic* (July 24, 2014), http://www.slate.com/articles/news_and_politics/politics/2014/07/paul_ryan_s_anti_poverty_plan_is_paternalistic_it_s_also_a_thoughtful_compassionate.html (offering a paternalism-based defense).

³²² See *supra* text accompanying notes 160, 177.

³²³ Mary K. Serdula et al., *Do Obese Children Become Obese Adults? A Review of the Literature*, 22 PREVENTIVE MED. 167, 175 (1993); see William H. Dietz, *Health Consequences of Obesity in Youth: Childhood Predictors of Adult Disease*, 101 PEDIATRICS 518, 523 (1998) (“Several of the obesity-associated morbidities in children and adolescents require urgent and aggressive therapy.

battles with the food industry, the USDA promulgated rules to make school-provided meals³²⁴ and other food sold during the school day³²⁵ more nutritious and less obesogenic. Though these actions may indeed help children during the hours they spend inside a school environment and influence tastes beyond, it appears that even in advance of these actions, childhood obesity rates declined for reasons not completely understood.³²⁶ It is difficult to imagine much harm resulting from slanting the choice environment for public school students toward better nutrition, but it may prove difficult to measure results because other forces may be at work.

Though the historically-rooted zone of paternalistic control over children in public schools is largely accepted, public school nutrition reform needs to gain traction and acceptance among the vast numbers of students and parents touched by the policies—and even modest efforts at reform may be failing.³²⁷ Even if the school zone is controlled to maximum effect, influence over children's consumption³²⁸ requires confinement for longer periods than a school day.³²⁹ In fact, weight-loss camps and even one weight-loss boarding school³³⁰ emerged to address this problem, but the costs per child of such programs prove impractical for offering such an experience to the broad population.³³¹ Some results seem

Furthermore, as severely overweight children and adolescents become more common, the risks of weight-related complications in adulthood will increase.”)

³²⁴ 7 C.F.R. §§ 210, 220 (2013).

³²⁵ Nutrition Standards for All Foods Sold in School as Required by the Healthy, Hunger-Free Kids Act of 2010, 78 Fed. Reg. 39,068 (proposed final rule as of June 28, 2013) (to be codified at 7 C.F.R. pt. 210, 220).

³²⁶ May et al., *supra* note 177, at 630.

³²⁷ For example, one Kentucky school official said that the students think the healthier food “tastes like vomit.” *Michelle Obama-Touted Federal Healthy Lunch Program Leaves Bad Taste in Some School Districts' Mouths*, CBS NEWS (Aug. 30, 2013), http://www.cbsnews.com/8301-505263_162-57600385/michelle-obama-touted-federal-healthy-lunch-program-leaves-bad-taste-in-some-school-districts-mouths/. Children may be rejecting the food under the new program. See Kevin Fallon, *Nutritious School Lunches, or the New Hunger Games?*, THE DAILY BEAST (Sept. 28, 2012), <http://www.thedailybeast.com/articles/2012/09/28/nutritious-school-lunches-or-the-new-hunger-games.html> (recounting anecdotal evidence that students, and even teachers, are complaining that the calorie content in school meals is too low).

³²⁸ Parents exercise strong influence over children's habits and one study affirms that seemingly obvious statement. See Katharine A. Hinkle et al., *Parents May Hold the Keys to Success in Immersion Treatment of Adolescent Obesity*, 33 CHILD & FAM. BEHAV. THERAPY 273, 273 (2011) (“[These] results suggest that helping parents adopt lifestyle changes for themselves, even within the context of relatively short immersion treatments, may maximize outcomes for obese teenagers.”).

³²⁹ If students spend eight hours per day and 180 days per year in school, assuming perfect attendance, and have sixteen waking hours per day, roughly seventy-five percent of their waking hours are spent outside of school boundaries. One can adjust the assumptions, but the result will always put the student outside the school for a significant time period.

³³⁰ Sandra G. Boodman, “*Fat School*,” WASH. POST, May 20, 2008, at HE01.

³³¹ See Karen Grigsby Bates, *School Transforms Teens' Lives, One Pound at a Time*, NPR (Dec. 12, 2011), <http://www.npr.org/2011/12/12/142661672/school-transforms-teens-lives-one-pound-at-a->

to indicate that environmental immersion can help children make gains by controlling and retraining children's calorie intake and outtake.³³² This example of deploying hard paternalism strategies in an existing zone of control therefore demonstrates how difficult it may be to effect change in habits—even in a space where *in loco parentis* describes the relationship between educational institutions and children.³³³

Another zone of control example to consider briefly would be the use of restrictions on SNAP to control or paternalistically influence the purchases of those who rely on the program. Some view regulatory control over SNAP as an opportunity to directly influence the diets of nearly forty-seven-million lower-income Americans—half of them children.³³⁴

An interim USDA report on the results of a pilot program that encouraged SNAP participants to purchase more nutritious foods revealed that the experiment changed purchasing patterns for the healthier.³³⁵ Under the pilot, participants received a thirty-cent incentive for every dollar that they directed toward certain fruits and vegetables—and that thirty-cent incentive could be spent on all other SNAP purchases.³³⁶ This 2011 to 2012 project, limited to Hampden County, Massachusetts, revealed that participants consumed twenty-five percent more of the targeted fruits and vegetables than the control group.³³⁷ The subsidy did not generate participant resentment toward SNAP, even with the lurking element of paternalism.³³⁸

Regardless of any measure of changes in consumption, political and moral clashes have hovered over the notion of controlling or restricting the habits of those who rely on SNAP.³³⁹ Logistically, SNAP recipients may

time (noting that one year at Wellspring Academy, a weight loss boarding school, cost \$62,500 in 2011).

³³² See, e.g., Daniel L. Patrick et al., *Weight Loss and Changes in Generic and Weight-Specific Quality of Life in Obese Adolescents*, 20 QUALITY OF LIFE RES. 961, 962 (2011) (measuring positive BMI effects from a four-week immersion program for adolescents).

³³³ See Susan Stuart, *In Loco Parentis in the Public Schools: Abused, Confused, and in Need of Change*, 78 U. CIN. L. REV. 969, 971 (2010) (describing the parent-institution relationship as a “voluntary delegation of parental authority,” but critiquing its modern form).

³³⁴ E.g., David S. Ludwig et al., *Opportunities to Reduce Childhood Hunger and Obesity Restructuring the Supplemental Nutrition Assistance Program (the Food Stamp Program)*, 308 JAMA 2567, 2567–68 (2012).

³³⁵ U.S. DEP'T OF AGRIC., HEALTHY INCENTIVES PILOT (HIP) INTERIM REPORT—SUMMARY 2 (2013).

³³⁶ *Id.* at 1.

³³⁷ *Id.*

³³⁸ Ninety-five percent of respondents wished to keep participating in the project. *Id.* at 2.

³³⁹ See, e.g., *Food Stamps: The Economics of Eating Well*, ROOM FOR DEBATE (Dec. 7, 2009, 7:37 PM), <http://roomfordebate.blogs.nytimes.com/2009/12/07/food-stamps-the-economics-of-eating-well/> (showcasing the opinions of six thought leaders about food stamps and healthy food); see also Conor Friedersdorf, *Should Food Stamps Exclude Unhealthy Purchases*, AM. SCENE (Dec. 8, 2009), <http://theamericanscene.com/2009/12/08/should-food-stamps-exclude-unhealthy-purchases/> (“[I]t is very easy for me to imagine why plenty of Americans are uncomfortable with the idea of government

strategically orient purchasing habits so they can continue to consume the diet they prefer, rather than the diet that the regulators prefer. For example, SNAP could be directed toward the purchase of a higher volume of nutritious foods, but the recipient can still use the resources freed by SNAP to buy obesogenic items. The government has the opportunity to be paternalistic in this zone, but serious normative questions remain about tying an autonomy sacrifice to a food benefit. Redesigning the SNAP subsidy to directly displace bad choices like soda would be more palatable to some, but would be much more likely to generate an outcry that is reminiscent of the Big Gulp ban.

Hard paternalism can be challenging, but possible, to implement politically in this major public health sphere. Next, I discuss opportunities for the deployment of hard paternalism where regulators can intervene somewhat more easily, i.e., when *their paternalistic presence is not felt*.

ii. Zones of Intangibility

Choices can be removed from the public menu without generating the feeling that autonomy has eroded. That is, some hard paternalistic initiatives can be implemented without triggering the perception of loss. If the regulators eliminate a truly poor choice, there should be an opportunity for a welfare gain. Regulators may find it difficult to identify these zones of intangible or hidden paternalism, but they can exist.

Outright bans of generally lawful substances for ingestion prove difficult, as the tobacco experience demonstrates.³⁴⁰ With food, and particularly with widely-used obesogenic ingredients, outright bans could prove especially challenging—unless the public does not object to or notice the removal of the ingredient. Regulators must find hard food restrictions that prove intangible or negligibly detectible to the end consumer. Arguably, the most successful example of an intangible intervention, a regulation that produced tangible health benefits, may be the banning of trans fats.

getting into the food police business even more than is already the case, and reacting against the paternalistic assumptions embedded in the idea that Congress best knows what poor people should eat.”); *Food Stamp Ban on Soda Purchases Is Flat-out Paternalism*, AM. COUNCIL ON SCI. & HEALTH (May 4, 2011), <http://acsh.org/2011/05/food-stamp-ban-on-soda-purchases-is-flat-out-paternalism/> (posing slippery slope argument about autonomy and government’s ability to discern “good foods” from “bad”).

³⁴⁰ With tobacco, partial restrictions have been applied aggressively to zones of control. See Anemona Hartocollis, *City Plan Sets 21 as Legal Age to Buy Tobacco*, N.Y. TIMES, Apr. 23, 2013, at A1 (describing restrictions in offices, restaurants, and parks—among others). These bans have not been total, but they have been significant in scope, particularly based on place and age. Smoking bans in certain places can be justified paternalistically by the desires of nonsmokers who are directly affected by the presence of smoke. In contrast, the consumption of a Big Gulp or a Big Mac produces few instant negative externalities. Initiatives based on age are ongoing. New York City health officials are actively proposing to raise the smoking age to 21. *Id.*

Trans fats entered U.S. diets in conjunction with the industrialization of food production in the twentieth century.³⁴¹ Trans fats act as a preservative, provide a boost to flavoring, and contribute to attractive food texture.³⁴² In 1911, Procter & Gamble rolled out Crisco to retail grocers, introducing trans fats to the masses.³⁴³ Food rationing during World War II accelerated the use of trans fats, when margarine served as a substitute for butter.³⁴⁴ Eventually, trans fats would find their way into common foods, most notably being used in the production of fast food.³⁴⁵ The presence of the substance in the food supply has apparently proven harmful to public health, as one group of researchers summarized:

[S]tudies and . . . trials indicate that [trans fat] consumption adversely affects multiple risk factors for chronic diseases, including numerous blood lipids and lipoproteins, systemic inflammation, endothelial dysfunction, and possibly insulin resistance, diabetes, and adiposity. Growing evidence for the latter effects is particularly concerning given the worldwide obesity pandemic and high contents of [trans fat] in many foods marketed toward children.³⁴⁶

Over the past decade, public health officials began to recognize the harms caused by trans fats and took action, first by mandating labeling,³⁴⁷ which is consistent with weak-form debiasing. This effort had some tangible impact. For example, in 2007, J.M. Smucker Co. responded to the labeling requirements by reinventing Crisco's ingredients entirely, altering a nearly century-old consumer brand.³⁴⁸ The company reduced the product's trans fat content to a point where the FDA would permit its label to declare *zero* trans fat content.³⁴⁹ Thus, labeling requirements became a starting point for change. Nonetheless, to reduce trans fat consumption, hard paternalism in the form of bans would be required and would find some success in local implementation, possibly due to the stealthy,

³⁴¹ *A History of Trans Fat*, AM. HEART ASS'N, http://www.heart.org/HEARTORG/GettingHealth/y/FatsAndOils/Fats101/A-History-of-Trans-Fat_UCM_301463_Article.jsp (last visited July 15, 2014).

³⁴² *Id.*

³⁴³ *Id.*

³⁴⁴ *Id.*

³⁴⁵ See U.S. FOOD & DRUG ADMIN., TALKING ABOUT TRANS FAT: WHAT YOU NEED TO KNOW 2 (2012) (listing various foods that commonly contain trans fats, including: baked goods, frozen pizza, fast food, margarines, coffee creamer, and ready-to-use frostings).

³⁴⁶ Shyam Mohan Teegala et al., *Consumption and Health Effects of Trans Fatty Acids: A Review*, 92 J. AOAC INT'L 1250, 1250 (2009).

³⁴⁷ See 21 C.F.R. §§ 101.1, 101.9(a), 101.9(e)(5) (2013) (mandating that food labeling indicate levels of trans fatty acids).

³⁴⁸ *Crisco Cuts the Trans Fat*, CNNMONEY.COM (Jan. 25, 2007), <http://money.cnn.com/2007/01/25/news/companies/crisco/>.

³⁴⁹ *Id.*

intangible, unperceivable impact of the regulation on consumer autonomy.

As Paul Diller describes, opposition to local food regulation often comes through the business community, but the business community's response to proposed regulations may not be "monolithic" or intuitive.³⁵⁰ Ultimately, with trans fats, it appears that producers and significant food retailers have voluntarily adjusted to move away from using the substance.³⁵¹ Part of the ease of implementing these bans and getting companies to move more broadly and voluntarily is that unlike the Big Gulp ban, the tangible impact on consumers would prove minimal. Here, the paternalism is hidden.

The localized trans fats ban movement is said to have roots in Tiburon, California, a local zone harboring eighteen restaurants that agreed to eliminate the use of trans fats through a purely voluntary effort.³⁵² Over the next few years, regulatory bans on trans fats of various forms were enacted in Montgomery County, Maryland,³⁵³ New York City,³⁵⁴ Philadelphia,³⁵⁵ Nassau County, New York,³⁵⁶ and California.³⁵⁷ Other jurisdictions have also followed suit to varying degrees.³⁵⁸ Perhaps in part due to a need for national standardization after the local initiatives,

³⁵⁰ Paul Diller, *Intrastate Preemption*, 87 B.U. L. REV. 1113, 1134–35 (2007). The national food chains feared product inconsistency in an industry where consumers expect consistency, as well as the potential for added operational complexity from maintaining different menus in different jurisdictions. *Id.* at 1135. Local restaurants, however, stood to be advantaged by a burden on big chain restaurants. *Id.* The National Restaurant Association chose a side and took a hard line against regulation that "banned the use of a product that was legal elsewhere." *Id.*

³⁵¹ See *supra* note 200.

³⁵² Jim Staats, *Tiburon's Trans-Fat Ban Started National Movement*, MARIN INDEP. J. (Feb. 3, 2007), http://www.marinij.com/fastsearchresults/ci_5155266.

³⁵³ Miranda S. Spivack, *Montgomery Bans Trans Fats in Restaurants, Markets*, WASH. POST, May 16, 2007, at A1.

³⁵⁴ N.Y.C., N.Y. HEALTH CODE tit. 24, § 81.08(a) (2013). For an illustrative summary, in the form of guidance to food licensees, see N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, THE REGULATION TO PHASE OUT ARTIFICIAL TRANS FAT IN NEW YORK CITY FOOD SERVICE ESTABLISHMENTS, HOW TO COMPLY: WHAT RESTAURANTS, CATERERS, MOBILE FOOD-VENDING UNITS AND OTHERS NEED TO KNOW, <http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-transfat-bro.pdf> (last visited July 15, 2014).

³⁵⁵ *Philadelphia Approves Ban on Trans Fats*, NBCNEWS.COM (Feb. 9, 2007), http://www.nbcnews.com/id/17066429/ns/health-diet_and_nutrition/t/philadelphia-approves-ban-trans-fats/#.Uhj3pJLFXUk.

³⁵⁶ Jordan Lite, *Nation Has Heart for Trans-Fat Ban*, N.Y. DAILY NEWS (Dec. 4, 2007), <http://www.nydailynews.com/news/nation-heart-trans-fat-ban-article-1.272772>.

³⁵⁷ California was the first state to ban restaurants from using trans fats. Jennifer Steinhauer, *California Bars Restaurant Use of Trans Fats*, N.Y. TIMES, July 26, 2008, at A1.

³⁵⁸ The regulatory trend still seems confined to the East Coast and West Coast, making the push toward voluntary reduction or elimination of trans fats more important for advocates seeking national change. See *State and Local Enacted Trans Fat Bans*, NAT'L REST. ASS'N (July 16, 2013), http://www.restaurant.org/Downloads/PDFs/advocacy/maps/map_transfat.pdf (illustrating, on a map, locales that have enacted bans on trans fat in restaurants). Trans fats restrictions of some manner are also in place in six Massachusetts cities, including Boston; New York's Westchester and Albany counties; Stamford, Connecticut; Baltimore, Maryland; and King County, Washington. *Id.*

industry voluntarism accelerated, in likely recognition of a trend moving toward bans rather than away from them.

New York City's ban on trans fats in restaurants has been found to have positive health effects on the city's population.³⁵⁹ One study suggested that, through regulation, "reductions in the trans fat content of restaurant purchases can be achieved without an offsetting increase in saturated fat."³⁶⁰ The study went on to state that the "regulatory strategy provided equal benefit to patrons of restaurants in high- and low-poverty neighborhoods."³⁶¹

Factors along two dimensions can potentially explain the relative success of the trans fat hard paternalism movement and the failure of the Big Gulp ban. The Big Gulp ban had a low potential impact, for reasons explained previously.³⁶² Trans fat bans have been proven to have a positive effect on public health.³⁶³ But the dominant factor might be the visible differences when it comes to autonomy. The Big Gulp initiative removed some autonomy, though as Bloomberg noted, not all autonomy.³⁶⁴ But the autonomy deprivation proved sufficient for the "Nanny Bloomberg" narrative to accelerate.³⁶⁵ The trans fats ban proved less tangible, possibly because consumers did not notice that it was missing. The National Restaurant Association loudly expressed concerns over switching costs,³⁶⁶ but consumers did not notice much difference in their food consumption experience. At least anecdotally, they did not *taste* a loss of autonomy.

For example, when taste tested, foods that were heavily dependent on trans fats before the ban were not noticeably different after the ban. The *New York Daily News* tested a quintessential Italian pastry, the cannoli,

³⁵⁹ Angell et al., *supra* note 4, at 81, 84–85.

³⁶⁰ *Id.* at 86.

³⁶¹ *Id.* at 85.

³⁶² See *supra* text accompanying notes 298–302.

³⁶³ See *supra* text accompanying note 346.

³⁶⁴ See Campbell, *supra* note 1 (quoting Michael Bloomberg as stating "The nice thing about the soda thing is it's really just a suggestion. So, if you want to buy 32 ounces, you have to carry it back to your seat in two cups. And maybe that would convince you to only take one, but if you want two you can do it.").

³⁶⁵ See Ron Dicker, "Nanny Bloomberg" Ad in *New York Times* Targets N.Y. Mayor's Anti-Soda Crusade, HUFFINGTON POST (June 4, 2012), http://www.huffingtonpost.com/2012/06/04/nanny-bloomberg-ad-in-new_n_1568037.html (showing the Center for Consumer Freedom's full-page advertisement in the *New York Times*, which featured a photoshopped image of Mayor Michael Bloomberg dressed in drag with a tagline reading "New Yorkers Need a Mayor, Not a Nanny").

³⁶⁶ See Emily Schmall, *Trans Fat War Threatens Restaurants*, FORBES (Dec. 21, 2006), http://www.forbes.com/2006/12/20/trans-fat-bans-biz-cz_es_1221fats.html ("Most of the resistance to switching from traditional trans fat is coming from the thousands of smaller, privately owned independent restaurants throughout the U.S., which complain the shift is simply too costly.").

with and without trans fats, and tasters could not discern a change.³⁶⁷ With some more scientific testing, a *Consumer Reports* test revealed little difference in the tasting experiences for French fries.³⁶⁸ The *Washington Post* asked two prominent pastry chefs to compare traditional Oreos with trans fat-free Oreos, and little difference was detected.³⁶⁹ Not everyone agrees, of course³⁷⁰—and tastes may vary across foods—but it is difficult to find recent taste-based campaigns to attack trans fats. Though public surveys are sparse, New York consumers in 2008 overwhelmingly supported the trans fats ban, implying that consumers were somewhat aware of it and did not bristle about autonomy.³⁷¹

Perhaps the key to regulatory success in the intangibility zone lies in a variant of the saying, “what you don’t know can’t hurt you.” In this instance, success lies in “what you don’t know might help you.” The challenge in deploying hard paternalism in the intangibility zone is finding hidden paternalism opportunities that can have a proven and widespread impact.

iii. Mandates

Mandated behavior might prove to be the most difficult form of hard paternalism to implement. Mandates do not deprive autonomy through mere choice elimination—they compel people to do certain things without an alternative. Generally, people are not forced to ingest substances unless they are institutionalized or are near death, and the purpose of such

³⁶⁷ See Kristen Brown & Owen Moritz, *Can't Find Fat Tooth. The News' Taste Test Shows N.Y.ers OK with Trans-ition*, N.Y. DAILY NEWS, July 2, 2008, at 17 (discussing the results of the newspaper's survey in Washington Square Park on the first day of the City's trans fat ban).

³⁶⁸ *French Fry Face-Off*, CONSUMER REP., <http://www.consumerreports.org/cro/magazine-archive/august-2009/food/french-fries/overview/french-fry-face-off-ov.htm> (last visited July 15, 2014) (discussing a taste test of Burger King, McDonald's, and Wendy's fries after switching to trans fat-free oil).

³⁶⁹ Judith Weinraub, *What's Missing from this Cookie?*, WASH. POST, Feb. 22, 2006, at F1.

³⁷⁰ Some vociferously expressed that there was a difference. The owner of a fish restaurant in Portland, Oregon, declared in 2006, “[a]fter I tasted the zero trans fat oil, I said take that nasty [stuff] out of my freaking fryers, because that stuff stays in the freaking fish’ ‘I’m taking bites of the fish cooked in it, and the [stuff]’s running down my face.’” Brittany Schaeffer, *No Fries for You!*, WILLAMETTE WK. (Oct. 25, 2006), http://www.wweek.com/portland/article-6206-no_fries_for_you_.html.

³⁷¹ The poll, showing that more than seven in ten favored a ban, was commissioned in 2008 by the Center for Science in the Public Interest. *New Yorkers Want Statewide Phase-out of Artificial Trans Fat*, CENTER FOR SCI. PUB. INT. (Apr. 24, 2008), <http://www.cspinet.org/new/200804241.html>; cf. Zogby International, *RE: Results from New York Survey*, CENTER FOR SCI. PUB. INT., <http://cspinet.org/new/pdf/nytranssurvey.pdf> (“[A] survey of eight hundred adults in New York State shows that a strong majority (73%) are concerned about the presence of artificial trans fat in restaurant food, and even more (84%) favor regulations that would require restaurants to disclose whether or not they use trans fats on menus and menu boards.”).

compulsion is not usually weight loss.³⁷²

The scientific community generally agrees that a sedentary lifestyle will lead to an array of health problems driven by and related to obesity. As previously noted, not all studies align, but there appears to be a consensus that moving people away from sedentary behaviors will reduce obesity and improve their health along a number of dimensions.³⁷³

The sedentary lifestyle may not be addressable through hard paternalism. Even Mayor Bloomberg conceded as much when, in the wake of having his Big Gulp ban struck down, he remarked, “Exercise is great for you, but how do you convince people to do it? And should you force them to do it? Probably not.”³⁷⁴ Bloomberg spoke to both the logistical challenge of convincing the public and the normative aspect of coercing people to exercise.

Softer, weaker forms of paternalism may prove to be the only hope for getting people to move more. One can only speculate whether changing default rules, incentivizing gym memberships, or changing office ergonomics would work—or whether, for example, finding ways to keep children, who are in a zone of influence, away from the television would prove effective.

The problem to concede here is that mandated behavior will likely prove impractical, even when directed against a serious contributor to a health problem. Paternalism simply proves ineffective. Some of the data appears to undermine whether soft paternalism can work here, too. People who tend toward sedentary lives *expressly* report that their health is poorer.³⁷⁵ One can speculate about whether these individuals know of the link or care about it, or whether heavier weight makes activity more difficult.³⁷⁶ *Gallup* reports a correlation between reported physical activity and income levels.³⁷⁷ Do those with higher incomes have more leisure for physical activity—or better access to superior exercise facilities? If socioeconomic dynamics drive the sedentary lifestyle problem, will any form of paternalism be able to get the lower-income segment of the population moving?

Physical activity may prove to be a key component in reducing

³⁷² See Mary K. Russell et al., *Standards for Specialized Nutrition Support: Adult Hospitalized Patients*, 17 NUTRITION CLINICAL PRAC. 384, 384 (2002) (describing the standards that are implemented in acute care institutions for hospitalized adult patients in need of specialized nutritional support).

³⁷³ See *supra* text accompanying notes 152–54.

³⁷⁴ Campbell, *supra* note 1.

³⁷⁵ See, e.g., Joseph Carroll, *Regular Exercise: Who’s Getting It?*, GALLUP (Dec. 6, 2005), <http://www.gallup.com/poll/20314/regular-exercise-whos-getting-it.aspx> (“Nearly 7 in 10 adults who say their health is only fair or poor are in the low (23%) or sedentary (46%) groupings.”).

³⁷⁶ See *id.* (noting that overweight people report exercising less).

³⁷⁷ *Id.* Note that the socioeconomic indicators around physical activity mirror that of obesity at large.

obesity. But apart from providing and mandating physical education for children or providing access to more parks and recreational activities, is there more that can be done to influence behavior? Would incremental education work? All of the paternalistic tools appear to be dulled in the face of this component of the problem.

In general, hard paternalism substitutes the choices of the regulator for that of the individual or mandates certain behaviors. Hard paternalism may prove difficult to implement in its purest forms because of the public's reaction to the complete deprivation of autonomy. There are spots, however, where hard paternalism could be deployed to address the obesity problem or broader public health issues. If the zone of the regulation already falls within the natural control of the regulator, the implementation might prove less objectionable. Hidden paternalism, where the regulation proves intangible to the public but improves public health, could also provide opportunities for high impact interventions. Nonetheless, these types of interventional opportunities may still raise the hackles of the public, and it may prove difficult to identify them on a grander scale.

The obesity problem did not emerge overnight, and it has myriad overlapping causes.³⁷⁸ Regulators must have a degree of humility in deploying paternalistic strategies. It is difficult to discern if any single initiative works or can work—but initiatives require resources. A paternalistic strategy, whether soft or hard, should be deployed with an understanding and balancing of the political costs, the financial costs, and the uncertain impacts.

This Article addresses paternalism in public health, with obesity leading as the primary illustration because of its centrality to public health—and its centrality to the recent public dialogue. To generalize about paternalism and public health, a discussion of obesity is required. In turn, a discussion of other spheres of public health is also required to see whether they reinforce the viewpoints about obesity and show general trends within public health.

I briefly look at three simpler, but also high-profile, public health issues to see if views about paternalism mirror and reinforce the dynamic observed in obesity. They are simpler because they address a single, discrete public health issue—and the paternalism involved typically focuses on one point on the spectrum.

C. Beyond Obesity: Other Public Health Issues

Major regulatory themes discussed in the obesity context reverberate with three other public health topics: marijuana, fluoride, and GMOs. For example, the trends in marijuana regulation and fluoridation seem to

³⁷⁸ See *supra* Part III.A.

coincide with some of the political resistance to harder paternalism that is also evident in the obesity sphere. People generally seem to balk when regulators restrict personal choice of what to ingest—or how to ingest it—unless the autonomy loss proves intangible. The debate over regulating GMOs is more nuanced, but the GMO controversy highlights the notion that not all paternalism emanates from regulators. To the contrary, regulators in public health can, in some circumstances, *expand* choice rather than restrict choice. And people applaud the addition of choice.

Though I concede again that anecdotes can be matched with countervailing anecdotes, I will use these three subjects as data points to demonstrate that paternalism has become a more difficult strategy to deploy and sustain in public health.

1. *Marijuana*

In November 2012, Washington State and Colorado passed measures legalizing marijuana use for non-medical, recreational purposes.³⁷⁹ Washington's initiative received 55.7% of the vote, and Colorado's received 54.8% of the vote.³⁸⁰ Though extrapolating from the election results may be a leap, some observers recognized these developments as part of a broader social trend toward freedom of choice and away from paternalism. For example, *The Economist* suggested that the local election results reflected the collective attitude of a "more tolerant country," which presumably would favor personal choice on issues like marijuana and marriage:

The right to marry whom you please may have been in Mr Obama's thoughts when he spoke of "the freedom which so many Americans have fought for" on victory night. The right to spark up a fat one probably was not. Yet stoners in Colorado and Washington will be able to do just that after those two states voted to legalise marijuana for recreational purposes, an electoral first not only for America but for the world.

³⁷⁹ An Act Relating to Marijuana, I.M. No. 502, 2013 Wash. Legis. Serv. ch. 3 (West); COLO. CONST. art. XVIII, § 16, *amended by* COLO. CONST. amend. LXIV. Oregon's 2012 marijuana initiative failed, but possibly for other reasons. See Matt Taylor, *Yes We Cannabis: The Legalization Movement Plots Its Next 4 Years*, THE ATLANTIC (Mar. 27, 2013), <http://www.theatlantic.com/politics/archive/2013/03/yes-we-cannabis-the-legalization-movement-plots-its-next-4-years/274356/> ("An Oregon effort would almost certainly have prevailed, too, if proponents there hadn't overreached with toxic legislative language that scared off donors and earned ridicule from local media").

³⁸⁰ *November 06, 2012 General Election Results, Initiative Measure No. 502 Concerns Marijuana*, WASH. SEC. STATE, <http://vote.wa.gov/results/20121106/Initiative-Measure-No-502-Concerns-marijuana.html> (last updated Nov. 27, 2012); *Amendment 64 – Legalize Marijuana Election Results*, DENVER POST, <http://www.data.denverpost.com/election/results/amendment/2012/64-legalize-marijuana/> (last updated Nov. 8, 2012).

....

The marijuana and marriage votes help confirm what was already clear from polls: that public opinion is relaxing on these (if not all) social issues.³⁸¹

The Controlled Substances Act (“CSA”) lists marijuana as a schedule one controlled substance.³⁸² Though federal laws and their associated enforcement present a potential block to state measures, August 2013 U.S. Department of Justice (DOJ) guidance to U.S. Attorneys indicates that federal enforcement of the CSA will be limited to certain scenarios.³⁸³ These scenarios for continued federal enforcement include sales of marijuana to minors, drugged driving, and linkage to larger criminal enterprises.³⁸⁴ Though some may quibble about the significance of the degree of federal retreat,³⁸⁵ the federal government has taken a step back to allow the states some room to deregulate marijuana use.³⁸⁶

In the wake of the federal government’s slight retreat, one analyst predicted that as many as ten states may soon follow through with legalization initiatives.³⁸⁷ Another analyst even broadly speculated that with the DOJ’s stance, marijuana legalization has the potential to find a foothold even in the South.³⁸⁸ In sum, the public attitude appears to be shifting against marijuana paternalism, and even though the DOJ has not declared that the states can act unfettered, the federal government seems to

³⁸¹ *Ballot Measures: A Liberal Drift*, ECONOMIST, Nov. 10, 2012, at 32, 32. Though linkages can be made in detail between paternalism and marriage choice, I put a more nuanced discussion aside because the nexus with public health is more tenuous, even if the political values are common.

³⁸² 21 U.S.C. § 812(c)(10) (2012).

³⁸³ Memorandum from James M. Cole, Deputy Att’y Gen., U.S. Dep’t of Justice, to all U.S. Attorneys (Aug. 29, 2013) [hereinafter Cole Memorandum], available at <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>.

³⁸⁴ *Id.*

³⁸⁵ Jacob Sullum, *Reactions to DOJ Marijuana Memo: Dismay, Exuberance, Skepticism*, FORBES (Aug. 29, 2013), <http://www.forbes.com/sites/jacobsullum/2013/08/29/reactions-to-doj-marijuana-memo-dismay-exuberance-skepticism/>.

³⁸⁶ See Cole Memorandum, *supra* note 383, at 2 (“Instead, the Department has left . . . localized activity to state and local authorities and . . . [will] enforce the CSA only when the use, possession, cultivation, or distribution of marijuana has threatened to cause . . . [specified] harms . . .”).

³⁸⁷ See Nick Wing, *These States Are Most Likely to Legalize Pot Next*, HUFFINGTON POST (Aug. 30, 2013), http://www.huffingtonpost.com/2013/08/30/marijuana-legalization-states_n_3838866.html (anticipating that Alaska, Arizona, California, Maine, Massachusetts, Montana, Nevada, Oregon, Rhode Island, and Vermont will mount legalization efforts).

³⁸⁸ See Patrik Jonsson, *As Feds Acquiesce on Marijuana, Might the South Legalize?*, CHRISTIAN SCI. MONITOR (Aug. 31, 2013), <http://www.csmonitor.com/USA/2013/0831/As-feds-acquiesce-on-marijuana-might-the-south-legalize-video> (“[O]ne sees small but potent signs of a legalization groundswell, in part fueled by the South’s unique contributions to marijuana culture and prohibition. In Texas and all over the South, there are a lot [of] Willie Nelson-style social and cultural ‘outlaw’ attitudes, all of which overlap with Ron Paul libertarianism.”).

be adapting to an emerging political reality and a rejection of hard paternalism.

Some aspects of marijuana deregulation indicate that the rejection of hard paternalism may be a key factor in and of itself. Marijuana usage rates have stabilized in the United States over the past decade,³⁸⁹ possibly reflecting the dynamics of tobacco use over the same period.³⁹⁰ Though some of the data on usage is murky,³⁹¹ recreational use of marijuana does not appear to be rising definitively. Marijuana use by teenagers also seems to have dropped dramatically since its peak in the late 1970s, even accounting for a slight rebound in the past few years.³⁹²

For the first time in the more than four-decade history of polling on marijuana issues, a Pew poll in 2013 showed that a majority of people in the United States supported legalization.³⁹³ The sharp contrast between the growing support for legalization, which outstrips the percentage of the population currently using marijuana,³⁹⁴ must reflect some degree of a rejection of paternalism. Put differently, the gap between approval and usage indicates that some portion of the population must be rejecting the paternalistic decision of regulators to remove a person's autonomy when it comes to choosing to use marijuana.

Paternalistic justifications still remain from a self-harm perspective when it comes to recreational use of marijuana.³⁹⁵ Yet, the public increasingly desires to eschew that paternalism in favor of more autonomy, even if there are harms that can be prevented from such a ban—and even if

³⁸⁹ U.N. OFFICE ON DRUGS & CRIME, WORLD DRUG REPORT 2010, at 194 (2010).

³⁹⁰ See *Trends in Current Cigarette Smoking Among High School Students and Adults, United States, 1965–2011*, CDC, http://www.cdc.gov/tobacco/data_statistics/tables/trends/cig_smoking/ (last updated Nov. 14, 2013) (“From 2001 to 2011, the decline in cigarette smoking stabilized, dropping from 22.8% to 19%.”).

³⁹¹ The surveying methods and metrics can vary. Pew's polling found a different trend, but the abrupt changes measured in the poll should be accounted for in weighing the quality of the numbers. See *Marijuana Use Increased over the Last Decade*, PEW RES. CENTER (Apr. 17, 2013), <http://www.pewresearch.org/daily-number/marijuana-use-increased-over-the-last-decade/> (finding an increase in marijuana use in the United States as opposed to a stabilization).

³⁹² *Percentage of U.S. Twelfth Grade Students Reporting Past Month Use of Cigarettes and Marijuana, 1975 to 2012*, NAT'L INST. ON DRUG ABUSE, <http://www.drugabuse.gov/longdesc/percentage-us-twelfth-grade-students-reporting-past-month-use-cigarettes-marijuana-1975-to-2012> (last visited July 15, 2014).

³⁹³ *Majority Now Supports Legalizing Marijuana*, PEW RES. CENTER FOR PEOPLE & PRESS (Apr. 4, 2013), <http://www.people-press.org/2013/04/04/majority-now-supports-legalizing-marijuana/>.

³⁹⁴ Compare *id.* (showing that, as of 2013, 52% of people in the United States think marijuana should be legalized), with U.N. OFFICE ON DRUGS & CRIME, *supra* note 389, at 194 (reporting that, as of 2008, approximately 12% of people in the United States reported using marijuana).

³⁹⁵ For a list of potential harms caused by marijuana use, see Lauren Cox, *Effects of Marijuana*, LIVESCIENCE (Nov. 5, 2012), <http://www.livescience.com/24558-marijuana-effects.html>. For the respiratory harms associated with *smoking* marijuana, as opposed to other means of ingesting it, see *Learn About Marijuana: Respiratory Effects of Marijuana*, U. WASH. ALCOHOL & DRUG ABUSE INST., <http://ada.uw.edu/marijuana/factsheets/respiratoryeffects.htm> (last visited July 15, 2014).

they will not necessarily be the actors *exercising* that autonomy. Similar dynamics to the Big Gulp ban abound here, because the public increasingly objects to the paternalism in spite of the fact that it would affect the daily lives of only a small portion of the population.³⁹⁶ The resistance to paternalism in the obesity regulation debate echoes in the marijuana debate. Fluoride presents a similar story, but instead of the hard paternalism being framed as a ban, paternalism in this context more closely resembles a mandate.

2. Fluoride

It is difficult to identify a more paternalistic intervention than altering the contents of the water supply with the objective of improving public health. Even though, with some effort and expense, people can opt out from drinking tap water³⁹⁷ or in some cases can source well water, if regulators add a substance to the water to promote public health, they deprive the public of autonomy. It is common knowledge that approximately 60% of the human body is water,³⁹⁸ so when regulators add a substance to water, they are not only mandating consumption—they are mandating consumption of something that comprises human essence. The fluoridation of water since World War II represents a remarkable acceptance of hard paternalism in public health. One might note that, in the past, fluoridation could be analogized to trans fats because it could have been in the zone of intangibility. The fluoride might not have noticeably changed the water consumption experience, preempting objections.³⁹⁹

The public health story of deploying water fluoridation to prevent bone and tooth decay (“caries”) began in earnest in 1945.⁴⁰⁰ Within eleven years of convincing public health authorities in Grand Rapids, Michigan, to fluoridate the water supply, the incidence of caries in schoolchildren there dropped 60%.⁴⁰¹ This remarkable experiment “amounted to a giant scientific breakthrough that promised to revolutionize dental care, making tooth decay for the first time in history a preventable disease for most people.”⁴⁰²

³⁹⁶ See *supra* text accompanying notes 311–13.

³⁹⁷ For example, by purchasing bottled water from a non-fluoridated source.

³⁹⁸ *The Water in You*, U.S.G.S. WATER SCI. SCH., <http://ga.water.usgs.gov/edu/propertyyou.html> (last updated Mar. 6, 2014).

³⁹⁹ See Gordon Dillow, *Bodily Fluids Fine with Fluoride*, ORANGE COUNTY REG., Sept. 23, 2007, at Cover_B (noting that one cannot see or taste the difference between regular water and fluoridated water).

⁴⁰⁰ *The Story of Fluoridation*, NAT'L INST. DENTAL & CRANIOFACIAL RES., <http://www.nidcr.nih.gov/oralhealth/topics/fluoride/thestoryoffluoridation.htm> (last updated Jan. 6, 2014).

⁴⁰¹ *Id.*

⁴⁰² *Id.*

Unsurprisingly, efforts to realize this discovery accelerated across the country. After World War II, only a negligible portion of the U.S. population received fluoride in its drinking water.⁴⁰³ By 1960, almost 23% of the public had fluoride on tap, and 50% would have it by the late 1970s.⁴⁰⁴ By 2006, 61.5% of the public was fluoridated⁴⁰⁵—and by a different measure, the “[p]ercentage of [the] population served by community water systems receiving fluoridated water” reached 69.2%.⁴⁰⁶ Another way of looking at the remarkable scale of this paternalistic effort is that the government found a way to regularly deliver a substance to 60% to 70% of the public without leaving another feasible choice.

In a few recent instances, communities have successfully rejected fluoridation efforts promoted by public health officials. Some expressed fears that the choice made by the regulators displaced a very personal choice that they would not favor. Another way to frame resistance to fluoride efforts would be to look at the incumbent regime as the one that preserves real autonomy. People can always choose to supplement their oral hygiene with extra dosages of fluoride through other means. If fluoride is imposed on the public, however, no autonomy remains for anyone to make his or her own judgments about the science.

The recent debate about fluoridation in Portland, Oregon, focused not just on science, but also on the paternalistic nature of the initiative. Portland is the only city among the thirty largest in the United States without a fluoridated water supply.⁴⁰⁷ Oregon has the fifth highest rate in the nation of caries among third-graders,⁴⁰⁸ and the Multnomah County water supply serves nearly 20% of Oregon residents.⁴⁰⁹ In May 2013, the voters in Multnomah County, a county mostly comprising Portland residents, rejected fluoridation by a 60% to 40% vote, despite the fact that pro-fluoridation groups out-fundraised anti-fluoridation groups 3 to 1.⁴¹⁰ Scientific⁴¹¹ and socioeconomic⁴¹² arguments were brought to bear, but

⁴⁰³ *Fluoridation Growth, by Population, United States 1940–2006*, CDC, http://www.cdc.gov/nohss/FSGrowth_text.htm#Data (last updated Oct. 30, 2008).

⁴⁰⁴ *Id.*

⁴⁰⁵ *Id.*

⁴⁰⁶ *Id.*

⁴⁰⁷ Ryan Kost, *Portland Fluoride: For the Fourth Time Since 1956, Portland Voters Reject Fluoridation*, THE OREGONIAN (May 21, 2013), http://www.oregonlive.com/portland/index.ssf/2013/05/portland_fluoride_for_the_four.html.

⁴⁰⁸ *Caries Experience*, CDC, <http://apps.nccd.cdc.gov/nohss/IndicatorV.asp?Indicator=2> (last updated Jan. 4, 2011).

⁴⁰⁹ See *Multnomah County, Oregon*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/41/41051.html> (last updated Jan. 6, 2014) (exhibiting that out of Oregon’s 3,899,801 residents, Multnomah County is home to 759,256 of them, which is approximately 19.5% of the state population).

⁴¹⁰ Kost, *supra* note 407.

⁴¹¹ For example, the CDC endorses five studies supporting fluoridation that the National Academy of Sciences and the National Research Service have conducted regularly since 1951. *National*

somewhat perplexingly,⁴¹³ to no avail.⁴¹⁴

Anti-paternalism did surface in these arguments. One advocacy group, Oregon Citizens for Safe Drinking Water, offered this broad declaration as a final word:

The United Nations has declared that “access to safe [uncontaminated] water is a fundamental human need and, therefore, a basic human right.” . . . [M]any individuals hold that Americans have *the right of informed consent* regarding medication. The addition of a contaminated, non-FDA approved medicament to a public water supply violates both of these most basic human rights.⁴¹⁵

This statement is all about personal sovereignty and personal autonomy, elevating the ability to choose fluoride-free water to that of a human right. Another group, Clean Water Portland, not only framed the issue as one of informed consent, but directly posed the question about

Academy of Sciences on Fluoride in Drinking Water, CDC, <http://www.cdc.gov/fluoridation/safety/nas.htm> (last updated July 10, 2013).

⁴¹² One premise, for example, is that poorer children will not have access to the dental care and supplements that wealthier children will have—and that fluoride would serve to help these children the most. See C.M. Jones & H. Worthington, *Water Fluoridation, Poverty and Tooth Decay in 12-Year-Old Children*, 28 J. DENTISTRY 389, 390–92 (2000) (“The result from this study reaffirms the effectiveness of water fluoridation [was] the primary preventive measure capable of bridging the ‘dental health gap’ by differentially improving the dental health of those who are socio-economically deprived.”).

⁴¹³ See, e.g., Henry Grabar, *With Portland’s Latest Rejection of Fluoride, Science Loses Out to History’s Weirdest Alliance of Paranoiacs*, ATLANTIC CITIES (May 22, 2013), <http://www.theatlanticcities.com/technology/2013/05/portlands-latest-rejection-fluoride-science-loses-out-historys-weirdest-alliance-paranoiacs/5674/> (“Oregon has one of the highest rates of tooth decay in the nation, and yet, the state’s biggest city [Portland] will remain an outlier, thanks to the remarkable efforts of the anti-fluoride lobby, a non-partisan alliance of paranoiacs.”); Kyle Hill, *Why Portland Is Wrong About Water Fluoridation*, SCI. AM. (May 22, 2013), <http://blogs.scientificamerican.com/but-not-simpler/2013/05/22/why-portland-is-wrong-about-water-fluoridation/> (arguing that voters in Portland, by electing to reject fluoride, have ignored the scientific evidence of the benefits of fluoridation, and suggesting that the reason for rejection is mostly political).

⁴¹⁴ Political action groups fighting fluoridation raised a number of claims and arguments that seemed to take hold. See, e.g., *Fluoridation Overview*, OR. CITIZENS FOR SAFE DRINKING WATER, <http://www.safewateroregon.org/fluoridation.html#P> (last visited July 15, 2014) (listing a number of anti-fluoridation studies and reports that promote voting against fluoridation). Local business interests also played a role in the debate, particularly those businesses concerned with how fluoride might affect water quality. See, e.g., Lucy Burningham, *Why Brewers and Coffee Roasters in Portland, OR, Don’t Want Fluoridated Water*, BON APPÉTIT (Apr. 17, 2013), <http://www.bonappetit.com/trends/article/why-brewers-and-coffee-roasters-in-portland-or-don-t-want-fluoridated-water> (“Voters may reject a ballot measure that would add fluoride to the municipal water supply, an additive that 72 percent of Americans encounter when they turn on their taps Why would some Portlanders prefer to remain in the 28 percent? Because water is the primary ingredient in beer and coffee—for which Portland is justly renowned—and both brewers and baristas are concerned that fluoridation could irrevocably alter their products.”).

⁴¹⁵ *Fluoridation Overview*, *supra* note 414 (emphasis added).

whether one group's choice should be imposed on others:

Fluoridation violates the fundamental principle that every individual has the right to consent to or reject a given medical treatment. Fluoride meets every legal and medical definition of a drug. It is intended to “treat,” “mitigate” or “cure” the disease known as dental caries.

....

*Even if you consent to drinking fluoride in your own water, is it really ethical to require other Portlanders and their children to ingest fluoride?*⁴¹⁶

Long-established scientific arguments did not prevail with the public in Portland. Though resistance to hard paternalism can prove difficult to isolate, it does lie at the center of resistance to any mandatory public health policies that affect personal choice.⁴¹⁷

Of course, with respect to fluoride, Portland may not represent a trend. Its voters have been rejecting fluoride measures since 1956.⁴¹⁸ Moreover, Portland—a city where Subaru drivers⁴¹⁹ proudly display bumper stickers that blare, “Keep Portland Weird”⁴²⁰—is concededly an outlier on many cultural and political matters. But something, if not “weird,” then otherwise noteworthy, did happen in Portland: voters in the higher-income neighborhoods on the west side of the city were distinctly more supportive of the fluoridation measure than those in neighborhoods with a comparatively lower median income.⁴²¹ Could voters in the lower-income neighborhoods have been more sensitive to the paternalism that the elites embraced?

⁴¹⁶ *12 Reasons to Vote No*, CLEAN WATER PORTLAND, http://www.cleanwaterportland.org/12_reasons_to_vote_no (last visited Feb. 27, 2014) (emphasis added).

⁴¹⁷ “Choice” has also emerged as a keyword in the anti-mandatory vaccine sphere. See, e.g., *State Vaccine Choice Advocacy*, NAT’L VACCINE INFO. CENTER, <http://www.nvic.org/resource-center/statevaccine.aspx> (last visited Feb. 27, 2014) (utilizing “Your Choice” in the headline of the website); N.H. COAL. FOR VACCINATION CHOICE, <http://www.vacchoicenh.org/> (last visited Feb. 27, 2014) (describing how this coalition is seeking to provide New Hampshire citizens with a “pro-choice vaccination initiative”); VT. COAL. FOR VACCINE CHOICE, <http://www.vaxchoicevt.com/> (last visited Feb. 27, 2014) (displaying “choice” in numerous spots on the main page).

⁴¹⁸ See Kost, *supra* note 407 (detailing reasons behind Portland’s history of rejecting fluoridation).

⁴¹⁹ Subarus are so disproportionately omnipresent in Portland, it is a literal joke. See Sonari Ginton, *Beyond Portlandia: Subaru Drives for America’s Heartland*, NAT’L PUB. RADIO (Jan. 28, 2013), <http://www.npr.org/2013/01/28/169972505/beyond-portlandia-subaru-drives-for-americas-heartland> (describing a *Portlandia* comedy skit that involved two Subaru drivers).

⁴²⁰ Joseph B. Frazier, *Portland, Ore., Celebrates Its Quirky Side*, USA TODAY (May 12, 2008), http://usatoday30.usatoday.com/travel/destinations/2008-05-12-quirky-portland_N.htm.

⁴²¹ See *2013 Portland Fluoride Measure Results, by Precinct*, THE OREGONIAN, <http://gov.oregonlive.com/election/2013/fluoride/> (last visited July 15, 2014) (displaying an interactive map that shows the percentage of voters who voted against fluoridation).

Portland did not stand alone in facing the fluoridation question. In recent years, fluoridation has been reexamined but retained in Phoenix, Arizona, voted down in Wichita, Kansas, and *stopped* and then reinitiated after some political changes in Pinellas County, Florida.⁴²² One anti-fluoride group has compiled an up-to-date list of communities around the world that have rejected fluoride.⁴²³ Fluoridation may no longer be gaining ground, and it may in fact be losing ground to the anti-fluoride movement.⁴²⁴ As Dr. Bill Maas, the former director of the CDC's oral health division, observed in 2011, "This isn't something that we're slowly expanding across the country and getting one more community (fluoridated) across the United States. This is people actually saying we should take this out of the water . . . It's amazing to us how it's resonating with people."⁴²⁵

The unique coalition standing together in Portland did not break along traditional political lines, reminiscent of strange bedfellows that united against the Big Gulp ban.⁴²⁶ On the pro-fluoride side in Portland, the following lined up: "OPAL Environmental Justice Oregon, the Urban League of Portland, the Northwest Health Foundation, the campaign funds

⁴²² Joel Millman, *Tooth and Nail: Fluoride Fight Cracks Portland's Left—Liberal City Chews over Water Vote*, WALL ST. J., May 20, 2013, at A1.

⁴²³ *Communities Which Have Rejected Fluoride Since 1990*, FLUORIDE ACTION NETWORK, <http://www.fluoridealert.org/content/communities/> (last visited July 15, 2014). Communities listed since 2012 span many sizes and regions of the United States: Woodland, Washington; Parkland, Washington; Portland, Oregon; Kenton, Tennessee; Southwest Harbor, Maine; Au Gres, Michigan; Tyrone, Pennsylvania; Olivehurst, California; Plumas Lake, California; Smithville, Missouri; St. Croix Falls, Wisconsin; Balsam Lake, Wisconsin; Pine Island, Florida; Milton, Florida; Bradford, Vermont; Romulus, New York; Pulaski, New York; Wichita, Kansas; Harvard, Nebraska; Crescent City, California; Lake View, Iowa; Cassadaga, New York; Santa Fe, New Mexico; Argos, Indiana; Palisades, Colorado; Pevely, Missouri; Lakeville, Indiana; North Liberty, Indiana; Walkerton, Indiana; Albuquerque New Mexico; West Manheim, Pennsylvania; Bourbon, Indiana; Bolivar, Missouri; and Myerstown, Pennsylvania. *Id.*

⁴²⁴ One analysis suggests that over the much longer arc of time since the 1950s, the fluoridation forces appear to be winning. See Sarah Kliff, *A Brief History of America's Fluoride Wars*, WASH. POST (May 21, 2013, 9:11 AM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/21/a-brief-history-of-americas-fluoride-wars/> ("[T]he Centers For Disease Control . . . described widespread fluoridation as one of the . . . most important public health accomplishments of the 20th century."). Nonetheless, after a peak of fluoridation success in the 1990s, the fluoridation movement has experienced setbacks. See *id.* ("In the 2000 election cycle, there were 23 fluoridation ballot initiatives and those were bad news for fluoride advocates, who lost 14 of those fights.")

⁴²⁵ Donna Jones & Marissa Fessenden, *Watsonville Fluoride Battle 10 Years After Approval: Backers Fight Back as Support Wanes*, SANTA CRUZ SENTINEL (Cal.) (Nov. 26, 2011), http://www.santacruzsentinel.com/ci_19416925 (internal quotation marks omitted).

⁴²⁶ As one Portland-area political science academic, Phil Keisling, summarized, "[The fluoride debate] really does reshuffle the deck in some fascinating ways that confound traditional lines . . . It has created some pretty interesting bedfellows on both sides of the ideological divide." Helen Jung, *Portland Fluoride Vote: Contentious Issue Sparks a Civil War Among Progressives*, THE OREGONIAN (May 3, 2013), http://www.oregonlive.com/Portland/index.ssf/2013/05/Portland_fluoride_vote_content.html (internal quotation marks omitted).

from several Democratic state legislators and [regionally-influential] conservative talk-radio host Lars Larson.⁴²⁷ Opposing fluoride were “the Oregon Sierra Club’s Columbia Group, the Portland NAACP, the libertarian Cascade Policy Institute, the Kansas Taxpayers Network and an Indiana-based alternative health company that advocates, among other things, using tanning beds for vitamin D dosage.”⁴²⁸ One tension remained evident, according to a local Portland political scientist⁴²⁹—the tension between “public health and individual rights.”⁴³⁰

The new political line, this tension between public health and individual rights focuses on a rejection of hard paternalism in public health. Different values may come into play, even in zones where science appears to be settled. For obesity and other public health issues, similarities echo about the inherent value of personal autonomy and the role of intervention. Here, as with obesity and marijuana use, the momentum seems to be veering against hard paternalism.

3. *GMO Foods*

The movement away from paternalism toward autonomy in matters of personal choice and public health can manifest in different forms. As noted previously, Gerald Dworkin identifies a broad paternalism that expands the range of paternal institutions beyond the government.⁴³¹ In some matters of public health, the public desires choice and autonomy—but the natural state of the commercial environment may not provide real choices, requiring the public to influence the government to intervene to create that desired autonomy.

The movement with respect to GMO foods reflects such a dynamic. GMOs are “produced from plants, animals, and microbes that have had their genetic code modified by the selective introduction of specific DNA segments through the use of gene splicing.”⁴³² Among the agricultural benefits of deploying genetic science in food production are “pest protection” and “herbicid[al] resistance,” which enable better food yields—and the ability to add nutrients.⁴³³ Critiques of the genetic modification approach appear to mostly center around unknown ecological risks that, if realized, might be catastrophically irreversible—and around

⁴²⁷ *Id.*

⁴²⁸ *Id.*

⁴²⁹ This tension proved unsettling to those who were more comfortable knowing who their natural political bedfellows were, as Portland’s daily newspaper, *The Oregonian*, colorfully chronicled. *Id.*

⁴³⁰ *Id.*

⁴³¹ See Dworkin, *supra* note 23 (stating that other paternalistic institutions that fall within this broad understanding can include hospitals or even individuals).

⁴³² CARL K. WINTER & LISA K. GALLEGOS, UNIV. OF CAL., SAFETY OF GENETICALLY ENGINEERED FOOD 1 (2006).

⁴³³ *Id.*

potential allergic reactions to the food products.⁴³⁴

The larger-scale entry of GMOs into the food supply inspired a grassroots consumer movement to lobby regulators to require food manufacturers to label GMO content, so that consumers would be able to consciously choose whether to exclude GMO foods from their diets.⁴³⁵ This movement has already influenced the enactment of a state law in Connecticut⁴³⁶ and a legislation in Maine.⁴³⁷ Additionally, at the federal level,⁴³⁸ Senator Barbara Boxer and Congressman Peter DeFazio introduced a bill in April 2013, The Genetically Engineered Food Right-to-Know Act,⁴³⁹ which would require the FDA to enforce GMO content labeling.⁴⁴⁰

Public opinion and perception appear to clash loudly with the scientific consensus about the safety of GMO foods.⁴⁴¹ According to the National Institutes of Health (“NIH”), “Genetically engineered foods are generally regarded as safe. . . . There are no reports of illness or injury due to genetically engineered foods.”⁴⁴² In spite of this established view by the

⁴³⁴ See *Genetically Engineered Foods*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/002432.htm> (last updated July 5, 2012) (listing potential risks of GMOs).

⁴³⁵ See Dan D’Ambrosio, *Labels Sought for Genetically Modified Food*, USA TODAY (June 13, 2013), <http://www.usatoday.com/story/money/business/2013/06/12/labels-being-sought-for-genetically-modified-food/2417459/> (discussing the state response to the “decades-old debate about whether the [GMOs] are dangerous to human health”).

⁴³⁶ The Connecticut law animates upon enactment of similar laws by other states in the region. See Act of June 25, 2013, Conn. Pub. Act No. 13-183 (to be codified at CONN. GEN. STAT. § 21(a)) (stipulating that the legislation would activate once “(1) Four states, not including this state, enact a mandatory labeling law for genetically-engineered foods that is consistent with the provisions of this subsection, provided one such state borders Connecticut; and (2) the aggregate population of such states located in the northeast region of the United States that have enacted a mandatory labeling law for genetically-engineered foods that is consistent with this subsection exceed twenty million based on 2010 census figures”).

⁴³⁷ Act of Feb. 26, 2013, Me. Legis. Serv. Doc. No. 718 (to be codified at ME. REV. STAT. tit. 22, ch. 565). Maine’s governor pledged to sign the bill into law, explaining his strategy to wait for other jurisdictions to test the constitutionality of similar measures. Steve Mistler, *LePage: I’ll Sign Bill Requiring Labels for Genetically Modified Foods*, PORTLAND PRESS HERALD (Portland, Me.) (July 9, 2013), <http://www.pressherald.com/news/LePage-tells-GMO-labeling-bill-sponsors-hell-make-it-law.html> (“It is to Maine’s benefit to simply delay implementation of the law, and take advantage of the results of litigation in other states,” the governor wrote.”).

⁴³⁸ This legislative attempt to label GMOs at the federal level was not the first, but it was the first with “bicameral” and “bipartisan” support. Joe Satran, *Genetically Engineered Food Labeling Taken on by Congress in Right-To-Know Act*, HUFFINGTON POST (Apr. 25, 2013), http://www.huffingtonpost.com/2013/04/25/genetically-engineered-food_n_3149418.html.

⁴³⁹ S. 809, 113th Cong. § 1 (2013).

⁴⁴⁰ The proposed legislation would amend the Federal Food, Drug, and Cosmetic Act to include “food that has been genetically engineered or contains 1 or more genetically engineered ingredients” as misbranded “unless such information is clearly disclosed.” *Id.* § 3(a).

⁴⁴¹ For the purposes of this Article, I am interested purely in the dynamics of paternalism in the debate, not the substance.

⁴⁴² *Genetically Engineered Foods*, *supra* note 434. The NIH does note that “complete safety” cannot be ensured without adequate testing. *Id.*

scientific community,⁴⁴³ the public expresses uniform discomfort with the inability to make choices about GMO consumption. A June 2013 poll indicated that 52% of the public believed that GMO foods are unsafe—but, more remarkably, 93% supported the notion that “the federal government should require labels on food saying whether it’s been genetically modified, or ‘bio-engineered’ Such near-unanimity in public opinion is rare.”⁴⁴⁴ The public is essentially clamoring for regulators to engage in weak-form debiasing to *enable* choice where there simply was no choice.

The scientific community has, in one notable case, embraced the choice argument and flipped it. A *Scientific American* editorial opined that “[m]any people argue for GMO labels in the name of increased consumer choice[, but o]n the contrary, such labels have limited people’s options.”⁴⁴⁵ The premise is that GMO crops produce less expensive and more nutritious foods, affording more consumer autonomy and that reduction of GMO consumption would negatively affect overall food production.⁴⁴⁶ Of course, this viewpoint incited nearly instant counterattacks⁴⁴⁷—but as the debate continues, public opinion and political momentum appear to be on the side of labeling. As of September 2013, GMO disclosure legislation is pending in at least twenty states.⁴⁴⁸

The unanimity about the value of informed choice and autonomy seems to be reflected in the words of one state senator after passage of the Connecticut law: “This law doesn’t ban, or restrict, or tax anything. It simply lets moms and dads know what’s in the food they’re buying for their children.”⁴⁴⁹ The notion of having the ability to know and control “what’s in the food your children are eating” echoes the fluoride debate’s often triumphant value: the ability to know and control “what’s in the

⁴⁴³ See, e.g., Editorial, *Fight the GM Food Scare*, 309 SCI. AM. 10, 10 (2013) (“Instead of providing people with useful information, mandatory GMO labels would only intensify the misconception that so-called Frankenfoods endanger people’s health . . .”).

⁴⁴⁴ Gary Langer, *Poll: Skepticism of Genetically Modified Foods*, ABC NEWS, <http://abcnews.go.com/Technology/story?id=97567&page=1> (last visited Feb. 28, 2014).

⁴⁴⁵ *Fight the GM Food Scare*, *supra* note 443.

⁴⁴⁶ See *id.* (“Because conventional crops often require more water and pesticides than GMOs do, the former are usually more expensive. Consequently, we would all have to pay a premium on non-GMO foods—and for a questionable return.”).

⁴⁴⁷ See David Knowles, *GMO Foes Blast Scientific American Editorial Decrying Labeling Laws*, N.Y. DAILY NEWS (Sept. 6, 2013), <http://www.nydailynews.com/news/national/gmo-foes-blast-scientific-american-editorial-article-1.1448232> (“A contested point . . . is the contention that requiring labeling of GMO ingredients will result in higher food prices because genetically engineered seeds can produce higher yields and require less pesticide.”).

⁴⁴⁸ *Fight the GM Food Scare*, *supra* note 443. “Pending” could be susceptible to many definitions—under some, bills could be pending in as many as thirty states. Mistler, *supra* note 437.

⁴⁴⁹ Press Release, Conn. Governor Dannel P. Malloy, Governor Malloy and Legislative Leaders Announce Agreement on GMO Labeling Legislation (June 1, 2013), *available at* <http://www.ct.gov/malloy/cwp/view.asp?A=4010&Q=525816> (quoting Senate Republican Leader John McKinney).

water your children are drinking.”

The GMO debate fits comfortably into the broader narrative about the limits of paternalism in public health. Without legislation, the broader, hard paternalism of food producers would reign, leaving no visible choices (or fewer choices). In this case, consumers overwhelmingly reject the notion of sacrificing autonomy when it comes to choosing the nature of their food. They continue to press regulators to create autonomy in this area—just as consumers have pressed for autonomy in many jurisdictions with respect to fluoridation and the choice to use marijuana.⁴⁵⁰ In pressing for autonomy, consumers generally press against paternalism, particularly hard paternalism. This spirit removes a lot of tools for regulators seeking to curb obesity and improve public health.

Note also that the GMO debate reveals that the anti-paternalistic wave should not always be conflated with libertarianism. Libertarianism eschews public intervention in the market in favor of private solutions.⁴⁵¹ In the food market, libertarians would expect non-GMO alternatives like certified organic products to emerge in response to demand. Here, according to public opinion, the market did not produce the desired level of consumer autonomy. The government intervened, at activists’ behest, in the spirit of anti-paternalism.

* * *

Taken together, marijuana legalization, fluoridation, and GMO foods all provide examples of a trend in public health that appears to reflect a rejection of paternalism. Elements of efforts to regulate obesity, ranging from the Big Gulp ban to changing the contents of school lunches, also seem to reflect this rejection. As Part IV will discuss, this dynamic portends ills for the future use of regulatory tools, soft and hard, to address the larger, more complex problems like obesity.

IV. ACCEPTING PATERNALISM’S LIMITS IN PUBLIC HEALTH

We’re paying a very high price as a society for obesity, and why don’t we think about it as a problem of enormous magnitude to our economy? . . . We’re creating obesity and *we need to do a man-on-the-moon effort* to solve this before those poor kids in elementary school become diabetic

⁴⁵⁰ See *supra* Parts III.C.1–2.

⁴⁵¹ See David D. Friedman, *Libertarianism*, in 5 THE NEW PALGRAVE DICTIONARY OF ECONOMICS 103, 107–08 (Steven N. Durlauf & Lawrence E. Blume eds., 2d ed. 2008) (“Most of the arguments against price control, wage control, rent control, usury laws, and similar restrictions on the terms of market exchange are familiar to any economist. Many libertarians also argue that such restrictions violate individual rights.”).

middle-aged people.⁴⁵²

The man-on-the-moon analogy for solving obesity and other public health concerns,⁴⁵³ envies but misplaces the popularity and drivers of support for the Apollo program,⁴⁵⁴ disregards the complexity of the public health problem,⁴⁵⁵ and ignores attitudinal obstacles toward paternalism. Nonetheless, debunking the man-on-the-moon myth provides a starting point for understanding the limits of regulation in the public health sphere.

Contrary to current public understanding, with the exception of the time period around the first moon landings, the public did not unite solidly behind the Apollo program.⁴⁵⁶ President Kennedy's call to launch the program was embedded inside a larger geopolitical strategy, endorsed by the public.⁴⁵⁷ A call to unite popular opinion behind a purely civilian government effort might prove more important and complex. Putting a man on the moon did not require individuals to surrender autonomy—it required a more abstract commitment of tax dollars.⁴⁵⁸ Also, the problem of putting a man on the moon did not require changing and controlling a complex system of human behaviors, as the more challenging public health problems do. Though ultimately an amazing triumph of human ingenuity, putting a man on the moon presented addressable physics and logistical questions, solvable with 1960s knowledge and technology, and a concentrated and sincere resource commitment.⁴⁵⁹ Paternalism and

⁴⁵² *Obesity's Yearly Costs: \$4,879 for a Woman, \$2,646 for a Man*, USA TODAY (Sept. 21, 2010), http://usatoday30.usatoday.com/yourlife/fitness/2010-09-21-obesity-costs_N.htm?csp=34 (emphasis added) (quoting Dr. Kevin Schulman, Professor of Medicine and Health Economist at Duke University) (internal quotation marks omitted).

⁴⁵³ See, e.g., *Cancer Treatment Myths: Any Truth to These Common Beliefs?*, MAYO CLINIC, <http://www.mayoclinic.org/diseases-conditions/cancer/in-depth/cancer/art-20046762> (last visited July 15, 2014) (“Finding the cure for cancer is proving to be more complex than mastering the engineering and physics required for spaceflight.”).

⁴⁵⁴ See Roger D. Launius, *Public Opinion Polls and Perceptions of US Human Spaceflight*, 19 SPACE POL'Y 163, 165–66 (2003) (suggesting that public support for the *Apollo* program was not as great as originally thought).

⁴⁵⁵ Michelle Obama disregarded this complexity when she said, “[Solving childhood obesity] isn't like putting a man on the moon or inventing the Internet. It doesn't take a stroke of genius or a feat of technology. We have everything we need right now to help our kids lead healthy lives.” Sheryl Gay Stolberg, *Childhood Obesity Battle Is Taken Up by First Lady*, N.Y. TIMES, Feb. 10, 2010, at A16.

⁴⁵⁶ Launius, *supra* note 454, at 166–67.

⁴⁵⁷ See *id.* at 172 (noting President Kennedy's assertion that “[e]verything we do should be tied into getting on to the Moon ahead of the Russians” (internal quotation marks omitted)).

⁴⁵⁸ See Trevor Butterworth, *To Infinity and Beyond*, FORBES (Feb. 17, 2010), <http://www.forbes.com/2010/02/16/eggars-oleary-moon-campaign-book-opinions-columnists-trevor-butterworth.html> (stating that it took “\$145 billion to achieve lunar triumph”).

⁴⁵⁹ See *id.* (“[I]t took 200 university laboratories, 20,000 industrial firms, 400,000 public and private sector workers, and (when rounded out to 2008 dollars) \$145 billion to achieve lunar triumph. It also required a brilliant, indefatigable project manager, James Webb, and the gift of a government agency—NASA—that had not pushed paper long enough to calcify into a brittle bureaucracy All-in-all the space race was an epic competition of human ingenuity run by characters, every bit as driven

societal dynamics obviously had no opportunity to emerge as issues with Apollo. One could argue that addressing obesity might be a harder mission for regulators than the Apollo was for policymakers and engineers.

Though this Article takes on public health regulation generally, the paternalism involved with obesity regulation provides the most recent and controversial example. Solving a public health problem like obesity on a grand scale requires a multi-pronged, full-scale commitment—but some tactics may prove more pragmatic than others. Undoubtedly, obesity presents a health crisis, but the complexity of the contributing dynamics renders the problem difficult to solve. Though the problem has started to level off by some measures, no consensus has emerged to explain that trend.

For those who would advocate a total war on the obesity problem⁴⁶⁰—perhaps absorbing the Sarah Conly view of harm-prevention—all brands of paternalism would be deployed to prevent people from harming themselves.⁴⁶¹ Where healthier choices could not be shaped through market solutions, or tactics on the softer end of the paternalism intervention spectrum, the government would force the healthier choice, according to this view.⁴⁶² A full effort or total war on obesity would run into two distinct categories of obstacles: (1) hostility toward paternalism; and (2) the complexity of the problem and the stubbornness of the problem's components.

A. *Obstacles*

The first obstacle category would be the cross-cutting negative public attitude toward autonomy loss and most forms of visible, hard paternalism in public health. When regulators or other actors interfere with something as fundamentally personal as the choice of food, people take notice. Generalizing to the public health sphere, the rejection of paternalism in favor of autonomy in the three high-profile contexts discussed in detail—marijuana, fluoride, and GMOs—all seem to mirror the dynamic in the obesity realm. It appears that gently-induced free market

and, perhaps, as possessed as the Greeks who laid siege to Troy. When you think of it like that, when you conceptualize the problem from design to execution . . . it's quite understandable why we did put several men on the moon.”).

⁴⁶⁰ War, like the moonshot, offers another familiar metaphor. See, e.g., Lydia DePillis, *Looks Like the U.S. Is Winning Its War on Childhood Obesity*, WASH. POST (July 12, 2013, 12:54 PM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/07/12/looks-like-the-u-s-is-winning-its-war-on-childhood-obesity/> (using the term “war” to describe the battle against childhood obesity); Dan Munro, *Are We Fighting the Wrong Battle in the Obesity War?*, FORBES (June 29, 2013), <http://www.forbes.com/sites/danmunro/2013/06/29/are-we-fighting-the-wrong-battle-in-the-obesity-war/> (discussing the “obesity war”).

⁴⁶¹ See CONLY, *supra* note 11, at 7 (justifying the benefits of paternalistic laws).

⁴⁶² See *id.* at 6 (discussing an example of forcing behavior using “soft” paternalism).

voluntarism—which affects the consumption marketplace through the changed behavior of large producers—and hidden hard paternalism offer the sharpest available regulatory tools.⁴⁶³

Of further note is that resistance to public health paternalism may not even be uniquely American. German Chancellor Angela Merkel's successful campaign, which led to her party's political victory in September 2013, has been noted for its stand against the Green Party's efforts to mandate a "veggie day" in public cafeterias.⁴⁶⁴ Merkel proclaimed, "You will never hear from the Christian Democratic Union party when you should eat meat and when you shouldn't [W]e are a party [that is] confident [that] people can manage their own lives."⁴⁶⁵ The potential globalization of this phenomenon, or at least a prominence in other Western cultures, has not been explored here, but would speak to a broader power of the trend.

The second obstacle category would be the factors that drive the complexity of public health problems. In order to make serious advancements, given the limits of scientific knowledge, efforts would be required on a wide variety of fronts. Unfortunately, many efforts would be blocked due to the weakness of most soft paternalism strategies, and the rejection of most hard paternalism strategies—except in the most narrow of circumstances.

The natural resistance points to reducing obesity are stubborn and many. The causes of obesity are not completely understood, in that it might prove difficult to measure what causes might be given the highest priority to address.⁴⁶⁶ Caloric intake, caloric expenditure, socioeconomic, cultural, gender, and age factors can prove difficult to untangle as causes. Difficulty in untangling the root causes makes prioritization of underlying problems difficult, which in turn is compounded by the challenge of finding palatable and effective solutions to these problems. Here, for example, the compulsion of physical activity may prove impractical, as would reducing the large-scale consumption of a potentially large culprit like the omnipresent consumption of processed grains.

Changing overall behavior in public health often requires addressing a

⁴⁶³ See *supra* Parts III.B.1, III.B.2.d.

⁴⁶⁴ Josh Gerstein, *Germany, "Veggie Day," and Michelle Obama*, POLITICO (Sept. 21, 2013, 7:39 PM), <http://www.politico.com/blogs/under-the-radar/2013/09/germany-veggie-day-and-michelle-obama-173206.html>. One German newspaper referred to the controversy over veggie day as a "s---storm." *Id.* (internal quotation marks omitted).

⁴⁶⁵ *Id.*

⁴⁶⁶ Michelle Obama's efforts through "Let's Move!" to encourage people to drink more water may provide yet another example of a regulatory failure to prioritize public health initiatives properly. See James Hamblin, *Why "Drink More Water"?*, THE ATLANTIC (Sept. 12, 2013), <http://www.theatlantic.com/health/archive/2013/09/why-drink-more-water/279591/> (questioning the scientific basis and strategy of the water initiative).

strong natural behavioral obstacle, the present bias. It may be that the softer paternalistic efforts help debias at the margin, but simply do not provide the power to put significant dents in this Gordian problem. The harder paternalism that may work must effectively insulate people from making bad choices, must be implemented in zones that are already controlled by regulators, or must be implemented through high-impact opportunities that do not *appear* to affect personal autonomy.

Ultimately, regulators confront real boundaries in their attempts to address major public health issues. In addition to scientific challenges, public tolerance for autonomy-reducing interventions appears low. The question emerges about what policymakers should do in light of the nature, magnitude, and complexity of public health problems—and the limited toolkit they have for addressing them.

B. *Implications for Policymakers*

Regulators are in a bind, given the limits of paternalism in public health. The limits are defined by practicality and efficacy, but the problems, like obesity, remain significant. Should regulators surrender? Morally, that might not be an option. Scientists and policymakers might have the obligation to play the paternal role, even if it proves unpopular. Nonetheless, unpopular interventions run a risk of backfiring, as Mayor Bloomberg experienced in the wake of the Big Gulp effort.

In the wake of a serious public health challenge, regulators should pursue all solutions open to them—but they should do so with a cost-benefit rationalization that includes the likelihood that paternalism will present an obstacle to implementing the solution. Efforts should concentrate on the areas that science indicates would be the most impactful, and which would be the most practical to implement.

For example, initiatives that harness the market and promote voluntarism in areas that could matter (e.g., the voluntary changes made by food retailers), would meet those criteria. Debiasing initiatives that prove effective while preserving autonomy might prove weaker, but also could add up if enough of them were pressed. Opportunities to deploy hard paternalism should be sought with care, so as to minimize the perception that the regulators are usurping a tangible choice or are treading beyond the zone normally ceded to regulators. These opportunities may prove few, but if sought and pressed aggressively, they may have powerful effect.

Though the opportunities for deploying paternalism effectively in the public health arena may prove limited, they do exist. If regulators minimize the perception that they are reducing autonomy, perhaps the public might give more slack to initiatives that tread on the border.

I do not argue that these challenges to public health regulation should lead to the hoisting of a white flag. Rather, regulators should be attuned to public sentiment—and should not only seek the best scientific solutions for

improving public health, but should also take a highly opportunistic approach and pursue the most practical course. An integrated response that accounts for the potential to improve public health along with the popular tolerance or appetite for regulatory interventions will produce the best possible social outcomes.

Though this constraint may lack the inspirational call to solve an immense problem, it may guide regulators toward the most effective course, even if it proves difficult. After all, if one clings to the moonshot analogy, the words of President Kennedy may provide guidance, particularly the clause that follows the most famous line in his 1962 Moon Speech: “We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, *because that goal will serve to organize and measure the best of our energies and skills.*”⁴⁶⁷ Solving public health problems that are more complex than a moonshot will require organized focus of our energies and skills and tell us about their boundaries.

V. CONCLUSION

Public health regulation faces the constraint of paternalism in several spheres, but perhaps most importantly, in the massive problem that obesity presents. People have natural biases toward consuming in the present while discounting future consequences. Environmental factors, driven by socioeconomics and food availability, present obstacles for lowering obesity rates. Even if those obstacles are solvable, regulators now face resistance to regulation that appears paternalistic insofar as it reduces choice.

However, if regulators examine the entire spectrum of options—ranging from encouraging voluntarism, to debiasing, to insulating from harm, to bans and mandates—they may identify a mix of initiatives that combine efficacy with practicality. As we move forward to address challenging social concerns in an environment where actors value autonomy, regulators will find it crucial to identify this balance. Regulatory interventions into personal behavior have proven financially and socially expensive—a smarter framework for guiding them will create the momentum needed to solve the serious and complex public health problems that we face.

⁴⁶⁷ President John F. Kennedy, Address at Rice University (Sept. 12, 1962), *available at* <http://www.jfklibrary.org/Asset-Viewer/MkATdOcdU06X5uNHbmqm1Q.aspx> (emphasis added).