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An Assessment of Mayor Bloomberg's Public Health Legacy

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Lawrence O. Gostin

Q You begin by noting that Mayor Bloomberg's public health policies have been controversial and that "his health legacy is bitterly contested."

LG Yes. "The public health community views him as an urban innovator—a rare political and business leader willing to fight for a built environment conducive to healthier, safer lifestyles. To his detractors, however, Bloomberg epitomizes a meddling nanny—an elitist dictating to largely poor and working class people about how they ought to lead their lives."

Q And just so we know your views from the start, are you generally supportive of Mayor Bloomberg's efforts with respect to public health law?

LG Yes. I believe that "[g]overnments should be held accountable for the health of their inhabitants." I also believe that "[t]hose who disrupt the status quo," such as Mayor Bloomberg, "are not the only ones who must shoulder the burden of accountability. Public officials have largely stood by as obesity rates have skyrocketed. While the Mayor has drawn fierce criticism and legal challenges, there has been scant accountability for government inaction.

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

Q Do you have any thoughts on how Mr. Bloomberg could continue to promote public health now that he no longer is Mayor? Will it simply be a matter of supporting programs through his foundations?

LG Mr. Bloomberg has announced a new nonprofit consulting group that will troubleshoot for big cities, advising them about how to address the critical problems of urbanization and health, such as smoking, diet, and physical activity. He plans to help design cities to make health the easier choice. He will also continue his work on diet and tobacco through Bloomberg philanthropies, as well as engage in issue-oriented political advertising such as on firearm control. All of this is positive from a public health perspective.

Anti-Obesity Measures

Q Before we discuss the various measures taken during the Bloomberg administration to combat obesity, can you describe the nature and extent of obesity in New York City?

LG "Mirroring national trends, being overweight or obese is now the norm in New York City (58 percent of adults), with black, Latino, and low-income communities hardest hit—reaching 70 percent in the poorest neighborhoods.[3] Perhaps more disturbing: 40 percent of the city's youth are overweight or obese, compared to 33.2 percent nationally.[4] If not reversed, today's generation could live shorter lives than their parents."

Q You note that Mayor Bloomberg banned trans fats, required menu labeling, launched a salt reduction initiative, and has attempted—so far unsuccessfully—to regulate the container size of sugary drinks. Can you describe each measure? And can you also explain what has been controversial about each measure? Let's start with the trans fats ban.

LG Trans fat is made through the process of hydrogenation of oils. Essentially, hydrogenation solidifies liquid oils; this increases the shelf life and flavor stability of oils and foods that contain them. "Artificial trans fatty acids provide no health benefit and are unsafe at any consumption level.[5] In 2006, the City required that any food served to customers (unless in a sealed package) contain less than 0.5 grams of trans fat per serving, and many cities have followed suit.… Although the trans fat limit received a warmer public response than other diet-related policies, it still met opposition from restaurants and civil libertarians. Economic interests drove much of the debate, with claims

that it would raise food prices, affecting employment and consumers. Consumers feared the ban would affect the taste of baked goods, arguing that the state should not dictate what people eat. But after a half-decade of experience, the fears proved unfounded, with no attributable rise in food prices or noticeable difference in taste."

Q With menu labeling, there was litigation challenging the measure.

LG Yes. "The Board of Health in 2006 required restaurants that voluntarily disclosed calorie information to post calories in standard form. The New York State Restaurant Association (NYSRA) challenged the regulation, alleging that federal law preempted the Board's action. The court agreed, but only because the statute did not apply uniformly to all chain restaurants.[6] A revised regulation, enacted in 2008, addressed the court's concerns by requiring all chain restaurants to disclose calories on menus and menu boards. The NYSRA then challenged the amended regulation under the First Amendment, but the Second Circuit found that compelled disclosure of truthful, objective information did not violate the commercial speech doctrine.[7]"

Q What is the purpose of menu labeling? And is it effective?

LG "Menu labeling facilitates informed decision-making. Individuals underestimate the caloric content of food, and, on average, consume more than one-third of their calories away from home.[8] Most studies, however, show that posting calories has little effect on aggregate purchasing decisions.[9] This may be attributable, in part, to the failure to provide context. Researchers suggest that providing a physical activity equivalent (e.g., 450 calories equals 80 minutes of running) would be effective.[10]"

Q What was the National Salt Reduction Initiative ("NSRI")? And why was it adopted?

LG "The City launched the NSRI in 2009—a public-private partnership of more than 90 health agencies and associations. Companies voluntarily pledged to reduce sodium by 20 percent in overall sales within a given food category (e.g., canned soup) by 2014. This still left ample room for high sodium foods provided the producer offset these with low sodium alternatives within the category. Many companies have joined NSRI, with 21 meeting sodium checkpoints in 2012.[11]

"Americans consume over twice the daily recommended 1,500 mg of sodium, increasing blood pressure. Excess salt intake is associated with 136,000 deaths per year, and a small reduction could prevent many of these deaths, saving $10-24 billion annually in medical costs.[12] Little of the sodium excess comes from the shaker—80 percent is added to prepared or packaged foods. The problem, then, is not primarily behavioral but rather lies in food manufacturing and marketing."

Q Last, but certainly not least, we come to the regulation of the size of containers for sugary drinks.[13] You note that, over time, "[s]oft drink portion sizes have grown dramatically, along with Americans' waistlines." This measure regulates only the serving size for certain sugary drinks[14]—yet it has been enormously controversial. Why is that?

LG "While a 12-ounce soda was 'king-size' in 1950, it is now marketed as a child portion… Sugar-sweetened drinks account for a substantial portion of increased caloric intake.[15] The beverage size limit has come to exemplify Bloomberg's Nanny State. Amid intense publicity, polls registered disapproval among city residents and nationally."

Q Do you have any thoughts on how Mayor Bloomberg attempted to promote the measure? As a political matter, should he have done anything differently?

LG He decided to act in this area because research demonstrates a significant correlation between portion sizes and weight gain, as well as between sugary drink consumption and weight gain. It makes sense to gently guide consumers to drink small portions of sugary drinks. The best way to enact such a measure would have been through the elected city council. However, he may have been concerned that politically it would not pass the city council. Consequently, he sought to effectuate the change through the New York City Board of Health.

Q Do you have a prediction as to how the New York Court of Appeals will rule on the validity of the soda container regulation? As you note, both the New York Supreme Court and Appellate Division held that the measures violated the doctrine of separation of powers.

LG I am not confident the measure will be upheld by New York's highest court, although I think it should be. The major sticking point will be that the mayor circumvented the elected city council, and thus violated the principle of separation of powers. This is essentially an administrative law, rather than a public health, question.

Efforts to Regulate Tobacco

Q Mayor Bloomberg seems to be just as famous for his anti-smoking measures as he is for his campaign against super-size sodas. Can you describe the extent to which smoking presents a public health problem?

LG "At the turn of the millennium, smoking took nearly 9,000 lives annually in New York City—and it remains the leading cause of preventable death. Half of the city's 1.3 million smokers were expected to die prematurely from tobacco-related diseases. A disproportionate toll of suffering and early death fell on minorities and the poor. These grim facts motivated the Mayor's office to develop a suite of tobacco control policies. The results have been remarkable, with the rate of smoking falling from 21.5 percent to 14.8 percent between 2002 and 2011 among adults, and from 17.5 percent to 8.5 percent among youth."[16]

Q His initial efforts involved enacting smoke-free laws and raising cigarette taxes. Let's start with the former. What effect have measures like the Smoke-Free Act had on the population?

LG "In 2002, 57 percent of city food workers spent most of their waking hours inhaling second-hand smoke, increasing their cancer risk by 50 percent. That year, New York City banned smoking in all restaurants and bars. The environmental effects were powerful: just one year later, cotinine concentrations—a biomarker to detect nicotine exposure—decreased by 83 percent and tobacco-related symptoms decreased from 88 percent to 38 percent.[17] The vociferous protests by businesses that this would drive customers away proved unfounded, with patrons welcoming the change. The City's Smoke-Free Act changed norms nationwide. At the time, only California and a few cities had smoke-free laws, but now more than 80 percent of Americans live smoke-free.

"The mayor went further in 2011 by extending the smoking ban to parks, beaches, and pedestrian plazas. Side-stream smoke poses a much lower risk in outdoor spaces." Banning cigarettes outdoors is highly paternalistic. But smoking has become culturally unacceptable, with the regulation receiving wide support (69 percent).[18] Even though the ban is not rigorously enforced, it reinforced the culture of a smoke-free environment.

Q Cigarette taxes discourage smoking, but also are criticized as regressive. Is that a correct statement and a fair criticism?

LG The first statement is correct, the second is not incorrect but it also is incomplete. "Raising cigarette prices reduces smoking, with youth particularly susceptible—for every 10 percent price rise, youth smoke 7 percent less.[19] In 2002, New York City increased the tax per pack from $0.08 to $1.50, precipitating a decline in smoking prevalence. Initially many smokers avoided the tax by buying in adjacent jurisdictions, but over time this avoidance behavior subsided. The tax is regressive, falling on smokers who are disproportionately poor and working class. Yet, the resulting benefits of reduced smoking are distributed progressively—a tradeoff between economic justice and health justice."

Q And, as with some of the efforts to combat obesity, one of the anti-smoking laws involving marketing restrictions resulted in litigation. Can you say more about the measure?

LG "In 2009, the City required retailers to display graphic warnings with images of cancerous lungs, decayed teeth, or stroke-damaged brains. The regulation, however, never went into effect" because "the Second Circuit ruled that federal law preempted the local regulation.[20] Fast-forward to 2013: the United States and other countries have proposed graphic labeling. These too are bitterly contested, with Big Tobacco claiming they violate commercial speech rights and take property without just compensation. Despite the setback, Bloomberg has sought other ways to discourage tobacco purchases at the point of sale." For example, in April 2013, "Bloomberg proposed an increase in the minimum age for buying tobacco from 18 to 21, giving New York City the strictest age limits in the nation." This proposal has now received the approval of the City Council, and has been enacted into law.

Critiques of Bloomberg's Policies

Q You note that "a familiar litany of critiques shadows any novel public health policy: the science is inconclusive; freedom of choice is constrained; the executive is exercising unilateral power; beware of slippery slopes; corporations have rights too; and justice demands protecting the vulnerable against state interference." The most significant seems to be the charge of paternalism.

LG "The societal discomfort with Bloomberg's agenda, at its core, is grounded in distrust of government telling autonomous adults how to conduct their lives. The City's health policies intrude on personal space—a sphere over which individuals supposedly exercise free will. Many believe that the State should not assume responsibility for these self-regarding decisions."

Q What is your view of the paternalism criticism?

LG "American antipathy toward paternalism drives policy makers to try to justify interventions under the harm principle—e.g., second-hand smoke, medical costs, and lost productivity. Third party harms are not imaginary, but the real policy intent is to ease the grave burdens of diabetes, heart disease, cancer, and emphysema. Health officials genuinely believe it is unwise for individuals to smoke, overeat, live sedentary lives, or do myriad other things that cause them suffering and early death. The public health approach rejects the idea of unfettered free will, recogniz-

ing instead that the built environment, social networks, marketing, and a range of situational cues drive complex behaviors. There are reasons, beyond personal responsibility, that health outcomes skew drastically by socioeconomic status. The job of public health is to make healthy living the easier choice.

"More importantly, Bloomberg's policies are not all that intrusive, and certainly not as burdensome as the underlying diseases. Nutrition, physical activity, and tobacco control policies are not morally equivalent to quarantines or forced treatment. Often, they represent nothing more than a return to the norms of the recent past—such as smaller food portions and more livable spaces. Other interventions actively create a 'new normal' such as reduced trans fat, sodium, and sugar, or limiting advertising to children. Once implemented, many interventions are embraced; few of us are nostalgic for the days of smoke-filled restaurants and workplaces. The real burden, moreover, is on industry, not consumers. One can see this vividly in New York City, where food makers funded public opposition to the soda portion ban."

Q In your view, it seems, the value of "unfettered free will" should be balanced against the burdens and costs of the underlying diseases that may follow from the exercise of free will. Is this view widely held by the public? If not, why not?

LG Although I believe this framing of the issue is correct ethically, it has been difficult to sustain in public and political discourse. I think that the value of unfettered autonomy in the United States has gotten way out of proportion. In the end, what matters is how much an invasion of individual interests the measure will entail, balanced against the public good. This kind of balancing of interests would give equal value to the common good and to individual autonomy.

Q I always find the intersection of law and science interesting. How has that intersection played out with respect to the criticism that because the scientific evidence is inconclusive, Bloomberg's measures should not have been adopted or have not been effective?

LG "Critics invariably challenge chronic disease policies as lacking sufficient evidence of effectiveness. At the most extreme, they demand conclusive proof, charging for example that the science behind the trans fat ban is 'not indubitable.'[21] Science, of course, seldom reaches consensus, least of all on the causation of complex multifactorial diseases. Rarely are policymakers expected to demonstrate a certainty, or even high probability, of 'success' in other domains. In most policy spheres, we understand that causal relationships are difficult to demonstrate in a world filled with complexity—but critics often demand it of public health.

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

"Related to scientific uncertainty is the demand for consistency—illustrated by the criticism of the soda portion limit, which applies to McDonald's supersized drinks but not to 7-Eleven's Big Gulps. Few policies are perfectly consistent, but rather are crafted as political compromises.… A direct tax on sugary drinks would have been a more logical intervention than portion control, but New York State has been unwilling, despite Bloomberg's requests."

Q You discuss a number of criticisms in the article that, in my view, are self-explanatory. For example, the corporate rights critique involves corporations attempting to protect their economic interests by contending that public health measures are not in the public interest and violate consumer's rights; the unilateral executive power criticism asserts that the Mayor has exceeded his legal authority in violation of separation of powers principles; and the slippery slope argument is, as you note, that "if a particular policy is implemented, it will lead to ever-more invasive policies in the future."

The last critique I want you to address in this question concerns what you call "dueling conceptions of justice." What do you mean by that?

LG "Because obesity- and tobacco-related diseases fall primarily on African Americans, Latinos, and the working class, interventions necessarily apply disproportionately to those groups. This means, of course, that any intrusion on autonomy or privacy will fall primarily on the vulnerable.…Tobacco taxes are regressive, which liberals normally oppose. Industry and civil libertarians have joined together to decry the injustice of health measures that tread disproportionately on the liberty of the poor and minorities."

Q What is your view of this critique?

LG I think that "[t]his is a curious conception of justice because it focuses solely on the fair distribution of the downsides of obesity or tobacco policies—i.e., limits on liberty. The justice argument fails miserably in weighing the corresponding health benefits to the poor. Government's *failure* to act to reduce suffering and early death visited mostly in poor neighborhoods is the far greater injustice…If policies work, a negligible limit on unfettered choice seems a very small price to pay for ameliorating the devastation to the individual and her family from chronic diseases. The opportunity for a healthy life is the primary freedom, as it underwrites so many of life's options."

Endnotes

1. Lawrence O. Gostin, Bloomberg's Health Legacy: Urban Innovator or Meddling Nanny, in 43 Hastings Ctr. Rep. 19, 19-25 (2013).
2. The text in quotation marks comes from Professor Gostin's article in the Hastings Center Report. The text of Professor Gostin's answers that is not in quotation marks was provided by Professor Gostin via email in respone to questions by Rodger Citron.
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6. New York State Restaurant Ass'n v. New York City Bd. of Health (NYSRA I), 509 F. Supp. 2d 351, 362 (S.D.N.Y. 2007).
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8. Lisa R. Young & Marion Nestle, Portion Sizes and Obesity: Responses of Fast-Food Companies, 28 J. Pub. Health Pol'y 238, 239 (2007).
9. Tamara Dumanovsky et al., Changes in Energy Content of Lunchtime Purchases from Fast Food Restaurants after Introduction of Calorie Labeling: Cross Sectional Customer Surveys, 343 Brit. Med. J 299, 299 (2011).
10. Sara N. Bleich & Lainie Rutkow, Improving Obesity Prevention at the Local Level: Emerging Opportunities, 368 New Eng. J. Med. 1761, 1762 (2013).
11. National Salt Reduction Initiative Corporate Commitments, NYC.gov, available at http://www.nyc.gov/html/doh/downloads/pdf/cardio/nsri-corporate-achievements.pdf.
12. Kirsten Bibbins-Domingo et al., Projected Effect of Dietary Salt Reductions on Future Cardiovascular Disease, 362 New Eng. J. Med. 590, 590 (2010).
13. Rodger Citron & Paige Bartholomew, The Soda Ban or the Portion Cap Rule? Litigation Over the Size of Sugary Drink Containers as an Exercise in Framing, 27 Mun. Law. 29, 29 (2013).
14. See *supra* note 1, at 20. "To curb consumption, the Board of Health proscribed serving sizes greater than 16 ounces for sweetened beverages containing more than 25 calories per eight ounces. The rule, however, excluded beverages containing alcohol or more than 50 percent milk and did not cover state regulated businesses—including 7-Eleven." *Id*.
15. Vasanti S. Malik, Matthias B. Schulze, & Frank B. Hu, Intake of Sugar-sweetened Beverages and Weight Gain: a Systematic Review, 84 Am. J. Clinical Nutrition 274, 274 (2006).
16. N.Y.C. Global Partners Innovation Exchange, Best Practice: Tobacco Control Program, NYC.gov (Jul. 12, 2011), available at http://www.nyc.gov/html/unccp/gprb/downloads/pdf/NYC_Health_TobaccoControl.pdf.
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18. Marist Coll. Inst. for Pub. Op., Good in Theory, But Not Necessarily in Practice, Marist Poll (Aug. 8, 2011), available at http://maristpoll.marist.edu/88-nyc%E2%80%99s-smoking-ban-good-in-theory-but-not-necessarily-in-practice/.
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21. David Resnick, Trans Fat Bans and Human Freedom, 10 Am. J. Bioethics 27, 28 (2010).

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