Rule, such as higher taxes on all sales of sodas. Higher prices often discourage consumption, as has been the case with cigarettes. Such taxes tend to be regressive, however, with disproportionate effects on lower-income people, who in this case could not afford to buy fancy bottled water or juice drinks. That may be one reason why some New York communities oppose such taxes.

Some alternatives, however, are not reasonable — in particular, the current proposals to shame people who are overweight.[5] Such shaming amounts to treating a health risk, whose development may be involuntary, as a moral failure. Any public policy entailing overt discrimination based on physical appearance is simply wrong. People who are obese know it; making them feel worse about themselves encourages bullying, another public health problem, and helps no one.

Perhaps the most important lesson is old news: economics often drives health policy. New York City's efforts to reduce obesity grew with its desire to control its health care costs for its residents, a disproportionate share of whom are obese or have diabetes. Meanwhile, large corporations continue to use their influence and money to derail public health measures that could reduce their profits. Although the general public shares the goals of public health, many people remain skeptical of government's choice of means for achieving those goals. Agencies that overstep their bounds or adopt rules that are intrusive or just plain silly invite backlash, which can make effective public health regulation impossible. They make fools of themselves and heroes of the opponents of public health.

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Half Empty or Half Full? New York's Soda Rule in Historical Perspective

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Despite New York City Mayor Michael Bloomberg's plans to appeal it, the March 11 decision by Justice Milton A. Tingling of the New York State Supreme Court striking down the city's partial ban on sugar-sweetened drinks larger than 16 fluid ounces might easily be seen as a cup half empty. The ruling represents a major setback for a controversial and ambitious proposal, which was approved by the New York City Board of Health on September 13, 2012, and was immediately challenged in court by a group of small businesses along with the National Restaurant Association and the American Beverage Association. But many people remain torn over whether the giant-soda ban is an important measure for combating obesity or a gross intrusion on personal liberty — and so whether such a public health regulation should itself be seen as a glass half empty or a glass half full.

From the glass-half-empty perspective, the policy is a drop in the bucket of what would be required to solve the obesity problem. Setting limits on just a single behavior, in the face of all the other unhealthy choices we must avoid (fried foods, excessive portions, carbohydrates galore), can hardly be expected to turn the obesity tide. Moreover, because the ban contains all kinds of loopholes — it doesn't set limits on refills, for instance, and it excludes ("on suspect grounds") "other beverages that have significantly higher concentrations of sugar sweeteners and/or calories" — the charge that it is "arbitrary and capricious" may strike opponents as more descriptive than acerbic.[1]

But from the glass-half-full

point of view, the ban is not about attacking individual choice but rather about limiting corporate damage. If we see supersized drinks not in terms of the individual's freedom to be foolish but instead as a kind of industrial pollution that is super-concentrated in impoverished neighborhoods,[2] limits on drink size become a far different kind of regulatory measure. The target is not the individual: it is the beverage industry, corporate America. To be sure, the ban does not take on every industrial enterprise that is bent on profiting from inundating Americans with cheap, empty calories. But it does set what may be taken as a new precedent — though it's also a move with deep historical roots.

In the late 19th and early 20th centuries, an alliance of public health, labor, social, and housing reformers organized to get garbage, filth, and the accompanying microbes off city streets, out of water supplies, and out of the fetid halls of tenement buildings. But they also sought to confront unfair labor practices, hazardous working conditions, child labor, and "slave wages" that made the poor as a class susceptible to disease. They succeeded in reducing the toll of infectious diseases because of the power of this dual assault — on the environmental conditions that bred germs and the social conditions that bred poverty.[3]

But a tension would emerge that provides the backdrop for the bitter controversy over the giant-soda ban. By the second decade of the 20th century, public health efforts began to turn away from social reform and industrial regulation. The germ became the target. And of course so did individual behavior.[4] One of the leaders in the field of public health, Hibbert Hill, wrote in his influential 1916 book, *The New Public Health*, "The old public health was concerned with the environment; the new is concerned with the individual. The old sought the sources of infectious disease in the surroundings of man; the new finds them in man himself. The old public health . . . failed because it sought them . . . in every place and in every thing where they were not." Hill was making the case that it was time to start educating people about the consequences of their behavior and to abandon sweeping attempts to alter social or environmental conditions. The individual behavioral approach was far more pragmatic and considerably cheaper, and it carried the imprimatur of science. It was a seductive argument.[3]

Since that turning point, the field of public health has struggled to define its mission. Is it to address the roots of disease or to cajole or even coerce people into behaving in self-protective ways? To be sure, paternalistic measures, practices that limit people's choices for their own good, can be justified from an ethical perspective. Motorcycle-helmet laws, for example, are ultimately intended to prevent people from harming themselves.[5] But particularly in instances in which behavior involves a hazardous product, such as tobacco, debate becomes so embroiled in arguments about liberty that we may fail to engage with equal vigor in arguments about the chief target of regulation.

This century-old struggle is playing out again in the case of the giant-soda ban. The *New York Times* reports that even lawyers for the Bloomberg administration have strained to articulate a compelling public rationale for the policy. Do we interpret the ban as a narrow, quixotic measure that would present public health authorities as little more than scolding nannies? Or do we frame it in the grand tradition of public health activism, as a challenge to corporate and industrial practices that place profit above public health?

A ban on containers larger than a certain size does not alter our capacity to drink as much sugary beverage as our bodies can tolerate — indeed, in a context of constant exposure, more than either our bodies or underserved communities can withstand. As with tobacco, it would take a tax on sugary beverages to effectively limit our individual ability to drink ourselves silly. But that is not what the currently contested proposal seeks to do. The aim of a ban on oversized sodas is to reduce the level of sugar and calorie assault that any single beverage dose represents. The assumption, of course, is that people won't simply buy more and that intake will be reduced. But the target is corporate behavior.

A cap on beverage size would leave us with a soda cup half empty, but it opens an avenue to changing corporate practice. The New York City ban is limited to businesses that the city itself can regulate without causing undue hardship; addressing inconsistencies such as limiting the size of some drinks in establishments that receive inspection grades from the city health department

while leaving others free to brim over would require similar regulatory action on the part of New York State. But if Bloomberg is bent on appealing Tingling's ruling, it is time to start making a case with some muscle, which will require strong, active support from the medical and public health communities. If we can challenge the industries and businesses that profit by promoting bloated serving sizes, perhaps we can take on other corporate enterprises that similarly contaminate our social environment.

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The Medical Device Excise Tax — Over before It Begins?

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In June 2012, the Supreme Court upheld critical provisions of the Affordable Care Act (ACA), which aims to expand health insurance to many of the 50 million currently uninsured Americans. With prospects dimming for legislative reversal of the entire law, the various stakeholders in the health care market are now focusing on its implementation. One of the numerous controversial elements to date has been the medical device excise tax, a 2.3% tax on domestic sales of medical devices, paid by the manufacturer, which went into effect in January 2013. Several categories of device sales are exempted, including purchases by government agencies and nonprofit institutions. Retail purchases of devices such as blood-glucose–monitoring equipment for use by individuals, as well as devices such as wheelchairs, hearing aids, eyeglasses, and contact lenses, are also excluded from taxation. All told, the excise tax is predicted to raise approximately $2 billion to $3 billion annually, from a medical device industry with estimated annual U.S. sales of more than $100 billion.[1]

Yet this source of funding for the ACA now faces an uncertain future, even as other key provisions of the law, such as state-run health insurance exchanges, slowly come to fruition. The U.S. Senate voted overwhelmingly on March 21, 2013, to repeal the excise tax in a nonbinding budget resolution, with 79 senators voting in favor of repeal and only 20 voting against. This bipartisan push followed months of intense lobbying from industry groups, which spent nearly $30 million in 2012 alone.[2] This raises several questions. Where did the excise tax come from? Why is it now in danger of repeal? And what would repeal mean for the ACA?

The ACA emerged in an economic and political environment in which major new spending proposals were usually paired with plans for offsetting revenue generation. To balance the primary public expense of the ACA — expansion of coverage through state Medicaid programs — several initiatives to limit spending were included in the law, such as decreased Medicare payments to physicians and hospitals, reduced subsidies to Medicare Advantage plans, and streamlining of pathways toward approval of follow-on biologics (i.e., new versions of existing biopharmaceuticals). At the same time, several new revenue streams were created, including the device excise tax, as well as taxes on high-cost health care plans and disbursements from health savings accounts. The device tax was therefore conceived as one of several strategies for balancing the overall expense