support that she can accept and understand. Is the physician's professional and ethical dilemma resolved by the California law? Maybe or maybe not. In a doctor-patient relationship, it really isn't the surrogate who is the patient.

• ***Maurice Bernstein***
Keck School of Medicine
University of Southern California
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▶ Public Health Paternalism and "Expenditure Harm"

In "Making the Case for Health-Enhancing Laws after Bloomberg" (January-February 2014), Michelle Mello and David Studdert criticize then mayor Michael Bloomberg for "lurching too quickly toward benevolent paternalism" when defending his public health policies. Mello and Studdert prefer to stress the "negative externalities" that one person's unhealthful behavior can impose on others. They argue that people who wish to be free from nanny-state meddling should nevertheless "be angered by the prospect that people's poor choices about nutrition, physical activity, and tobacco and alcohol use are pushing up insurance premiums for everyone." Thus Bloomberg should have invoked something like the harm principle to justify the policies he in fact justified on paternalistic grounds.

I believe this "expenditure harm" argument faces three main hurdles, and I worry it cannot surmount them all. First, many critics of Bloomberg's policies will also be libertarian critics of tax-financed health care. Yet the expenditure harms that Mello and Studdert highlight arise only because the government forces some to subsidize the health care of others. Of course it is true that any politically savvy libertarian will see that programs like Medicare and Medicaid and the Affordable Care Act are here to stay. But it does not follow that she will thereby support laws intended to constrain her unhealthy (and thus costly) fellow citizens, for while libertarians certainly do not like taxes, it is possible they dislike soda bans even more.

The second main hurdle for the expenditure harm argument stems from the fact that health behaviors are but one part of the story behind high health care spending in the United States. Consider, for example, that in 2009 more than 500,000 people underwent arthroscopic surgery for frequent knee pain from osteoarthritis, at a total cost of $3 billion. This was despite the fact that a 2002 randomized control trial by J. Bruce Moseley and colleagues showed that the procedure is no more effective than a totally fake surgery involving skin incisions but no arthroscope. This question therefore arises: In a country where doctors make the world's highest medical incomes by providing services that are often of questionable benefit and where even nonprofit hospitals make money hand over fist by charging the world's highest medical prices, how strong is the case for blaming and constraining the soda-drinking man on the street? If personal freedom continues to be an important value—as I assume Mello and Studdert believe—then it is not clear why we should restrict individual freedom to address a problem that can also be addressed by restricting the freedom of an often irresponsible set of profit-seeking providers.

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The third main hurdle for the expenditure harm argument comes from noting that the health behaviors at issue may be less than fully voluntary. We know, for instance, that the vast majority of smokers began smoking before they were eighteen and, thus, before the stage at which decision-making capacities are sufficiently developed. And once an addiction has formed, voluntariness is perforce compromised. Indeed, for all we know, the habits of soda drinking, donut eating, and getting a lack of exercise are themselves reinforced by neurological patterns that resemble those present in "genuine" addiction. Moreover, public health scholars are increasingly concerned about further root causes such as agricultural policies' promotion of abundant, cheap, and unhealthy calories, as well as "obesogenic" built environments that discourage active lifestyles. At the very least, the possible presence of these forces should lead one to pause before becoming "angry" at those whose "poor choices about nutrition, physical activity, and tobacco and alcohol use are pushing up insurance premiums for everyone."

To my mind, this third consideration in particular provides reason to show more compassion than anger, and I believe it may explain—contra Mello and Studdert—why it is better to justify Bloombergian policies on paternalistic grounds. For if the modern food environment really does significantly affect the decisional autonomy of significant numbers of individuals—and especially if this is the case for children whose habits and appetites for unhealthy foods are being primed for life—then that provides considerable reason to use public health policies to enhance decisional autonomy, informed choice, and, yes, the beneficial habits that are evidently so hard to instill all on one's own. This line of reasoning lends support to Bloombergian policies on decidedly "weak paternalist" grounds, that is, on the grounds that they aim to promote the good of those whose decision-making abilities are to some extent compromised. But unlike with many weak paternalistic arguments, the target group here is not some relatively small segment of the population who (for example) might be judged legally incompetent by a court. Rather, the target group is that majority of the population whose decisions are so often shaped by unhealthy forces beyond their full control.

• ***J. Paul Kelleher***
University of Wisconsin-Madison
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