

# Obesity, Courts, and the New Politics of Public Health

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**Abstract** Health care politics are changing. They increasingly focus not on avowedly public projects (such as building the health care infrastructure) but on regulating private behavior. Examples include tobacco, obesity, abortion, drug abuse, the right to die, and even a patient's relationship with his or her managed care organization. Regulating private behavior introduces a distinctive policy process; it alters the way we introduce (or frame) political issues and shifts many important decisions from the legislatures to the courts. In this article, we illustrate the politics of private regulation by following a dramatic case, obesity, through the political process. We describe how obesity evolved from a private matter to a political issue. We then assess how different political institutions have responded and conclude that courts will continue to take the leading role.

The image is among the most memorable in recent political history. Seven tobacco company executives stood before a House subcommittee in April 1994, affirming under oath that nicotine is not addictive and that cigarette smoking does not cause cancer. Both claims were quickly exposed as fraudulent, inspiring public outrage, official inquiries, legislative proposals, and denunciations from every quarter including the Oval Office. Government action eventually followed, but it took a distinctive form—one that does not fit neatly into our usual models of health care policy making.

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Congress debated bold changes but failed to enact any significant legislation affecting the tobacco industry. Parts of the executive branch also attempted strong action and fell short; the U.S. Food and Drug Administration (FDA) moved to regulate tobacco as a drug but the industry blocked the effort in the courts. State and local governments wrestled with the issue and came up with limited restrictions, most notably smoking bans in some public places. Decisive government actions—a whopping \$246 billion financial settlement, dramatic limits on marketing, restrictions on advertising, and selective smoking bans—all took place in the judicial branch. In a relatively speedy and creative burst, the courts broke a legislative logjam, dramatically reshaped a vast public health domain, and changed the public policy calculus for activists, policy makers, medical professionals, the tobacco industry, and millions of smokers.<sup>1</sup>

The tobacco case marked an important change in American health policy. In particular, it introduced two features that are, we argue, increasingly typical of the political process.

First, tobacco turned the political focus onto what had once been seen as purely private behavior. Of course, public meddling in private lives is nothing new; the United States banned contraceptives and abortions (in 1872) and prohibited liquor sales (in 1920).<sup>2</sup> Today, however, the political urge to regulate private behavior extends to a growing array of issues: tobacco, obesity, abortion, the right to die, drug abuse, and even a patient's relationship with his or her managed care organization. The list goes on. Traditional health policy debates turned on avowedly public matters such as building a health care infrastructure (through programs like Hill-Burton), increasing access to health care (national health insurance), or organizing research (Centers for Disease Control). Of course, these issues remain important. But today they are often eclipsed by (or even reframed as) fierce conflicts over private behavior.

Second, regulating private behavior prompts a distinctive political process. To place an issue on the political agenda, advocates must persuade others that private behavior holds important public ramifications; as we have argued elsewhere, that threshold puts a particular premium on demonizing either users or providers (Kersh and Morone 2002a, 2002b). Although regulating private behavior, like everything else in American politics, often bogs down in legislative stalemate, the focus on individu-

1. This episode is well chronicled in Kessler 2001; Derthick 2005; and Adams and Brock 1999.

2. On the long history of regulating private lives, see Morone 2003 and Kersh and Morone 2002a, 2002b.

als makes it especially well suited for judicial action. The emphasis on regulating private behavior leads to an increasing reliance on the courts. Judicial actors have become key health care policy makers across a wide range of contentious issues.

Tobacco is the best-known case of the changing politics of health policy. Beginning in the early 1990s a long-standing tradition of debating tobacco issues in Congress and state legislatures suddenly shifted. As Martha Derthick (2005: 2) summarizes, tobacco policy was “largely removed from legislatures and instead made a subject of litigation.” More on tobacco follows; here, two further examples will suggest the sheer scope of this political trend. As managed care organizations spread in the 1990s, patients and physicians lodged complaints about arbitrary limits on care. Politicians responded by promising a patient’s bill of rights. Note that individual rights—enforceable in court—eclipsed more traditional, universal solutions such as tough-minded regulation or compulsory insurance benefits. Congress never managed to pass a patient’s rights measure; after several years of failure, Ted Kennedy lamented publicly “when you’ve got a situation where Republicans control all the levers of power in Washington, and the insurance industry [is] calling the tune, it would be impossible to get a good bill through the House and the Senate” (Goldstein 2003: A4). The issue was, however, successfully litigated in a variety of state and federal venues, culminating in “a series of United States Supreme Court cases between 2000 and 2003 that have dramatically changed the legal landscape for managed care” (McLean and Richards 2004: 284).

In a very different case, removing Terri Schiavo’s feeding tube (the Florida resident had been in a persistent vegetative state for fifteen years) prompted a political frenzy. Congress, the Florida legislature, President Bush, conservative interest groups, and the media leapt into action—only to discover that Schiavo’s fate was controlled almost entirely by the courts. An especially telling feature of the case was the response from moderate public officials in both political parties. They passed over all the complex issues surrounding end-of-life care: What do we owe each individual? What can we as a society afford to provide? Instead, the oft-repeated moral of the case was focused on private lives and the law: get your living will in good legal order.

Understanding the new health policy frame is crucial for analyzing the politics of obesity, and obesity, in turn, offers a clear illustration of the emerging political pattern. We also draw comparisons to other health policy cases along the way—recognizing that each is different and that variations are as important as similarities. Ultimately, however, obesity

reflects an increasingly familiar routine at each step of the political process: the definition of the problem; the response from Congress, administrative agencies, and the courts; and the important cultural consequences of the policy debate.

### **Making the Problem Political**

In 2001, the surgeon general issued a report that warned of an obesity epidemic; since then, obesity rates have continued to increase. Over 65 percent of all Americans are overweight and 31 percent are clinically obese.<sup>3</sup> Policy makers suddenly found themselves bombarded by data about obesity's toll—on our lives, our health, and our budgets. At first glance, politics may seem irrelevant. What could be more personal than the food we eat or the shape of our bodies?

As it happens, making a political issue out of private behavior is nothing new. Americans often turn private actions into national problems. Temperance advocates challenged drinking, Victorian reformers (led by the American Medical Association) banned abortion and birth control, and various drug wars sprang up to proscribe substances from smoked opium (in the 1870s) to marijuana (in 1937). While much has changed over the years, the first hurdle as politics moves into personal lives is always the same: persuading policy makers that some familiar private activity poses a public problem and requires government action.

Obesity's rise to political prominence—to a crisis demanding action—has been astonishingly swift. Fewer than a dozen stories on obesity-related public policy appeared in major U.S. media outlets during the final quarter of 1999. The surgeon general issued an alarm, in the form of the first official report on obesity, in 2001. By the final quarter of 2002, the stack of obesity articles topped 1,200—a thousandfold increase. Over 1,400 stories appeared during the second quarter (April–June) of 2003, and the total has remained well over 1,000 stories per quarter since.<sup>4</sup> Most national publicity offers variations on the same theme: Americans face a crisis. The obesity epidemic reaches beyond adults and increasingly endangers children. An estimated one in three U.S. adolescents are overweight (15 percent are clinically obese), a figure that has tripled in the past twenty years; some 80 percent of this group will become obese adults.

3. Standard classifications of obesity are based on body mass index (BMI), a ratio of weight to height. Nearly two-thirds of Americans have a BMI of twenty-five or higher (overweight); just under a third register BMIs over thirty (obese). Severe obesity—a BMI of forty and higher—quadrupled among American adults between 1986 and 2000.

4. Figures from International Food Information Council 2004.

Two institutional forces propel the problem onto the public agenda: the medical establishment and the financial incentives in our high-cost health care system. Both are longstanding features of the American policy scene. They helped drive the tobacco wars, and they are likely to turn other risky private behaviors into policy problems in the future.

## Medical

Health care is America's largest business and health one of popular culture's obsessions. Medical advice, health fads, and health warnings get major media play. When the health care establishment converges on a message, especially a warning of danger, it becomes front-page news. Obesity had been a medical concern since the 1950s, but it was much more recently—and very suddenly—that medical leaders such as the surgeon general, prominent physicians, and health researchers began targeting fat as the nation's greatest public health danger.<sup>5</sup>

Physicians urge the government to combat obesity on two broad grounds. First, reducing obesity clearly has life-saving and life-prolonging effects. Second, reduced obesity can significantly enhance the quality of life, especially among adolescents and young adults. Health specialists have powerfully documented these claims. They estimate nearly 300,000 deaths annually due to obesity.<sup>6</sup> Overweight and obese persons, especially adolescents and young adults, face a greatly heightened risk of diseases such as diabetes (Pereira et al. 2005) and marked losses in life expectancy (Olshansky et al. 2005; Allison et al. 1999). Across all races and age cohorts, even moderate levels of obesity—a body mass index (BMI) higher than thirty—result in an estimated loss of life of two to five years. A greater sense of urgency lies in the details. Twenty- to thirty-year-old white men with severe obesity (a BMI of more than forty-five), for example, face an average of thirteen years of lost life. Highly obese white women in the same age group face a loss of eight years. Severely obese African American men in the same age range lose up to twenty years of life and African American women up to five (Fontaine et al. 2003).

5. On the medicalization of obesity, see Kersh and Morone 2002a: 169. On obesity as national health threat, the Cleveland Clinic's chief of cardiology recently commented that "the word 'epidemic' doesn't even do this justice. It is one of the most profound medical crises we've had in generations. . . . We are at the point now where it is so profound we have to be creative, and we can't take decades to fix this because it's happening so fast" (quoted in Connolly 2003b; compare Olshansky et al. 2005).

6. The debate surrounding estimates of deaths due to obesity is summarized in Flegal et al. 2004.

Eye-popping numbers such as those turn clinical studies into calls for action.

Obesity rates among preschool children have soared, leading to unexpected rates of increase in diabetes, hypertension, and even heart attacks among especially obese children (Komaroff 2003: 8; Quattrin et al. 2005; Stephenson 2003). The piles of data come peppered with moving profiles of obesity's young victims. Perhaps most unsettling, recent studies estimate that obese young adults face a major and significant reduction (approaching 25 percent) in expected remaining years of life (Fontaine et al. 2003). Recent medical research suggests that, as a result, today's youth may be the first generation in American history with a shorter life span than their parents (Olshansky et al. 2005). And the United States is not alone: the World Health Organization recently classified obesity as one of the ten most pressing global health problems (Kelner and Helmuth 2003: 845).

Obesity also deeply affects quality of life. Researchers surveying severely obese youth about lifestyle factors (physical activity, friendship, missed school days) found that their quality of life was roughly equivalent to that of pediatric cancer patients undergoing chemotherapy (Schwimmer, Burwinkle, and Varni 2003). Compared to healthy children, the highly obese cohort was more than five times as likely to report a low quality of life along multiple dimensions. Studies of obese and overweight adults also chronicle very low levels of self-esteem and elevated levels of anxiety, depression, and other measures associated with an impaired quality of life.<sup>7</sup> The stream of epidemiological data all converge on the same point: government officials ought to take action for the public good.

### Economic

America's high—and rising—health care costs mean that people's risky private behavior raises taxes (for government health care) and increases premiums (for private insurance). There is a direct economic logic to arresting bad health behavior. In an era when no policy assessment is complete without cost-benefit analysis,<sup>8</sup> the fight against obesity gets plenty of attention.

7. On the antifat culture in the United States and many other advanced industrial nations, see Kersh and Morone 2002a: 166–168. Even health professionals who specialize in obesity display a decided prejudice against obese patients: see Schwartz et al. 2003.

8. On the (lamentable) ubiquity of the “market model” in contemporary policy analysis, see Stone 1997.

Estimated economic losses due to obesity are calculated with increasing precision. Recent estimates peg direct U.S. medical expenditures for obesity-related conditions (which include diabetes, heart disease, renal failure, and hypertension) at between \$92 and \$117 billion in 2002; the higher figure represents nearly 10 percent of all U.S. health care costs. Indirect costs of obesity, such as lost productivity, lost wages, and future earnings lost due to premature death, add another \$56 billion.<sup>9</sup> Obesity's economic effects already rival those of smoking, reports the U.S. surgeon general (Satcher 2001: 8); Roland Sturm, the author of a RAND Corporation study, concluded that the health care costs of obesity "are exploding. Any absolute number you quote will be wrong next year" (Olick 2003). Public perception of obesity's costly toll is also spreading. A widely reprinted *Baltimore Sun* editorial (2003) warns that "the size of your waistline may no longer be your own private business," explaining that "the obesity epidemic is driving up health care costs at the same deadly rate as tobacco use, and everyone is picking up part of the tab. . . . With evidence that nearly 10% of all medical spending can be attributed to excessive weight[,] questions are being raised about how to address what is largely a preventable ailment."

Many policy makers who dismiss the health alarms find themselves moved by budgetary arguments, especially when they are made by business leaders. Prominent business periodicals showcased a 1998 study analyzing the economic burden of obesity on American businesses; the increased costs of health insurance, sick leave, and disability insurance came to an estimated \$12.7 billion (Thompson et al. 1998). A front-page Sunday *Washington Post* article bluntly reported this latest moral hazard: "the non-obese are forced to subsidize the obese" via higher insurance rates and higher Medicare and Medicaid costs (Connolly 2003a: A1). The most definitive study to date, released in the *Journal of the American Medical Association* in December 2004, substantiates the claim that average annual and cumulative Medicare charges rise significantly with increasing BMI, for both men and women. As that notion gains currency, a political issue gathers force (Daviglius et al. 2004).

9. On direct medical costs, \$92 billion is reported in Finkelstein, Fiebelkorn, and Wang 2003; health economist Roland Sturm's RAND Corporation study puts the figure at \$117 billion (Sturm 2002). On indirect costs, see Thompson and Wolf 2001; \$56 billion is the official Department of Health and Human Services figure for 2002 (Connolly 2003a).

## **Explaining the Epidemic: Why Are We Getting Fat?**

Identifying a national health problem does not, in itself, guide policy makers to a solution. A comprehensive public-opinion survey undertaken by political scientists Eric Oliver and Taeku Lee (in this issue) suggests a distinct lack of public consensus about the topic; however, media attention to the politics of fat has spiraled since their survey was conducted in spring 2001. As public health warnings mount, pressure for some kind of government action increases. In fact, the spotlight on obesity has drawn attention from the White House, Congress, and all fifty states. A nation that is extremely chary of explicit limits on health care—we dread rationing health care—is always eager to identify a culprit behind inexorably rising costs. But what might policy makers do about eating?

Framing a response requires explaining the root of the problem. Why are people overweight and obese? Two overarching explanations define two very different kinds of solutions, involving dramatically different policy recommendations. The responses are not mutually exclusive. Indeed, in the past, both worked together to prompt government action. However, in our highly partisan political environment, political activists often seize on one and dismiss the other.

### **Personal Choices: Weak Will**

An explanation dating to the early twentieth century blames individuals for getting fat. They lack willpower; they make foolish food choices; they live unhealthy lifestyles. A century of diets is built on this logic. So are endless late-night advertisements touting (rather dangerous-looking) devices that promise to restore American abs to their prelapsarian condition. Fat people, the argument goes—like smokers or heavy drinkers—make their own personal choices. Put bluntly, overeaters could “just say no” and push away from the table.<sup>10</sup>

This commonsense view yields a range of political responses. Some observers simply insist on personal freedom. The first response, as obesity (like smoking or virtually any personal matter) reaches political consciousness, generally emphasizes the personal nature of the activity and that

10. Among many such claims, see the editorial comment in the *Superior (Wisconsin) Daily-Telegram* (2003) decrying obesity lawsuits: “When it comes to eating, we all have to take responsibility for the choices we make, whether ordering a salad, veggie burger or a Big Mac.”



bottom American line: free choice. In a culture that prides itself on individualism, private behavior is brusquely declared off-limits to state intervention. “The government should stay out of personal choices I make. . . . my eating habits or yours don’t justify the government’s involvement in the kitchen,” writes Washington University economist Russell Roberts (2002: A13).<sup>11</sup> This call for freedom was (and remains) the tobacco industry’s major line of defense against government intrusion and is frequently sounded by food industry representatives as well. In this view, a nanny state interfering with basic life choices—like what I eat for dessert—is a cure far worse than the disease.

Fat, fitness, and related issues also provoke images of vice and virtue. From the nation’s Puritan start, Americans have read health and wealth as marks of personal virtue (Morone 2003). Some people work hard to maintain a healthy lifestyle, on this view, and they reap the benefits of their virtue: good health, better social lives, and additional happiness. The inevitable downside sees obesity (like smoking, heavy drinking, or poverty) as personal failures. Obese people have no one to blame but themselves. This view gathers strength from basic demographics: obesity (like smoking) is more of a problem among poorer people. American Enterprise Institute scholar Douglas Besharov (2002) promotes a similar claim in casting federal school-lunch and the Women Infants Children (WIC) programs as “helping to make the poor fat.” Tellingly, a bill forbidding lawsuits against the food industry—one that passed the House in 2004, but died in the Senate—was titled the Personal Responsibility in Food Consumption Act.

Arguments against interfering in private lives tend to retreat as public health advocates and budget hawks bombard Americans with warnings and data. Media attention impels politicians to do something. The next step is to suggest that perhaps people do not really understand the dangers implicit in their lifestyle choices. Tobacco companies’ experience is instructive in this regard: after the surgeon general’s famous 1964 report that definitively linked smoking and cancer, the public relations firm Hill and Knowlton privately recommended “mailing a copy to every citizen in the country. . . . Their idea was to convey the message that adults should understand their risks and accept the responsibility of intelligent decision-making” (Kessler 2001: 202–203). The suggestion was vehemently rejected by tobacco executives, whose stonewalling eventually became a “fatal flaw” (*ibid.*: 369) in their defense against litigation.

11. Roberts’s op-ed piece was syndicated nationally.

Food industry leaders have reacted more nimbly, embracing government recommendations that consumers should be educated to eat (or drink) wisely. Everyone should be encouraged to exercise. Government officials can act as educators and mentors, promoting improved health habits and publicizing the dangers of obesity. The food industry can chip in and sponsor sports events, donate athletic equipment to schools and tout new “lite,” “healthy,” or “slimfast” product lines.

In short, a range of solutions—in both private and public sectors—demonstrate concern for the rising problem without violating the imperatives of privacy, choice, and free enterprise. If the problem lies entirely in people’s personal lifestyle decisions, sensible policy solutions must inform those choices.

But what if people are being manipulated or misled? The politics of tobacco changed when critics persuaded the public that the industry had lied. Does the food industry also make misleading claims? Perhaps those lite products, for example, contain less fat but more sugar? Would more careful labels help guide consumers? Such suggestions shift the focus from obese individuals to the environmental factors that might impel them to overeat.

### The Alternate Villain: Fat Food Nation

An alternative definition of the problem targets an “unhealthy food environment.” Suddenly, a dizzying variety of health snares snap into focus. For starters, American portion sizes have undergone an extraordinary expansion. The typical hamburger in 1957, for example, weighed in at one ounce (and 210 calories). Today, that burger is up to six ounces (618 calories)—and that is before you add bacon, cheese, supersized fries (another 610 calories all by themselves), and a double gulp (sixty-four-ounce) soft drink (Brownell and Horgen 2003: 183–185; Rolls 2003). Entrepreneurs in the highly competitive food service business trumpet ever-larger portions—think Whopper, Xtreme Gulp, Big Grab, and The Beast—which keep upping the ante in serving sizes.

A subtler version of the same problem lies in hidden ingredients. Food specialists, such as Brownell and Horgen, point out that even relatively healthy products come loaded with sugar, which is “a cheap way to make food taste good.” Sugar (or high-fructose corn syrup) is the first ingredient in Kellogg’s Strawberry Nutri-Grain yogurt bars, second in Skippy Super Chunk peanut butter, and third in Heinz ketchup (*ibid.*: 29–30; Nestle 2002).

Obesity as a policy problem is redefined, in this perspective, and focuses on a powerful food industry organized to push ever more calories into the American public. The problem includes hidden content, portion size, relentless advertising, and the ubiquity of high-fat junk food (your airport terminal gate is never far from a donut).

Some critics take the next step and identify corporate villains. Food merchants cynically manipulate children. They put soda machines in schools and fast-food outlets in the lunchrooms. Nothing moves the political system like tales of greed and profit—especially when they menace kids. As the most ardent critics put it, a cynical industry targets children, reshapes their eating habits, and casually sponsors an obesity epidemic. As medical researchers directly relate children and young adults' fast-food eating habits to dangerous health conditions, Ronald McDonald joins Joe Camel as a threat to American children.<sup>12</sup>

When policy makers trace the problem partially to the industry (or, less pointedly, the “food environment”) rather than obese people themselves, an entirely different set of solutions comes into view. These include more detailed food labels, controlling the advertising directed at children, rethinking school nutrition, regulating the fat content of foods, imposing higher taxes on unhealthy ingredients, punishing false or misleading nutritional claims, and subsidizing healthy alternatives. This roster of strong action—echoing tobacco policy outcomes—represents a series of strategies for shifting the incentives that face the food industry today.

Of course, redefining the problem also redefines the politics. At first, most industries resist government regulation and this one has done so extremely effectively. The food industry—well organized, well financed, and politically savvy—does not deny the obesity crisis or epidemic. Rather, it shifts attention to the first definition of the problem, focusing on individual diet and lifestyle.

Still, as long as public attention remains focused on obesity, the definition of the problem—personal or environmental or both—will remain contested. Policy makers typically begin by following the path of least political resistance. Public policy focuses on individuals and unexceptional efforts (strong on exhortation and symbols) to help them stay healthy. If the problem (or, rather, the publicity) persists, the prospect of more

12. See, for example, Schlosser 2001; Farley and Cohen 2001; and Brownell and Horgen 2003. For one representative recent study, see Pereira et al. 2005 (which analyzes over three thousand young adults' eating habits; controlling for other factors, consuming fast food two or more times a week resulted, on average, in an extra weight gain of ten pounds and doubled the risk of prediabetes over the study's fifteen-year period of analysis).

complex and intrusive public action emerges. Actual decisions—concrete policy choices—turn our attention to the political arenas themselves.

### **Traditional Health Policy Institutions Respond**

Issues often move through the policy stream fueled more by rhetoric than action.<sup>13</sup> Obesity has been no exception. A drumbeat of messages from the Bush administration and congressional leaders primarily encourages self-help activities such as exercise and sensible eating. Congress's highest profile activity concerning obesity has involved efforts to ban lawsuits against the food industry. Will government action grow bolder?

#### **Congress**

In a representative democracy, that question is traditionally answered in the elected branches of government. However, students of recent health policy know that change—especially at the national level—has been either halting or nonexistent. Health care reform, a patient's bill of rights, the tobacco settlement, medical privacy regulations, malpractice reform, and a host of other policies have all failed to pass Congress. The most significant health care measure enacted in recent years, a prescription drug benefit, has encountered massive criticism (including from former backers such as the American Association of Retired Persons [AARP]) and is likely to be revamped considerably. After a thorough survey of high hopes and legislative defeats, Mark Peterson (2005) tagged Congress "the graveyard of health care reform" (207).

Congress's principal response to obesity has been a wealth of rhetoric deploring the crisis, along with occasional expressions of concern about consumption habits and (from the Democratic minority) industry practices. Scant legislation has resulted. The 108th Congress's most prominent bill to combat obesity, introduced by Senate Majority Leader Frist in 2004, promised little beyond grants to encourage "healthy behavior" and "active lifestyles" (Dyer 2005). Even this modest measure failed to pass the House.<sup>14</sup>

Republican proposals and responsibility rhetoric keep the focus on indi-

13. The gap between agenda importance and substantive action is analyzed in Kingdon 1984.

14. Childhood Obesity Reduction Act (S. 1172; the failed House version was H.R. 716); some public health advocacy groups dismissed the Frist legislation as "very suspect."

viduals, rather than any broader policies that might accompany a more environmental analysis of the problem. When Majority Leader Frist introduced a bill promoting nutrition education in 2003, he emphasized that the measure “is not going to have ‘sin’ taxes or ‘fat’ taxes. It’s not going to be punitive in any way.” Representative Ric Keller (R-FL) introduced the Personal Responsibility in Food Consumption Act (H.R. 339) in July 2003 to block frivolous lawsuits against food and beverage companies. An accompanying press release concluded, “We need to put the brakes on plans by the trial lawyers to make the restaurants and the food industry the next Big Tobacco.” Senate Majority Whip Mitch McConnell (R-KY), who described the lawsuits as “abusive,” introduced a similar measure in the Senate. Though the proposed act did not pass the 108th Congress, as of early 2005, fourteen states had enacted so-called “cheeseburger bills” forbidding obesity lawsuits, with eighteen others considering such legislation.<sup>15</sup>

On the other side of the aisle, some Democrats have pushed for more expansive legislation. But as the minority party in both congressional chambers, their proposals have been nonstarters. Senators Patrick Leahy (D-VT) and Tom Harkin (D-IA) have called for stronger government action and—predictably beginning with children—unsuccessfully sought expanded Department of Agriculture regulatory authority over meals served in public schools (Greenblatt 2003: 92–93). Another recent Harkin measure included some regulation of TV advertising as well as other regulatory provisions; the Healthy Lifestyles and Prevention (HeLP) America Act (S. 2558) died in committee in the 108th Congress.

Why such congressional inaction in the face of what observers on both the left and the right define as a policy crisis? Political scientists have perhaps overexplained the stalemate. The checks and balances of the American political system make any ambitious change difficult, and barriers have multiplied in recent years. Congress is evenly divided and fiercely partisan. Recent trends in political campaigning exacerbate this partisanship, thanks to a revolution in political information technology that permits the majority party in each state to craft safe congressional districts. A representative who raises sufficient funds in a reliable district need only worry about a maverick challenge from the political fringe; in primaries, when only the most committed partisans vote, Republicans

15. McConnell made his remarks in testimony on the bill before the Senate Judiciary Committee in October 2003 (McConnell 2003: 1); Frist and Keller commented in press releases from their respective offices. Frist’s measure, the Improved Nutrition and Physical Activity Act (IMPACT), was S. 1172, reintroduced in June 2003. The measure primarily provides funds for expanded studies and record-keeping concerning obesity.

face challenges from their right, Democrats from the left (Shafer 2003). Partisan calculations point to different explanations of the obesity problem (individual versus industry), clashing attitudes toward government action, and very little inclination to compromise.

Obesity politics is further complicated by the dizzying array of foods and the complicated claims and counterclaims about nutrition.<sup>16</sup> Naturally, food companies and their lobbyists play a major political role. As with most industries, their initial response is to bluntly resist all intrusive regulations (Nestle 2002: 99–110; Brownell and Horgen 2003). However, food producers are different from tobacco companies. Once regulations begin to take hold, different sectors of the industry—health foods, organic producers, fruit companies—might abandon the united front and seek market advantage in a new antifat regulatory regime (Brownell and Horgen 2003: 275). Still, these are speculations for the distant future. For now, we can expect a partisan and divided Congress to balk at significant action. After all, a legislature that did not act on tobacco is unlikely to wade into the far more complicated currents of regulating food.

### Executive Agencies

The Department of Health and Human Services (DHHS) has also been rhetorically active. In May 2003 alone, for example, Secretary Tommy Thompson issued major statements on Americans' physical activity and on the costs of obesity, sponsored a national town meeting on obesity-related diabetes, and called for society to "pressure the food industry, the fast food industry, [and] the soft-drink industry . . . to offer healthier foods" (while rejecting lawsuits as an option for doing so) (Carey 2003). In the early fall Thompson publicly challenged overweight employees of the Department of Health and Human Services to improve their health and launched a weight-loss regimen himself (Carey 2003). Similar pronouncements and activities have continued through the appointment of a new secretary in 2005.

But no concrete policy recommendations, much less integrated programs for combating obesity, have been issued from the DHHS secretary's office. As the nonpartisan *Congressional Quarterly* reported, "rather than imposing new nutrition labeling or other rules on the restaurant industry,

16. On this, see Kersh and Morone 2002b (suggesting, in part, that the FDA manages to regulate the equally complex realm of drugs, distinguishing among over-the-counter, prescription, and banned substances).

the Administration prefers to focus on funding local efforts to encourage more exercise” (Greenblatt 2003: 91, 97). Partly in response to such apparent caution, a variety of academics and journalists have called for a new federal agency to coordinate antiobesity measures: a Department of Exercise or perhaps a National Institute of Obesity (or, as one wag had it, a Department of Homeland Obesity). The institute would be housed in the National Institutes of Health (Downey 2004; Jamieson 2003).

The FDA has also moved slowly with respect to obesity politics. With surprisingly little regulatory authority (despite “food” in the agency’s name), the FDA must bargain with and cajole food companies and entreat public support for its aims. As of this writing, these included three principal policies, all in the planning stage: nutritional-information displays in restaurants, highlighting calorie counts on packaged-food labels, and some as-yet-undefined program encouraging healthier diets among Americans (Mathews and Leung 2003; U.S. FDA 2005). After the FDA’s failure to gain regulatory authority over tobacco (discussed later), it is unreasonable to expect assertive action with respect to the food industry.

Finally, like Congress, the executive branch is subject to multiple and overlapping jurisdictions over personal health behaviors such as smoking and obesity. The DHHS, the Agriculture Department, the FDA, and even the Office of Management and Budget (through its central clearance authority) all have important responsibilities for various aspects of the food and obesity issue. As with Congress, the executive branch’s institutional framework blunts policy action. And where national executive and legislative officials tread cautiously (or not at all), other actors move to fill the void.

### State Policy Makers and Obesity

The obesity epidemic has set off a flurry of activity in the states. During 2003, state lawmakers filed some 170 bills to combat obesity, more than twice the then-record 72 bills filed in 2002; the number doubled again, to more than 350, in 2004. A patchwork quilt of state laws now seeks to reduce obesity rates by getting tough with food industry (through policies like junk food taxes) on the one hand and protecting the industry (by banning lawsuits) on the other.<sup>17</sup> Inconsistent programs across different

17. Figures are from the National Conference of State Legislatures (NCSL), Health Policy Tracking Service. The NCSL separates its count for general obesity bills and those specifically affecting childhood obesity; the latter made up more than three-fifths of the 2004 total.

states—and the vulnerability of state regulatory regimes to industry lobbying efforts—push antiobesity advocates and stakeholders such as school officials to seek coherent national policies.<sup>18</sup> And the judiciary may be the easiest venue in which to pursue such a systematic policy. The emerging politics of public health—with its emphasis on regulating private behavior—makes the courts an increasingly important locus of decision.

### **The New Litigation and Public Health**

The judiciary remains the most active venue for social change in health politics, especially on the federal level. In part this is by simple default—the other branches are not inclined (or not able) to act. Moreover, issues of private behavior fit easily into the judicial process. Judicial policy making is, however, a profoundly controversial topic. Constitutional critics charge that judges entering the political fray undermine the autonomy of executive agencies or legislators and upsets the delicate balance of separated powers at the heart of American politics. Defenders claim that an active judiciary in fact reaffirms that balance. Obesity and other public health issues have become a new and vital locus in this debate.

In the next sections, we outline an emerging “new litigation” paradigm, then describe its lineaments in detail via the case of tobacco politics in the 1990s. We then consider the alleged drawbacks to judicial policy making (which inspire so many legislative proposals restricting lawsuits) and conclude with speculation about the future of obesity politics in light of the new litigation.

### **Courts and Public Health**

Almost from the origins of the American republic, constitutional commentary has sought to reconcile judicial review and democratic representation. The central question turns on whether courts may legitimately overturn decisions of the elective branches—declaring unconstitutional the acts of legislators or executives at various levels of government. Legal scholar Cass Sunstein offers a popular standard when he promotes “judi-

18. To take one of countless examples, the *State Education Standard*—a quarterly journal published by the National Association of State Boards of Education—devoted its entire December 2004 issue to childhood obesity, including prominent calls for *federal* leadership and policy responses (Rhiner 2004: 22). On the rollback of state regulations, see Nestle and Jacobson 2000.



cial minimalism.” Writes Sunstein (1999: 99), as long as “there is no democratic defect in the underlying political process, the Court should not strike down reasonable legislative judgments.”<sup>19</sup> But what happens when the elective branches become bogged down in partisan stalemate and fail to meet demands for action?

Health policy has not moved through Congress despite (or perhaps because of) the enormous stakes involved. Issues including health maintenance organization (HMO)/managed care reform, asbestos, tobacco control, and gun restrictions have all proceeded up the U.S. policy agenda without decisive action by the elected branches of national government. Enter the judiciary. Of course, courts do not possess roving commissions; they are constitutionally limited to a passive role. Judges rule on policy issues only when they are petitioned to do so. However, in contrast to frequent legislative impasses, courts eventually decide, one way or another. And the volume of health-related petitions keeps growing. As one veteran of the health policy wars concludes, “Litigation . . . is replacing regulation as the ticket to corporate accountability” (Kusnet 2003: 7). Some critics charge in response that the rationale for judicial intervention is conveniently broad: “Under this theory, any failure to intervene in the name of public health, no matter the cost, is a failure to serve the public interest. Given that government has failed, special interest groups that claim to be serving the public interest move to the courts” (Morriss, Yandle, and Dorchak 2005: 245).

Litigious approaches to public policy take several different forms. The most prominent has traditionally been class-action lawsuits and a subset of these, mass torts. Each has entered a new phase in recent years. During their initial surge in the 1960s, class-action suits primarily concerned civil rights, securities, or consumer issues; lawyers aimed to recover compensation for injured parties or to encourage regulatory enforcement. These goals are present in the recent public health court cases, but are supplemented by a novel twist. Legal scholar Deborah Hensler (2001a: 207) detects a shift to a “new litigation” characterized by an emerging form of *social policy torts*: “In addition to seeking monetary compensation for individuals and public entities, the new litigation seeks the kind of industry-wide changes in corporate products and practices that advocates have pursued, without much success, in state and federal legislatures. . . . these lawsuits have a political dimension that is not generally present in other

19. Much room remains for debate, as Sunstein acknowledges, about what constitutes “reasonable.” See also Choper 1980.

damage class actions” (compare Clermont and Eisenberg 2002; Hensler 2001b: 888–890).

The most prominent social policy torts have directly addressed public health issues blocked in Congress. Many of these cases involve private behavior, including tobacco, obesity, dietary supplements, patients’ rights, and gun safety. Efforts to regulate private behavior have traditionally landed in the courts, perhaps because such issues require governments to negotiate the tension between public needs and private rights. Now, however, a much broader range of public health matters—managed care, asbestos, pharmaceutical costs and imports, diesel emissions, and so forth—have also moved from Congress to the courts. Why does this new litigation have such a distinctly public health tint? Perhaps the answer lies in common denominators running across the cases: a large collection of affected individuals (smokers, health-plan members, pharmaceutical users, etc.); an easily identifiable corporate target (“Big Tobacco,” gun manufacturers, managed care bureaucracies, fast food companies); widespread demands for action; and stalemate on Capitol Hill, in the White House, or both. In each case a coalition of advocates has formed, often led by state attorneys general and private class-action attorneys—a novel public-private combination in American politics.

The first obesity cases are now just reaching the courts, accompanied by angry complaints from politicians seeking to block intrusive action in the legislatures and administrative agencies. What does the future hold for this new spate of suits? A closer look at the tobacco example may provide a rough guide.<sup>20</sup> It also offers cautions for every political side. Tobacco illustrates both the promises and the pitfalls of the new litigation.

### The Tobacco Model

Smoking regulations date to the late nineteenth century. Several states outlawed cigarette advertising and sales as far back as 1893. In 1907, Illinois went further and also outlawed cigarettes’ manufacture and use. The National Anti-Cigarette League was launched around the same time; in 1920, its president, Lucy Page Gaston, became the second woman to run a prominent campaign for U.S. president. But neither public health advo-

20. The tobacco/fatty foods analogy is increasingly drawn, as in Oliver and Lee (in this issue): “The parallels—among other things, the multifactorial causal determinants and the contentious dynamics of individual autonomy, the nation’s physical and economic well-being, and government regulation—are all present.” See also Kersh and Morone 2002a, 2002b.

cates nor occasional prohibitions seemed to slow the rise in American cigarette consumption, which peaked at some 4,300 cigarettes per capita in 1963. The following year's report of a special commission established by the U.S. attorney general launched a new round of antismoking policy efforts. These culminated in Congress's mandating warning labels on cigarette packs and cartons (1965), advertising restrictions (1970), and excise taxes (doubled in 1982, with several subsequent increases). A range of regulatory restrictions on smoking was also promulgated by agencies as diverse as the Federal Aviation Administration, the Interstate Commerce Commission, and the Environmental Protection Agency. State governments chipped in with a welter of antismoking restrictions between the mid-1960s and the early 1990s (Derthick 2005: 11–24; Adams and Brock 1999: 15–21, 128). The traditional model of tobacco policy making involved an active Congress and executive branch promoting change in tandem (or at least simultaneously) with state officials.

The most recent round in the tobacco wars began in 1991, spearheaded by FDA efforts to regulate tobacco as a drug. Eventually, an elaborate settlement brokered by the industry, tort lawyers, state attorneys general, and public interest groups came before Congress—and was killed in the Senate in June 1998. Two years later, the Supreme Court denied the FDA's regulatory authority over tobacco, by a 5–4 vote. The Court held that the agency had exceeded its constitutional powers.<sup>21</sup>

Yet despite failures by both elective branches to enact legislation or assert regulatory authority, an extensive regime of tobacco control did result from the 1990s tobacco battles. That regime was established through the courts, both federal and state. Tobacco control policy making shifted during the 1990s from an ordinary politics centered in elected legislatures to a new litigation (or, in Martha Derthick's term, a model of “adversarial legalism”) rooted in the judicial branch.

This wave of new litigation featured three principal elements. First, a broad coalition of state and federal actors, including attorneys general and tort lawyers, formed around the tobacco issue. Mississippi's attorney general was the first to file; within three years, thirty-one other states and the federal government had brought similar suits. Second, this coalition

21. Martha Derthick traces the convoluted policy efforts, and David Kessler's book-length account reviews the regulatory episode in even more detail (Derthick 2005: 50–67, 152–161 [FDA regulation], 119–146 [Congress and the settlement]; Kessler 2001: 49–339 [regulatory development], 355–384 [court decisions]). A few members of Congress continue to pursue legislation expanding FDA jurisdiction to cover tobacco; for a firsthand account, see Kennedy 2002.

sought not merely punitive or civil damages, but sweeping changes in the tobacco industry's products and practices—in short, they pursued policy goals more normally associated with legislatures. Enormous media attention marked the tobacco case, as it does other social-policy torts.<sup>22</sup> Third, the antismoking coalition adopted a multidistrict litigation strategy, collecting lawsuits arising from similar circumstances and bringing them before a single court or judge—a strategy which, as Hensler (2001a: 186) notes, “often encourages [pretrial] settlement of these claims, which may be the real goal of the parties requesting multi-districting” (cf. Hensler 2001b: 889–892). The settlement failed after Congress was unable to ratify it. The legal actors—attorneys general—pushed their states to separately sign on to the agreement negotiated with the tobacco industry in the context of their combined suits. The outcome: damages of \$246 billion spread across forty-six states and six other entities.

This description of the new litigation helps explain how courts became the key locus of action in the tobacco wars, a development that increasingly characterizes health politics more generally. First, inaction in national elective branches led an aroused public (spurred by interest-group advocates and expansive media coverage) to demand other means of redress. Second, a set of entrepreneurial actors, some relatively new to national politics, actively promoted their cause in the courts. Foremost among these were state attorneys general, who since the 1970s had become far more active, expanding their caseloads and filing more amicus briefs in Supreme Court cases. Initially their heightened workload was primarily in antitrust, civil rights, and consumer protection; with tobacco they turned to public health on a national scale. Similarly, tort lawyers have increased their presence in various realms of national policy making, including health care, during and after the 1980s. These plaintiffs' attorneys also adopted a much more coordinated strategy during the tobacco fight, a practice that has continued in other public health suits (Hensler 2001a).

Political partisanship likely further impelled this exercise in political entrepreneurship. During the height of the tobacco wars, Republicans controlled both chambers of Congress and thirty-three state governorships—but Democrats held the attorney general's office in thirty states. As Derthick (2005: 105) notes, “Although tobacco control sometimes elicits bipartisan alliances, as a general rule Democrats are far more committed to it than Republicans are, and the partisan difference sharpened in 1994.”<sup>23</sup> Political entrepreneurs inspired by partisan aims, media-fueled

22. On media attention in the tobacco case, see Derthick 2005: 110–114.

public outcry, and judicial officials willing to act where other federal officials would not: these were the main ingredients in the tobacco case and serve as a broad template for other public health efforts to rechannel private behavior.

Antismoking activists' jurisprudential strategy was not an unmitigated success. The courts blocked the FDA's effort to expand its authority and regulate tobacco as a drug; that move would have permitted extensive government intervention in the tobacco business. In effect, multiple court rulings add up to a kind of judicially imposed compromise between public health advocates and the tobacco industry. As the courts begin to dominate public health politics, the limits of judicial capacity become more important.

### The Limits of Judicial Capacity?

The tobacco case as well as class actions affecting managed care, gun manufacturers, asbestos producers, diesel engine emissions, and other industries—all pursued in the name of protecting public health—suggests that courts can be the locus for sweeping policy change.<sup>24</sup> But *should* they perform this role? One popular perspective, the *limited judicial capacity* view made prominent by Gerald Rosenberg and Donald Horowitz, strongly suggests that they should not. The judiciary is incapable of well-formulated and sustainable policy change, this school holds, owing to an elaborate set of structural and normative constraints.

First, critics argue that the constitutionality of court decision making is ambiguous. The Constitution plainly emphasizes policy making through elected—and therefore more accountable—officials in Congress, the executive branch, and state legislatures. Critics of judicial policy making caution further that the rights approach favored by courts is inappropriate for addressing complex social issues; the *stare decisis* requirement binds judges in ways that limit their inclination or ability to create policy innovations. The case method prevalent in court adjudication is “piecemeal,” using Gregory Intocchia's term, providing no sense of a broad spectrum of relevant problems—or a means of solving them (Intocchia 2001; see also Rosenberg 1993; Horowitz 1977; Derthick 2005, esp. 209–235; Epp 1998; Lovell 2003, esp. 3–42).

23. On political entrepreneurship in U.S. policy making more generally, see Sheingate 2003.

24. Differences color all of these cases; our interest here is in the general category of regulating public health by litigation, especially in areas once considered private.

Moreover, continue the critics, courts are usually inadequately equipped to deal with the technical, specialized nature of most policy concerns. Judges and litigators are trained as generalists, leaving them poorly situated to resolve complex questions concerning health effects, medical technologies, and the like. On another critical front, a glut of cases can result from mass-tort action in a public health arena, overwhelming the judiciary's capacity to address the issue. Exhibit A is asbestos litigation, which by 2001 had "morphed and grown into a colossus that nobody could have foreseen even just a few years ago" (Behrens 2002: 335). Moreover, note the foes of judicial policy making, the courts' focus on rights and obligations, along with the fact that federal judges are unelected officials, undercuts the democratic ideal of communal, deliberative solutions. As law professor W. Kip Viscusi (2002: 1) warns, "The policies that result from litigation almost invariably involve less public input and accountability than government regulation" (see also Lovell 2003: 13–14).

Beyond these principled reasons to oppose court involvement in public policy making, some critics question the effectiveness of judicial activity (see especially Rosenberg 1993). In the tobacco case, the aftermath of the 1998 settlement has witnessed only a slight decline in smoking rates across the United States; recent figures from the National Youth Tobacco Survey report little to no decline in youth smoking rates between 2002 and 2004 (CDC 2005). Alongside these evolving empirical judgments, a related matter colors the tobacco case—and, by extension, the broader implications of new social policy litigation: the politics of implementation. Courts are rarely able to devote sustained attention or significant resources to implement their policy directives; the tobacco settlement provides a prominent example of this difficulty with regulation by litigation.

A related source of controversy is the distribution of settlement funds. The 1998 Master Settlement Agreement includes no restrictions on how states spend their share of the \$246 billion—monies that will be provided in perpetuity and that may well be replenished by additional judgments against tobacco companies. Thus, a new set of distributional political issues arises in the wake of regulatory controversies. Some states, including Montana and Michigan, opted for state constitutional amendments governing their settlement allocations; others, including Pennsylvania and North Carolina, fought the matter out in their legislatures and in state courts. Thus one result of the new litigation approach to tobacco, again mirrored in other public health debates, is a fresh round of legal battles in the implementation stage—further cause for lament to critics of judicial policy making.

The limited-capacity view of judicial involvement has won wide currency in contemporary political science scholarship on law and courts. But as a few legal scholars counter, we are constantly thrown back to the legislative stalemate. As demands for action—even cries of crisis—meet a divided legislature, political action flows willy-nilly to the courts. As Judge David Souter (1991: 142) put it during his Supreme Court confirmation hearing before the U.S. Senate, “If there is, in fact, a profound social problem . . . and if the other branches of the Government do not deal with it, ultimately, it does and must land before the bench of the judiciary.” Such a view is developed in rich detail by George Lovell (2003), whose *Legislative Deferrals* sets out several reasons that elected officials actively (if quietly) seek court involvement: perhaps most worrisome, Lovell argues that legislators have increasingly—and deliberately—empowered judges as policy makers as a means of escaping accountability themselves, especially for potentially unpopular decisions. *Bush v. Gore*, anyone?

Other responses to judicial incapacity question the empirical evidence of courts’ inability to act. Intocchia’s (2001: 145) careful study of this question concludes that “those who would advocate limiting judicial involvement *cannot do so on empirical grounds* stemming from some claimed institutional limited capacity” (emphasis added). Courts have always been the final arbiters when private behaviors turn political. Now they have turned to a broad range of public health matters. Initial evidence confirms the judgment that the courts possess adequate institutional capacity. For better or worse, U.S. courts are remaking health policy related to tobacco, guns, asbestos, and HMOs. The food industry is now shaping up as the new litigators’ next target.

## Conclusion

The politics of obesity offers the latest version of an emerging form of public health politics—one that often focuses on private behavior, generally stimulates warnings about a crisis (from public health advocates, budget hawks, or both), and finds itself bogged down in legislative stalemate. The result is a policy process increasingly centered in the courts.

Both liberals and conservatives have, at times inadvertently, fostered the move toward the new politics of private regulation. Liberals have long drawn on the civil rights movement as an inspiration and a template for reform. That movement offers a rousing model for judicial activism in the face of legislative stalemate (Jacobson and Selvin 2005). Perhaps, too, the logic of *Roe v. Wade* and even the rise of feminism added to the trend. *Roe*

(and the case law leading up to it, most notably *Griswold v. Connecticut*) redefined a hotly contested political question (reproductive technologies from condoms to abortions) as a fundamentally private matter protected by a constitutional right to privacy (Morone 2003: 487–492). From the start, feminists understood that—in the classic phrase—the personal is political. To liberal thinkers, unequal power, even in very private conflicts (fast-food companies versus children, tobacco companies versus smokers), is a matter for political intervention. And when legislatures bog down in the face of perceived injustice, the courts beckon.

Ironically, conservatives unwittingly facilitated the trend. As they became the majority party, they firmly resisted new programs. The surgeon general's crisis warnings would not be enough to generate a taste for government action from the conservative majority. Inaction in the face of perceived crisis ratchets up the search for alternate solutions. Moreover, conservatives have long tended to blame policy problems (from obesity to poverty) on individual choices. Focusing on individuals and their behavior inadvertently shifts the policy process precisely toward the realm we have been describing.

■

What lies ahead for obesity? The tobacco wars' salient features may all be recognized, if sometimes in faint outline. Calls of crisis have received a recently familiar (non)response from the elected branches. Congressional action has been limited to committee hearings, rhetorical posturing, and near passage of bills explicitly opposing regulations on the food industry. The executive branch has pitched in with exhortations to a healthier lifestyle. In contrast, the judiciary has begun to signal a willingness to hear relevant class-action cases. National publicity, most of it derisive or bemused, focused on a February 2003 lawsuit brought by obese teenagers against McDonald's (*Pelman v. McDonald's Corp.*, 237 F. Supp. 2d 512, 2003). Although the court tossed out the case, the judge “went on—in less noted parts of his ruling—to set the stage for future lawsuits” (Zefutie 2004: 1405–1413). He practically instructed the plaintiffs in how to file a more successful brief. And in January 2005, a federal appeals court reopened parts of the 2003 *Pelman* case to allow discovery—precisely the step that led tobacco executives to agree to negotiations leading to the 1998 settlement.

The “new political entrepreneurs” identified in the tobacco case are also turning to obesity politics. One typical recent account reports that “attorneys-general in the US, encouraged by success against tobacco companies,



now have the food companies in their sights. ‘The attorneys-general will be the cutting [edge] force in the obesity argument,’ says Robert Merrell, a former governor and attorney-general of New Hampshire” (Grant 2005; see also Zefutie 2004: 1411–1413). Tort lawyers have filed dozens of class-action suits on behalf of obese litigants. And in a final parallel, one early and highly prominent litigant in the tobacco wars, law professor John Banzhaf III, was lead plaintiff in the McDonald’s case and has turned his attention more generally to the food industry.<sup>25</sup>

For its part, the food industry is responding, both by taking preemptive actions (reducing portion sizes in some packaged foods, for example) and quietly raising internal alarms: May 2005 marked the second annual international meeting of the Forum on Obesity Policy, Regulation, and Litigation: An Advanced Guide for the Food Industry, the invitation for which warns that “every company in the food industry needs to have a coherent but responsive strategic plan in place to grasp the opportunities and meet the challenges.” It is, of course, possible that industry representatives mindful of the tobacco example will encourage their congressional supporters to strike a legislative deal that wards off a judicial settlement (or manage to pass antilawsuit legislation, though Senate Democrats have consistently threatened a filibuster).

If the courts remain obesity politics’ principal venue, a series of finely honed suits target two of the vulnerabilities exploited in the tobacco case. One is aggressive marketing to children, which if found actionable could far outstrip the illegitimate print advertising cited in antismoking cases. Food companies advertise extensively on television and radio, often targeting children’s programming. They also bring their products directly into schools through in-school advertising on programs such as Channel One and “pouring rights” contracts signed with local school boards (some notorious contracts put the schools at financial risk if the children did not drink a specified quantity of the soft drinks).

A second topic of antiobesity litigation is deceptive advertising by fast-food companies and packaged-food manufacturers. Lawsuits have already been filed against companies both large (McDonald’s, which settled a suit for \$12.5 million concerning how its fries were cooked) and small (Robert’s American Gourmet, which paid out over \$3 million in a class-action suit

25. On Banzhaf and tobacco, see Derthick 2005: 97–98, 102. Banzhaf’s entry into obesity politics has been amply chronicled, not always positively: editorialized one Chicago journalist, Banzhaf “has never met a consumable product he didn’t hate or a hugely profitable company he didn’t want to sue” (Parker 2003: A1).

alleging that the firm misstated calorie and fat content of its best-selling Pirate's Booty snacks).

Antiobesity advocates in American public life applaud the involvement of courts as policy makers. It *does* appear easier to mobilize public support, move an issue forward, and finance activism in the judicial realm. But those targeting the food industry would also do well to remember that the sword of justice cuts both ways. Courts are less responsive to shifts in public mood, and—as would-be FDA regulators and advocates of the patient's bill of rights learned to their dismay in the late 1990s—can rule against advocates for public health.

Finally, the most significant result from past efforts to regulate private behavior—from a century of liquor prohibition to the recent tobacco wars—takes us beyond politics and into the cultural realm: Americans have often rethought their private behavior. When advocates detect a crisis, define a problem, and seek a solution, they are—indirectly and perhaps often unexpectedly—educating the public. Political conflict surrounding obesity is likely to grow, spread into the courts, bring some regulatory limits to the food industry, and generate considerable political heat. However, past efforts to regulate private behavior all point to something more fundamental: the most important consequence of a public health assault on the industry may lie in the changes that citizens make in their own personal lifestyles.

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