

Fat Tax

Judith Bell, Oakland
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David Leonhardt hits at the most underexamined part of the nation's obesity crisis. Our choices are constrained by the options available in our communities. A healthful diet is impossible if there are no nearby places to buy healthful food. Regular exercise is unsustainable in a community without a park or safe streets for running. Low-income communities suffer the most from such environments, so it is no wonder that low-income Americans suffer disproportionately from obesity and obesity-related issues like diabetes and heart disease.

Public policy is the only route to deal with these underlying problems. If we pursue a tax on unhealthful foods, the revenue should be directly used to solve these problems. We must act quickly. The obesity crisis will only get worse until and unless we act decisively.

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Original Article

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Two years ago, the [Cleveland Clinic](#) stopped hiring smokers. It was one part of a “wellness initiative” that has won the renowned hospital — which [President Obama](#) recently visited — some very nice publicity. The clinic has a farmers’ market on its main campus and has offered [smoking](#)-cessation classes for the surrounding community. Refusing to hire smokers may be more hard-nosed than the other parts of the program. But given the social marginalization of smoking, the policy is hardly shocking. All in all, the wellness initiative seems to be a feel-good story.

Which is why it is so striking to talk to Delos M. Cosgrove, the heart surgeon who is the clinic’s chief executive, about the initiative. Cosgrove says that if it were up to him, if there weren’t legal issues, he would not only stop hiring smokers. He would also stop hiring obese people. When he mentioned this to me during a recent phone conversation, I told him that I thought many people might consider it unfair. He was unapologetic.

“Why is it unfair?” he asked. “Has anyone ever shown the law of conservation of matter doesn’t apply?” People’s weight is a reflection of how much they eat and how active they are. The country has grown fat because it’s consuming more [calories](#) and burning fewer. Our national weight problem brings huge costs, both medical and economic. Yet our anti-[obesity](#) efforts have none of the urgency of our antismoking efforts. “We should declare obesity a disease and say we’re going to help you get over it,” Cosgrove said.

You can disagree with the doctor — you can even be offended — and still come to see that there is a larger point behind his tough-love approach. The debate over [health care reform](#) has so far revolved around how insurers, drug companies, doctors, nurses and government technocrats might be persuaded to change their behavior. And for the sake of the economy and the [federal budget](#), they do need to change their behavior. But there has been far less discussion about how the rest of us might also change our behavior. It’s as if we have little responsibility for our own health. We instead outsource it to something called the health care system.

The promise of that system is undeniably alluring: whatever your ailment, a pill or a procedure will fix it. Yet the promise hasn’t been kept. For all the miracles that modern medicine really does perform, it is not the primary determinant of most people’s health. J. Michael McGinnis, a senior scholar at the [Institute of Medicine](#), has estimated that only 10 percent of early deaths are the result of substandard medical care. About 20 percent stem from social and physical environments, and 30 percent from [genetics](#). The biggest contributor, at 40 percent, is behavior.

Today, the great American public-health problem is indeed obesity. The statistics have become rote, but consider that people in their 50s are about 20 pounds heavier on average than 50-somethings were in the late 1970s. As a convenient point of reference, a typical car tire weighs 20 pounds.

This extra weight has caused a sharp increase in chronic diseases, like [diabetes](#), that are unusually costly. Other public-health scourges, like lung [cancer](#), have tended to kill their victims quickly, which (in the most tragic possible way) holds down their long-term cost. Obesity is different. A recent article in Health Affairs estimated its annual cost to be \$147 billion and growing. That translates into \$1,250 per household, mostly in taxes and insurance premiums.

A natural response to this cost would be to say that the people imposing it on society should be required to pay it. Cosgrove mentioned to me an idea that some economists favor: charging higher health-insurance premiums to anyone with a certain body-mass index. Harsh? Yes. Fair? You can see the argument. And yet it turns out that the obese already do pay something resembling their fair share of medical costs, albeit in an indirect way. Overweight workers are paid less than similarly qualified, thinner colleagues, according to [research by](#) Jay Bhattacharya and M. Kate Bundorf of Stanford. The cause isn’t entirely clear. But the size of the wage difference is roughly similar to the size of the difference in their medical costs.

It's also worth noting that the obese, as well as any of the rest of us suffering from a medical condition affected by behavior, already have plenty of incentive to get healthy. But we struggle to do so. Daily life gets in the way. Inertia triumphs.

The question of personal responsibility, then, ends up being more complicated than it may seem. It's hard to argue that Americans have collectively become more irresponsible over the last 30 years; the murder rate has plummeted, and divorce and [abortion](#) rates have fallen. And our genes certainly haven't changed in 30 years.

What has changed [is our environment](#). Parents are working longer, and takeout meals have become a default dinner. Gym classes have been cut. The real price of soda has fallen 33 percent over the last three decades. The real price of fruit and vegetables has risen more than 40 percent.

The solutions to these problems are beyond the control of any individual. They involve a different sort of responsibility: civic — even political — responsibility. They depend on the kind of collective action that helped cut smoking rates nearly in half. Anyone who smoked in an elementary-school hallway today would be thrown out of the building. But if you served an obesity-inducing, federally financed meal to a kindergartner, you would fit right in. Taxes on tobacco, meanwhile, have skyrocketed. A [modest tax on sodas](#) — one of the few proposals in the various health-reform bills aimed at health, rather than health care — has struggled to get through Congress.

Cosgrove's would-be approach may have its problems. The obvious one is its severity. The more important one is probably its narrowness: not even one of the nation's most prestigious [hospitals](#) can do much to reduce obesity. The government, however, can. And that is the great virtue of Cosgrove's idea. He is acknowledging that any effort to attack obesity will inevitably involve making value judgments and even limiting people's choices. Most of the time, the government has no business doing such things. But there is really no other way to cure an epidemic.

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