were true, there still would be better and worse or more healthful and less healthful foods. The traffic-light system facilitates such a relative assessment and thus may promote more informed decision making. In addition, the greater value of the traffic-light approach may lie in its ability to motivate manufacturers to reformulate their food products to diminish red classifications and, in so doing, to improve the overall healthfulness of the food supply.

Evaluation of the various classification models for front-of-package labeling is under way. The effectiveness of any given system may vary with the population's nationality, culture, level of health literacy, and socioeconomic status. The IOM is currently undertaking an assessment of front-of-package alternatives — hence our dismay at the unilateral, unscientific, preemptive approach taken by the food companies. The industry leaders who profess to be responsible partners in preventing and controlling the obesity epidemic have an opportunity now to reject this noncollaborative, premature approach and show good faith by awaiting the IOM report and endorsing the best evidence-based approach to front-of-package labeling. Otherwise, industry may have proven itself untrustworthy again[2,3] and raised the risk of what it wishes to avoid — government's exercising its authority to mandate some types of labeling and to restrict others.[4]

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From Yale University, New Haven, CT (K.D.B.); and Emory University, Atlanta (J.P.K.).

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Nowhere Left to Hide? The Banishment of Smoking from Public Spaces

James Colgrove, Ph.D., M.P.H., Ronald Bayer, Ph.D., and Kathleen E. Bachynski, M.P.H.

On May 23, smoking in any New York City park, beach, or pedestrian mall — from Van Cortlandt Park in the Bronx to Brighton Beach in Brooklyn — became illegal. The city council passed the ban last fall by a vote of 36 to 12, rejecting a compromise proposal that small areas remain available to people who wanted to smoke. "I think in the future," the city's health commissioner, Thomas Farley, said at a public hearing, "we will look back on this time and say 'How could we have ever tolerated smoking in a park?'"[1]

New York City has often been a bellwether for the passage of public health laws, and there was symbolic significance in the fact that such iconic public spaces as Central Park and the pedestrian plazas of Times Square would be closed to smoking. Yet though the city's action may prove influential, it was not radical. According to the American Nonsmokers' Rights Foundation, more than 500 municipalities in the United States have passed some type of law banning smoking in outdoor recreation areas (see table). Such laws have been enacted in 43 states, most of them during the past 10 years.

The elimination of cigarettes from parks, beaches, and other outdoor spaces represents the most recent phase in a trend that began four decades ago, when the demarcation of areas where smoking would be allowed or prohibited emerged as the central point of conflict for tobacco-control efforts. Initial restrictions focused on enclosed spaces where nonsmokers faced prolonged exposure to secondhand smoke. In 1973, the Civil Aeronautics Board required airlines to designate nonsmoking sections of airplanes for domestic flights; similar rules for interstate buses soon followed. Over the next several years, cities began requiring that restaurants set aside seats for nonsmokers. The stated rationale for these early measures was not a paternalistic one — that smokers must abstain for their own good — but rather the protection of nonsmoking bystanders. Strikingly, these early restrictions were implemented in the absence of scientific data that secondhand smoke posed a health threat to nonsmokers. Instead, the measures advanced on the prem-

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Outdoor Smoking Bans in U.S. Municipalities.*

Outdoor Places Where Smoking Is Banned	Number of Municipalities as of April 1, 2011
Beaches	105
Public-transit waiting areas	210
Dining areas	180
Parks	507
Zoos	50

* Data are from the Americans for Nonsmokers' Rights, Outdoor Area Lists, April 2011. (Available at www.no-smoke.org/goingsmokefree.php?id=519#outdoor.)

ise that secondhand smoke was unpleasant and annoying.

Epidemiologic research eventually documented associations between exposure to secondhand smoke and a host of health problems, including elevated risks of lung cancer, cardiovascular disease, and acute episodes of asthma; the Environmental Protection Agency classified secondhand smoke as a Class A carcinogen in 1993. As the scientific basis for restrictions grew, so did the number of places that became off-limits to smoking, including schools, stadiums, convention centers, and private workplaces.

Parks and beaches are increasingly joining this list. As the zones of prohibition are extended from indoor to outdoor spaces, however, the evidence of physical harm to bystanders grows more tenuous. Smoking in partially enclosed outdoor settings such as patio seating areas in restaurants may be hazardous to servers who spend hours there. But air-monitoring studies have shown that health risks to people exposed to secondhand smoke outdoors drop off dramatically when the source of the smoke is more than 2 m away.[2] The editor of the journal *Tobacco Control* dismissed as "flimsy" the evidence that secondhand smoke poses a threat to the health of nonsmokers in most outdoor settings.[3] Nevertheless, smoking opponents continue to press their case using a variety of claims, including public health rationales as well as "public nuisance" arguments such as litter abatement.

The arguments put forth at the public hearing on the New York City ban last fall exemplified this mixture of rationales. Health commissioner Farley cited data showing that 57% of New Yorkers had tested positive for cotinine, a marker of exposure to tobacco smoke, even though only 16% of city residents smoked. He also argued that cigarette-related litter accounted for three quarters of all litter on beaches and a third of the litter in parks. This claim — based on the counting of individual items of litter rather than overall volume — was met with skeptical questioning by city council members. Finally, Farley emphasized the importance of protecting children from exposure to adult smokers who would serve as negative role models. "Families," he said, "should be able to bring their children to parks and beaches knowing that they won't see others smoking."[1]

This frank statement revealed the extent to which denormalizing smoking has become a central prong of antitobacco efforts, both as a way of discouraging initiation of smoking and as a means of pressuring current smokers to quit. Transforming smoking from a desirable behavior that will be imitated to a stigmatized one that will be shunned has motivated such efforts as the push to give movies depicting smoking an "R" rating and cigarette counter-advertising campaigns that depict smoking as a dirty and disgusting habit.

Given the addictive nature of nicotine and the difficulty of quitting smoking, strategies of denormalization raise both pragmatic and ethical concerns. Some tobacco-control experts have questioned whether the denormalization of smoking may have unwanted negative effects on the mental and physical health of smokers but fail to lead them to quit.[4] Also relevant are issues of social justice. The decline in U.S. smoking rates since the 1960s has coincided with the development of a sharp gradient along the lines of socioeconomic status. Whereas about one fifth of all Americans are smokers, about one third of those with incomes below the federal poverty level smoke. These data are especially pertinent to the question of bans in parks. Since smokers are more likely to be poor and therefore dependent on free public spaces for enjoyment and recreation, refusing to allow them to smoke in those places poses potential problems of fairness.

Antitobacco advocates find themselves at a crossroads. Smoking remains a leading cause of preventable illness and death. After several years in which rates of smoking in the United States have remained stagnant, the most successful policy tools for combating the problem, including taxation, provision of cessation services, and public education campaigns, seem to be producing diminishing returns. Most health professionals agree that an outright prohibition on the sale of cigarettes would be unfeasible and would lead to unwanted consequences such as black markets and the crime that accompanies them.

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Yet steadily winnowing the spaces in which smoking is legally allowed may be leading to a kind of de facto prohibition. Smoking bans imposed by states and municipalities have been accompanied by comparable measures in the private sector. Some employers and property owners prohibit smokers from congregating in building doorways; colleges and universities have banned smoking on their campuses; condominiums, apartments, and other multi-unit dwellings have passed requirements for smoke-free apartments. As the historian Allan Brandt has noted, smokers may soon have nowhere left to hide. Pressed by a city council member about where he believed people should be allowed to smoke in New York City, Farley responded, "I'm not prepared to answer that."[1]

In the absence of direct health risks to others, bans on smoking in parks and beaches raise questions about the acceptable limits for government to impose on conduct. In 2008, legal scholar Robert Rabin, the former program director for the Robert Wood Johnson Foundation's Tobacco Policy Research and Evaluation Program, commented, "We should not lose perspective on the question of how restrictive a society we want to create — that is, how far we want to go in reducing individual autonomy, including what can be perceived as self-destructive behavior."[5] This question should be central as we pursue the critically important goal of reducing rates of smoking.

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From the Mailman School of Public Health, Columbia University, New York.

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The Independent Payment Advisory Board — Congress's "Good Deed"

Henry J. Aaron, Ph.D.

Among the most important attributes of legislative statesmanship is self-abnegation — the willingness of legislators to abstain from meddling in matters they are poorly equipped to manage. The law creating the Federal Reserve embodied that virtue. Congress recognized the abiding temptation to use monetary policy for political ends and realized that it would, at times, prove irresistible. To save themselves from themselves, wise legislators created an organization whose funding and operations were largely beyond the reach of normal legislative controls. Short of repealing the law, Congress denied itself the power to do more than kibitz about monetary policy.

In establishing the Independent Payment Advisory Board (IPAB) in section 3403 of the Affordable Care Act (ACA), Congress may once again have shown such statesmanship. For several reasons, however, it is too early to be sure. The board must surmount major challenges — first to survive and then to function effectively. Harold Pollack has neatly summarized the problem, the solution, and the problem with that solution: "Every Democratic and Republican policy expert knows that we must reduce congressional micromanagement of Medicare policy. Unfortunately, every Democratic and Republican legislator knows that mechanisms such as IPAB that might do so would thereby constrain their own individual prerogatives."[1]

Medicare's founding legislation stated that "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine."[2] Duly warned, Medicare administrators have largely forborne from using coverage policy or financial incentives to discourage ineffective or needlessly costly methods of care. Members of the legislative branch have not, however, displayed similar restraint. They have pressured those same administrators on coverage policies and passed laws to impose them.

In the view of many observers,

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