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The Weight of a Nation: The Crisis of Childhood Obesity and a Blueprint for Reforms



The Weight of a Nation: *The Crisis of Childhood Obesity and a Blueprint for Reforms*

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Introduction

Over the past several decades, the American diet has undergone a profound transformation, and the United States now stands at a critical juncture in the fight against childhood obesity and malnutrition. Once a distant concern, the crisis has now escalated into an urgent public health emergency, shaping the well-being of an entire generation. Today, one in five American children is classified as obese—an alarming statistic that foreshadows a future burdened by chronic disease, diminished quality of life, and escalating healthcare costs.¹ Millions of children are at increased risk for chronic illnesses such as diabetes, cardiovascular disease, and mental health challenges, with a larger share of America's youth joining their cohorts every year. Obesity is both a matter of individual responsibility and a systemic issue, deeply entrenched in economic disparities, misguided policies, and a food industry that contributes to poor public health.²

Ultra-processed foods, once a novelty, have become dietary staples. Marketing campaigns engineered to exploit children's taste preferences flood their daily lives, while federal subsidies incentivize the mass production of refined grains and high-fructose corn syrup over fresh, nutrient-dense alternatives. At the same time, physical activity has dwindled, with digital entertainment supplanting outdoor play and school curricula steadily eroding physical education requirements. The result is a perfect storm—an environment where unhealthy choices are not only accessible - they're incentivized and encouraged.

The nomination of Robert F. Kennedy Jr. (RFK Jr.) to be Secretary of the Department of Health and Human Services and the rise of the Make America Healthy Again (MAHA) movement has renewed interest in the debate and analysis of America's health, and thus renewed hope.³ Most of all, it has shifted the political alignment on the issue in Washington, bringing analysis of what's in our food, from unhealthy ingredients to potentially dangerous chemicals and food practices, from the fringe of food politics and into the forefront.

This report examines the historical trends that have shaped modern childhood nutrition, outlining the timeline that has brought us here and the alarming data and statistics that are now the norm. It includes the ramifications of childhood obesity and, while the issue has reached all demographics to a crisis level, the specific disparities in impact and results for various demographics. The report provides an in-depth analysis of the contributing factors for childhood obesity, including the entrenched economic, cultural, and political headwinds that are fostering childhood obesity in America. Key findings from recent studies, data, and insights further emphasize the strength of these headwinds. Finally, the report provides an analysis of the current uncertain landscape, and proposed solutions going forward, outlining actionable recommendations in addressing the root causes of the dramatic increase in childhood obesity.

While systemic change is certainly warranted, it is not one of a topdown approach that dictates and controls. Conversely, it will take a bottom-up approach to change the trajectory of the health of America's youth, and thus America's future-one that informs and empowers parents and consumers.

I. Historical Trends in Childhood Obesity

• Early Awareness and Initial Data (1950s-1970s)

The groundwork for what we see today in childhood nutrition began in a post- World War II America in the 1950's. In its first full year of production, the Swanson company sold ten million TV dinner trays in 1954.⁴ The golden arches of McDonalds began to expand and television sets started to become a mainstay in homes.

By the 1970's, the convenience and popularity of processed and fast food was in full swing. For children, sugary cereals, canned

vegetables, and TV dinners were staples of the era, heavily marketed as both time-saving for parents and enjoyable for kids.

To be sure, the 70's marked a period of significant evolution in childhood nutrition in the United States, driven by federal programs and changing cultural norms. The first hints towards concerns over childhood obesity formed as well, although they were not yet at the crisis levels that would be witnessed decades later. Obesity among children was still relatively rare, settling at 5% of children ages 2-19.⁵

At the federal level, the federal government began to get more involved in childhood nutrition. The National School Lunch Program (NSLP), initially established in 1946, expanded during this decade. While efforts were made to include fresh fruits. vegetables, and whole grains, many meals were heavily reliant on processed and pre-packaged foods, reflecting broader trends in American food culture at the time. Additionally, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), launched in 1974, began providing direct access to food, in the form of food stamps, for young children and their mothers, particularly in low-income households. Counter to the growing trends of declining childhood health and nutrition, it is worth noting the passage of Title IX in 1972, which began to reshape opportunities for girls in sports, leading to an increase in participation and a broader cultural appreciation for physical fitness.

• Escalation in the 1980s and 1990s

By the 1980s, preliminary data from the National Health and Nutrition Examination Survey (NHANES) revealed an increasing trend in obesity across the board, but particularly among children. During the 1990s, childhood obesity rates began to accelerate dramatically. By the end of the decade, the prevalence had risen to nearly 14%, more than double the rate seen in previous decades.⁶ This increase coincided with shifts in dietary habits and lifestyle changes, including a further rise in fast-food consumption, larger portion sizes, and reduced physical activity, as children increasingly engaged in screen-based leisure activities. Federal guidance was not particularly helpful at this time, either. The Department of Agriculture's (USDA) Food Pyramid encouraged high carbohydrate intake while fat was demonized, leading to increased consumption of low-fat but high-sugar processed foods, which worsened childhood obesity trends. Super-sizing culture grew as fast-food chains aggressively marketed larger portions. Schools also began contracting with soda and snack companies, making sugary drinks and junk food widely available in cafeterias and vending machines.

The 2000s and Widespread Recognition

The turn of the millennium marked a point of heightened public and governmental awareness of childhood obesity. In 2001, the Surgeon General's Call to Action on Obesity was released, officially recognizing childhood obesity as a national public health crisis. By 2003, the prevalence of obesity in children had surged to 17%.⁷

Figure. Trends in obesity among children and adolescents aged 2-19 years, by age: United States, 1963-1965 through 2017-2018



NOTE: Obesity is body mass index (BMI) at or above the 95th percentile from the sex-specific BMI-for-age 2000 CDC Growth Charts.

SOURCES: National Center for Health Statistics, National Health Examiniation Surveys II (ages 6-11). III (ages 12-17); and National Health and Nutrition Examiniation Surveys (NHANES) I-III, and NHANES 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, and 2017-2018

II. Current Data and Demographic Breakdown of Childhood Obesity

Overall Prevalence

The Centers for Disease Control and Prevention's (CDC) most recent data (2020) shows that 1 in 5 children and adolescents in the U.S. are considered obese. This represents nearly 14.7 million children who are at higher risk for chronic conditions such as diabetes, cardiovascular disease, and orthopedic complications.⁹ Additionally, a CDC study with 432,302 U.S. children found that the COVID-19 pandemic doubled the rate of body mass index (BMI), with preschoolers and schoolage children experiencing the largest increase.¹⁰ More broadly, the CDC notes that more than 40% of school-aged children and adolescents have at least one chronic illness. The CDC defines chronic illnesses as "conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both."¹¹ They include asthma, obesity and other physical conditions, as well as behavioral problems.

Childhood obesity is shown to increase with age. Additionally, racial and regional demographics show a disparity that's stemmed largely in economic factors, namely, the income of the family.¹²

Age-Specific Trends

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- Young Children (Ages 2-5): Obesity affects about 12.7% of children in this age group. While lower than rates in older children, this early onset of obesity is concerning as it sets a trajectory for lifelong health complications.¹³
- School-Aged Children (Ages 6-11): The prevalence of obesity in this age group is approximately 20.7%. These years are critical for establishing healthy habits.¹⁴
- Adolescents (Ages 12-19): Obesity affects about 22.2% of adolescents, who face unique challenges as they encounter hormonal changes, increased independence, lack of

scheduled school physical activity, and greater exposure to fast-food marketing and sedentary screen-based activities.¹⁵

Socioeconomic and Racial Disparities

 Low-Income Families: According to the National Survey of Children's Health, children in the lowest income group (<130% or less of the federal poverty level) have the highest rates of obesity, with 25.8%. For middle income families (130% to 350% of the federal poverty level), the obesity rate is 21.2%. Meanwhile, children in the highest income group (≥400% of the poverty level) have the lowest rates of obesity, with 10.4%.¹⁶

Children in low-income households are disproportionately affected, with food insecurity and lack of access to affordable, healthy foods contributing to higher obesity rates. Convenience foods high in calories, sugar, and fat are often more accessible than fresh fruits, vegetables, and lean proteins.

A study by the Harvard School of Public Health found that healthier diets cost approximately \$1.50 more per day than less healthy diets.^{17 18} Another study from Drexel University indicated that healthier perishable foods were nearly twice as expensive as unhealthy packaged foods. In addition, the study found that as the price gap between healthier and unhealthy food widened, individuals had lower odds of maintaining a healthy diet.¹⁹ Many of these low-income families depend on the Supplemental Nutrition Assistance Program (SNAP) to meet their nutritional needs, but the affordability of fresh and organic produce remains a challenge, and SNAP is largely used for the exact convenience foods that further increase obesity.

Furthermore, wealthier neighborhoods often benefit from wellmaintained parks, walkable environments, and greater access to health-conscious grocery stores. Conversely, low-income urban communities struggle with food deserts, higher crime rates that discourage outdoor play, and school systems that lack the resources to implement robust physical activity programs. The difference in obesity rates between affluent and low-income children within these metropolitan areas underscores the role of economic inequality in shaping health outcomes.

 Racial and Ethnic Groups: Data indicates significant disparities among racial and ethnic groups. Hispanic (26.2%) and Black (24.8%) children experience the highest rates of obesity, compared to White (16.6%) and Asian (9.0%) children.²⁰ These disparities stem from a combination of socioeconomic, environmental, and cultural factors that limit access to healthy food options, safe spaces for physical activity, and nutritional education.

Economic constraints further exacerbate these disparities. Food deserts—areas with limited access to fresh, healthy foods—are common in urban environments, forcing families to rely on fast food and processed options that are high in calories but low in nutritional value. Research from the USDA shows that nearly 19 million Americans live in food deserts.²¹ These areas, often found in predominantly African-American and Hispanic neighborhoods, lack full-service grocery stores but have an overrepresentation of fast-food establishments and convenience stores that offer calorie-dense, highly processed foods. Before the COVID pandemic, USDA data showed that, in 2019, 19.1% of Black households experienced food insecurity, as well as 15.6% of Hispanic households, compared to 7.9% for White households.²²

The National Health and Nutrition Examination survey found that that non-Hispanic black girls, aged 2-19 years, consume higher amounts of sugar-sweetened beverages (156 kilocalories), than their non-Hispanic White (124 kcal), nonHispanic Asian (58 kcal), and Hispanic (115 kcal) counterparts.²³ However, non-Hispanic White boys consume more (176 kcal) than non-Hispanic Black boys (167 kcal), Hispanic boys (156 kcal), and non-Hispanic Asian (73 kcal). Additionally, data from the CDC indicates that among children aged 2 to 5 years, non-Hispanic Black children had an average daily intake of 13 teaspoons of added sugars, higher than their non-Hispanic White (12 teaspoons) and non-Hispanic Asian (7 teaspoons) peers. This trend continues into the ages 6-11 group, with non-Hispanic Black children and non-Hispanic White children aged 12-19 both consuming 20 teaspoons.²⁴

Geographic Variations

Certain regions in the U.S., particularly the Southeast, report higher obesity rates among children. In the National Survey for Children's Health for 2022-2023, seven states had youth obesity rates significantly higher than the national average of 17%: Mississippi (25%), West Virginia (24.1%), Louisiana (23.1%), Alabama (22.8%), Arkansas (22.7%), Texas (21.0%), and Tennessee (19.9%). According to the Youth Risk Behavior Surveillance System (a biannual survey conducted by the CDC), West Virginia leads the nation in obesity among high school students. Naturally, these trends continue into adulthood. According to the CDC's data for 2023, Arkansas, Mississippi and West Virginia had an adult obesity prevalence of 40% or greater.^{25 26}

This trend is linked to several socio-economic and environmental factors, such as higher poverty rates, lower access to healthy food options, and fewer opportunities for physical activity. Many rural communities in these regions face a shortage of grocery stores offering fresh produce, leading families to rely on fast food or processed options that contribute to poor nutritional outcomes. Additionally, schools in these areas often have underfunded physical education programs, further limiting children's ability to engage in consistent exercise.

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III. Consequences of Childhood Obesity

1. Health Impacts

 Obese children are more likely to suffer from high blood pressure, high cholesterol, cardiovascular disease and insulin resistance. Pediatric Type 2 diabetes, once rare, has become increasingly common, and many obese children also face orthopedic issues due to excess weight. Childhood obesity can also exacerbate asthma and sleep apnea, impacting overall quality of life.²⁷

Long-Term Health Risks

Obese children are more likely to remain obese into adulthood, leading to an increased risk of heart disease, type 2 diabetes, and various cancers. Research shows that 80% of obese adolescents will continue to be obese as adults, setting a trajectory for lifelong health issues.²⁸

2. Educational, Economic, and Social Impacts

- Poor nutrition is linked to decreased cognitive performance and lower academic achievement. Numerous studies show a correlation between children who are obese and a lower average academic performance, as well as increased rates of absenteeism.²⁹
- Obese children face higher rates of bullying, social stigma, and negative self-image. As a result, obese children face higher rates of depression, anxiety, and low self-esteem. Studies show that children with obesity are twice as likely to suffer from mental health disorders compared to their peers. The emotional, mental, and social distress feed into a negative cycle of habits and actions, further spiraling the issue. Social withdrawal, difficulty forming friendships, and reduced participation in sports and social events leads to further isolation, emotional and mental health issues. This often leads to coping mechanisms centered around comfort food.^{32 33 34}

The economic burden of obesity is substantial, with estimated annual healthcare costs reaching \$14 billion for childhood obesity alone.³⁵ For the individual, the nature of poor health begets further healthcare needs, meaning increased medical visits and prescriptions, greater need for medical tests, surgeries, and more, with all of this further leading to the likelihood of higher insurance premiums. Since children who are obese are likely to remain obese into adulthood, the issue is magnified in terms of lifelong healthcare expenses and workforce productivity decline. This has an adverse economic impact on the individual and the nation, from Medicaid and Medicare to federal nutrition assistance.

IV. Contributing Factors to Childhood Obesity

1. Dietary Patterns: A key contributor to rising obesity rates has been the increase in consumption of calorie-dense, nutrient-poor foods. Sugary beverages, processed snacks, and fast food have become staples in many children's diets, replacing traditional, home-cooked meals. A combination of socioeconomic factors, government systems and practices, and broad cultural trends have led to this rapid increase.

The Role of Ultra-Processed Foods

There is a great deal of research cataloguing the rise of ultraprocessed foods in the American diet, especially among children. Dr. Fang Zhang from Tufts University examined recent trends in this regard by looking at data from the National Health and Nutrition Examination Survey collected between 1999 and 2018. They surveyed almost thirty-four thousand children from ages 2 to 19. The study notes an increase in the proportion of ultra-processed foods from 1999 to 2018, rising from 61% to 67%. The largest increase came in the form of ready-to-heat-and-eat dishes, which were only 2% in 1999, but had risen to 11% in 2018.³⁶ Ultra-processed foods are linked to increased calorie consumption, metabolic dysfunction, and addictionlike eating behaviors. These foods are often stripped of nutrients and loaded with sugars, unhealthy fats, and artificial additives. These foods are chemically engineered to maximize consumption by manipulating the "bliss point," the precise balance of sugar, salt, and fat that stimulates reward centers in the brain, making them hard to resist. The food industry employs "craving experts" to enhance these effects, creating a biological compulsion to overconsume.^{37 38 39} Anyone who has ever tried to simply eat one Lay's potato chip understands this concept on its most basic level.

Causes of the Rise in Ultra-Processed Food Consumption:

a. Marketing

Marketing efforts disproportionately target children, spending billions annually to influence their preferences and habits through advertisements on television, online platforms, and even in schools. A 2012 study published in the American Journal of Public Health examined the extensive reach and nutritional content of food and beverage marketing directed at children and adolescents in the United States. The research revealed that the food industry invests over \$1.6 billion annually in marketing campaigns targeting young audiences. On average, a child in the U.S. is exposed to 13 food advertisements daily on television, with these ads constituting approximately 30% of all paid television advertising viewed by children.⁴⁰

A 2024 study in a medical journal published by the American Medical Association found that from 2013 to 2022, there was a noticeable decline in advertising on television programs for children for products limited in nutrients (e.g., sugary cereal, fried foods). This is a promising trend; however, since children were already highly targeted by this industry, their total exposure still remains incredibly high - 63.9% for children's programming for 2 to 5-yearolds and 60.6% for those 6 to 11. However, the vast majority of these marketed products are still high in calories, fats, sugars, or sodium, contributing to unhealthy dietary habits among youth. Studies show that children exposed to such advertising are more likely to develop preferences for sugary, processed foods and to form unhealthy eating habits that persist into adulthood.⁴¹

b. The School Lunch System

School meal programs play a critical role in shaping children's eating habits, particularly for low-income students who depend on these meals for daily nutrition. In 1946, the National School Lunch Act was passed, establishing the National School Lunch Program. It was originally designed to combat malnutrition and ensure children received adequate calories, but it unintentionally contributed to childhood obesity as meals often prioritized calorie-dense foods.⁴²

According to the Food Research & Action Center's report, "The Reach of School Breakfast and Lunch During the 2021– 2022 School Year," more than 15.5 million children received a school breakfast and 29.9 million received a school lunch on an average day during the '21-'22 school year.⁴³

School lunch programs often rely on processed foods due to funding, budget constraints, and infrastructure. This is particularly true for urban, low-income schools compared to suburban and wealthier districts. These low-income schools, on top of budget constraints, face a multitude of other issues, including supply chain limitations and inadequate kitchen facilities. This leads to an overreliance on processed, pre-packaged meals that are high in sodium, saturated fats, and refined sugars. $^{\rm 44}$

Additionally, it's all about choice. A 12-year-old-child, given freedom to choose, will almost always pick the fried chicken sandwich over much healthier options.

c. The Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP) heavily subsidizes unhealthy foods. Research from the USDA and public health studies confirms that SNAP participants have comparable or worse dietary habits than non-participants in the same income bracket, challenging the assumption that simply increasing access to food equates to better nutrition.

A 2016 USDA study, using point-of-sale data, found that 23% of purchases by SNAP households were sugary drinks, desserts, salty snacks, candy, and sugar.⁴⁵ Those parameters, it is worth noting, include only some of the many forms of processed, unhealthy foods, not all of them. In 2018, USDA also conducted a study comparing the food purchases of households participating in SNAP to those of lower-income non-SNAP households and higher-income households. The findings revealed that, per 1,000 calories acquired, SNAP households purchased 31% fewer total vegetables, 40% fewer dark green vegetables and beans, 24% fewer whole fruits, 20% fewer whole grains, and 27% fewer seafood and plant proteins compared to lower-income non-SNAP households. The study concluded that SNAP-participating households acquired foods of lower overall nutritional quality than their non-participating counterparts.⁴⁶ Other studies indicate more of the same, that SNAP households purchase more sugar-sweetened beverages than





non-SNAP households, contributing to excessive caloric intake without providing essential nutrients necessary for childhood development. This policy undermines public health objectives and perpetuates food insecurity by prioritizing calorie count over nutritional quality.

The core issue lies in the program's failure to differentiate between nutrient-dense and nutritionally deficient foods. Unlike the WIC program, which restricts purchases to nutritionally approved items such as whole grains, dairy, and fresh produce, SNAP imposes no such limitations. This lack of regulation incentivizes the purchase of cheap, calorie-dense, but nutritionally poor foods, as these often provide more immediate satiety for struggling families on tight budgets. Moreover, the unrestricted nature of SNAP spending effectively subsidizes the processed food industry, reinforcing poor dietary patterns. According to USDA, the share of U.S. residents who received SNAP benefits in FY 2023 was 12.6%, and totaled \$112.8 billion.⁴⁷

d. The Role of Federal Subsidization of Commodity Crops

The rise of ultra-processed foods is not solely due to convenience and the prevailing notion that a cheeseburger tastes better than asparagus. As is always the case, the cost of goods in a market greatly impacts the choice of consumers. Ultra-processed foods are generally more affordable for consumers than healthier alternatives.

The surge in childhood obesity across the United States is not merely a consequence of individual choices or a cultural shift toward convenience; it is, in many ways, a structural issue deeply embedded in federal agricultural policy. At the heart of this crisis lies the federal subsidization of commodity crops—primarily corn, wheat, and soy which has fundamentally altered the American food landscape by making ultra-processed foods abundantly available, highly affordable, and nutritionally deficient.

The market distortions created by federal agricultural subsidies have long favored industrial-scale production of staple commodities over the cultivation of fruits, vegetables, and other nutrient-dense foods. Originally designed to stabilize food prices and secure a reliable food supply, these subsidies have instead incentivized the mass production of calorie-dense, low-nutrient processed foods, disproportionately affecting the health of economically disadvantaged communities.

One of the most profound effects of this policy structure is its impact on the cost of food. Ultra-processed foods are significantly cheaper than fresh, whole foods, largely due to the subsidization of their primary ingredients:

- **Corn** The backbone of high-fructose corn syrup (HFCS), a ubiquitous sweetener found in sodas, candies, and processed snacks.
- **Soy** A key component in hydrogenated oils and emulsifiers, widely used in processed foods, increasing unhealthy fat consumption.
- Wheat The foundation of refined grains, which dominate packaged baked goods, cereals, and snack foods, contributing to excessive carbohydrate intake and poor metabolic health.

These cheap, government-supported ingredients enable food manufacturers to create high-margin, hyper-palatable products that are aggressively marketed to children. Meanwhile, fresh produce, lean proteins, and whole grains remain unsubsidized, making them more expensive and less accessible, particularly in low-income communities. This economic disparity steers consumer choices toward processed alternatives, exacerbating childhood obesity rates.

The relationship between federal agricultural subsidies and the fastfood industry further amplifies the problem. Subsidized corn and soy are key inputs for cheap animal feed, reducing the cost of meat and dairy production. As a result, fast-food chains can offer oversized portions of calorie-dense meals at artificially low prices, driving overconsumption. Studies indicate that fast-food consumption is a major contributor to childhood obesity, particularly among lower-income families where price sensitivity dictates dietary choices.^{48 49}

The affordability of processed, fast foods—combined with strategic marketing aimed at children—creates a reinforcing cycle of poor nutrition, excess calorie intake, and declining health outcomes. This phenomenon is not a natural market outcome but the direct result of policy-driven economic incentives that favor corporate food producers over public health priorities.

The future of federal subsidies for commodity crops remains uncertain as conservative lawmakers and advocacy groups push for significant cuts to long-standing agricultural support programs. The Conservation Reserve Program (CRP), which pays farmers to leave marginal land fallow for environmental benefits, is proposed for elimination in Project 2025, a policy blueprint developed by the Heritage Foundation.⁵⁰ The House Republican Study Committee (RSC) has proposed ending new enrollments in CRP as well.⁵¹ If the CRP was eliminated, this would likely lead to millions of more acres for commodity crop farming. Approximately 25 million acres are currently enrolled in CRP.⁵²

Alongside these proposals, both Project 2025 and the RSC's budget suggest reducing crop insurance subsidies and scaling back or eliminating commodity payments altogether. The RSC budget proposed that only farms with an adjusted gross income below \$500,000 receive payments. The RSC budget reads "This was a policy proposed in the FY 2021 Trump Budget and would ensure that commodity support payments are going to smaller farms that may struggle obtaining capital from private lenders,"⁵⁵ For Project 2025, the proposal is to eliminate commodity programs altogether.⁵⁴ While fiscal conservatives argue that such cuts align with broader efforts to reduce government spending, these proposals directly challenge the traditional support for farm subsidies among legislators in agricultural states and congressional districts.

Despite these proposals, substantial opposition remains, making full-scale cuts unlikely in the immediate future. The House Agriculture Committee's 2024 farm bill draft, heavily influenced by RSC members, paradoxically increases funding for commodity programs and keeps crop insurance subsidies intact, signaling strong political resistance to major cuts.⁵⁵ Additionally, powerful agricultural lobbying groups such as the American Farm Bureau Federation and the National Farmers Union continue to advocate for maintaining federal farm payments, given their importance to rural economies.

In December 2024, Congress enacted a one-year extension of the 2018 Farm Bill, maintaining existing agricultural programs through September 30, 2025. This extension preserved the current structure of commodity crop subsidies without implementing increases. However, the legislation did include \$31 billion in one-time natural and economic disaster aid for farmers and ranchers in order to provide immediate financial relief.⁵⁶ Specifically, \$10 billion was required to be distributed for eligible commodities within 90 days of enactment of the legislation.⁵⁷

2. Decline in Physical Activity

Physical activity is a crucial factor in maintaining a healthy weight. When children do not engage in sufficient exercise, they are more likely to consume excess calories without expending them, leading to weight gain.

Decades ago, American children engaged in far more outdoor play, recreational sports, and physical education than they do today. The advent of digital entertainment, increased academic pressures, and safety concerns have all contributed to a steep reduction in children's physical activity. The COVID pandemic further exacerbated these trends. According to a study published in JAMA Pediatrics, a monthly peer-reviewed medical journal published by the American Medical Association, children's physical activity dropped by a whopping 20% over the course of the pandemic. The study warned that this marked a "developmental turning point, that it was a "perfect storm of habit discontinuity" that could very likely have a long-lasting impact in childhood physical activity, and for the children currently, a negative health impact that lasts a lifetime.⁵⁸

The Current State of Play

In October 2024, the Physical Activity Alliance (PAA) released its 2024 U.S. Report Card on Physical Activity for Children and Youth. Based on data from the National Survey of Children's Health and National Health and Nutrition Examination Survey, the most recent data being for the 2021-2022 school year, the PAA gave the overall physical activity grade for children a D-. The report notes that only 20% to 28% of children 6-17 years old meet the 60 minutes of daily physical activity recommended by the U.S. Physical Activity Guidelines for Americans. Furthermore, there is a significant decline in physical activity as a child ages; 26% to 42% of 6- to 11-year-olds meet the physical activity guidelines, while only 15% of 12- to 17-year-olds do.⁵⁹ The report also notes data from the Youth Risk Behavior Surveillance System, a program managed by the CDC, specifically its Data Summary & Trends Report for Dietary, Physical Activity, and Sleep Behaviors: 2013-2023. This study found slightly higher rates of activity. but they still corroborated a decline, with 9th graders at a 27% activity rate and 12th graders at 21%.60



Approximately 51.9% of high school students report playing at least one sport during the previous year. Similarly, 51% of children ages 6-17 participate in sports teams or lessons after school or on weekends, down from 58% in the 2016-2017 school year.⁶¹ Dr. Bianca R. Edison, a sports medicine specialist at the Children's Hospital Los Angeles, further echoed concerns regarding declining participation in sports as a child ages. Dr. Edison and her colleagues performed a longitudinal survey of the graduating class of 2023. She notes that the transition from middle school to high school serves as a key point at which physical activity changes, and that a further declining trend takes place as a child moves through high school. She notes that sports participation decreased from 82% in 7th grade to 39% by 12th grade. ⁶² The PAA's report offers a simple reason as to why that may be the case - the percentage of schools requiring a PE course be taught in each grade decreases from 97% in 6th grade to 43% in 12th grade.⁶³



Racial disparities are also apparent in youth sports participation. According to the PAA's report card, among 6–12-year-olds, 38.0% of non-Hispanic white children played a sport on a regular basis compared to 31% of black children of the same age. Among older children the rates are less disparate, with 43.9% of non-Hispanic white 13-17-year-olds playing a sport on a regular basis compared to 42.4% of their black counterparts.⁶⁴

More recent data from the Aspen Institute notes that while Hispanic participation in sports is increasing, there is a decrease for black children. Data from the Sports & Fitness Industry Association shows that only 35% of Black youth ages 6-17 regularly participated in sports during 2023, a significant decrease from 45% in 2013.⁶⁵ In the 2024 National Black Sport Participation and Physical Activity Report, the authors note that the COVID pandemic specifically had a greater

impact on participation rates for black youth, stating that white sports participation increased by 0.7% since 2019, while black participation decreased by 2.5%.⁶⁶

A disparity is seen across genders as well. High school males are much more likely to participate in sports (55.7%) compared to 48.1% of high school females.⁶⁷ The gender gap in youth sports participation has narrowed over the last decade. While girls' participation has increased, the narrowing gap is more so due to a greater decline in boys participation.⁶⁸

Causes for Decline in Physical Activity

Physical activity and education are so often on the chopping block in schools, and there are several common reasons across school districts as to why. It is commonly assumed that there are alternatives outside of school for students to play sports and other activities. Such programs often require an investment of time and money from the parents, however. Parents in lower income brackets may not have enough of either to spare. Financial constraints limit participation in organized sports and extracurricular activities, as fees, equipment costs, and transportation challenges can make these programs inaccessible to low-income families. Data from the Aspen Institute's Project Play initiative reveals that African-American and Hispanic children are significantly less likely to participate in organized sports compared to white children partly due to economic barriers.⁶⁹ This contributes towards socioeconomic differences in childhood physical activity, which then leads to a gap in childhood health and wellness, including childhood obesity.

The increased emphasis on academic performance, and particularly standardized testing, has led to schools allocating more time, resources, and funding to those areas. Schools, teachers and students face pressure to meet these academic benchmarks and improve test scores. Thus, physical education and other physical activity has been relegated to a less critical tier than academics. Screen time has been another significant contributing factor to the decline in physical activity among U.S. children. The American Academy of Pediatrics notes a clear association between screen time duration and unhealthy weight gain, with just two hours or more of screen time a day leading to a higher risk of a child becoming obese.⁷⁰

The Commonsense Consensus: The Media Use by Tweens and Teens, 2021 report notes in the following table and graphics that entertainment screen time for children has risen from 4 hours 44 minutes in 2019 to 5 hours 33 minutes in 2021. For every fifth child of those 8-12 years old, they reportedly have more than 8 hours of entertainment screen time per day. The same survey found that among teens (13 to 18 years-old), average entertainment screen time reached 8 hours 39 minutes in 2021. That's up from 7 hours 22 minutes prepandemic in 2019.⁷¹



Daily screen time for specific activity	8-12 years old	13-18 years old
Television, Videos	2 hours 40 minutes	3 hours 16 minutes
Gaming	1 hour 27 minutes	1 hour 46 minutes
Browsing websites	24 minutes	51 minutes
Social media	18 minutes	1 hour 27 minutes
Content creation	8 minutes	14 minutes
Video-chatting	12 minutes	20 minutes
E-reading	9 minutes	15 minutes
Other	15 minutes	29 minutes

The PAA's report echoes this data and trend, even with pre-pandemic numbers. In the '09-'10 school year, 53.5% of children ages 6-17 years spent less than two hours of screen time a day. By the '17-'18 school year, only 20% of children in that age range spent less than two hours a day in front of a screen.⁷²



Disparities exist across racial demographics as well. Black children ages 9-10 years have reported 1.6 more hours of screen time per day than non-Hispanic white children (an average of 5.1 hours per day for black children and 3.5 hours per day for non-Hispanic white children). Hispanic children reported 0.2 more hours of screen time per day compared to white children, whereas Asian children reported 0.4 less hours of screen time per day compared to non-Hispanic white children.⁷³

Other factors have also contributed to the declining physical activity of America's youth. Increased concerns about the safety of children have led to fewer children walking or riding their bikes, especially to school, as well as decreased "time outside" in general.

V. A Changing Landscape for GMOs, Pesticides, and Food-Additives

Consumers took notice when, on January 15, 2025, the Food and Drug Administration (FDA) banned Red Dye Number 3. In the FDA's announcement of revoking authorization for the use of Red Dye Number 3, the FDA cites data from a 2022 color additive petition. They note how it had sparked concerns regarding links to cancer, after showing that this ingredient causes cancer in male laboratory rats exposed to high levels of Red Dye Number 3.⁷⁴ The food coloring had already been banned in food in California, and was banned from cosmetics in 1990 due to cancer risks.⁷⁵ It had been used in food and other products since as early as 1969.⁷⁶ The FDA's action naturally heightened concerns among consumers regarding the degree of risk of harm to their health from chemicals in food and other products.

The FDA's action also occurred at a time when Washington, DC was geared up for the arrival of President Trump's administration and the MAHA movement. This action could be indicative of more to come and a renewed national focus on the chemicals in our nation's foods. Regulations with widespread impact on food and nutrition are not a new phenomenon. In 2015, the FDA banned partially hydrogenated oils (PHOs), a manufacturing process that converts vegetable oil into a solid fat.⁷⁷ This was the major source of trans fat in foods. Trans fat raises the level of bad cholesterol in the blood, which in turn increases the risk of developing heart disease, the number one cause of death in the United States.^{78 79}

The FDA's 2015 action on PHOs had a significant negative impact on oilseed processors, since many were major suppliers of PHOs. With the ban leading to an obvious sharp decline in PHO production and sales, many processors who were heavily invested in the PHO production infrastructure had to switch to alternatives and reformulate their products. RFK Jr. has long advocated against seed oils, even recently, warning that they are "one of the most unhealthy ingredients that we have in foods," that Americans are "unknowingly poisoned," and directing his followers to buy hats with the slogan "Make Frying Oil Tallow Again."⁸⁰

Perhaps one of the most notable recent examples of the dangers of food additives is that of tara flour. In 2022, a popular direct-toconsumer food service, Daily Harvest, began selling frozen vegetablebased meat substitute French Lentil + Leek Crumbles.⁸¹ With over 2 million customers, and popular investors such as Serena Williams and Gwyneth Paltrow, any new products were certain to reach many consumers.⁸²

Almost immediately, Daily Harvest received 470 complaints of gastrointestinal, liver, bile duct and gallbladder illness.⁸³ As a result, more than 130 people were hospitalized, with dozens of them needing to have their gallbladder removed.⁸⁴

The culprit was a new ingredient called tara flour. Derived from the seed pods of a thorny shrub native to Peru, tara flour had "not been adequately characterized nor previously utilized as a human food

ingredient in the United States," according to the FDA. Tara gum, which is another product derived from the same seed pods, has been used for years as a thickening agent or stabilizer in human foods without any issue. It took two years, and much public outcry, for the FDA to officially ban tara flour.⁸⁵

Analytically diving into the "weeds" of current food politics provides an example of how interwoven and interconnected the politics and policies of any chemical or ingredient can be, not only complicating the road to solutions, but even complicating the directional winds of research.

In their 2017 book, "What's Making Our Children Sick?: How Industrial Food Is Causing an Epidemic of Chronic Illness, and What Parents (and Doctors) Can Do About It," Dr. Michelle Perro and Dr. Vincanne Adams highlight the politics of food science, which leads to connecting the dots to explain the ailing health of American children.⁸⁶ The doctors point to how Genetically Modified Organisms (GMOs) were introduced into the food supply in 1996, and even though they are widely consumed, there are only three human studies on GMOs that exist. The use of GMOs and pesticides, especially glyphosate in the herbicide Roundup, have been major contributors to gut damage, the authors say. They note a CDC study that showed more than 80% of urine samples drawn from children and adults contained glyphosate.⁸⁷ Among many other serious risks and issues, children's gut and liver are impacted. This raises additional childhood obesity and health concerns.

In further work by Dr. Michelle Perro, she notes that substantial evidence has emerged regarding the exposure of endocrine disrupting chemicals (EDCs) and their connection to obesity and obesityrelated metabolic diseases. Dr. Perro says there are a vast variety of ways children are exposed to EDCs (e.g., personal care products, processed food container liners, cookware). She notes that obesogens (one of the classes of EDCs) represent some of the most severe impacts of concern.⁸⁸ In studies published in the journal Biochemical Pharmacology, the biochemist Jerry Heindel echoes these concerns. Heindel warns that obesogens can negatively act on the body in a variety of ways, noting that some can disrupt metabolism, cause the body to produce new fat cells, disrupt the gastrointestinal tract, and alter eating behavior. The body of science has established that young children are more vulnerable to obesogens, as the metabolic system is still under development and thus more susceptible to chemical influences.⁸⁹ Ryan Baldwin, a spokesperson for the American Chemistry Council, an organization representing more than 190 chemical companies, pushes back against these arguments. He and others argue that the body of evidence for other theories is much larger than that regarding obesogens concerns.⁹⁰ However, that reinforces the arguments made by Dr. Perro, Heindel, and others that we need more research.

The idea of looking at research such as this and calling for much more research, is now more prominent in the politics of food science, as this is the path RFK Jr. has highlighted time and again. As HHS secretary, he will oversee NIH's funding and coordination of medical research in the United States. Jay Bhattacharya, President Trump's nominee to lead NIH, seems to align closely with the policies and priorities of Kennedy.

Regarding GMOs and pesticides, Kennedy's advocacy for organic farming and his criticism of industrial agricultural practices have led to a notable political realignment.⁹¹ Culturally, organic foods and farming have brought to mind Whole Foods shoppers in suburban areas, many of whom are left-leaning. Conservative lawmakers, however, have already started to publicly embrace and advocate for organic food as well. At the very least, there is a notable shift in interest.

Advocacy groups and organizations that have long been advocating for a greater shift to organic farming and food supply are pleased about this heightened interest. Gordon Merrick, a senior official at the Organic Farming Research Foundation, recently said in an interview that "historically we haven't gotten a lot of interest from the more conservative-leaning members of Congress." He went on to note that he's been having a lot more meetings as of late with "very conservative" legislators, pointing out that those legislators mentioned they are more interested in hearing about organics due to Kennedy and the rapid growth of the MAHA movement.⁹²

Despite this rise in interest, the official data remains murky. USDA's National Agricultural Statistics Service began conducting Organic Survey's in 2008 in order to gather new data on certified organic crops and livestock commodities in the U.S.⁹³ The number of organic farms saw a 56% increase from 2011 to 2016. In 2016, U.S. farms and ranches sold nearly \$7.6 billion in certified organic goods. This was more than double the \$3.5 billion in 2011. However, the 2021 survey showed that trend began to reverse, with a 7% decrease in the number of organic farms in the U.S. While the number of farms has decreased, the dollar amount of sales continues to rise. USDA data shows that in 2022, farmers sold over \$9.5 billion in organic products. With all that said, organic farmland represents only 1% of total farmland in the U.S.⁹⁴

Kennedy can likely shift more research into pesticides, chemicals, and food additives, and that research could potentially sway lawmakers towards legislative reform. Just as the FDA's ban regarding trans fat shifted the work of seed oil processors, FDA regulation could shift practices and actions of producers, ranchers and farmers. It's worth noting, as Kennedy often has, that the U.S. lags behind globally in regulation of food additives. Many additives and chemicals banned in the European Union and in other developed global regions are still permitted in U.S. food products.^{95 96}

Industry and some consumer advocates will likely remain resistant to change and new regulation. President Trump and Agriculture Secretary Brooke Rollins may be more focused on aiding struggling American farmers and ranchers than upending the system and changing it dramatically. The MAHA movement can potentially channel bottom-up action, and thereby increase consumers' interest in organic foods. If further research yields compelling findings, parents may be willing to absorb some additional costs in order to better the health of their children. This remains a priority area in the observation of childhood obesity moving forward.

VI. Policy Recommendations

Community-based initiatives offer the most achievable and direct potential for impact. A 2019 paper published by the Brookings Institution and partners highlights the importance of a "whole-ofcommunity obesity prevention intervention" approach.⁹⁷

The paper notes a discernible example through the "Romp & Chomp" project implemented in Geelong, Australia from 2004 to 2008.⁹⁸ That initiative adopted a comprehensive and inclusive strategy to foster healthier environments for young children in the area. It focused on encouraging nutritious eating habits and promoting active play within early childhood education and care settings.

A key element of this effort was the establishment of a central steering committee that brought together representatives from various community stakeholder groups. This committee convened regularly to coordinate intervention activities across the community, including professional training for early childhood educators, public awareness campaigns, and the development and implementation of policies within early childhood programs.

The Romp & Chomp initiative led to a notable reduction in childhood overweight and obesity rates within the targeted community. Additionally, it contributed to meaningful behavioral changes, such as decreased consumption of processed snacks and sugar-sweetened drinks.⁹⁹

Stories like this abound in the research targeting childhood obesity. There's the "High Five for Kids" program in Boston, a pediatric primary care-based intervention focused on supporting families in adopting healthier habits. They use motivational interviewing techniques to help parents and children make healthier choices. Counseling sessions to reduce screen time, promote physical activity, and improve diet are also employed. These techniques led to improved health behaviors in children, including reduced consumption of sugar-sweetened beverages and increased physical activity. Compared to usual care, children in the trial who received the intervention had a smaller increase in BMI and reduced screen time.¹⁰⁰

Shape Up Somerville, a whole-of-community approach in Massachusetts, aimed at reducing childhood obesity among elementary school children by improving school meals with healthier options, enhancing physical education and after-school activity programs, collaborating with local restaurants to offer healthier kids' menu items, and fostering community-wide campaigns to encourage walking and biking. A study found that children in Somerville gained less weight compared to those in control communities over a two-year period.¹⁰¹

Strengthening Family and Parental Engagement

At the core of any effective policy addressing childhood obesity is the role of the family. Research shows what is already self-evident – parental behavior, action, direction, and encouragement strongly shapes a child's diet and physical activity patterns.^{102 103}

Parents have the greatest influence over their children's eating habits and activity levels, making it essential to empower families with knowledge and resources rather than impose one-size-fits-all mandates.

Parental Education Programs should be expanded through faithbased organizations, local community centers, and pediatricians' offices to equip parents with the tools to make informed decisions about their children's health. Voluntary workshops can provide guidance on meal planning, budgeting for nutritious foods, and integrating physical activity into daily life. The USDA's Expanded Food and Nutrition Education Program already offers classes where participants learn about healthy eating, family meal planning, grocery budgeting, and the importance of physical activity.¹⁰⁴ The government's role in these programs should be limited to facilitating partnerships with nonprofit and private sector groups that offer expertise in nutrition and wellness.

Incentivizing healthy home practices through tax credits or grocery vouchers can further encourage families to prioritize healthier choices. Families that participate in local nutrition and exercise programs, such as community cooking classes or fitness challenges, could qualify for modest financial incentives, reinforcing personal responsibility without expanding government bureaucracy.

Faith-Based Solutions

Churches and faith-based organizations are often the heart of communities and trusted sources of guidance. They have long been the pillars of community engagement. Leveraging these institutions can be transformative in shaping healthier environments. Encouraging church-led wellness initiatives—such as nutritional workshops, community gardens, and fitness programs—can effectively promote healthier lifestyles within a moral and values-driven framework. By mobilizing religious communities, these initiatives can have a lasting impact, particularly in underserved areas where church organizations often have stronger community ties than government agencies.

Research from the University of Texas, funded by NIH and conducted in 2011, analyzed the impact and reach of churches and faith-based organizations in the health field, in the practice of recruitment for clinical trials. In recruitment of African Americans with type 2 diabetes, the health system yielded an initial recruitment of 61%, compared to the 19% through community organizations and 14% through faithbased organizations. However, the overall participation rate was much higher in the recruits from the faith-based organizations, who were the most likely to attend four or more sessions.¹⁰⁵ The research further found that in a low-income, predominantly African American neighborhoods, 37% of the residents attended church at least monthly, and there was a positive correlation between church attendance and health visits (e.g., dental appointments, blood pressure measurements). Simply put, the research states *"Church attendance has a positive effect on health care practices, and partnering with churches to deliver health promotion is a valuable opportunity to improve the health care of low-income and minority populations."*¹⁰⁶

What Church Leaders Can Do

1. Host Nutritional and Cooking Workshops

- Partner with local dietitians and chefs to teach families how to prepare healthy, affordable meals.
- Provide free meal prep classes and healthy recipe booklets.

2. Organize Church-Based Food Co-Ops and Pantries

- Establish church-led food banks that prioritize fresh, whole foods over canned or processed items.
- Work with local farmers to develop discounted Community Supported Agriculture programs, community gardens, or food co-ops on church grounds

3. Launch "Healthy Sundays" Physical Activity Initiatives

- Dedicate part of Sunday worship service to health awareness discussions.
- Organize church-based walking groups, dance classes, and youth fitness programs.

4. Advocate for Local Policy Changes

• Use the church as a platform to mobilize community members to petition city officials for grocery store investments, park renovations, and better school meals.

Expanding Community-Based Physical Activity Programs

Community engagement is vital in ensuring that children have ample opportunities to stay active outside of school. Instead of governmentrun recreational programs, public-private partnerships should be leveraged to fund and maintain local parks, playgrounds, and youth sports initiatives. Businesses and nonprofit organizations can play an active role in financing these efforts, reducing the need for increased government spending.

After-school fitness programs should be expanded through grants to community organizations such as the YMCA and faith-based groups. These entities are better equipped than the federal government to design and implement programs tailored to the unique needs of their communities.

Additionally, ensuring that children have safe routes to school can encourage more walking and biking. Collaborations between local law enforcement, city planners, and community groups can enhance infrastructure and promote safer pedestrian pathways without excessive federal oversight.

Expanding School-Based Health Initiatives Without Overreach

While schools play an essential role in childhood nutrition and physical activity, they must do so in partnership with parents and local communities rather than under heavy-handed federal mandates.

When the "Healthy, Hunger-Free Kids Act" (HHFKA) was signed into law in 2010, it imposed stricter federal guidelines on school meals, including calorie and sodium limits. These mandates, led and championed by First Lady Michelle Obama, led to substantially more food waste, higher costs per meal, and lower overall student participation in school meal programs. The U.S. Government Accountability Office (GAO) found that nationwide student participation in school lunches dropped by 1.2 million students in the first two years after the HHFKA standards took effect.¹⁰⁷ GAO also found that schools reported increased food waste and higher per-meal costs in complying with the new rules. A study by researchers at the University of Vermont using photos of students' lunch trays provided visual proof: after HHFKA required every student to take a fruit or vegetable, children's consumption of fruits/vegetables actually dropped and food waste increased by 35%.¹⁰⁸

Local control over school nutrition should be emphasized, allowing school boards to collaborate with parents and nutrition experts in setting meal standards that align with community needs and cultural preferences. This approach ensures that school meals are both nutritious and appealing to students, increasing participation rates in school lunch programs.

Private-sector partnerships should be encouraged to improve the quality of school meals. Farm-to-school programs connecting schools with local farmers can provide fresh produce while stimulating local economies. Additionally, small businesses specializing in healthy food options can be incentivized to supply schools with nutritious meals through tax breaks and competitive bidding opportunities.

Physical activity should be promoted through voluntary fitness incentive programs, where students are recognized for meeting physical activity goals. Reward-based systems, rather than mandates, encourage participation without imposing burdensome requirements on schools.

States could implement state-sponsored urban farming grants to further enable residents in distressed zip codes to develop community gardens. A block grant approach would transfer federal school meal funding to state and local governments. In 1996, the federal government took this approach with the Temporary Assistance for Needy Families program. Through block grants, states are able to provide more direct, tailored assistance. In simpler terms, the potential diet (and thus potential healthy alternatives) of a child in Bangor, Maine has many stark differences to that of a child in Dallas, Texas or Minneapolis, Minnesota.

Increasing Health Education in Schools

A well-rounded health education curriculum is essential for equipping students with the knowledge they need to make informed dietary and lifestyle choices. Instead of "health class" occupying a single semester within 13 years of education, it should hold a much more prominent place in the curriculum of America's youth. According to data from the CDC's School Health Policies and Practices Study, on average, U.S. students get less than 8 hours of nutrition education per school year – far short of the 40–50 hours research suggests is needed to drive lasting behavioral change.¹¹⁰

States should take the lead in strengthening health education programs that include nutrition science, the impact of processed foods, and the benefits of an active lifestyle. Schools should be encouraged to integrate comprehensive nutrition education into existing health and science curricula, teaching students not just about calories and exercise, but also about the importance of whole foods, reading ingredient labels, and making long-term healthy choices.

State governments should also explore partnerships with healthcare professionals to provide guest lectures, hands-on cooking demonstrations, and interactive lessons to engage students in understanding their food and health.

Better health education empowers young people to take charge of their own well-being. Lessons on nutrition, fitness, and lifestyle teach students how daily choices affect their bodies, instilling personal accountability for maintaining a healthy life.

Encouraging Partnerships to Expand Healthy Options

Market-driven solutions provide a sustainable and efficient way to address food accessibility. Tax incentives for grocery stores opening locations in food deserts can help combat nutritional inequality without expanding government control. Instead of direct government intervention, policymakers should facilitate the entry of private grocery retailers into underserved areas, ensuring families have access to fresh food.

Fast-food, business-friendly incentives, such as voluntary nutritional labeling and promotional benefits for restaurants offering healthier kid's meals, can encourage industry-led solutions without intrusive government mandates.

Private companies should also be incentivized to contribute to community wellness. Corporate wellness sponsorships, where businesses fund youth sports leagues and nutrition education programs, can bolster local efforts to improve childhood health while fostering corporate social responsibility. Some of them already exist, but a renewed national focus on the issue of childhood health could greatly expand the reach and scope.

Companies such as Nike and Under Armour, as well as national sports organizations and local fitness organizations, already do wellness sponsorships, but such efforts do not need to be limited solely to companies within the athletic space. The reach and impact of childhood health is vast, and so is its interest and importance to numerous industries and organizations.

Implementing Tax Policy Incentives to Promote Healthy Choices

Instead of punitive measures like sugary drink taxes, policymakers should focus on positive incentives to encourage healthier consumer behavior.

Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) could be expanded for nutrition, allowing parents to use HSAs/FSAs for purchasing healthier foods or nutritional counseling. New Jersey created a Food Desert Relief Tax Credit to incentivize supermarkets in underserved areas.¹¹¹

Employer wellness tax credits could be expanded to encourage small businesses to support family-oriented health initiatives, such as gym memberships, workplace wellness programs, and family fitness challenges.

Reforming Government Assistance Programs Without Expanding Bureaucracy

Government assistance programs should be structured to support healthier choices without creating additional layers of regulation.

SNAP reform should allow states greater flexibility to prioritize funding for nutritious food purchases while placing reasonable limitations on items such as sugary drinks and processed snacks. Programs like Double Up Food Bucks, which match SNAP benefits when used to purchase fresh produce, should be expanded through state-managed block grants rather than direct federal intervention.¹¹²

USDA Secretary Rollins has mentioned that she might be open to some kind of reform that better directs SNAP dollars towards being used on healthy and nutritious food, instead of ultra-high processed foods and sugary drinks. Secretary Rollins has said she's looking forward to working with HHS Secretary Kennedy on this issue.¹¹³

Leveraging Technology and Innovation

Innovative solutions can play a significant role in promoting childhood health without expanding government control. Expanding telehealth options for nutrition counseling can provide low-income families with affordable access to registered dietitians and wellness coaches, improving dietary habits through education and guidance rather than coercion.

Digital rewards programs can incentivize healthier lifestyles through smartphone apps that track fitness progress, healthy eating habits, and participation in wellness programs. Private-sector partnerships should be encouraged to develop and manage these initiatives, ensuring efficiency and effectiveness without unnecessary government expansion. The simple act of mapping out a diet plan or a physical activity plan is made significantly easier if one has access to industry leading devices and apps.

When it comes to expanding health education in school curricula, technology can play a pivotal role in overcoming significant barriers. Because the regular school schedule is already crowded, policymakers should support alternative models to deliver health education beyond the traditional classroom setting. One promising avenue is online learning modules for health topics – interactive programs or video lessons that students can complete for credit outside normal class hours. This offers flexibility for schools that may lack time or qualified staff to teach additional health classes. States could develop standards-aligned online curricula (in partnership with e-learning providers) and make them available statewide, enabling rural or under-resourced schools to access high-quality content at low cost.

Measuring Impact and Ensuring Accountability

For any policy to be effective, it must include mechanisms for tracking progress and ensuring accountability.

Annual community health metrics should be established at the local level to measure changes in childhood obesity rates, food accessibility, and participation in fitness programs. These evaluations should be conducted by independent entities rather than government agencies, ensuring objectivity and data-driven policy adjustments. Public stakeholders should be required to report progress on their contributions to nutrition and wellness programs, allowing for transparency and informed decision-making.

Increasing Federal Research on Food Safety and Nutrition

To develop more effective policies and consumer education programs, the federal government should prioritize research into food safety and nutrition through agencies like NIH and USDA. Increased funding should be allocated for studies examining the long-term health effects of food additives, preservatives, and ultra-processed foods on children's development and overall well-being.

Research should also focus on how diet influences chronic disease and what policy interventions—market-driven or otherwise—yield the best outcomes. By expanding scientific understanding, policymakers can make data-driven decisions that empower consumers and promote public health without unnecessary regulatory overreach. Simply put, there is a great need for much, much more research and data. Increasing research will continue to be a pivotal pillar in addressing childhood obesity.

Reforming the GRAS Loophole: Transparency, Accountability, and Market-Driven Oversight

One of the most glaring regulatory failures contributing to childhood obesity and food safety concerns is the "Generally Recognized as Safe" (GRAS) loophole in the FDA regulatory framework. Originally, GRAS was intended for common, well-established ingredients, such as salt and sugar. GRAS allowed a streamline approval for these long-established food ingredients. In 1996, the FDA determined that it couldn't keep up with all of the requested reviews of new additives.¹¹⁴ The solution was to make the GRAS regulation voluntary. This loophole allows companies to determine on their own whether a

substance is safe for consumption, often without notifying the FDA. This has led to the GRAS designation being exploited by large food manufacturers to introduce new additives without independent review. With the voluntary notification system allowing manufacturers to self-certify ingredients and bypass FDA scrutiny entirely, the public is left vulnerable to unknown health risks. As a result, untested and potentially harmful ingredients, such as the previously mentioned tara flour, have entered the food supply.

The free market relies on transparency, yet the voluntary nature of GRAS reporting has allowed companies to operate without proper disclosure, leaving parents and consumers in the dark. The key is to enforce accountability and promote informed choice. Reform should focus on three key principles: market-driven transparency, corporate accountability, and state-level innovation.

Fixing the GRAS loophole doesn't mean bloating the federal government with more regulations—it means putting power back in the hands of consumers and holding corporations accountable without stifling innovation. Instead of adding more federal red tape, Congress should encourage states to take the lead in bringing more transparency to the GRAS process. A good example of this is New York's proposed legislation, which would require companies to at least notify the state when they introduce new additives under GRAS without FDA oversight.

At the federal level, the FDA should require a public database where companies voluntarily list GRAS-approved additives. This would give parents, researchers, and food safety groups easy access to ingredient safety data.

Right now, if a company introduces an additive that turns out to be harmful, there's little recourse for consumers. That needs to change.

Strengthening liability protections would put the burden where it belongs—on the corporations using untested ingredients. Additionally, encouraging independent, third-party certification—similar to organic or non-GMO labels—for companies to prove their additives are safe would go a long way.

Finally, there's a need for stronger and quicker action when food additives are discovered to be dangerous and are already in use. When the tara flour contamination led to hundreds of hospitalizations, it took the FDA two years to issue a ban. Rather than relying on a slow-moving federal agency, there's the potential to leverage private partnerships with universities, independent labs, and consumer watchdog groups to track potential risks in real-time.

Conclusion: Reclaiming the Health of America's Future

Childhood obesity is not merely a crisis of personal responsibility; it is a systemic issue deeply embedded in the economic, cultural, and policy frameworks that shape the modern American diet and lifestyle. Over decades, the proliferation of ultra-processed foods, the erosion of physical activity, and the misalignment of government incentives have converged to create an environment where unhealthy choices are not just accessible but actively encouraged. The consequences are profound—millions of children are now facing a lifetime of chronic illness, diminished well-being, and escalating healthcare costs that strain families and the broader economy.

Addressing this crisis requires a paradigm shift—one that does not rely solely on top-down regulatory mandates but instead empowers parents, communities, and private-sector stakeholders to take charge of America's health trajectory. Policy solutions must prioritize marketdriven incentives over government overreach, ensuring that families have the knowledge and resources to make healthier choices while fostering a food system that prioritizes nutrition over corporate profit. Community engagement, parental education, and faith-based initiatives offer powerful avenues for change, providing grassroots solutions that reinforce personal responsibility without bureaucratic expansion. Schools, while integral to children's health, must collaborate with families and local organizations rather than impose rigid federal mandates that ignore regional and cultural needs. Similarly, reforming federal assistance programs to incentivize healthy food choices—without increasing dependency on government intervention—can play a critical role in reversing childhood obesity trends.

The broader political landscape is shifting, with a renewed focus on food safety, the dangers of ultra-processed diets, and the long-term consequences of chemical additives. While federal action on these issues remains uncertain, the increasing demand for transparency and accountability from food manufacturers offers hope for a future in which consumers are better informed and empowered to demand healthier options.

The path forward is clear: childhood obesity must be confronted with a combination of policy innovation, community-driven initiatives, and an unwavering commitment to restoring health as a national priority. America's children deserve more than a future dictated by preventable disease and diminished opportunities. They deserve a nation that prioritizes their well-being—not through coercion, but through education, access, and a reinvigorated culture of health and vitality.

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End



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