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A Tale of Two ObesCities: The Role of Municipal Governance in Reducing Childhood Obesity in New York City and London

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ABSTRACT *As rates of childhood obesity and overweight rise around the world, researchers and policy makers seek new ways to reverse these trends. Given the concentration of the world's population, income inequalities, unhealthy diets, and patterns of physical activity in cities, urban areas bear a disproportionate burden of obesity. To address these issues, in 2008, researchers from the City University of New York and London Metropolitan University created the Municipal Responses to Childhood Obesity Collaborative. The Collaborative examined three questions: What role has city government played in responding to childhood obesity in each jurisdiction? How have municipal governance structures in each city influenced its capacity to respond effectively? How can policy and programmatic interventions to reduce childhood obesity also reduce the growing socioeconomic and racial/ethnic inequities in its prevalence? Based on a review of existing initiatives in London and New York City, the Collaborative recommended 11 broad strategies by which each city could reduce childhood obesity. These recommendations were selected because they can be enacted at the municipal level; will reduce socioeconomic and racial/ethnic inequalities in obesity; are either well supported by research or are already being implemented in one city, demonstrating their feasibility; build on existing city assets; and are both green and healthy.*

KEYWORDS *Childhood obesity, Municipal governance, Health inequities, Urban health*

INTRODUCTION

In recent decades, rates of childhood obesity have soared around the world, imposing health and economic burdens on both developed and developing nations.[1] Given obesity's role in the etiology of major chronic diseases, this trend threatens global progress in achieving improvements in population health. Because of the increasing concentration of the world's population in cities and the role of the urban built environment and urban life styles in obesity, cities experience a disproportionately heavy cost from rising rates of childhood obesity.[2] Although municipal governments have the potential to play a leading role in the effort to reduce obesity, researchers have focused little attention on defining these opportunities or

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comparing the efficacy of various municipal-level approaches to obesity prevention and control.

To address these problems, in 2008, researchers from the City University of New York (CUNY) and London Metropolitan University (London Met) created the Municipal Responses to Childhood Obesity Collaborative to seek answers to these questions:

1. How have New York City and London responded to rising rates of childhood obesity?
2. What are the similarities and differences in their responses?
3. How have different municipal governance systems shaped these responses?
4. What can the two cities learn from each other to strengthen their responses to childhood obesity?
5. What can other cities learn from the New York City and London experiences?

Our collaborative sought to build on the work of other local, national, and global bodies that have recently examined childhood obesity,[3–8] but we identified three distinct themes that characterized our inquiry. First, we focused on the role of city government in responding to childhood obesity. While we acknowledged that national governments and the food industry, among others, need to act to reduce childhood obesity, we believe that city governments are ideally situated to implement multisectoral and pragmatic approaches that can reduce childhood obesity in those areas where it is most prevalent. Second, we were interested in how municipal governance structures influence the capacity of cities to respond effectively. Evidence shows that municipal governance contributes to health and health inequalities.[9–12] We hoped to investigate its role in childhood obesity. Third, evidence suggested that in many societies, childhood obesity is becoming an important cause and consequence of wider disparities in health, both within cities and between nations.[13,14] Thus, effective responses had to be linked to broader efforts to reduce the social and economic gaps that produced these health inequities.

THE COLLABORATIVE

The Municipal Responses to Childhood Obesity Collaborative (the Collaborative) was created by urban health researchers at CUNY and London Met, the two largest public universities in those cities, who sought to develop cross-city investigations of common urban health problems. We decided to focus on childhood obesity because both municipal governments had already identified this as a priority area for action, childhood obesity has played an important role in driving health inequities, and it served as a lens through which to examine many of the pathogenic and salutogenic features of the urban environment. In 2008 and 2009, a group of about 40 researchers, public health officials, staff from the Mayors' Offices, and advocates (listed in the Acknowledgements) met, first in London and then in New York, to review and analyze epidemiological data, program and policy analyses, and municipal reports on childhood obesity from the two cities. At the final meeting, the group developed 11 policy recommendations designed to strengthen the response in each city. A draft summary of these deliberations was prepared and circulated to all participants and revised several times based on feedback. Our report, *A Tale of Two ObesCities: Comparing Responses to Childhood Obesity in London and New*

York,[15] was released in London in January 2010 and a few weeks later in New York City.

CHILDHOOD OBESITY IN NEW YORK CITY AND LONDON

New York City and London share social and political characteristics. As shown in Table 1, both cities have large and diverse populations. Because London is geographically larger, and development is subject to more stringent planning controls, it is less densely populated than New York. Available evidence indicates that New York has greater extremes of inequality and is more segregated by race/ethnicity and class than London. Both cities have the highest rates of income inequality in their nations.

Rates of childhood obesity and overweight also share common patterns in the two cities, as shown in Table 2. In both cities, the prevalence of obesity and overweight increases with age; is more common among boys than girls until puberty, when the gender ratio changes; and is more common among low income, immigrant, and certain ethnic/racial groups. Racial and ethnic disparities in childhood obesity in these cities reflect the geopolitical histories of United States and Great Britain, so that in New York, Latino children are the most obese and in London, this burden falls on Southeast Asian children. These striking socioeconomic differences highlight the ways that differences in childhood obesity and overweight mirror broader health inequities in the two cities. Figure 1 shows some of the pathways by which poverty contributes to childhood obesity, key intervention points explored by members of the Collaborative.

GOVERNANCE IN TWO CITIES

New York City and London have municipal governance structures that are firmly embedded in the national systems of government in the United States and Great Britain. These differences have shaped the cities' responses to childhood obesity and created unique opportunities and constraints for each.

New York. New York City has a government structure with a strong mayor and a relatively weak legislative body, the City Council, whose members represent 51 neighborhood districts. Most municipal services are delivered by city agencies run by Mayoral appointees. Community districts have boards with limited power over land use decisions and the responsibility to coordinate services at the local level and provide feedback to elected officials. Unlike some other big US cities and unlike London, New York City plays a strong role in delivering many services. It operates the school system, runs a public hospital system, plays a role in transportation policy, and sets some zoning rules, all powers that can be used to influence childhood obesity.

Many public services require cooperation between the three levels of city, state, and national government. For example, the city Department of Education purchases food, plans menus, and delivers food to the schools, where local staff actually prepare and serve the food. Through its education department, New York State monitors local school food programs and provides technical assistance to local school food programs. The federal government sets standards, specifies products, and pays for some food served in school lunch programs. Improving school food requires either changing policies at all three levels or accepting the constraints imposed by higher levels.

TABLE 1 Demographic profile of London and New York[34]

	London	New York
Area	1,579 km^2 (610 square miles)	321.8 square miles
Average population density	4,682 people per square kilometer (10,300 per square mile)[35]	25, 383 people per square mile[36]
Total population	7, 560,000	8,246,310
Race/ethnicity		
White	69%	44.9%
Black	11%	25.7%
Hispanic or Latino		27.4%[a]
Asian	14%	11.8%
Chinese	3%	
Mixed race	3%	1.9%
Foreign born	33%	36.7%
Poverty[b]	22%	18.9%[c]
Unemployment	8.2%[37]	9.6%[38]

[a]In the US census, Hispanic or Latino is an ethnic and not a racial designation thus percentages do not add to 100

[b]Poverty is defined differently in the United States and UK. In the UK, the poverty line is set at 60% of median income after housing costs. In the United States, poverty is measured using an annual income threshold set by the US Census. The current threshold for an individual is $10,830 and for a family of four is $22,050

[c]Of all people in New York City whose income was below the poverty level during the year before the census

In the United States, each level of government and the private sector have responsibilities for paying for and delivering health care and assuring public health. The city government has responsibilities for public health and operates a municipal hospital system. Through the state and federal governments, the Medicaid program pays for health care for low-income people. The recently enacted legislation that reforms the US health care system will not change this dispersion of responsibility for health care.

In New York, the city's Health Code gives government a unique tool to advance public health without undue political interference. Under the city charter, the Board of Health may enact, alter, amend, or repeal any part of the Sanitary Code and "may therein publish additional provisions for the security of life and health for the city and confer additional powers on the department not inconsistent with the constitution or laws of the State or with this charter."[16] The Health Code, created in 1866 and modified periodically since, was intended to provide public health experts with an opportunity to set health regulations without going through the legislative process.

Recently, the Board of Health, an independent body appointed by the Health Commissioner and the Mayor, has used its authority to address obesity. In the past four years, the Board of Health has issued rules requiring chain restaurants to post the calorie content of the foods they sell (2007);[17] child care centers to offer healthier food and more opportunities for physical activity (2007); city agencies to follow guidelines that mandate purchase of healthier foods for schools, jails, senior citizen centers, and other municipal services (2007); and restaurants to eliminate transfat from their products (2006).[18] In these and other cases, the city was able to use its authority to make healthier food and activity choices more available.

TABLE 2 Overview of childhood obesity in London and New York

New York	London
Prevalence	
In both cities, by the end of primary school, about one in five children is obese. Rates of overweight are slightly lower in London than in New York (14.7% vs. 18%). Childhood obesity in both cities exceeds national averages.	
In New York City, nearly 40% of public school children in grades K–8 are overweight or obese. Specifically, 21% of young people are obese, and 18% are overweight.[39]	In London, nearly 23% of children entering school are obese or overweight (10.9% are obese and 12% are overweight).[40]
Race and ethnicity	
Among Hispanic children in New York City, 19% of boys and 23% of girls are designated as obese.	Black African, Caribbean, and other Black children aged 10–11 in London have obesity rates higher than 25%.
Among Black children, 21% of boys and girls are obese.	Bangladeshi and Pakistani children have obesity rates of 22%.
Among Whites, 20% of boys and 14% of girls are obese.	White Irish and British children have obesity rates of less than 20%.[40]
Among Asians, 18% of boys and 9% of girls are obese.[39]	
Among teens, one in three teens living in the poor neighborhoods of Bedford-Stuyvesant, Bushwick, the South Bronx, and East and Central Harlem is overweight or obese compared to one in four for the rest of the city.[41]	
Gender	
In both cities, childhood obesity is higher among boys than girls.	
Overall, 24% of New York's boys are obese as compared to 19% of girls.[39]	At ages 10–11, boys and girls in London are equally likely to be overweight, but boys are more likely to be obese, 24% vs. 19%.[40]

London. The Greater London Authority (GLA) is the regional authority for London. It includes the Mayor and the 25 members of the London Assembly, all elected every 4 years. The Mayor co-ordinates strategies aimed at improving London and articulating a vision for the city. The principal strategies cover such issues as spatial and economic development, transport, air quality, and culture. In 2000, the Mayor of London created the London Health Commission to improve the health and well-being of Londoners. Through its reports and partnerships, the Commission has played an important role in calling attention to the problem of childhood obesity.

Since 2007, the central government accorded the Mayor a statutory duty to reduce inequalities in health. The GLA has the power to order health impact assessments for any policy including those for transport or the built environment, a potential tool for the control of childhood obesity. While the position of Mayor in London is much less powerful than in New York, the previous and current Mayors have used the office to advance health-related initiatives such as using the 2012

Food	Poor neighborhoods have more fast food outlets and fewer supermarkets or other retail outlets that sell fruits and vegetables; unhealthy food advertising targets the poor; those with low incomes purchase calorie-dense, nutrient-poor foods because they are cheaper than healthier products; public food programs often serve on healthy or low quality food;
Physical activity	Poor neighborhoods have fewer parks and recreation centers; fears of crime prevent low income people from going out to be active; heavy traffic and highways in poor neighborhoods discourage walking or bicycling;
Health care	Health care providers provide less counseling and health education to poor children; poor children (in United States) are more likely to be uninsured or lack access to health care;
Schooling	Schools serving poor children offers less healthy school food; fewer opportunities for sports and recreation and less nutrition and health education in schools in poor areas;
Other	Stressful living associated with poverty can lead to over-eating; poor children watch more television, associated with more exposure to unhealthy food advertising and with higher rates of inactivity.

FIGURE 1. Poverty as pathway to obesity. Sources: [42–45]

Olympics to create a "health legacy" of improved opportunities for physical activity for all Londoners[19] and the recent appointment of a high profile food adviser to oversee the implementation of the London Food Strategy.[20]

Most public services in London, such as education, housing, social services, street cleaning, waste disposal, roads, local planning, and many arts and leisure services, are delivered by the 32 boroughs, geographic areas that include about 200,000 to 250,000 people. Assigning responsibilities for these services to boroughs enables local authorities to tailor services to meet specific needs, but makes citywide initiatives more difficult.

Health services are provided by the national government, which operates the National Health Service (NHS), the government body that funds guaranteed health care to all UK residents. Primary care trusts have been developed to commission and fund a range of community and primary health services, hospital care, and medical prescriptions. In London, 31 local primary care trusts oversee public health and medical care, playing an active role in responding to obesity by, for example, funding staff to work to improve school food and conducting studies of the prevalence of childhood obesity in London boroughs. The NHS is currently undergoing a controversial transformation that devolves authority to more local levels. As in the case of schools, primary care practices may be able to provide more locally sensitive services, but citywide initiatives become more difficult. In London, the city government has little direct responsibility for health care or public health, limiting its ability to address childhood obesity.

COMMON CHALLENGES

In both London and New York, other levels of government compete with city government for power and turf. In Great Britain, the national government and local

boroughs each control many aspects of urban life that influence obesity, perhaps making it more difficult to bring about change at the municipal level. In New York, the state government has powerful control over health and social services, sometimes blocking the city from acting on its own. One observer has noted that New York State has given New York City a heart but no brain, while Parliament has given London a brain but no muscle.[21]

In both cities, private interests such as the financial sector, food services, and real estate developers generally speak with a more unified voice than government or advocacy groups.[22] Several obesity-related policies, such as more public oversight of the food and advertising industries, zoning changes to limit density of fast food outlets, taxes on unhealthy products such as sweetened beverages, or reductions in the income equality that drives obesity, threaten the interest of established groups. When these groups oppose policies that affect obesity, private interests generally have more resources and skills than public health reformers to achieve their policy goals, and are more successful in resisting changes than advocates are in implementing them. These structural barriers are a powerful deterrent to reducing childhood obesity. Creating cities where health rather than business concerns take precedence will require new approaches to governance and democracy. Frug has observed that in today's global cities, building a city based on concern for social justice "takes a back seat to building a globalized business environment,"[23] an observation that applies to New York and London.

Both New York and London have recognized that human-induced climate change poses a grave threat to the cities' futures and that some strategies can simultaneously reduce global warming and obesity. In 2007, New York's Mayor Bloomberg announced PlaNYC 2030, a planning agenda to address New York's growing population, aging infrastructure, and their connections to global warming.[24] While omitting comprehensive discussions of food and public health, it includes sections on land, water, transportation, energy, air, and climate change. By contrast, London's 2002 Sustainable World City strategy placed healthy school food at the center of a vision for making London the first world city to make sustainability a priority.[25] In following the United Nation's definition of sustainable development, the London strategy combines social and environmental sustainability. In their recent analysis of London policy options,[26] Wilkinson and Pickett argue that cities do not have to trade sustainability for commitment to reducing inequalities in health. Given the connections between rising rates of obesity and human-induced climate change,[27] both cities can benefit from the development of synergistic strategies to address both these global problems.

MUNICIPAL PROGRAMS TO CONTROL CHILDHOOD OBESITY

The Collaborative identified responses to childhood obesity in the two cities in six sectors: food, transportation, green space, planning and housing, schools, and health care and health inequities. These initiatives fell into three broad categories: policy changes to modify environments that shaped health choices, programs to increase access to services or resources that helped to prevent obesity, and educational initiatives to assist individuals to make more informed choices. Table 3 illustrates examples of each in the two cities.

As shown in Table 3, each city has created a diverse portfolio of educational, programmatic, and policy initiatives in the six sectors. To a large extent, these

TABLE 3 Selected municipal responses to childhood obesity in New York City and London[15]

	New York City			London		
Sector	Education	Programs	Policies	Education	Programs	Policies
Food	Require calorie labeling in chain restaurants Public campaign against sweetened beverages	Green Carts make fruits and vegetables more available in low-income areas	Create Office of Food Policy Coordinator FRESH funds super markets to expand in poor areas; mandate city agencies to procure healthier food for city agencies	Eatwell programs offer community-based classes on how to cook healthfully	Buywell programs make healthy food more available	Create Food Policy Coordinator Borough of Waltham Forest considering restricting hot food take-aways
Transportation	Post signs encouraging people to use stairs inside buildings	Create 200 additional miles of bike lanes on city streets; safe routes to schools improves walkability of target schools		See schools	Walk on Wednesdays walk-to-school program	Congestion pricing encourages use of mass transit and walking
Green space		GreenThumb, a program of city parks department, supports community gardens in school yards and neighborhoods			Capital Growth's landshare website engages the public in identifying potential spaces for food growing and creates a portal where people without land can connect with people who have available land and no desire to cultivate it Each borough identifies new areas for play for children and youth	The Capital Growth campaign sets a target for creating 2,012 new food growing spaces by 2012

Planning and housing	Starting this fall, the city will offer trainings to institutions and community groups on the active design guidelines		City issues guidelines for active living design			Local boroughs required to have plan for open space for children and young people
Schools	Create new curriculum for physical education in the schools	Make school yards into public playgrounds	City advocacy to increase federal funding for school food program		Each London school has developed a travel plan that provides guidance to students and parents on how to be more active during the journey to school	Islington borough funds free school lunch for all
	Fitness testing and fitnessgrams to monitor children's weight and regularly report their fitness to their families	School Wellness Councils	Remove unhealthy foods from school cafeterias		Schools increase parking spaces for bicycles	
Health care and health inequalities	DOHMH is conducting outreach to doctors to support their capacity to counsel families on childhood obesity	District public health offices coordinate and channel resources and programs in the three communities where the burden of disease is highest	Take Care NY policy agenda set goals on adult but not childhood obesity	Some primary care trusts have launched obesity education and counseling programs	Tailor national Change4Life for London communities	London Health Inequalities Strategy
				Walking the Way to Health allows providers to counsel patients on physical activity		Mayor's Healthy Weight, Healthy Lives Action Plan for London focuses on reducing health disparities

responses reflect the much larger universe of policy proposals that have made their way through the policy and political processes in the two cities. In his influential essay on policy development, Kingdon suggests that policy proposals that are actually implemented are those that can find “windows of opportunity” in three overlapping “streams”: framing the problem, proposing feasible policy solutions, and negotiating political processes.[28] In the ecology of policy terrains in New York and London, the responses to childhood obesity listed in Table 3 are the survivors of this evolutionary struggle.

To what extent are the paths chosen the most effective ways for reducing childhood obesity? An examination of policy proposals that have not succeeded provides some insights. For example, in New York City, proposals to impose congestion pricing fees to reduce traffic and promote mass transit and walking; to tax sweetened beverages; to use zoning laws to reduce the density of fast food outlets; or to balance growing budget deficits with new taxes on the wealthy rather than cuts in health, educational, and other services for the poor have for the most part not succeeded. These examples show that suggestions for even modest reforms that challenge the status quo of elites face formidable opposition.

Similarly, in London, the 2012 Olympics and Paralympics will be hosted by five boroughs whose children experience some of the deepest deprivation and health burdens in the UK. It is notable that the intended health legacy of the 2012 Olympics is at odds with its commercial sponsorship, which includes McDonalds, Coca Cola, and Cadbury, companies implicated in the spread of obesity.[29] In both cities, modest efforts to increase availability of healthy food and opportunities for physical activity seem more feasible than reducing the promotion and availability of unhealthy food or making more substantial changes in the built environment.

The GLA’s London Health Inequalities Strategy commits to attempting to “influence the food industry to provide clearer information and reduce unhealthy food content” and hopes to work in partnership with the Food and Drink Federation, the food industry trade association.[30] Whether these intentions can be translated into policy change will test the city’s ability to address more fundamental causes of childhood obesity.

DISCUSSION

The Collaborative recommended 11 broad strategies by which each city could reduce childhood obesity, as shown in Table 4. These recommendations were selected because they can be enacted at the municipal level; will reduce socio-economic and racial/ethnic inequalities in obesity; are either well supported by research or are already being implemented in one city, thus demonstrating their ability to survive in the real world; use or reframe existing city assets; and are both green and healthy. If implemented, these recommendations would help each city to develop a more balanced portfolio of obesity interventions that addresses all six sectors and includes educational, programmatic, and policy approaches.

While it is premature to assess the impact of the Collaborative, we note several insights from our experience to date. First, the paucity of policy-based research on the contributions of policy change to obesity reduction has meant that the evidence base that can guide municipal policy makers is slim. By examining the implementation of policies in situ in two world cities, the cities learned lessons that allow them and perhaps other cities to benefit from these experiences without the delays usually required to translate policy innovation into the peer-reviewed studies that provide

TABLE 4 Summary of recommendations by sector

Recommendations	Key Actors	
	London	New York
Land use and planning		
Use zoning authority, land use review, and other municipal authority to limit access to fast food and the promotion of unhealthy foods to children	Mayor's London Plan, London Councils, Mayor, HCA	Dept of City Planning, Mayor City Council
Use zoning, tax incentives, and publicly owned property to increase the availability of healthy, affordable, and culturally appropriate foods in neighborhoods where it is limited		
Incorporate active design principles into building codes, housing strategies, and neighborhood planning		
Food		
Set standards for municipal purchase of food in public agencies and leverage economies of scale to promote food systems that support economic, environmental, and human health	Mayor, London Councils, London boroughs' environmental health officers	Mayor, Department of Health, Board of Health, food businesses, consumers
Redefine food safety standards to reflect current threats to health and use the municipal food safety workforce to promote healthier eating		
Parks and green space		
Promote and support urban agriculture as a sustainable and health-promoting use of green space	Mayor and Metropolitan Police	Mayor, Department of Parks and recreation, advocates
Increase access to and safety of places where people can be physically active		

TABLE 4 ***Continued***

Recommendations	Key Actors	
	London	New York
Transportation and physical activity		
Promote walking and cycling in neighborhoods with high levels of childhood and adult obesity	Mayor, Trust for Land, London Council	Mayor, Department of Transportation, Metro Transport Authority
Schools		
Implement a universal school meals program with nutritional standards that promote health	Department for Children, Schools, and Families; London Councils	NYC and State Departments of Education; food, parents and youth advocacy groups
Provide drinking water in schools by improving infrastructure for tap water delivery and bathrooms		
Research and training	NHS/PCTs, London Health, Commission, London Health, Observatory, London Met, Academics	Mayor, Department of Health, universities, researchers
Promote research that helps cities understand how to best address health inequalities and childhood obesity by		
Developing and improving the data systems that monitor childhood obesity so that cities can track and report citywide prevalence as well as information about social, economic, and geographic disparities		
Tracking the cost and outcomes of municipal policies and programs that address childhood obesity and disseminate this work internationally		
Documenting the adverse impact of food marketing practices on children and designing and evaluating strategies to reduce this influence		
Finding the best ways to prepare health providers, educators, and others to reduce childhood obesity		
Using urban planning as a tool for assessing and changing the built environment to promote health		

Source: [15]

the "evidence base" for action. Given the serious health consequences of childhood obesity, this shortcut recognizes the imperatives of the precautionary principle of acting with uncertain knowledge if the consequences of inaction are high.[31]

Second, even cities that share a language, patterns of development, and high levels of wealth and poverty have very different governance systems that strongly influence the potential for action. This suggests the need for research to better understand how various governance systems promote or undermine efforts to reduce childhood obesity or other conditions and to identify which strategies are most feasible in differing governance regimes.

Third, in the months following the release of our report, both cities have accelerated their efforts to address policy determinants of childhood obesity. In New York City, for example, the City Council Speaker has introduced a proposal to reduce the density of fast food restaurants.[32] In Great Britain, the Department of Health has asked the National Institute for Health and Clinical Excellence to develop guidance on the use of whole systems approaches to reducing obesity at local and community levels,[33] very much the approach advocated in our report. While we are unable to attribute these changes directly to our efforts, collaborative exchanges among researchers, advocates, and policy makers can help reframe the policy discourse on obesity, perhaps especially at the more accessible local level.

The proposed policy agenda (see Table 4) recognizes that city governments play an important role in creating policies and structures that support community action, create incentives for responsible business practices, and deliver essential goods and services. While city government can lead the charge on this agenda, community and user engagement are essential elements of shaping the messages, programs, and policies that will be its tangible results. In addition, regional and national governments and businesses must also play a role if municipal changes are to be sustained and brought to scale. Defining more carefully what city government can and cannot do and how it can use its authority to leverage action at different levels are important priorities.

Finally, we believe that success in reducing childhood obesity will require both incremental and transformative change. Both cities have demonstrated substantial success in devising and implementing the incremental changes that will make it easier for more children, families, communities, schools, and other institutions to take action to reduce obesity. Unfortunately, many knowledgeable observers believe that these incremental changes will be insufficient to reverse childhood obesity trends and that delaying action for one or two decades will doom another generation to the burden of chronic diseases that childhood obesity produces.

How can the two cities accelerate their response and move to enact more transformative changes? How can cities tackle the more fundamental causes of childhood obesity such as growing rates of childhood poverty, increasing income inequality, relentless and ubiquitous promotion of unhealthy food, deep cuts in health and educational services in the face of an economic crisis, and a built urban environment that favors large-scale real estate development over livable, active communities?

Historically, urban living conditions have improved when social movements and urban reformers can agree and act on a plan that will change the living conditions for the population as a whole. In both New York and London, the embryos of such a movement are becoming visible in citizen action around school food, restrictions on fast food outlets and take-away shops, urban design that promotes walking and bicycling, and expanding urban green space and agricultural projects. Our success in reversing the epidemics of childhood obesity depends on whether these early efforts can be nurtured to become viable forces for changes in municipal governance and obesogenic business practices, leveling the political playing field, and transformations of the living conditions that contribute to childhood obesity and other health problems.

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