

Welcome to the Food Research & Action Center's spring issue of ResearchWire. This quarterly periodical e-newsletter focuses on the latest research, reports, and resources from government agencies, academic researchers, think tanks, and elsewhere at the intersection of food insecurity, poverty, the federal nutrition programs, and health.



IN FOCUS

SNAP Benefits Need To Be Made Adequate, Not Cut or Restricted

The Supplemental Nutrition Assistance Program (SNAP) is one of the crown jewels of U.S. public policy. More than 40 million children, parents working at low wages, seniors, people with disabilities, veterans, members of the active duty military, unemployed working-age adults, and others receive SNAP in an average month.

FRAC's new brief, *SNAP Benefits Need To Be Made Adequate, Not Cut or Restricted*, outlines the numerous values of this federal program, how attacks on the program misunderstand the breadth of the program, why the proposals to restrict SNAP foods are misplaced, and policy solutions that exist to improve SNAP beneficiaries' health. Highlights from, and a link to, the document are provided below.

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Effectiveness and Value of SNAP

A surge of recent research has shown how vital SNAP is to a wide variety of the nation's most important health, employment, education, and other goals.¹ In addition to the program's effectiveness, SNAP is efficient because it provides access to normal streams of food commerce and also preserves the dignity of beneficiaries by making the food-purchase smooth and akin to all other commercial food purchases through the use of an electronic benefits card at all types of food outlets.

The Faces of SNAP

Each month in recent years, about 1 in 8 Americans participated in SNAP. Over longer periods of time the program reaches an even larger share of the population. An estimated one-half of all children will receive SNAP benefits at some point during childhood; and half of all adults will use SNAP at some point by age 65.

Attacks on SNAP and its beneficiaries often are based on stereotypes that do not acknowledge these demographics — that the face of SNAP is the face of much of America. And proposals to reshape the

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program through benefit cuts, eligibility reductions, restrictions on food choice, or different delivery mechanisms typically fail to recognize this as well.

SNAP Benefits are Inadequate

The greatest shortcoming of SNAP is that benefits for most households are not enough to get through the entire month without hunger or being forced to sacrifice nutrition quality. In 2013, after a thorough study, the prestigious Institute of Medicine (IOM) outlined the factors that explain why the SNAP allotment is not enough to get most families through the month with a minimally adequate diet.² These factors include, among others, the lag in SNAP benefits keeping up with inflation; households' shelter costs that consume income that SNAP rules incorrectly treat as available for food purchases (therefore reducing SNAP allotments); and the cost-time trade-offs in obtaining a nutritious diet. An analysis by FRAC found that SNAP benefits also are inadequate because they are based on the U.S. Department of Agriculture's (USDA) flawed Thrifty Food Plan.³

Proposals to Restrict SNAP Foods are Misplaced

As SNAP families struggle to overcome the shortfall of inadequate benefits, they generally do a first-rate job of shopping and extending allotments as long as possible. Research also demonstrates that the differences between SNAP recipients' purchases and diets and those of other consumers are very modest.⁴ It should not be surprising that the dietary

patterns of SNAP recipients are so much like those of other Americans, since so many Americans at one point or another benefit from SNAP. The dietary constraints that are unique to SNAP recipients are due to monthly SNAP benefit inadequacy or lack of resources in poor communities.

Despite all this, beneficiaries are constantly under attack for the foods they buy. This means that this proven and effective program is subject to proposals often rooted in stereotyped judgments of low-income people and sometimes on a politically motivated desire to harm the program. The constant stream of attacks from many competing corners has the effect in the aggregate of weakening the program and stigmatizing beneficiaries.

Much of this is evident from the range of proposals themselves, where some seek to eliminate foods from SNAP eligibility because they are not good enough (e.g., sugar-sweetened beverages), while others want to eliminate foods that are too good (e.g., shellfish). It is a toxic version of the Goldilocks story, in this case there is no food "just right," as interest groups and political actors fight over ways to carve out restrictions based on competing and often contradictory ideologies. Rarely do any proponents of restrictions meaningfully seek to confront and address the inadequacy of monthly benefits as a barrier for low-income families in achieving dietary adequacy.

In addition, as USDA has pointed out, restriction proposals for SNAP introduce additional administrative costs for retailers, create difficulties in deciding on the exclusion criteria for particular foods or food categories, and lack evidence that restrictions yield meaningful improvements in health outcomes while doing no harm to participants.

Policy Solutions Exist to Improve the Health of SNAP Beneficiaries

There are policy solutions to improve SNAP beneficiaries' health. One key step is to improve benefit adequacy. The IOM report contains many valuable recommendations to make SNAP benefits more adequate, and FRAC has long supported those adjustments. FRAC also recommends replacing the Thrifty Food Plan with the Low-Cost Food Plan. The amount of USDA's Low-Cost Food Plan is generally in line with what low- and moderate-income families report they need to spend on food, as opposed to the lower amount the Thrifty Food Plan-based SNAP allotment provides. The Low-Cost Food Plan also allows for greater food variety and choices to support a healthful, palatable diet.

Research has shown that increasing benefits to more adequate levels would have important positive health impacts.⁵ For instance, after the temporary increase in benefits created by the American Recovery and Reinvestment Act (ARRA) of 2009 (an increase that was terminated in 2013), inpatient Medicaid cost growth significantly declined, especially among people with chronic illnesses.

Improving benefit adequacy and other strategies (e.g., increasing access to healthy affordable foods in underserved communities; supporting use of SNAP at farmers' markets and in other farm-to-consumer venues; enhancing SNAP Nutrition Education) build on, rather than undercut, SNAP's strengths. Proposals for food choice restrictions make the program weaker. The program is so valuable and so effective that the smart path is to enhance its strengths.

Read the full report, including citations, [here](#).

Research Highlights

Supplemental Nutrition Assistance Program (SNAP)

[The antipoverty effects of the Supplemental Nutrition Assistance Program](#)

The Urban Institute estimated that the Supplemental Nutrition Assistance Program (SNAP) lifted 8.4 million people, including 3.8 million children, out of poverty in 2015, resulting in a 17 percent reduction in the poverty rate. SNAP also reduced poverty 20.9 percent for non-Hispanic Blacks, 17.6 percent for Hispanics, and 15.5 percent for non-Hispanic Whites. In addition, SNAP lifted 6.8 million residents of metropolitan areas out of poverty (a 16 percent reduction in poverty), and lifted 1.5 million residents of nonmetropolitan areas out of poverty (a 24 percent reduction in poverty). Nearly 6.2 million people in working families were removed from poverty by SNAP, a 21.3 percent reduction in poverty. Overall, the largest proportionate declines in poverty from SNAP were observed for children, non-Hispanic Blacks, working families, residents of the Midwest and Northeast, and residents of nonmetropolitan areas. In these and other analyses in the Urban Institute report, researchers used the Census Bureau's Supplemental Poverty Measure (an alternative poverty computation that counts SNAP benefits as income) and corrected for the underreporting of SNAP and other means-tested programs.

[How far do SNAP benefits fall short of covering the cost of a meal?](#)

"The maximum SNAP benefit does not cover the cost of a meal in 99

percent of U.S. continental counties and D.C.," according to an Urban Institute report published in February. Using 2015 data and focusing on the 48 continental states and District of Columbia, researchers calculated the average cost of the components of a low-income meal based on the Thrifty Food Plan and adjusted for geographic variation in food prices. (The monthly SNAP allotment is based on the Thrifty Food Plan, which the U.S. Department of Agriculture defends as a national standard for a minimal cost, nutritionally adequate diet.)

The average cost of a low-income meal was estimated at \$2.36 among low-income, food-insecure households, which was 27 percent higher than the per meal SNAP maximum benefit of \$1.86. The average cost of a low-income meal was 21 and 28 percent higher than the SNAP benefit per meal in rural and urban counties, respectively. The largest gaps between average meal cost and SNAP benefits were observed in high-cost urban counties as well as smaller rural counties. The researchers conclude by summarizing various proposals to improve SNAP benefit adequacy,

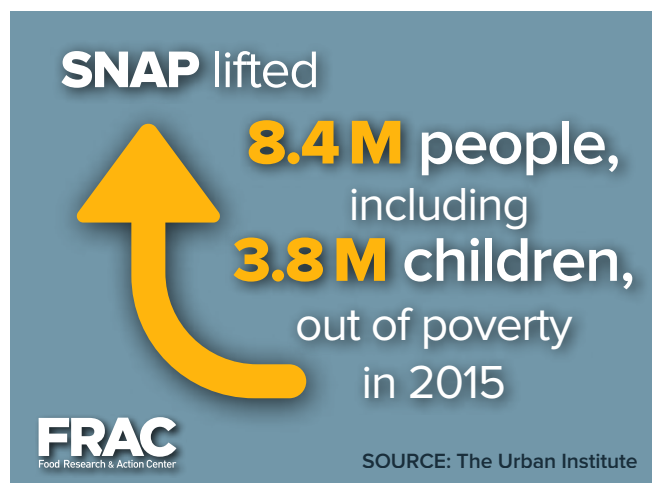
including increasing the Thrifty Food Plan amount by 20 percent, increasing SNAP benefits, and better accounting for geographic variation in food prices when determining SNAP allotments.

[Cost-related medication nonadherence for older adults participating in SNAP, 2013-2015](#)

A study in the *American Journal of Public Health* found that older adults participating in SNAP were less likely to engage in cost-related medication nonadherence (CRN). Using national data on adults 60 years of age and older, researchers compared CRN between SNAP participants and eligible non-participants. CRN was defined as having, in the past 12 months, delayed refilling a prescription to save money, skipping medication doses to save money, or taking less medication to save money.

SNAP participants were 4.8 percentage points less likely to engage in CRN than eligible non-participants, even after accounting for factors such as demographics, health characteristics, and insurance and prescription drug coverage. The

SNAP effect was even stronger for older adults who were "threatened by hunger" (9.1 percentage points less likely to engage in CRN) and experiencing food insecurity (7.4 percentage points less likely to engage in CRN). (In this study, the term



According to one estimate, SNAP reduced the probability of food insecurity

by **7.1** percentage points



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SOURCE: Food Policy

“threatened by hunger” was defined as being marginally food secure or food insecure; meaning, those older adults who were not fully food secure.) According to the study’s authors, the “findings point to a spillover ‘income effect’ as SNAP may help older adults better afford their medications, conceivably by reducing out-of-pocket food expenditures. When prescribing treatment plans, health systems and payers have a vested interest in connecting older patients to SNAP and other resources that may help address barriers to care.”

[Household history, SNAP participation, and food insecurity](#)

According to a study in *Food Policy*, negative income shocks, moves, and changes in household size increase the probability of food insecurity, whereas SNAP reduces the probability of food insecurity. The study used data on 23,693 low-income families from the Survey of Income and Program Participation to examine associations between food insecurity and a household’s history the previous year and SNAP participation. The likelihood of food insecurity increased with both a lower level of income in the

previous year and a negative income shock. In addition, each additional move increased the probability of food insecurity by 1.9 percentage points. Each time the household size increased and decreased, the probability of food insecurity increased

by 1.7 and 1.3 percentage points, respectively (possibly because of a disruption in household resource management strategies). SNAP was estimated to reduce the probability of food insecurity by 7.1 percentage points, and owning a home reduced the probability of food insecurity by 7.4 percentage points. A recent change in marital status had no impact on food insecurity. The findings in this study demonstrate that recent household economic and non-economic experiences are important determinants of food insecurity.

[Design issues in USDA’s Supplemental Nutrition Assistance Program: looking ahead by looking back](#)

A U.S. Department of Agriculture (USDA) report from earlier this year critically examined the following six issues that have surfaced in Supplemental Nutrition Assistance Program (SNAP) policy debates: block granting SNAP, food restrictions, store eligibility requirements, the adequacy and timing of benefits, program access and outreach, and work requirements. USDA researchers first reviewed SNAP

laws, regulations, data, and research to examine the evolution of the program over time, and then explored the tradeoffs of these six policy issues. For example, while block granting SNAP may give states flexibility in tailoring the program to their specific needs, such a policy change, among other challenges, would make it difficult to respond to increased program need (e.g., an economic downturn) if funding is fixed and would remove a national standard for program eligibility (i.e., an individual may be eligible for SNAP in one state, but not another). Proponents of restricting food choice suggest that such a policy change could improve participants’ nutrition, but, as pointed out by USDA, such a policy has tradeoffs, including diminished consumer choice, increased administrative complexity, and a possible reduction in SNAP participation. The report serves as an important resource for policymakers and stakeholders interested in learning more about the program’s history and current policy debates.

Child Nutrition Programs

[Impact of the 2010 US Healthy, Hunger-Free Kids Act on school breakfast and lunch participation rates between 2008 and 2015](#)

New nutrition standards for school breakfast and lunch that were required by the 2010 Healthy, Hunger-Free Kids Act (HHFKA) did not have a negative impact on school meal participation over time, according to a recent analysis in the *American Journal of Public Health*. The study examined National School Lunch Program (NSLP) and School Breakfast Program (SBP)

participation rates from school year (SY) 2008–2009 to SY2014–2015 in low-income, high-minority elementary, middle, and high schools in New Jersey. The new meal patterns and nutrition requirements for NSLP and SBP were implemented in SY2012–2013 and SY2013–2014, respectively.

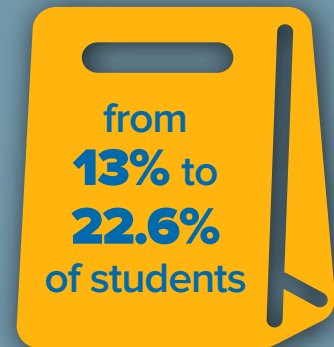
Among all students, NSLP average daily participation rates were stable over the 7-year study period, ranging from 70 to 72 percent. Among students eligible for free or reduced-price meals, participation rates were the highest during the Great Recession, dropped to their lowest levels in SY2012–2013 when the NSLP standards first went into effect, and then rebounded for the rest of the study period. For SBP, average daily participation rates were stable the first five school years (ranging from 50 to 52 percent), and then climbed to 59 percent in SY2013–2014 and 60 percent in SY2014–2015. Among students eligible for free or reduced-price meals, SBP participation rates increased from 49 percent in SY2008–2009 to 59 percent in SY2013–2014 and 64 percent in SY 2014–2015. According to the authors, these SBP increases were possibly due to the HHFKA provision allowing high-poverty schools to offer free meals to all students as well as the implementation of innovative school breakfast models (e.g., breakfast after the bell). The authors conclude that, “overall, our results are consistent with those of previous studies indicating that, contrary to controversial media reports on reactions to the new standards, the effects of the HHFKA on school meal acceptance and participation are minimal.”

[Breakfast quality varies by location among low-income ethnically diverse children in public urban schools](#)

According to a study in the *Journal of Nutrition Education and Behavior*, eating breakfast at school was associated with better quality breakfast choices among low-income, urban youth. Researchers examined the breakfast location and choices of 1,371 fourth through sixth grade students from 16 public schools in Philadelphia. All schools provided breakfast to students in the cafeteria at no charge. Among the 1,133 students who ate breakfast, 46 percent ate only at home, 13.1 percent ate only at school, 21.8 percent ate at corner stores, and 41 percent ate at multiple locations (e.g., home and school; home, school, and corner store). Nearly 80 percent and 39 percent of students reported consuming a food or beverage at home and at school, respectively.

Those students eating any breakfast at school were more likely to consume fruits and vegetables, compared to students who did not eat at school. Students who ate exclusively at school were less likely to eat foods high in saturated fats and added sugars, and more likely to consume a breakfast that met School Breakfast Program meal component requirements, compared to students who ate exclusively at home. Despite these positive findings, 20 percent of the full sample skipped breakfast, even with a breakfast policy that offered breakfast to all students at no charge in the school cafeteria. As a result, the authors recommend further research on and implementation of innovative strategies to promote school breakfast participation (e.g., breakfast in the classroom).

School breakfast participation increased



after implementing the “grab and go” program

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SOURCE: Journal of Nutrition Education and Behavior

[A low-cost, grab-and-go breakfast intervention for rural high school students: changes in School Breakfast Program participation among at-risk students in Minnesota](#)

“Grab and go” breakfast improved School Breakfast Program (SBP) participation rates in rural high schools, based on new research in the *Journal of Nutrition Education and Behavior*. In this study, “grab and go” breakfast carts and policies were introduced in eight rural Minnesota high schools, allowing students to eat breakfast outside of the cafeteria. Average school-level SBP participation increased from 13 percent to 22.6 percent of students after implementing the “grab and go” program.

Among a sub-sample of students with irregular breakfast habits (defined as “at-risk” students), SBP participation increased among students eligible for free or reduced-price school meals (from 13.9 to 30.7 percent); students paying full price for school meals

(from 4.3 to 17.2 percent); students of non-Hispanic white race (from 6.2 to 19.7 percent); and students of Hispanic ethnicity or non-White race (from 13 to 29.5 percent). According to the researchers, “because prior work has also documented that skipping breakfast is highly and disproportionately prevalent among nutritionally vulnerable populations of school-aged youth, the findings of the current study regarding the positive intervention impact for adolescents eligible for free and reduced-price school meals and of non-white race are of particular importance.”

[The impact of WIC on infant immunizations and health care utilization](#)

Prenatal WIC participation was associated with increased infant health care utilization in the first year of life in terms of increased well-child visits and vaccinations, based on a study published in *Health Services Research*. (WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children.) Using South Carolina Medicaid claims data, researchers examined how the pregnant mother’s (prenatal) WIC participation impacts preventive and acute health care utilization within the first year of an infant’s life. Prenatal WIC participation was associated with an increase in well-child visits and infant vaccinations. Prenatal WIC participation also was associated with a decrease in the average number of days spent in the hospital in the first year of life. This study adds to the research literature demonstrating the importance and effectiveness of WIC in improving infant health.



Physical and Mental Health

[Access to care and health outcomes among women veterans using Veteran’s Administration health care: association with food insufficiency](#)

A study in *Women’s Health Issues* found that 27.6 percent of female veterans were food insufficient, and food insufficiency was associated with delayed access to health care and worse health outcomes in this population. The study examined the connections between food insufficiency and health care access, screening positive for anxiety, screening positive for depression, and self-reported fair to poor health status among 818 female veterans who used Veteran’s Administration (VA) healthcare. (Food insufficiency is commonly defined as inadequate food intake due to lack of money or resources.)

In addition to the high rate of food insufficiency found among this sample, food insufficiency was associated with an increased probability of delayed/missed health care, anxiety, depression, and fair to poor health status after accounting for race/ethnicity, marital

status, and employment. Given recent pilot programs to screen for food insecurity in VA clinics, the researchers conclude that this study provides evidence for expanding screening efforts to include VA clinics serving large numbers of female veterans.

[Hungry to learn: the prevalence and effects of food insecurity on health behaviors and outcomes over time among a diverse sample of university freshmen](#)

Food insecurity was more prevalent at the end of the semester for university freshmen and linked to poor health behaviors and mental health, based on a study in the *International Journal of Behavioral Nutrition and Physical Activity*. Among 1,138 freshman students in Arizona, rates of food insecurity were 28 percent at the start of the fall semester, and then rose to 35 percent and 36 percent at the end of the fall and spring semesters, respectively. When looking at concurrent food insecurity and behaviors, those who were food insecure were less likely to regularly consume breakfast, consume a daily evening meal, have healthy eating habits on campus, and have healthy physical activity habits on campus. Food insecurity also was associated with an increased likelihood of experiencing stress and a depressed mood. However, no similar associations were found in longitudinal analyses that examined the impact of food insecurity on health behaviors over time, “suggesting that at least in this population of university students, short-term effects of food insecurity on health outcomes are more notable.” The researchers call on public health

professionals to work with universities to screen for food insecurity, and for more research on how to prevent and address food insecurity on college campuses.

[Food insecurity and emotional health in the USA: a systematic narrative review of longitudinal research](#)

According to a review in *Public Health Nutrition*, there is evidence for a “bidirectional” relationship between food insecurity and emotional health over time: food insecurity increases the risk of poor emotional health, and poor emotional health increases the risk of food insecurity. Researchers examined the links between food insecurity and emotional health (e.g., depression, stress, anxiety) by reviewing longitudinal studies published between January 2006 and July 2016. These studies assessed food insecurity at baseline and emotional health at follow-up, and/or emotional health at baseline and food insecurity at follow-up. Of the 12 studies included in the review, 83 percent reported an association between food insecurity and poor emotional health over time.

In their conclusion, the researchers point to federal nutrition program participation, specifically the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as a way to promote food security and emotional health in at-risk populations. The researchers also recommend screening for food insecurity in health care settings and connecting those who screen positive for food insecurity to federal nutrition programs and emergency food providers.

[Functional limitation and chronic diseases are associated with food insecurity among U.S. adults](#)

Food insecurity was associated with functional limitation and a number of common chronic diseases in a study of U.S. adults published in *Annals of Epidemiology*. Using national survey data for 30,010 U.S. adults, researchers examined the links between functional limitation, six chronic diseases (arthritis, coronary heart disease, diabetes, heart attack, hypertension, stroke), and food security status. After accounting for sociodemographic and lifestyle factors (e.g., age, marital status, family income, smoking status), both very low food security and low food security were associated with functional limitation due to any health problem. In addition, very low food security was linked to higher odds of arthritis, coronary heart disease, diabetes, heart attack, and hypertension. Low food security was linked to higher odds of arthritis, diabetes, hypertension, and stroke. These findings are consistent with prior research on food insecurity and poor health.

Race and Nativity

[Examining the impact of structural racism on food insecurity](#)

A new paper in *Family and Community Health* explores the complex relationship between race/ethnicity and food insecurity in the U.S., and calls for more research and strategies that address racial discrimination and structural racism. There has been a persistent gap in food insecurity rates between people of color and Whites over time. While social and

economic disadvantages are important drivers of these disparities, there also is evidence that the higher risk of food insecurity for people of color persists even after accounting for these factors. The authors of this paper argue that racial discrimination and structural racism likely play a critical — albeit understudied — role as well. For example, research shows that racial discrimination limits access to educational and employment opportunities for people of color, which, in turn, has consequences (e.g., lower wages, underemployment) that can contribute to food insecurity. Given the higher incarceration rates in state prisons for African Americans, policies that restrict employment for those previously incarcerated could impact people of color by causing hardship that also can contribute to food insecurity.

The authors discuss several promising solutions that have been proposed to address racial disparities in food insecurity, including connecting people to the federal nutrition programs, expanding access to federal income supports, increasing employment opportunities and wages, and screening patients for food insecurity. “Still, to address persistent racial disparities in food insecurity, advocates and researchers need to also examine the potential impact of utilizing approaches that address structural racism and discrimination more broadly. These efforts will likely pave the way for the emergence of policy and programmatic strategies that promote equity in food access and health by addressing the legacy of racial, ethnic, and class inequality.”

[Food insecurity in the United States of America: an examination of race/ethnicity and nativity](#)

Blacks and Latinos, regardless of nativity status, were more likely to be food insecure than foreign- and native-born Whites, based on an analysis in *Food Security* using over 10 years of national data from 32,464 adults. The researchers argue that this “white/nonwhite” divide in food insecurity, even after accounting for socioeconomic status, may be due, in part, to spatial inequality (i.e., the uneven distribution of resources in an area). For instance, Blacks and Latinos are more likely to have limited access to supermarkets, a key source of affordable, nutritious food. Contrary to expectations, the study found no nativity effect on food insecurity within racial/ethnic groups. The authors speculate that this unexpected finding could be a result of certain characteristics of immigrants that help them overcome food insecurity, such as settling in coethnic neighborhoods, having access to better quality food from ethnic grocers in communities with a high concentration of immigrants, and cultural values and behaviors from their native country. The authors write, “our results [suggest] that race/ethnicity is more influential than nativity status for food insecurity in the United States.”



Food Insecurity Research

[Food insecurity research in the United States: where we have been and where we need to go](#)

While the food insecurity literature has matured over time and addressed many important questions, two prominent food insecurity scholars identify numerous research questions that remain, as described in *Applied Economic Perspectives and Policy*. The authors first provide a brief review of the existing research on risk factors for food insecurity (e.g., lower income, single-parent households); health consequences of food insecurity for children (e.g., lower nutrient intakes, cognitive problems) and adults (e.g., depression, diabetes, higher health care costs); effectiveness of the Supplemental Nutrition Assistance

Program (SNAP) and school meals in reducing food insecurity; and inadequacy of SNAP benefits.

The paper then moves into a discussion of the future direction of the food insecurity research agenda. A number of specific research questions are offered, including the following: How is food insecurity distributed within a household? Why are the food insecurity rates of American Indians so high? What is the causal relationship between food insecurity and health outcomes? How does labor force participation effect food insecurity? What is the impact of the Affordable Care Act (ACA) on food insecurity? What are the long-term consequences of food insecurity? Overall, this paper serves as an important resource for researchers examining food insecurity and food assistance in the U.S.

Food Insecurity: An Avoidable Cost



FRAC wishes to thank Ana Poblacion, PhD, MSc, a Postdoctoral Fellow at Children's HealthWatch, for contributing this column to ResearchWire.

In 2014, we found that the United States spent \$178 billion dollars in avoidable healthcare, educational costs and lost work productivity.

Imagine a scenario where the ability to access enough food for an active, healthy life for you and your family is compromised by a lack of money. Imagine that without enough money to buy enough nutritious food, you are more likely to have poor health, chronic stress, and multiple hospitalizations. Your children's health and ability to learn also may be profoundly affected, with a greater risk of iron deficiency anemia and possible need for special education services to keep up with their peers. These are some of the consequences faced by millions of people who live with food insecurity.

Food insecurity not only damages the health and well-being of individual Americans in these and other ways, but it also [costs](#) the healthcare system billions of dollars per year. At Children's HealthWatch, we gathered evidence from in-depth analyses of peer-reviewed journal articles and reports on associations between food insecurity and poor health and educational conditions. We then determined what portion of expenditures for those diseases and conditions could be attributed to food insecurity. In 2014, we found that the United States spent [\\$178 billion dollars](#) in avoidable healthcare, educational costs and lost work productivity. Fair or poor health status and multiple hospitalizations in adults and children as well as anxiety and depression in adults figured among the higher health-related costs in this estimate.

Children live within the context of their families and experience the same hardships as the rest of the family. Though it is well-documented that parents frequently make tremendous sacrifices to ensure their children have enough to eat, the stress and anxiety of household food insecurity takes its toll on all family members. Thus, in 2016 we focused our research on early childhood and found that costs of health care and early intervention services attributed to food insecurity were [\\$1.2 billion dollars](#). Young children's higher costs were driven heavily by special education (\$672 million), followed by hospitalizations (\$516 million).

Because healthcare and educational costs are a significant and growing portion of federal and state governments' budgets, states also face rising costs. Minnesota estimated food insecurity-related costs at [\\$1.6 billion](#) in 2010, and we estimated costs for Massachusetts at [\\$2.4 billion](#) in 2016. Of that \$2.4 billion, about \$1.9 billion were direct and indirect health-related costs, and special education accounted for \$520 million in expenditures.

Food insecurity is an expensive condition we cannot ignore. If our country makes a commitment to improving food security across our nation, and follows through with sustained action, children and their families will become healthier and perform better in school and in their workplaces, seniors will be able to remain at home and maintain their independence, the economy will experience an increase in productivity, and healthcare and special education costs will decrease substantially.

Endnotes

- ¹ Hartline-Grafton, H. (2017). *SNAP and Public Health: The Role of the Supplemental Nutrition Assistance Program in Improving the Health and Well-Being of Americans*. Washington, DC: Food Research & Action Center.
- ² Institute of Medicine and National Research Council Committee on Examination of the Adequacy of Food Resources and SNAP Allotments. (2013). *Supplemental Nutrition Assistance Program: Examining the Evidence to Define Benefit Adequacy*. Washington, DC: National Academies Press.
- ³ Hartline-Grafton, H., & Weill, J. (2012). *Replacing the Thrifty Food Plan in Order to Provide Adequate Allotments for SNAP Beneficiaries*. Washington, DC: Food Research & Action Center.
- ⁴ See, for example, testimony from economist Diane Whitmore Schanzenbach before the House Committee on Agriculture, February 16, 2017: “There has been much media discussion of the November 2016 USDA report on typical food purchase patterns by SNAP participants and non-participants. The top-line finding of that report is that SNAP and non-SNAP households have extremely similar food spending patterns ... The USDA findings are consistent with my own published research using the Consumer Expenditure Survey that also found similar spending patterns across food categories for SNAP and non-SNAP households ... [As to soft drink consumption, the] USDA study indicates that this is an issue across the income distribution, and there is no need to single out SNAP recipients for their consumption of soft drinks. Among the spending observed in the USDA study, about 5 cents of each dollar went to the purchase of soft drinks. This rate is similar to non-SNAP households, which spend an average of 4 percent of their grocery dollars on soft drinks.” The [full testimony](#) is available at The Brookings Institution. As another example, the [USDA Economic Research Service](#) (ERS) has noted that, after accounting for individual and household demographic characteristics, a 2014 study found that SNAP participants are no more likely to consume sugar-sweetened beverages than are low-income nonparticipants. “These findings are consistent with other ERS research on overall diet quality, which also found that SNAP participants’ diets do not differ greatly relative to otherwise similar nonparticipants.”
- ⁵ Hartline-Grafton, H. (2017). *SNAP and Public Health: The Role of the Supplemental Nutrition Assistance Program in Improving the Health and Well-Being of Americans*. Washington, DC: Food Research & Action Center.