

SNAP cuts will harm children in the USA

Food insecurity, or hunger, exists in high-income countries, including the USA. Food insecurity has been associated with many adverse child health outcomes that can have long-term consequences, including fair or poor child health, history of admission to hospitals, and developmental risk.¹ In the 1960s, the USA initiated the Food Stamp Program, now the Supplemental Nutrition Assistance Program (SNAP), to combat widespread malnutrition and provide food purchasing assistance. According to 2011 data from the US Department of Agriculture, more than 70% of benefits from SNAP went to households with children,² and one in four American children are recipients.³

Evidence for the beneficial effect of SNAP on childhood food insecurity is strong. In response to the global recession from December, 2007, to June, 2009, the American Recovery and Reinvestment Act (ARRA) of 2009 increased the average SNAP benefit from US\$1.30 to \$1.60 per meal per person. Despite increases in national unemployment in 2008, after the 2009 ARRA boost to SNAP, the number of children in food-insecure households decreased from 17.2 million in 2009, to 16.2 million in 2010.⁴ Even after accounting for adverse selection bias—whereby families with the gravest health and economic burdens who are most threatened by food insecurity are more likely to access the programme than are less distressed families—SNAP participation has been associated with decreased food insecurity.⁵

Although some speculate that SNAP contributes to childhood obesity because few restrictions are placed on items that can be purchased, no data have shown that receipt of SNAP is associated with childhood obesity⁵ or other negative effects.⁶ By contrast, many studies have shown positive associations between receipt of SNAP and child wellbeing beyond that of decreased risk of food insecurity, including increased intake of B vitamins, iron, and calcium,⁷ and a lower risk of anaemia, obesity, poor health, hospital admission for failure to thrive, and reports of child abuse or neglect.⁸ Children aged 5–9 years of SNAP-participating families had better academic outcomes and less obesity than had children of non-participating families.⁶ Nationally representative data suggest that SNAP-recipient school-age children and adolescents were less likely to suffer from obesity than were non-recipient peers.⁹

History provided for a natural experiment on SNAP's effects on pregnancy and early life. Between 1961 and 1975, the programme was implemented county by county, thus, allowing for comparison across counties that differed only by SNAP availability. In SNAP-available counties, there was a 6% decrease in very low birthweight births (<1500 g) in black women and a significant increase of 12–42 g in mean birthweight for both black and white Americans compared with those counties where SNAP was not available.¹⁰ Children of low-income women in SNAP-available counties were less likely to have metabolic syndrome in adulthood and women who had received food stamps during early childhood were more likely to be economically self-sufficient.¹¹

However, as the Institute of Medicine reported recently,¹² the full potential of SNAP's positive health effects has not been achieved because the benefit, even with the ARRA boost, is tied to an outdated nutrition plan, providing a marginally adequate diet that is not intended for long-term use, and with no regional benefit adjustment for differences in food price or availability.

Despite convincing evidence of the beneficial effects of SNAP on child health, American legislators have targeted SNAP as they struggle to address the federal budget and the US farm bill, the main blueprint of USA food and agriculture policy. SNAP must be reauthorised every 5 years. Yet the current political debate often ignores the evidence that SNAP improves the health and development of America's children. SNAP is in

See [Editorial](#) page 1153



jeopardy, which means that American children's health is in jeopardy. Not only do proposals include a cut to SNAP, but also, without Congressional intervention, the ARRA benefit boost will end in November, 2013, creating a double benefit cut. SNAP is a crucial nutritional support for the health and development of America's children. Scientific evidence shows that SNAP is a wise investment in the brains and bodies of America's children, an investment that should be increased, not curtailed.

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- 1 Cook JT, Black MM, Chilton M, et al. Are food insecurity's health impacts underestimated in the U.S. population? Marginal food security also predicts adverse health outcomes in young U.S. children and mothers. *Adv Nutr* 2013; **4**: 51-61.

- 2 Keith-Jennings B. SNAP plays a critical role in helping children. Center on Budget and Policy Priorities. July 17, 2012. <http://www.cbpp.org/cms/?fa=view&id=3805> (accessed Sept 27, 2013).
- 3 Strayer M, Eslami E, Leftin J. Characteristics of Supplemental Nutrition Assistance Program households: fiscal year 2011. Alexandria, VA: Office of Research and Analysis, US Department of Agriculture, Food and Nutrition Service: 2012.
- 4 Nord M, Prell M. Food security improved following the 2009 ARRA increase in SNAP benefits. Economic Research Report No. (ERR-116) p 52. April, 2011. <http://www.ers.usda.gov/publications/err-economic-research-report/err116.aspx> (accessed Sept 18, 2013).
- 5 Kreider B, Pepper JV, Gunderson C, Jolliffe D. Identifying the effects of SNAP (food stamps) on child health outcomes when participation is endogenous and misreported. *J Am Stat Assoc* 2012; **107**: 958-75.
- 6 Frongillo EA, Jyoti DF, Jones SJ. Food stamp participation is associated with better academic learning among school children. *J Nutr* 2006; **136**: 1077-80.
- 7 Leung CW, Blumenthal SJ, Hoffnagle EE, et al. Associations of food stamp participation with dietary quality and obesity in children. *Pediatrics* 2013; **131**: 463-72.
- 8 Lee BJ, Mackey-Bilaver L. Effects of WIC and Food Stamp Program participation on child outcomes. *Child Youth Serv Rev* 2007; **29**: 501-17.
- 9 Jones SJ, Jahns L, Lارايا BA, Haughton B. Lower risk of overweight in school-aged food insecure girls who participate in food assistance: results from the Panel Study of Income Dynamics Child Development Supplement. *Arch Pediatr Adolesc Med* 2003; **157**: 780-84.
- 10 Almond D, Hoynes HW, Schanzenbach DW. Inside the war on poverty: the impact of food stamps on birth outcomes. *Rev Econ Stat* 2011; **93**: 387-403.
- 11 Hoynes HW, Schanzenbach DW, Almond D. Long run impacts of childhood access to the safety net. NBER working paper 17667/18535. Cambridge, MA: National Bureau of Economic Research, 2012. http://www.econ.ucdavis.edu/faculty/hoynes/working_papers/Hoynes-Schanzenbach-Almond-11-6-12.pdf (accessed Sept 18, 2013).
- 12 Institute of Medicine, National Research Council. Supplemental Nutrition Assistance Program: examining the evidence to define benefit adequacy. Washington, DC: The National Academies Press, 2013.

Primary-care research to inform policy and implementation



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On a daily basis general practitioners (GPs) deal with a wide range of disorders—from benign to life threatening—and mixed populations of patients, in whom even minor illness might pose a severe health threat. The ability to handle uncertainty is, therefore, an essential part of day-to-day general practice. Much of what has been called the essence of general practice¹ can be seen as the development of effective coping strategies, achieved through the application of knowledge built up over time about the patient, understanding of risks, case reviews, continuity, leadership, and advocacy. These empirically acquired characteristics, however, have only occasionally been brought to the scientific test.

Respiratory-tract infections illustrate well the uncertainty in general practice. Infections are generally self-limiting, and explanation and advice is frequently sufficient for management. Antibiotics might occasionally be required, but prescription on a better-safe-than-sorry basis from the early days of antibiotic use has led to

population resistance, the effects of which are becoming ever clearer in primary care.²

Concerted action is needed to maintain a range of effective antibiotics. In *The Lancet*, Paul Little and colleagues³ present a large randomised intervention study done in 246 European GP practices. The intervention was directed at two aspects of the consultation. First, diagnostic support was offered through point-of-care C-reactive-protein (CRP) testing to help distinguish between self-limiting and more severe infections. Second, online training in communication skills was aimed at improving GPs' understanding of patients' concerns, perceived needs, and expectations, enabling GPs to provide information about the disease course, and make informed management decisions. Each intervention alone was associated with a decrease in prescribing of antibiotics compared with usual care (CRP 33% vs 48%, adjusted risk ratio 0.54, 95% CI 0.42-0.69; communication training 36% vs 45%, 0.69, 0.54-0.87). When the interventions were combined the prescribing of antibiotics was

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See [Articles](#) page 1175