

Child Hunger in the United States: A Doctor's View

Dr. Deborah A. Frank, MD



Celia Escudero Espadas

In Boston a face like Maura's is called "map of Ireland," pale skin, straight red hair and a scattering of freckles across the nose and cheeks. If she weren't so terribly thin, she could be on a travel poster, but at 4 years old, Maura weighs only 27 lbs, the weight of a normal little girl of 2 ¼ years. When I lift her tee shirt to listen to her heart, Maura's thinness is obvious. Her face still retains some roundness but her ribs protrude through her skin.

Maura's mother gets up every morning at 3 :00 am, wakes and then dresses her sleepy 4-year-old. Together, they walk through the dark streets to a nearby fast food outlet where mother works the breakfast shift. Maura goes back to sleep under the table in the staff room. On mother's 8 a.m. "lunch break," they get on a bus to take Maura to family daycare, eating forbidden crumbs from the fast food restaurant during the ride.

At 12:30 p.m., when mother's shift is over, she retrieves Maura and rushes down to the local women and children's shelter for free lunch. Mother carefully explains to the horrified medical student who listens in on this story with me that this is a "dry shelter," which means no one there is drunk or high. Only if they are truly desperate do mother and Maura go to the local "wet" day shelter.

Depending on when mother's paycheck comes, she buys food at the local convenience store and cooks it over the electric hot plate in their one-room apartment for supper. Sometimes instead, she and

Maura share a “supersized” cup of French fries and a large soda (which Bostoners call “tonic”) from the fast food restaurant. Mother is very happy to receive a referral to WIC and to the clinic’s therapeutic pantry.

Child hunger obviously does not discriminate by color. Nor does child hunger only affect those whose parents are out of work. As one of the Principal Investigators of the Multi-Site Sentinel Nutrition Assessment Program (C-SNAP), I know that my young patients are not isolated aberrations occurring only in Boston. Our data on more than 20,000 children under the age of three across the country show that 1 in 5 families with children under three report that they do not consistently have enough food for an active and healthy life.

Undernutrition in early life can place lasting constraints on children’s intellectual development. Even after my colleagues and I manage their acute infections and mobilize nutritional supplements to restore their stunted growth, many of these children will be left with invisible scars on their developing brains. By the time children show up in the Multi-Disciplinary Grow Clinic, or on the ward of our hospital, they have already missed many opportunities for learning.

When I first saw Jojo, he was curled up in his mother’s lap beside the hospital crib. He reminded me of an African American version of a Renaissance cherub with big brown eyes, curly hair and a lovely smile. He looked like a charming infant. At first it wasn’t obvious why the interns were so concerned. I had to go back to look at his medical records to remind myself of how old he was,

since at 15 months, he weighed 19 lbs., the weight of a normal 7 month old.

Jojo was a much-wanted baby. He was born weighing nearly 8 lbs., healthy in every way. When Jojo was 6 months old his father was laid off and ultimately relapsed into alcoholism. At 9 months, father became violent toward mother, who fled to live with her own mother in senior citizen housing, where Jojo and mother slept in the same bed as grandmother. Grandmother struggles to care for Jojo while mother looks for work whenever Jojo isn’t sick. Although Jojo and his mother get Food Stamps and WIC, mother has not been able to keep up with his increased nutritional needs from recurring episodes of fever, diarrhea, and respiratory illness brought on by his crowded living conditions. Despite this hardship, Jojo is clearly a much-loved child.

When I can abstract myself from the daily challenges of trying to salvage individual children, I wonder how the richest country on earth permits policies that are etched so painfully on the thin bodies of our children. Above my desk are written the words of Winston Churchill, who wrote, in the middle of England’s fight for survival during World War II, “There is no finer investment for any community than putting milk into babies!”

Of all the problems facing America today,

hunger is the one that can be the most readily solved, since we lack neither food nor a distribution mechanism but only the political will to resolve the issue. Feeding hungry children is not a partisan issue. In all my 30 years of practicing pediatrics, I have never yet met a baby who is either a Republican or a Democrat.

Hungry young children in America are all but invisible. They don’t hold press conferences, issue statements, or march in the streets, but as a pediatrician in an inner city hospital in Boston, I find them ever before me.

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Can Food Aid Contribute to Improved Nutrition?

Patrick Webb

Much is known about how to design effective nutrition interventions. We know, for example, that food is not the only—or always the optimal—resource required. The most effective use of food is in combination with relevant non-food resources. However, where malnutrition is linked to constrained food access, and where

“Though increased incomes are essential, it has been shown that countries implementing direct nutrition interventions have been more successful in reducing malnutrition.”

– *Organization for Economic Co-operation and Development/World Health Organization, 2003.*

This approach was expanded considerably during the 1970s after the World Food Conference (1974) called on governments and donors

to provide supplementary foods to vulnerable groups “on a scale large enough to cover on a continuing basis a substantial part of their need.” Today, programs seeking to protect or enhance the nutritional status of mothers and infants represent roughly 20 percent of WFP’s development portfolio. They also account for as much as half of the development resources channelled through USAID

from Public Law 480 Title II.¹

Use of resources is no longer restricted to clinic-based supplementary feeding activities. A wide range of interventions can be included under the umbrella of ‘nutrition’ programs in both development and humanitarian relief settings. For example, the distribution of a ‘basket’ of food commodities to crisis-affected populations represents general nutrition support. The immediate aim of general distribution is to meet the food needs of people with constrained access to normal sources of food, and thus try to ‘protect’ their nutritional

status—that is, prevent sustained food shortfalls that would contribute to excess mortality due to increased malnutrition.

There are other targeted feeding interventions that provide ‘special’ foods, such as those that are micronutrient-fortified, sometimes tailored to child needs and aimed at reversing malnutrition and stabilizing these gains. Additionally, therapeutic feeding involves the treatment of severely malnourished children—and adults as necessary—with energy-dense foods combined with medical intervention protocols; in cases where deficiencies in vitamins or minerals are a threat to nutritional well being, fortified foods are targeted to defined vulnerable populations. This happened recently when fortified cereal flour was distributed to Angolan refugees at risk of pellagra (niacin deficiency). In Nepal, a micronutrient-fortified ‘porridge’ was made available to refugees from Bhutan; this brought a riboflavin-deficiency disease (angular stomatitis) under control and was also associated with higher birthweights.

Increased demand by donors for evidenced-based programming has led to an accumulation of empirical data documenting the positive nutritional impacts of these kinds of food-supported interventions. A review of maternal and child



Jim Stripe

World Food Program aid arrives by air after the October 2005 earthquake in Pakistan.

additional food of sufficient quality and quantity is required to meet identified needs, food is a critical element of a nutrition intervention.

For many years, food aid has been used to directly supplement the diets of young children and pregnant women. The World Food Programme of the United Nations (WFP) began supporting ‘mother and infant’ projects in the mid-1960s by delivering supplementary food through health clinics—an activity that accounted for six percent of WFP development expenditures during the decade.

programs implemented by Private Voluntary Organizations (PVOs) using Title II resources found that a large majority “have been successful in improving the nutritional status (as measured by stunting and/or underweight) of children in their target populations.”² Projects documented a reduction in the prevalence of stunting of an average 2.4 percentage points per year.

A recent study in Ethiopia showed that food aid had a significant impact on protecting child growth during droughts.³ Another study in Ethiopia showed that households receiving food aid through Food-for-Work, as well as general food distribution to drought-affected populations, had positive results in terms of child weight-for-height.⁴

Studies of refugees in Algeria found that fortified food given to stunted children permitted rapid nutritional improvement.⁵ It was shown that treatment of micronutrient deficiencies and growth retardation can be successful among seriously malnourished children even up to the age of five.

In Mexico, a government-supported program called Prograssa supplies food to children under 3 years old in poor households. This has had a significant impact on child growth rates, reducing stunting and anemia.⁶ Nutrition supplements alone are estimated to create an almost three percent increase in lifetime earnings for poor children through improved growth and productivity.⁷

A targeted food supplementation program in Bangladesh found that low-income women receiving supplementation during pregnancy had birth-weight outcomes comparable to those of women from wealthy



Internally displaced women receive food aid at a distribution center in Orissa, India.

Sean Sprague / Catholic Relief Services

households who did not receive the supplements.⁸

These results confirm that food aid can certainly play an important part in nutrition programming. That said, while the evidence suggests positive impacts on child growth, resolution of micronutrient deficiencies and effective reversal of severe malnutrition, this occurs only under certain conditions:

- i) interventions are carefully targeted to meet local needs after in-depth problem assessment.
- ii) malnutrition is widespread in the population and already contributing to morbidity and mortality.
- iii) supplementary food arrives in sufficient quantity and quality to be able to make an impact.
- iv) foods are consumed mostly by those most in need of them.
- v) appropriate non-food resources are available in combination with the food—including necessary medical

treatments, vaccinations, clean water, deworming, iron folate supplements, and nutrition and health counseling.⁹

When these key principles or conditions are met, “supplemental maternal and child feeding programs have been repeatedly shown to be a highly effective means of improving child nutrition.”¹⁰

Given the scale and persistence of malnutrition around the world, there needs to be a far greater share of development resources earmarked for nutrition interventions than is currently available. The aim in coming years should be not only to explore new avenues for action, but also to expand and enhance what is already done well.

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Fortifying Foods to Save Lives and Livelihoods

Mark Fryars and Zahra Popatia

Human beings need vitamins and minerals—known as micronutrients because our bodies need them only in minute quantities—for growth, brain development, and immunity against diseases. Deficiencies in vitamin A, iron, zinc and iodine in particular have major impacts on health, especially for the most vulnerable groups—women and children.

Millions of people in the developing world suffer from preventable vitamin and mineral deficiencies. Here are some examples of the suffering wrought by wide-scale vitamin and mineral deficiencies every year:

- 60,000 pregnant women die.
- 1,000,000 children under age five die.
- 200,000 babies are born with severe birth defects.
- 18 million babies are born severely mentally impaired.
- Millions of children and adults do not achieve their potential in school and work.
- \$6 billion in adult work performance is lost.
- Developing country economies lose up to 2 percent of their Gross Domestic Product.¹

The greatest tragedy of all is that ‘micronutrient malnutrition’ is largely preventable.

What needs to be done?

We can address this problem in two ways: by providing at-risk people with more vitamins and minerals, and by controlling the infections that cause or worsen deficiencies in essential nutrients.

Health workers can deliver millions of vitamin supplements and medicines to combat infections among women and children every year, but resource constraints mean they cannot reach everyone often enough to correct all the deficiencies.

Encouraging vulnerable people to diversify their diets can work in some settings, but changing behavior takes time and many do not have a variety of food sources. This is why developing programs to enrich the nutritional value of staples and other commonly consumed foods is particularly urgent.

While scientists are working on ways to improve the nutritional value of many foods, we already have the technology to fortify foods with essential vitamins and minerals. It is simple, cheap and effective.

What are fortified foods and how can they help?

Fortification is the addition of small quantities of vitamins and minerals to foods and condiments that are regularly consumed by large parts of the population. Simply adding essential micronutrients such as iodine, iron, zinc, folic acid, and vitamin A to foods can make a swift improvement in people’s health and well being.

Most food fortification takes place at the factory level. It involves adding



Sprinkles,TM a vitamin-enriched powder, is used to home fortify foods served to infants.

Rick Reinhard

measured amounts of a nutrient-rich ‘premix’ to staple foods when they are processed.

At just \$0.05 per person per year, iodizing salt has been tremendously successful in reducing iodine deficiency disorders, which can cause goiter and brain damage. The Micronutrient Initiative and other partners have developed a double-fortified salt by adding iron as well as iodine. At a cost of \$0.18 to \$0.20 per person per year,² this ‘super-salt’ has the potential to reduce the damage caused by iron deficiency by one third.

Flour fortification offers a low-cost, highly effective way to use a staple food to dramatically improve global health. The cost of the premix to fortify flour with iron and folic acid can be as little as \$0.30 to \$0.50 per metric ton.³ Vitamin B complex and vitamin A can also be added to the pre-mix for a total cost of between \$1.40 and \$1.60 per metric ton.⁴

Other foods, such as vegetable oils, milk, sugar and condiments like



Studies in Kenya, Mexico and Indonesia revealed that fortification increased workforce productivity by 7 to 42 times the cost of the program. In the Philippines, similar tests showed a rise in productivity of 6 to 21 times the cost of the program.”

soy sauce and bouillon cubes have proven very suitable for fortification.

What progress has been made?

At the country level, public-private partnerships to start and sustain food fortification programs are already underway in parts of Africa, Latin America, the Middle East and Asia with the support of several agencies such as the Micronutrient Initiative, UNICEF, Helen Keller International, the World Food Program, World Vision, CARE and the Global Alliance for Improved Nutrition (GAIN).⁵

Nigeria has mandated the fortification of three staple foods with vitamin A: vegetable oil, wheat and maize flours. South Africa has started fortifying flour and other foods. Cote d’Ivoire, Morocco, Yemen and Bangladesh were among the first countries to start a voluntary program to fortify oil with vitamin A, and national vegetable oil fortification programs have now also started in Mali and Burkina Faso.

Several countries have fortified sugar with vitamin A. In Guatemala for example, blindness due to severe vitamin A deficiency among children had fallen in 2000 to just 20 percent of the level in 1990, when nationwide use of both fortified sugar and vitamin A supplements began.

Chile and Cuba have successfully fortified milk with iron. India is forti-

fyng lozenges for very poor children with vitamin A, vitamin C, folic acid and iron.

Many people in the world are not able to buy and consume processed fortified foods. However, households can now often fortify their own food at home. The Hospital for Sick Children in Toronto, Canada, for example, has developed Sprinkles™ for children under the age of two—and shown them to be highly effective in treating anemia. Sixty daily-use sachets are enough to treat and prevent anemia in children under two, the most critical time of life for learning development. The cost per sachet varies from \$0.015 to \$0.02, so the cost of a two-month treatment would be about \$1.00 per child.⁶

<p style="text-align: center;">Typical Formulation to Address Nutritional Anemia</p> <p style="text-align: center;">Dose Per Sachet</p> <p style="text-align: center;">12.5 mg Iron</p> <p style="text-align: center;">5 mg Zinc</p> <p style="text-align: center;">250 mcg Vitamin A</p> <p style="text-align: center;">30 mg Vitamin C</p> <p style="text-align: center;">160 mcg Folic Acid</p>
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So what still needs to be done?

Despite widespread international recognition of the value of fortified foods, a great many people in developing countries still do not have access to them. Iodized salt is the most successful fortified food so far, but 43 million babies every year are still unprotected from a debilitating lack of iodine.

As is often true, a lack of money is part of the problem. Starting up a fortification program requires up-front investment. But the return on investment is unprecedented. It has been estimated that to provide

all women and children in Asia who are at risk of vitamin and mineral deficiency with comprehensive protection would cost approximately \$0.5 billion per year—at least for an initial five-year investment period. Cost estimates for Africa come to less than half of that.⁷

GAIN is working with other agencies to compile a comprehensive investment strategy, but currently the total investment in micronutrients (from the Canadian Agency for International Development, the US Agency for International Development and The Bill & Melinda Gates Foundation) meets barely 20 percent of the need.

What can we do?

Here is one global problem that we—and that means you—can actually help solve. What we can do is raise the awareness of the public and private sectors—including policymakers, industry, consumer groups and the public at large—to demand better nutrition as part of people’s right to food and right to health.

Because malnutrition affects health, education, employment and life’s other essentials, it is everybody’s problem. Unfortunately, in too many countries this means that it ends up being nobody’s problem, so no one takes the lead to fix it.

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Is Healthy Eating an Affordable Option for Food Stamp Program Participants?

John T. Cook

A key element of the U.S. nutrition assistance policy is the Thrifty Food Plan (TFP). Developed by USDA, the TFP represents a set of “market baskets” of food that people of specific ages and gender can



The Thrifty Food Plan represents a set of “market baskets” of food that people of specific ages and gender can prepare and eat at home to maintain a basically healthy diet.

prepare and eat at home to maintain a basically healthy diet. The cost of the TFP is used to determine the maximum Food Stamp Program (FSP) allotment, and is also the basis for calculating U.S. poverty levels or thresholds.

In the early 1960s, it was observed that U.S. households spent, on average, about a third of their income on food. Thus, policymakers reasoned, if one-third of household expenditures went to food, then three times the cost of the TFP could be used to determine what low-income households spend altogether on

essential goods and services (e.g., food, housing, energy, clothing, transportation, healthcare, etc.).

This income level, updated annually for inflation, became (and remains) the basis for the official

poverty thresholds. The poverty thresholds, in turn, are translated into federal guidelines that are used to determine eligibility for a number of food and cash assistance programs, including the FSP. As a result, the TFP strongly influences whether

millions of low-income households gain access to healthful foods.

The U.S. government has established healthy eating as a top-priority public health initiative. Since millions of low-income households depend on the TFP, we cannot overstate the importance of frequent and thorough reviews of the plan’s effectiveness. A number of urgent questions have to be answered.

1. How great are geographic variations in the costs of living?

Several ongoing programs exist to estimate a cost of living index

(COLI) by city, major metropolitan area, state and region. One of the more frequently cited sources is the American Chamber of Commerce Research Association (ACCRA). Another source is the U.S. Bureau of labor Statistics (BLS).

ACCRA reports COLI estimates for 45 selected U.S. cities. In the most recent estimates, using data from the second quarter 2004 through first quarter 2005, the overall composite COLIs vary from 89.9 percent of the national composite in Memphis, TN to 177.0 percent of the national composite in San Francisco, CA (an overall cost of living difference of 87.1 percentage points between the two extremes).

The component COLI for “grocery items” in the ACCRA estimates ranges from 83.5 percent in San Antonio, TX to 153.6 percent of the national in Honolulu, HI (a difference of 70.1 percentage points). Component COLIs for housing range from 80.3 percent in El Paso, TX to 399.2 percent in New York, NY (a difference of 318.9 percentage points). A similar spread is reported for utilities as for grocery items, ranging from 79.9 percent in Colorado Springs, CO to 146.6 percent in New York, NY (a difference of 66.7 percentage points).¹

Other research based on ACCRA data for several different years in the 1990s report similar findings in COLIs across states. Based on data from 1990 and 1997, for example, high-to-low differences in state-level composite COLIs range from 34.9 to 49.7 percentage points.²

Regional estimates in 2004, this time using BLS data, show less variation—though there is still an overall difference of 18.4 percentage points in composite COLIs across the four major regions of the United States (Northeast, Midwest, South and West).³

These data indicate that there is considerable variation in the cost of food and other necessities across regions, states and major cities in the United States. Moreover, other recent research has shown differences of 9-18 percent in cost of living between rural and urban areas within the same regions.⁴

All of these results strongly suggest that using the same TFP costs throughout the nation to determine maximum FSP allotments, and poverty thresholds, is likely to lead to underestimates of the real need of many low-income families. The research suggests that the TFP cost should reflect actual differences in the costs of food and other necessities across geographic areas.

2. Does the TFP reflect the most current knowledge about nutrition?

The TFP was last reviewed and revised in 1999. It was described then by USDA as having “been revised to reflect current dietary recommendations, food consumption patterns, food composition data, and food prices while maintaining the cost at the level of the previous baskets.”

In January 2005, The Department of Health and Human Services (HHS) and USDA released the sixth edition of *Nutrition and Your Health: Dietary Guidelines for Americans*. In April 2005, USDA unveiled *MyPyramid*, “a new symbol and interactive



For setting Food Stamp benefit levels, the cost of the Thrifty Food Plan is assumed to be the same across all the lower 48 states, regardless of regional variations in food costs.

food guidance system. ‘Steps to a Healthier You,’ *MyPyramid*’s central message, supports President Bush’s *HealthierUS* initiative, which is designed to help Americans live longer, better and healthier lives.”

To date, the TFP has not been reviewed and revised to conform to the new dietary *Guidelines* or *MyPyramid*. As a result, the TFP market baskets and menus, the USDA costs of the TFP, and maximum FSP allotments do not reflect the most current understanding among nutrition and health professionals of what constitutes healthy eating. Nor do they reflect the real costs of a healthy diet as defined by the most recent dietary guidelines and food recommendations of the federal government.

3. Does an average U.S. family spend one-third of its income on food?

Data from the BLS Consumer Expenditure Survey (CES) for 2003 indicate that the average U.S. “consumer unit” (which in most cases is a family) spent 13.1 percent of total expenditures on food, 32.9 percent on housing, 19.1 percent on transportation, 9.9 percent on insurance and pensions, 5.9 percent on healthcare, 5.0 percent on entertainment, and the remaining 14.1 percent on other categories of goods and services.

Spending on each category varied by income level. Consumer units in the lowest income quintile spent 17.2 percent on food and 37.1 percent on housing. Those in the highest quintile spent only 11.1 percent on food and 30.6 percent on housing. Consumer



Low-income families often don't have enough money to buy healthy foods, which are difficult to find in their neighborhoods. Many poor neighborhoods lack large grocery stores that typically offer the lowest prices and greatest range of brands, package sizes and quality choices.

units in the third or middle-income quintile spent 14.1 percent on food and 32.3 percent on housing.⁵

Setting aside the difficult issue of disentangling income and total expenditures, it is extremely unlikely that an average U.S. family spends anywhere near one-third of their income on food. Consequently, the government has dramatically underestimated the amount of FSP benefits participants need, not to mention the extent of poverty in the United States, by using the cost of the TFP and the anachronistic multiplier of “three times the TFP” as the basis for determining maximum FSP allotments and poverty thresholds.

New research using actual local

costs of necessary goods and services, real tax, income and assistance program costs and benefits found that in most areas of the United States the income level needed for families to achieve minimal economic self-sufficiency is about 200 percent of the official poverty threshold.⁶

4. Does the TFP provide an effective basis for determining maximum FSP allotments and poverty thresholds?

For many low-income families and individuals relying on FSP benefits, healthy eating is simply not affordable. Regrettably, the most inexpensive foods available are highly processed, nutrient-sparse and

calorie-dense foods. While these “filling foods” may alleviate hunger in the short term, they cannot comprise a healthy diet.

The more expensive foods, on the other hand, include fresh fruits and vegetables, lean meats, fish and seafood, low-fat or fat-free dairy products, and whole-grain breads and cereal products, precisely the foods that the new dietary guidelines encourage people to eat more often.

The TFP does not yet provide FSP participants with sufficient purchasing power to afford healthful foods. In its current form, it is not an effective basis

for determining maximum FSP allotments and poverty thresholds.

The TFP urgently needs revision to take into account the most current nutrition and health knowledge and the U.S. government's own dietary guidelines and recommendations for healthy eating. Only after this is done, and FSP benefit levels are increased accordingly, will healthy eating be an affordable option for low-income families and individuals in the United States.

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Halving Hunger By 2010

In 1996, at the World Food Summit in Rome, the United States joined 185 other nations in a pledge to halve food insecurity and hunger by 2015. At that time, 11 percent of the U.S. population was food insecure.

In 2004, the most recent year for which data is available, the U.S. numbers were actually worse than when the pledge was made. In 2004, there were 38 million food insecure people in the United States, comprising 13 percent of the population.

To meet the goal set in Rome, food insecurity must be reduced to 6 percent. It may seem like time is running out, but it is still possible to reach this goal. The commitment to cut food insecurity and hunger in half needs to be matched by appropriate plans, investments and action.

What Needs to Change

The national nutrition programs hold the key, especially Food Stamps. The Food Stamp Program (FSP) is the largest nutrition assistance program in the United States. In 2004, the program provided benefits to close to 24 million people.

Indeed, the FSP has helped millions of people achieve some measure of food security. But given the benefit structure of the program, based on the Thrifty Food Plan (TFP), it does not ensure food security for all.

To be truly effective in reducing food insecurity, the FSP needs to be improved. One way to strengthen the program would be to increase the benefit to a level that would give all participants the means to achieve a healthy diet. By one definition, households are food secure when they

can afford to purchase healthy foods, while households that are food-insecure cannot.

Based on the most recent data provided by USDA on food security in the United States, the median value of weekly food spending for all U.S. households was 125 percent the official cost of the TFP market basket. A closer reading of the USDA data shows a significant difference in spending between food-secure and food-insecure households. The median weekly amount spent by food-secure households was 128 percent of the TFP, while food-insecure households spent only 98 percent of the cost of the TFP, a 30 percent differential.⁷

John Cook, associate professor of Pediatrics at Boston University School of Medicine, estimated the cost of a market basket of food consistent with recommendations by the American Heart Association would run 30 percent higher than the current cost of the TFP. A benefit increase of 30 percent for FSP recipients should therefore be enough to ensure that all households participating in the program can achieve food security.

The Cost of Halving Hunger

In 2004, the federal government provided \$24.63 billion in benefits to 10.3 million FSP households, or 24 million people as mentioned above.⁸ If the benefit size were increased by 30 percent, and if eligibility and participation rates remained the same, this could ensure the food



security of 24 million people and amount to a 63 percent drop in the number of food insecure people in the United States, leaving the nation with a food-insecurity rate of only five percent.

This could be accomplished for an additional \$7.39 billion in Food Stamp benefits. This is the equivalent of about 7 cents per U.S. citizen per day.

This cost estimate should be viewed as a rough approximation of the actual costs, which could be higher or lower depending on a number of unknown factors. If increasing the official cost of the TFP as suggested also meant that the federal poverty thresholds and guidelines were increased, then the number of households eligible to apply for the FSP could also increase, leading to larger numbers of participants and higher total benefit costs.

The benefits associated with improving national food-security status would be impressive and substantial: a healthier population and lower healthcare costs. The latter might outweigh the additional costs spent on the FSP to achieve these gains.