Support for Supplemental Nutrition Assistance Program (SNAP) Policy Alternatives Among US Adults, 2018

See also Nestle, p. 985.

The Supplemental Nutrition Assistance Program (SNAP), the largest federal nutrition assistance program, provides financial assistance for food purchases to 40 million Americans and has an annual budget of more than $65 billion (https://bit.ly/2K3g0l5). Although SNAP benefits can be used to purchase any food or nonalcoholic beverage, with the exception of hot or pre-prepared foods, there is strong interest among public health advocates and policymakers in identifying evidence-based SNAP policies that will promote healthier participant purchases.[1]

UNDERSTANDING PUBLIC OPINION IS CRITICAL

Past surveys have shown that the general public, including SNAP recipients, support program modifications to improve nutritional impact, such as increasing benefits for healthful foods and removing benefits for sugary drinks.[2,3] The timing and frequency of SNAP benefit distribution are other possible levers for improving nutritional impact. However, no previous national surveys have assessed public opinion about the frequency at which SNAP participants receive benefits (e.g., monthly, weekly) or about policy proposals recently considered by the US Department of Agriculture to restrict approved foods (e.g., Maine's request to prohibit purchases of sugar-sweetened beverages and candy with SNAP benefits).[4]

In a recent nationally representative telephone survey (n = 1073 US adults aged 18 and years older, including 387 SNAP participants and 686 nonparticipants), we asked about views on six hypothetical SNAP policies to promote healthier diets (for additional details, see the supplemental file, available as a supplement to the online version of this article at http://www.ajph.org):

1. Removing sugary drinks from the allowable products for purchase with SNAP benefits,
2. Removing candy from the allowable products for purchase with SNAP benefits,
3. Providing SNAP participants with more total benefits,
4. Providing SNAP participants with additional benefits for the sole purchase of fruits, vegetables, or other healthful foods,
5. Providing SNAP participants with additional benefits on the basis of the amount of fruits and vegetables purchased (i.e., fruits and vegetables incentive), and
6. Increasing the frequency of benefit issuance (currently all states issue SNAP benefits once monthly).

RESTRICTIVE VS INCENTIVIZING POLICIES

We found that the majority of adults supported each of the six policy modifications, with the highest levels of support for providing additional benefits that can only be used on fruits and vegetables (83% overall; Figure 1). Support for the "restrictive policies" (removing sugary drinks, removing candy) was significantly higher among nonparticipants than SNAP participants (Figure 1) and varied by political party affiliation, with significantly higher support for restrictions among Republicans than among Democrats (e.g., sugary drinks: 71% Republicans vs 56% Democrats; $P = .02$). Two thirds supported removing sugary drinks (63% overall); among the 34% who opposed this restriction, approximately half (47%) said they would support a sugary drink restriction if it was paired with additional benefits for healthful foods. Every proposed policy modification had bipartisan support by a majority of Democrats and Republicans.

Although both the sugary drink and candy restrictions were supported overall, only 48% of SNAP participants expressed support for restrictions. Although restrictions may be cost neutral from a government affordability perspective and cost saving from a health care perspective,[5] these may be less politically feasible options. It will be important for future research to determine whether restrictions would have the desired outcome of improving diet by reducing intake of sugary drinks and candy or whether they would merely shift purchasing of these items to SNAP participants' limited cash resources.

By contrast, "incentivizing" policies (providing additional benefits, fruits and vegetable benefits, fruits and vegetables incentive) were viewed more favorably. Support for the incentivizing policies tended to be higher among SNAP participants (Figure 1). Incentives also had stronger support from Democrats, women, and respondents younger than 30 years. We found very strong support among SNAP participants for incentivizing fruits and vegetables purchases with additional benefits (90%). Research has already demonstrated the effectiveness of these types of incentives on increasing fruit and vegetable purchases in supermarkets.[6] Despite a higher initial cost associated with incentivizing policies, recent models predict that fruit and vegetable subsidies (and subsidies combined with restrictions) would be cost saving once long-term health impacts are taken into account.[5]

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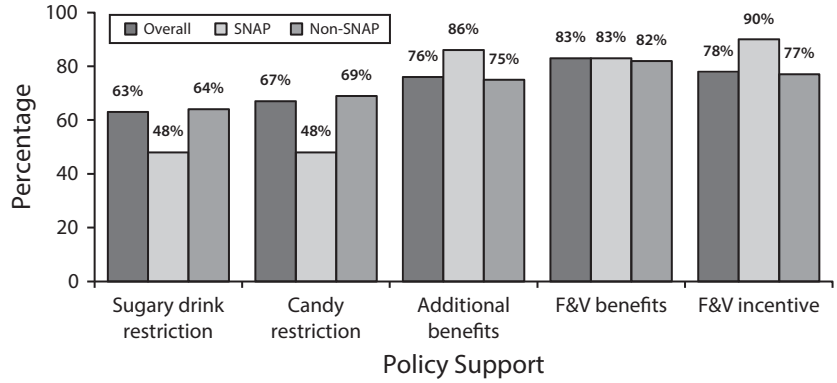

Note. F&V = fruits and vegetables. Population size was n = 1073. Proportions are presented on the basis of weighted frequencies.

FIGURE 1—Support for Supplemental Nutrition Assistance Program (SNAP) Policy Alternatives Among US Adults: May 8–31, 2018

TIMING AND FREQUENCY OF BENEFITS

Once monthly issuance of benefits may be associated with detrimental outcomes linked to insufficient benefits at the end of the benefit cycle (e.g., hunger, health, strain on retailers) as well as sugary beverage marketing timed with SNAP issuance.[7] More frequent issuance may be favored by some participants as a budgeting tool, could help participants smooth consumption over the benefit month, and has the potential to reduce the association between the timing of SNAP benefits and retail marketing strategies or promotional pricing. However, this administrative change may not be preferred by participants who shop once monthly to save on transportation costs or to take advantage of buying in bulk.

When asked about how frequently benefits should be issued to participants, 14% preferred once monthly, 31% preferred twice monthly, 21% supported giving participants the option to choose the frequency that works best for them, and 30% reported no preference. SNAP participants and nonparticipants did not significantly differ in their issuance preferences ($P = .25$). There was strong support, among SNAP participants and overall, either for increasing benefit issuance to twice per month or for allowing participants the option to choose the frequency that works best for them.

Congressional action would be necessary to permit more than once monthly issuance, and states may also have logistical concerns about changing the benefit issuance schedule. Potential challenges to twice-monthly issuance may include (1) participant confusion during the transition period, (2) effectively communicating the changes, and (3) participants' adjustment to the lag in receipt of the full monthly benefit each month. These issues are potentially compounded by administrative aspects (e.g., recertification frequency) that vary by state, so challenges would need to be considered and addressed on a state-by-state basis. Nevertheless, this type of administrative change may be more politically feasible than restrictive or incentivizing policies related to the types of foods purchased. Our findings demonstrate that there is significant public support for modifying the frequency of benefit issuance, including among current SNAP participants. Further consideration is warranted, and next steps may include funding demonstration projects to examine the feasibility of implementing these types of changes from the perspective of retailers and state administrators and studies to pilot test the impact of several issuance options.

PARTICIPANT SPENDING PATTERNS

We also asked SNAP participants about patterns in their benefit spending. A majority (61%) reported that SNAP benefits lasted two weeks or less each month, including 35% who reported one week or less. When asked to think about food purchases only (i.e., SNAP-eligible purchases), the majority (55%) reported that their SNAP benefits paid for half or less of their monthly groceries. This is likely one reason why additional benefits (rather that restrictions) were strongly supported by participants.

CONCLUSIONS

We found that a majority of Americans supported each of the six policy modifications presented. Despite recent political polarization, policy support for sugary drink restrictions, targeted fruits and vegetables benefits, and additional benefits to guarantee that SNAP participants can afford a healthy diet has strong bipartisan public support that policymakers should consider. The public overall and SNAP participants strongly favor changes to SNAP that would incentivize healthy purchases and modify the frequency with which participants receive their benefits each month. Together, these changes could improve the nutritional impact of the program and should be considered in the development of future SNAP program and policy proposals. AJPH

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R. L. Franckle conducted the final data analyses and drafted the editorial. R. L. Franckle and E. B. Rimm had full access to the study data and take responsibility for the integrity of the data and the accuracy of the data analysis; they conceptualized and obtained funding for the study. M. Polacsek, S. N. Bleich, A. N. Thorndike, M. T. G. Findling, A. Moran, and E. B. Rimm provided methodological and content expertise relevant to study design and data interpretation. All authors provided critical revisions and approved the final version of the editorial.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

REFERENCES

1. Bleich SN, Rimm EB, Brownell KD. U.S. nutrition assistance, 2018—modifying SNAP to promote population health. *N Engl J Med*. 2017;376(13):1205–1207.

2. Long MW, Leung CW, Cheung LW, Blumenthal SJ, Willett WC. Public support for policies to improve the nutritional impact of the Supplemental Nutrition Assistance Program (SNAP). *Public Health Nutr*. 2012;17(1):219–224.

3. Leung CW, Ryan-Ibarra S, Linares A, et al. Support for policies to improve the nutritional impact of the Supplemental Nutrition Assistance Program in California. *Am J Public Health*. 2015;105(8):1576–1580.

4. Maine Department of Health and Human Services. A new approach for the SNAP-Ed program, and renewal of soda and candy restriction waiver. 2017. Available at: https://www.maine.gov/dhhs/documents/FNS-Waiver-Request-2-17.pdf. Accessed September 21, 2018.

5. Mozaffarian D, Liu J, Sy S, et al. Cost-effectiveness of financial incentives and disincentives for improving food purchases and health through the US Supplemental Nutrition Assistance Program (SNAP): a microsimulation study. *PLoS Med*. 2018;15(10):e1002661.

6. Polacsek M, Moran A, Thorndike AN, et al. A supermarket double-dollar incentive program increases purchases of fresh fruits and vegetables among low-income families with children: the Healthy Double Study. *J Nutr Educ Behav*. 2018;50(3):217–228.

7. Moran AJ, Musicus A, Gorski Findling MT, et al. Increases in sugary drink marketing during Supplemental Nutrition Assistance Program benefit issuance in New York. *Am J Prev Med*. 2018;55(1):55–62.

Policy Solutions Are Needed for a Strong Latino Immigrant Workforce

Rapid changes in immigration patterns and demographic shifts in the United States require informed policies to address both the needs of our new residents and our country as a whole. The story of Latino immigration to the United States is intertwined with the economy and the nation's workforce. In the mid-20th century, the US and Mexican governments formalized the *Bracero* program designed to bring Mexican workers into agriculture to fill jobs unfilled by American workers because of war and low wages. In the 21st century, while the newest immigrants from Central and South American countries have moved into jobs in agriculture, there is also an increasing number of Latin American immigrants represented across a diversity of sectors, including the health sector. Latino immigrants are both having an impact on the demographic profiles of the US population and improving the nation's health as critical members of the health workforce. A public policy is therefore necessary to support the Latino immigrant workforce in the United States to address their lower access to affordable, high-quality, and culturally and linguistically competent health services. Such policy would ensure that our newest residents might enjoy the same opportunities for health care as the communities in which they work and enable their full participation in the workforce, including the health positions.

DEMOGRAPHICS AND EMPLOYMENT

Until recently, Mexican immigrants and their children have driven the composition of Latino immigrants; however, immigrants from Central America and Caribbean countries are now increasing. In 2017, there were 11 269 900 Mexican immigrants living in the United States, down from 11 711 100 in 2010 (https://pewrsr.ch/2OWaTlF).[1] Of those Mexican immigrant men, 94% were working. Newly arrived immigrants tend to work in hazardous jobs that pay low wages—mostly in service, construction, and agriculture. In the United States, 40% of dishwashers, 36% of roofers, and 35% of gardeners are Mexican immigrant men (https://www.census.gov/acs).

Since the end of the 2008 recession, more Mexicans have returned to Mexico than have migrated to the United States. This is a result of multiple factors including stricter border enforcement, the improved Mexican economy, and declines in Mexico's birth rate (https://pewrsr.ch/2OWaTlF). Conversely, the number of Central Americans in the United States has increased. In 2015, there were approximately 6.2 million immigrants who were born in Central America or reported Central American ancestry living in the United States. The majority of these immigrants are from the Northern Triangle (El Salvador, Guatemala, and Honduras). Most are employed in high-risk and low-paying industries such as construction, transportation, and agriculture. The type of work and their irregular migration status are key factors influencing their low health insurance coverage and utilization rates.[1]

ACCESS TO HEALTH CARE AND HEALTH WORKFORCE

In 2016, Latinos had the highest uninsured rate compared with other ethnic groups at 16.0% (https://www.census.gov/acs). However, over the past 30 years, Latino physicians per 100 000 Latinos decreased by 22% while the US population of Spanish-speaking households increased by 233%.[2] This mismatch, also seen in other health professional fields such as nursing,[3] is concerning at a time when the Latino population, representing the largest and second-fastest-growing ethnic group in the United States, is predicted to become 30% of the US population by 2050.[4]

Nonetheless, Latin American immigrants are active players

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