Combating Obesity of Low Income Food Stamp Recipients

An in depth looks at the effects of being obese on the economic health of low income communities

Tag words: Impact of obesity on low income families, Economic impact of obesity, Food stamps and obesity

Authors: Jason Emrani, Andrew Schwartzer, Amro Mahmoud and Paul Nam with Julie M. Fagan, Ph.D.

Summary

We researched the economic effects of being obese for individuals with lower incomes and specifically those on food stamps. First we discuss how the healthcare system operates and the costs imposed on this system from obese individuals. We then analyze the costs imposed on nongovernmental institutions, including hospitals, private practices and families. We show how individuals who are obese and are enrolled in insurance through their employer earn less than non obese workers, thus decreasing their income even more. Finally we show that individuals of low income status tend to be more obese than individuals of higher income status.

Video Link

Obesity Project: http://youtu.be/JtBiVg81KIE
The Issue: Obesity

Introduction
Once upon a time, being obese was a sign of wealth and being thin was a sign of being poor. This trend was attributed to the fact that only the rich had access to large amounts of food to gain excessive amounts of weight. Fat, once viewed as a sign of wealth and prosperity, has become an exponentially increasing trend amongst the population and has lost its esteemed rank. From fast food restaurants to super sized portions, Americans are taking in more and more calories each day and expending less. According to the World Health Organization (WHO), in 2008 1.8 billion adults were considered to be overweight. Out of that number, 500 million were considered obese. The WHO define overweight in terms of body mass index (BMI), which is defined as the weight in kilograms divided by the square of the height in meters. Individuals with a BMI greater than or equal to 25 but less than 30 are considered overweight. Individuals with a BMI greater than or equal to 30 are considered obese. There are many implications and unintended consequences associated with obesity. Health consequences associated with being obese include, but isn’t limited to, cardiovascular disease, diabetes, and hypertension. In addition to health consequences, obesity has economic consequences as well, which include putting a strain on the health care system, lower wages for obese employees who get insurance through their employer, increase in medical expenses for health institution (such as hospitals, clinics and Private practices), and is unequally distributed among social classes. In this paper we will show that low income individuals are more likely to be obese than higher income individuals and are usually enrolled in a government program such as Medicaid, Medicare and/or food stamps.

Low income individuals are more likely to be obese (JE)
Before the food stamp program, poverty used to be associated with decreased food consumption. As obesity increases in the United States, so does the correlation between obesity and economic status. In the United States, obesity rates are constantly increasing, especially for minorities and lower income communities (Zhang and Wang). In 2001, the Center for Disease Control reported that high obesity states generally had lower per capital income. According to Townsend, It is easier to be obese if an individual is food insecure, less education or has lower income. Drewnowski and Rolls hypothesize that the disproportionate affects of obesity on low income individuals can be attributed to: higher energy dense foods eaten by lower income individuals, food insecurities of lower income individuals and the majority of food stamp recipients live in lower income communities. In 1991, a study was conducted linking individuals with higher income to higher levels of physical activities during the week (Ford et al.). Another study reinforced this concept by concluding that as income increases, the probability that an individual will report none or less physical activity decreases (Pate, et al.).

If obesity is associated with lower income then obese individuals should earn less than non obese individuals. A study conducted by Bhattacharya and Bundorf (2009) shows that generally, obese individuals earn less income than non obese individuals. Bhattacharya and Bundorf (2009) use data from the National Longitudinal Survey of Youth and the Medical Expenditure Panel Survey, to find that the healthcare costs associated with obesity are passed on from employer to obese workers in the form of lower income. Their work is based in the idea that obese individuals with health insurance from an employer should receive lower wages relative to their nonobese
colleagues and there should be no difference between the wages of obese and nonobese individuals in jobs without health insurance (Bhattacharya and Bundorf, 2009).

The majority of the under 65 population receives health insurance through their employer (Bhattacharya and Bundorf, 2009). If the employer insurance is a pooled group health insurance, the group pays a rate adjusted for high medical expenditures associated with obesity (and other diseases), through higher premiums. Under this type of plan, an obese individual will generally pay the same amount as an individual who is skinny because these plans are rarely adjusted for risks factors such as obesity (Bhattacharya and Bundorf, 2009). Although these health insurance plans aren’t adjusted for health risks (such as obesity), employers pass these costs onto obese individuals in the form of lower income.

From the National Longitudinal Survey of Youth data, using a sample size of 38,645 observations, Bhattacharya and Bundorf (2009) calculate the unadjusted (for wage offset for obesity) hourly wage rate for insured and uninsured obese and nonobese individuals. Among workers with health insurance, on average obese workers earn $1.42 per hour less than nonobese workers. Among uninsured workers, the difference in hourly wages between those who are obese and those who are not is $0.25 and not statistically significant. The unadjusted difference in wages for insured (obese wages minus obese wages) and noninsured (obese wages minus nonobese wages) workers −$1.68 (Bhattacharya and Bundorf, 2009). Below is a table illustrating their findings:

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<td>Unadjusted difference-in-difference estimates of the wage offset for obesity. Sample: full-time workers either with employer-sponsored coverage in their own name or uninsured.</td>
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*Significant at 10%; **significant at 5%, ***significant at 1%. Note: Standard errors in parentheses are adjusted for repeated observations of individuals.

Using data from The Medical Expenditure Panel Survey from 2000 to 2005, they constructed a sample size of 26,478 replicate their findings regarding the relationship between wages, health insurance, and obesity from the NLSY, however, this time they adjusted wages for obesity. They found the adjusted wages to be −$1.45, which was similar to the unadjusted wages they calculated. To test the validity of their findings that wage offset should increase as obesity increases, they calculated wage offsets for overweight, mildly obese and morbidly obese individuals. Bhattacharya and Bundorf (2009) define overweight as $25 \leq \text{BMI} < 30$, mild obesity as $30 \leq \text{BMI} < 35$ and morbid obesity $\text{BMI} \geq 35$. Their findings show that overweight workers in jobs that provide health insurance earn $0.35 less than normal weight workers, which although
is statistically insignificant is still a loss, a decrease of $1.27 for mildly obese workers and a decrease $2.22 for morbidly obese workers (Bhattacharya and Bundorf, 2009).

According the Bureau of Labor Statistics, income differences affect diet quality as well. In 1992, top quintile by income spent 2.6% of their total expenditures, $1,997, for food per person while those in the bottom quintile of income spent 18.7% of their total income, $1,249 on food per person. Wealthier households bought higher quality meats, more fish and seafood, more fruit and vegetables, and more convenience foods. Although they bought less expensive items, poor households devoted a far greater share of their income to food (Kaufman and MacDonald). The Department of Epidemiology and Surveillance Research, American Cancer Society in Atlanta, GA used a United States mail survey of 34,158 male and 42,741 female to test the association between residence in geographic regions with relative income inequality and the likelihood of weight gain in the waist. The respondents of the mail survey came from 21 states that were characterized by the household income inequality (HII) index. Household income inequality is the uneven distribution of income in America.

The index used in this study measures the proportion of total income received by the more well off 50% of households in the state. The HII index ranged from 77.1% in Utah, which least income inequality, to 82.6% in Louisiana, greatest income inequality. Among these 21 states, the median household annual income ranged from $21,949 in Louisiana to $41,721 in Connecticut. Out of all the respondents, 20,329 men (59.5%) and 6,257 women (14.6%) specified the waist as the site where they mainly added weight (Kahn et al.).

The results showed that compared to men who came from the six states with the least income inequality, men who came from the two states with the greatest income inequality were about 12% more likely to experience weight gain at the waist. The same comparison among the women demonstrated about a 5% increased likelihood of experiencing weight gain at the waist (Kahn et al.). This study proves that that an adverse social environment, such as high household income inequality, is associated with an increased likelihood of weight gain in the waist.

Social Economic Status and Obesity (AM)
Of all the aspects of the American obesity epidemic, the most troubling is the prevalence of obesity amongst the different social classes. According to the National Health and Nutrition Examination Survey (NHANES), obesity has the highest prevalence in individuals of low-income then those who are more financially stable. How is this so? In older times, being obese or overweight was a sign of wealth. Having large amounts of body fat was designated to the rich such as the king and other position of power and wealth, meanwhile being of average or underweight was a sign of poverty and low class. How in the 21st century has there been a complete 360, where the poor are obese and the fit tend to be financially well-endowed? While there is no shortage of theories as to why there is a connection between poverty and obesity, it’s clear that if you visit any local grocery store, one will notice that healthy foods such as fruits, vegetables and lean meats are more expensive than the foods loaded with fat, calories, such as frozen dinners, cookies and chips. The price of healthy foods tends to be far more expensive than high density foods that lack any beneficial nutrients. If one was on a tight budget, similar to those of lower economic class an individual than they would have to choose between a small amount of healthy food or a larger amount of unhealthy food.
The choice for someone who doesn’t have much money and is just trying to feed their children or fill themselves up will be easy, go for the larger amount of unhealthy food. One of the reasons that many fatty foods cost less than fruits and vegetables has to do with the U.S. Department of Agriculture’s crop subsidy program. “Through this program, the government compensates farmers for growing certain kinds of crops, such as rice and cotton. The overwhelming majority of the government’s money goes toward subsidizing the production of soybeans and corn. Among other things, these crops are used to create soybean oil and high fructose corn syrup, two ingredients commonly found in fattening foods ranging from soft drinks to cheeseburgers and potato chips” (Dr. Hawn).

As a result of the subsidy program, corn syrup and soybean oil have become abundant and inexpensive, lowering the cost of the foods they’re used to produce. In research on agricultural subsidy programs, Dr. Adam Drewnowski of the University of Washington determined that “foods produced from subsidized crops, such as French fries and soda, cost about five times less per calorie than unsubsidized foods, such as broccoli and fruit juices” (Dr. Hawn). Based on this price-calorie comparison, Dr. Drewnowski says that from a short-term financial perspective, it may make sense for a low-income person to choose high-fat and highly sweetened foods over healthier alternatives.

Unfortunately, because fatty foods tend to be cheaper for consumers, the countless number of fast food chains aim to place their franchises in areas of poverty. It makes sense, if fast food chains sell food that is easy to afford, then placing them in areas where the people are poor will result in a greater sales and thus a greater profit for the fast food chain. In a study done by a group at the NPC (National Poverty Center) of the Gerald R. Ford School of Public Policy at The University of Michigan, they found “there to be a relationship between individual BMI values and the density of fast food restaurants in close proximity to these individuals” (Chen). The effect of the fast food chains has not only contributed to the obesity epidemic here in America, but has increased obesity in countries overseas as well. China, just like America is fighting obesity because of the abundance of fast food throughout the country.

Although the cost of fast food and other unhealthy choices remain minimal, it doesn’t completely explain why individuals of low economic status tend to be more obese than the other social classes. One area that has received much attention is school lunches. Most experts agree that healthy eating habits at a young age correlates with healthy body weight, and a decrease in weight related diseases later on in life. However, its hard to provide nutritious food to schools in areas of poverty who are already dealing with many hardships on their budgets. In recent years there have been nutrition standards place on school lunches to provide healthier food sources, but ‘no results show that these lunches are actually more beneficial than they were originally’ (Brown).

Healthy school lunches are not the only thing that many schools fail to provide, the rate of physical education has slowly declined in schools all around the country, more so in public schools. In an article by the Boston Globe, Eunice F. Sirianos a gym teacher in the New Bedford public school system claims that, “the school district sharply cut back gym classes for elementary school students because of budget constraints and the need to focus on standardized tests, the children now have gym class only once every two weeks or once a month. There is no
way we can expect these children to be physically active if we cut their Phys Ed out” (Lack of Phys Ed). The strain on the public school system has definitely impacted the obesity rates in young children. Without proper diet and increase in physical education, the obesity rate will only continue to climb.

Fortunately congress has been trying to place regulation on the amount of time spent in physical education and they have implemented plans to provide healthier opinions for children instead of their usual school lunches. The real next frontier in the war on obesity should be the Supplemental Nutrition Assistance Program (SNAP), or “food stamps.” “Some 38 million people one in eight Americans rely on this program, “up from one in 50 in the 1970s” (Bryant). Food stamps have done a good job fighting hunger since their 1964 roll-out, but as the program has grown, so has the percentage of Americans who are obese — from 13% in the early 1960s to about 35%. Now there's some evidence the two are related. “Jay Zagorsky, a scientist at Ohio State University, has calculated that, controlling for socioeconomic status, women who received food stamps were more likely to be overweight than non-recipients. They gained weight faster while receiving assistance than when not” (Bryant).

The food stamps program has received much attention in the past couple of years because the foods that are being bought with the money don’t always tend to be the healthiest choices. With the average being $124 a person per month, there is not much available to spend, and with healthier foods costing more than other food choices, most individuals will tend to buy the cheaper foods in order to get the most for the limited amount of money received. In most consumers’ minds, it’s a fight between hunger and obesity, and most would rather choose obesity. “There needs to be a way for a family to not have to choose between hunger and obesity,” says Lauren Dinour, a nutrition expert at the City University of New York (Peeples).

Medical Expenses (AS)
The burden of being overweight and obese has a heavy impact on medical expenses in the United States. The main factors contributing to these expenses include caring for individuals who have co-morbidity's as a result of their obesity, and the increased incidence of hospitalization and office visits for overweight and obese patients. Research has shown that there is a higher prevalence of obesity among those who are of lower income, which is an important underlying factor that contributes to the amount of money spent each year on obesity related health issues. People who are overweight and obese are at a much higher risk of developing other diseases. According to the CDC, obesity can lead to other diseases such as diabetes, heart disease, and hypertension being the most prevalent. The CDC also reports that among the top three leading causes of death in the United States are heart disease, cancer and stroke, all of which have strong association with individuals who are overweight and obesity (CDC, 2011). An epidemiological study done to evaluate the cost of illness due to obesity estimated that the aggregate economic cost of obesity related diseases totaled billions of dollars, accounting for 5.5% to 7.8% of total healthcare expenditures (Kortt, 1998). Chronic diseases require long-term care and treatment, which is what makes them so expensive. The medical care costs of obesity in the United States are staggering. In 2008 dollars, these costs totaled about $147 billion (Finkelstein, 2009). A Study was conducted at the UCLA Center for Health Policy Research to examine the increased prevalence of obesity and type II diabetes in California. The study aimed to look at these twin diseases in relation to social factors including low-income families. Adults living below the
poverty line had a significantly higher prevalence of obesity (27.7 percent) than higher-income adults (19.6 percent). Diabetes was also more prevalent among the poor (individuals living below 200 percent of the federal poverty level). In California, the total annual cost of diabetes is estimated to be $24 billion. The cost of obesity to families, employers, the health care industry and the government is equally concerning, totaling $21 billion (Diamant, 2010).

As you can see, the costs of controlling chronic diseases such as CHD, diabetes, and hypertension over a prolonged period of time can be astronomical. The Obesity Reviews Journal published a study that was done to measure the full economic costs of obesity related chronic diseases. The study concluded that in 2010, heart disease and stroke represented the largest direct health costs, both accounting for over $2 billion in expenses each. The disease responsible for the third highest health costs was hypertension coming in at $600 million (Popkin, 2006). It is also very interesting to notice that two of the leading causes of death were also among the most expensive obesity related chronic diseases (heart disease and stroke).

The fact that the prevalence of obesity is higher among those who are of lower income, leads us to believe that these co-morbidities are also more prevalent among the poor. In a study of obesity and its related health risk factors Mokdad explains, how low socio-economic status (SES) is associated with higher rates of obesity, and high rates of leading causes of illness and death (Mokdad, 2003). Results from the National Health Interview survey concluded that those of low SES are more likely to have diabetes, heart disease, hypertension, and cancer when compared to those of higher SES (Paeratakul, 2002). In regards to the expenses associated with obesity and obesity related diseases, it seems that a large proportion of those costs are coming from the low SES population. The vast majority of those who are of low income are registered with the food stamp system.

In 2009, the supplemental nutrition assistance program (SNAP) assisted 31 million people per month (FNS, 2011). This system is great in regards to putting food on the tables of those in need, but perhaps some adjustments need to be made on the quality of foods that can be purchased. One study showed how people on the food stamp program purchased 40% more sugar-sweetened beverages (SSB) than other consumers (Shenkin, 2010). If the food stamp system regulated what items can and cannot be purchased, and promoted healthier foods such as fruits and vegetables, then the prevalence of obesity among low-income individuals would decrease. If the prevalence of obesity decreased, then incidence of the mentioned co-morbidities associated with obesity would also decrease. This would not only increase the overall health of low-income individuals in our country, but lower the medical expenses associated with treating these individuals. For a system as large as SNAP, assisting 31 million people every month, there is great opportunity to make improvements on a large group of people, and a good start to lowering our countries medical expenses associated with obesity.

Another factor that affects medical expenses is the increased incidence of hospitalization and office visits. Candrilli, Senior Director of Health Economics conducted a study on the expenses associated with hospitalization. On average, for all medical conditions, a one-day stay at the hospital in 2005 was $1237. Different levels of care resulted in higher costs. For example the mean cost for patients with cardiac issues in the ICU was as high as $3315 (Candrilli, 2002). For overweight and obese individuals, there is an increased risk of being hospitalized.
Considering that diseases such as heart disease and stroke are so prevalent in obese patients, ICU hospitalization, and extended length of stay is not unusual. Hauck and Hollingsworth examined the impact of obesity on hospital length of stay based on different fields of medical specialties. The results differed for almost every specialty, but the most statistically significant difference was in general medicine. The average length of stay for severely obese individuals was four days longer than that of other patients (Hauck and Hollingsworth, 2010) The impact of morbid obesity on medical expenditures for obese patients translated into 50% greater per capita annual expenditures for office visits, 195% greater expenditures for outpatient hospital care, and 95% greater expenditures for inpatient hospital care. Figure 1 shows the breakdown of medical expenditures based on the different classes of obesity (Arterburn, 2005).

Figure 1

Obesity and the economic costs associated with it is a snowball affect. It is apparent that our current defense against combating obesity is not working. If we do not address the core risk factors that lead to obesity, then we will continue down the same path. If obesity is among the top risk factors for the development co-morbidities and costly hospitalizations, then we need to back up a little further address the risk factors that lead to obesity. One of the primary concerns is the fact that obesity has a much higher prevalence among low-income families. In order to reverse the obesity epidemic that our country currently faces, there needs to be a multifaceted approach that promotes healthy lifestyles and opportunity for everyone. Success in doing so will reduce the astronomical expenses associated with the treatment chronic diseases, and will also decrease the rate of hospitalization associated with obesity.

Obesity, Low Income and Government Program (PN)

A change in the food stamp system is needed to benefit the community as well as the individuals. Health hazards associated with obesity not only affect the individual, but also affect the society. The cost of obesity is not only a burden for the obese individual, but also to many American taxpayers. United States might not have a universal health care system, but its government still offers various public health care programs to eligible individuals. Medicare and Medicaid are two public health care programs that are offered to anyone in the United States that meet the requirements. The Medicaid program offers health insurance to individuals that meet a certain criteria. Medicaid is a state regulated and state funded program that receives some support from the federal government. Certain regulations set by the federal government must also be followed for the state to receive money in running the Medicaid program. Since these programs are state and federally funded the money to run this program essentially comes from the taxes that are paid by the general population of the country. To qualify for Medicaid the individual must meet
certain requirements which may be age, citizenship, disabilities, or income level. Income qualifications vary from state to state, but essentially the individual must have an income that is 130% below the federal poverty line (Medicaid Information for States, 2011). Once qualified the Medicaid program sends that payments for an individual’s medical bill directly to the health care provider. Sometimes a small co payment must be made by the patient. A variety of conditions and prescription drugs are covered under Medicaid. The types of conditions that qualify for Medicaid assistance varies from one state to the next. Many American that qualify for Medicaid are also eligible for many other federally funded assistance programs such as food stamps. Many individuals on food stamps that purchase unhealthy foods develop health complications that are paid for by Medicaid. A cycle is created that forces citizen to unnecessarily pour more money into programs that were meant to help the underprivileged. If the foods that people on food stamps were regulated to only include healthy foods, these individuals will have better health and will be using the Medicaid program a lot less. This will mean that the money that is saved can be used to fund other programs in the government.

Another program that is popular in the United States is Medicare. Medicare is different from Medicaid in that it offers coverage to only those that are age 65 and older. It only covers an individual under the age of 65 if they have an end stage renal disease or suffer from certain disabilities. Medicare is separated into four different parts, parts A, B, C, and D. Medicare Part A helps cover inpatient care at various health care facilities. Medicare Part B covers medically necessary services such as outpatient care and doctors’ services. Medicare part C is covers both inpatient care and medical services, along with other benefits. Medicare part D is a plan run by an outside insurance company that provides coverage for prescription drugs (Medicaid Information for States, 2011). The Medicare program is federally funded and most of its money comes from payroll taxes. Employees must pay a Medicare tax of 2.9% of their wages. The tax is split between employee and the employer so an employee may only need to pay 1.45% of their wages to Medicare. Self employed individuals must pay the entire 2.9% on their own (Medicaid Information for States, 2011). Many Americans that had health complication early on in their life will have even greater complications later on. Luckily Medicaid will be able to provide aid for these individuals. Unfortunately if nothing is done about the obesity epidemic the money to fund this program will become very limited. The cost of obesity creates a strain not only on the individual, but society as a whole.

The Medicaid and Medicare are two public health care programs that are affected by the rise in obesity. It is evident that the rise in cost of obesity and healthcare cost are related. According to the Center on Budget and Policy Priorities in 2010, the United States dedicated 21% of the national budget to healthcare (Center on Budget and Policy Policies, 2010). Amongst the world the United States has the highest percentage of its GDP going into health. In 2006 12.8% of its GDP went into health (Health Expenditure, 2009). The World Health Organization also estimates that the prevalence of obesity is the highest in the United States. A survey taken in 2010 estimates that the prevalence of obesity in the United States is 80.5% for males ages 15 and up and 76.7% for females ages 15 and up (WHO Global InfoBase : International Comparisons 2011). This survey also included anyone who is at risk for being obese; therefore this estimate includes all individuals with a BMI of 25 or greater. Obesity can lead to type II diabetes, cardiovascular disease, metabolic syndrome, thyroid dysfunction and a list of other dangerous conditions. Obesity is the cause of many diseases in the United States, so it is no surprise that the
increase in health care cost correlates with a high prevalence of obesity in the United States. These additional costs are essentially passed on to the rest of the community through Medicaid and Medicare.

A study has been done linking the rise in obesity with the rise in health care cost. The study was done by the Public Health Economics Program at RTI International in Triangle Park, North Carolina. The study observed the relationship between obesity and medical spending in 1998 and 2006. The study used the data set from the 1998 and 2006 Medical Expenditure Panel Surveys. The Medical Expenditure Panel Surveys looks at the total medical expenses of an individual as well as their health insurance status and their BMIs. The data looked at 10,597 people from 1998 and 21,877 people from 2006. Anyone with BMI above 30 was looked at as an obese individual. The data also showed that the 8.5 percent of spending on Medicare, 11.8 percent of spending on Medicaid, and 12.9 percent of private insurance spending is due to obesity in 2006. If the trends continue the rise in obesity will increase the amount of spending from these programs. The total annual spending on obesity has increased from 6.5% to 9.1% between 1998 and 2006. The research showed that the average spending difference between obese individuals and people of normal weight was $1,429 in 2006 and $930 in 1998. The study suggested that rise in the amount of spending was due to the increase in the prevalence of obesity between 1998 and 2006 and because of the rise in prescription drug cost and usage in the country between 1998 and 2006 (Finkelstein, 2003).

There is an obvious spending gap between normal weight individuals and people with higher BMIs. A study on health care expenditure and severe obesity was conducted by the Health Services Research and Development Department at Cincinnati Veterans Affairs Medical Center. Severe obesity was defined as anyone with a BMI of 35 or greater. This study took data from the 2000 Medical Expenditure Panel Survey. As mentioned earlier the Medical Expenditure Panel Surveys looks at the total medical expenses of an individual as well as their health insurance status and their BMIs. Analysis of the 2000 Medical Expenditure Panel Survey showed that 35.7% were overweight, 14.6% had class I obesity, and 5.1% had class II obesity. When the medical expenditure of these classes were observed it showed that morbidly obese adults were $1975 greater than normal-weight adults, $1735 greater than overweight adults, $1415 greater than adults with class I obesity, and $888 greater than adults with class II obesity. It was estimated that 45% of the medical expenditure that was spent by morbidly obese individuals were associated with excess body weight. 9%, 19%, and 31% of health care expenditures were associated with excess body weight among overweight adults and adults with class I and II obesity, respectively. From this research it was estimated that 56 billion dollars were associated with health care cost due to excess body weight. Another interesting finding that the data showed was that obese individuals were more likely to live 200% below the federal poverty line. This means that many of these individuals qualify to be covered by Medicaid and Medicare. Since many of these expenditure are covered by Medicaid and Medicare it can be expected that the medical expenditures of these individuals will ultimately be paid by the rest of the community.(Arterburn, 2005)
The Service Project: Regulate Food Stamps

It has been proposed to provide more money for food stamps, but the logical alternate would be to “regulate food stamps.” We propose a regulation on food stamp that would prevent recipients from using their monthly funds on unhealthy food choices. The process would be similar to the use of food stamps when buying items such as toilet paper, because the money can only be used to buy healthy food. With regulations on food stamp, the buyer will have to pay for unhealthy food choices with his or her own money, which will turn them away from buying it and opt for the items covered by the food stamps card.

In the regulations, all foods containing more than 10% saturated fat per serving should be banned from the list of foods that can be purchased with food stamps because the American Heart Association recommends that an individual consumes no more than 7% of saturated fat from their total caloric intake per day. Foods that contain more than 10 teaspoons of sugar (50 grams) should also be banned because the AHA recommends about 6 teaspoons of sugar for women and 9 teaspoons for men. Finally any foods containing trans-fats should be banned as well.

Every item in a grocery store has a universal Universal Product Code (UPC). When an item is scanned the UPC is scanned and the item will be automatically looked up in the database. Whenever this product is scanned by a bar code reader specific information will be available. Basic information such as the UPC itself, manufacturer, brand, and item name are currently provided in the UPC. Nutritional facts and product dimensions are currently optional information and will be made a mandatory requirement for food manufacturers to include in the UPC. If the item scanned is an item that falls into the unhealthy food category, the system will not allow the food stamp to pay for the item.

We have written to First Lady Michelle Obama and US Senator Robert Menendez about our idea to regulate what types of food purchasable with food stamps. We chose to write to First Lady Obama and Senator Menendez because they both find obesity a big problem in the US and are working to reduce obesity in the US. First Lady Obama started the *Let's Move!* initiative to combat child obesity and to “put children on the path to a healthy future during their earliest months and years”. This initiative aims to Give parents information on fostering environments that support healthy choices, provide healthier foods schools, ensure that every family has access to healthy, affordable food, and help children become more physically active. In response to this initiative, President Barack Obama signed a presidential memorandum creating the first ever task force on childhood obesity.

Senator Menendez has contributed to reducing obesity through his revisions of the 2008 Farm Bill. By supporting local farmers, Senator Menendez aimed to give healthier foods to families. His revisions of the bill expand the Fresh Fruit and Vegetable Program to every state in the country, targeting benefits to low income children to give them healthier snack options. The bill also gives additional funds for the Senior Farmers’ Market Nutrition Program to provide low income seniors with coupons that can be exchanged for healthy foods at farmers’ markets, roadside stands, and community supported agriculture. The bill also gives schools the power to buy local foods in the School Lunch Program to support local farms while giving children fresher and more nutritious food options.
References


cawley, p. 17.


Dear First Lady Michelle Obama,

I am writing on the behalf of my classmates for a group project for our Ethics in Science course. The assignment was to come up with a topic and create a service project related to the topic. The members of our project group are currently working on their bachelor’s degrees at Rutgers University in New Brunswick, NJ. We all have different backgrounds ranging from nutrition, public health, environmental planning, and exercise science. I am writing to you in hopes that changes will be made to our current food stamp program. With the growing epidemic of obesity certain actions must be taken to deter the downfall of this country’s health. We feel that certain high fat, high sugar, and high sodium content foods should be banned from the list of legible products that can be purchased with the food stamps.

It is a known fact that obesity greatly increases your risks of cardiovascular disease, type 2 diabetes, hypertension, and variety of other diseases. The cost of obesity is affecting not only the individuals suffering from the conditions, but also the country as a whole through both private and public health programs. In 2006 the World Health Organization estimated that the United States has spent 19.3% of its total expenditure on public health systems. Amongst the world the United States has the highest percentage of its GDP going into health. In 2006 12.8% of its GDP went into health. This might also have something to do with America having the highest prevalence of obesity. The World Health Organization estimates that the prevalence of obesity is the highest in the United States. A survey taken in 2010 estimates that the prevalence of obesity in the United States is 80.5% for males ages 15 and up and 76.7% for females ages 15 and up (2). This survey also included anyone who is at risk for being obese; therefore this estimate includes all individuals with a BMI of 25 or greater. To ease the financial burden on the country changes should be made to decrease the prevalence of obesity in the country.

It has been shown that the rate of obesity tends to be greater in low income individuals that participate in food stamps. A study done by Chad D. Meyerhoefer AND Yurity Plypchuk observed the relationship between food stamp participants and obesity. The study showed that female participants are 5.9% less likely to be of normal weight and 6.7% more likely to be obese than nonparticipants, while male participants are no more likely to become obese. They contributed this correlation to a variety of factors including, poor knowledge of healthy eating,
low availability of healthy foods, and low cost of junk foods. Another research done by the
University of Toronto showed that children of low income families tend to have a low quality
diet, which consisted of more refined carbohydrates and fewer meats, fruits and vegetables. Such
a diet will increase the rate of obesity in the community and decrease the health status of the
individual.
We are aware of your interest in childhood obesity, how you have tried to create programs to
encourage children and their parents to adopt habits that will promote activity and health and
decrease obesity. Most children overweight/obese tend to come from families of low economic
status. The program that we have set forth would help in decreasing the high calorie dense foods
that many parents purchase with their food stamps. A decrease in the amount of unhealthy foods
and an increase in healthy foods will promote proper eating habits and possibly lower the amount
of obese children.
Many of the food purchases that are made by low income individuals are made with little
knowledge. Most individuals with a low socioeconomic background do not know how to
maintain a healthy lifestyle. On top of that many prefer the high fat, high sugar foods because of
its low price. A change must be made to guide these individuals into making the right choice for
themselves and their families. I believe that all foods with any foods containing more than 10% saturated fat per serving should be banned from the list of foods that can be purchased with food stamps because the American Heart Association recommends that an individual consumes no more than 7% of saturated fat from their total caloric intake per day. Foods that contain more than 10 teaspoons of sugar (50 grams) should also be banned because the AHA recommends about 6 teaspoons of sugar for women and 9 teaspoons for men. Finally any foods containing trans-fats should be banned as well. Hopefully you will consider this revision for the current food stamp program and make a change that will improve the health of many citizens.

Dear Senator Robert Mendez,

I am writing on the behalf of my classmates for a group project for our Ethics in Science
course. The assignment was to come up with a topic and create a service project related to the
topic. The members of our project group are currently working on their bachelor’s degrees at
Rutgers University in New Brunswick, NJ. We all have different backgrounds ranging from
nutrition, public health, environmental planning, and exercise science. I am writing to you in
hopes that changes will be made to our current food stamp program. With the growing epidemic
of obesity certain actions must be taken to deter the downfall of this country’s health. We feel
that certain high fat, high sugar, and high sodium content foods should be banned from the list of legible products that can be purchased with the food stamps.

It is a known fact that obesity greatly increases your risks of cardiovascular disease, type 2 diabetes, hypertension, and variety of other diseases. The cost of obesity is affecting not only the individuals suffering from the conditions, but also the country as a whole through both private and public health programs. In 2006 the World Health Organization estimated that the United States has spent 19.3% of its total expenditure on public health systems. Amongst the world the United States has the highest percentage of its GDP going into health. In 2006 12.8% of its GDP went into health. This might also have something to do with America having the highest prevalence of obesity. The World Health Organization estimates that the prevalence of
obesity is the highest in the United States. A survey taken in 2010 estimates that the prevalence of obesity in the United States is 80.5% for males ages 15 and up and 76.7% for females ages 15 and up (2). This survey also included anyone who is at risk for being obese; therefore this estimate includes all individuals with a BMI of 25 or greater. To ease the financial burden on the country changes should be made to decrease the prevalence of obesity in the country.

It has been shown that the rate of obesity tends to be greater in low income individuals that participate in food stamps. A study done by Chad D. Meyerhoefer AND Yurity Plypchuk observed the relationship between food stamp participants and obesity. The study showed that female participants are 5.9%less likely to be of normal weight and 6.7%more likely to be obese than nonparticipants, while male participants are no more likely to become obese. They contributed this correlation to a variety of factors including, poor knowledge of healthy eating, low availability of healthy foods, and low cost of junk foods. Another research done by the University of Toronto showed that children of low income families tend to have a low quality diet, which consisted of more refined carbohydrates and fewer meats, fruits and vegetables. Such a diet will increase the rate of obesity in the community and decrease the health status of the individual.

Many of the food purchases that are made by low income individuals are made with little knowledge. Most individuals with a low socioeconomic background do not know how to maintain a healthy lifestyle. On top of that many prefer the high fat, high sugar foods because of its low price. A change must be made to guide these individuals into making the right choice for themselves and their families. I believe that all foods with any foods containing more than 10% saturated fat per serving should be banned from the list of foods that can be purchased with food stamps because the American Heart Association recommends that an individual consumes no more than 7% of saturated fat from their total caloric intake per day. Foods that contain more than 10 teaspoons of sugar (50 grams) should also be banned because the AHA recommends about 6 teaspoons of sugar for women and 9 teaspoons for men. Finally any foods containing trans-fats should be banned as well. Hopefully you will consider this revision for the current food stamp program and make a change that will improve the health of many citizens.

Editorials

Food Stamps Regulations: Fight Against Obesity (editorial by Amro Mahmoud)
The obesity epidemic is considered by most, to be the most important public health crisis of the 21st century. There’s no reason for debate, this crisis has put a strain on the healthcare system, costing the U.S approximately $75 billion a year to treat weight-related issues. This trend shows no sign of slowing down and the obesity rates of each state continue to rise with every new survey and study that appears. Of all the aspects of the American obesity epidemic, the most troubling is the prevalence of obesity amongst the different social classes. According to the National Health and Nutrition Examination Survey (NHANES), obesity has the highest prevalence in individuals of low-income then those who are more financially stable. How is this so? The people of low economic status should not have the money or the resources to eat a surplus of foods, which causes obesity. Although many theories have been opinioned, one large factor of causation is the “SNAP” program or better known as food stamps. The food stamp program created by the government to support individuals of low economic status purchase food was always intended to allow people to buy healthy food choices to feed their families. However, because of a lack of regulation on how the program is run, more and more people use their food
stamps card to purchase non-essential, high-calorie dense food, such as: candy, soda, chips, cookies, many processed food goods, etc.

There is no doubt that there needs to be some type of regulation placed on the type of foods bought with the money allocated to these individuals or essentially, we as a American Citizens are paying for the poor to be fat. The current idea to place a regulation on the SNAP is to write legislation stating that there needs to be a list of non-essential foods that cannot be bought with the food stamps card and if the individual wishes to still purchase the "non-essential" food product, they will have to pay out of their own pockets. The way the system will work is through the scanner system located at all supermarkets that accept food stamps, when the food is scanned the computer will quickly read the nutrition label and decipher whether the item is a calorie dense food, with little or no benefits (vitamins) or a healthier food choice. Of course soda, candy, chips, cookies and many processed foods will be placed in the calorie dense foods and when one uses their food stamps card it will only cover the foods listed as healthy. The new plan is stretch, but something must be done to slow down the rising obesity rate in the lower social classes.

Andrew Schwartzer
Daily News (New York, NY)
Editorial
3/23/11

Obesity and the Economy: Shedding the Problem

Obesity is among the public health’s top priorities. According to the World Health Organization in 2008, 1.8 billion people were considered to be overweight, and 500 million obese. Obesity has been proven to lead to other diseases such as type 2 diabetes, cardiovascular disease, hypertension and stroke. Treatment of weight-related issues costs the United States approximately $75 billion a year.

There is no question that people need to make better food choices and increase their physical activity, but suggesting that in its self will not fix this problem. The National Health and Nutrition Examination Survey (NHANES) concluded that obesity has the highest prevalence in individuals of low-income then those who are more financially stable. This is not surprising in the least. Our nation’s food industry has been designed to make high fat, high caloric foods cheap and readily available. Yes, fast food industries are the main culprits of such doings, but I am not suggesting going to war with them. I feel that we should re-construct our countries food stamp legislation, gearing it towards healthier more nutritious foods.

Individuals who are eligible for food stamps receive a benefit card that is to be swiped at the register. The items that one purchases are then deducted from the balance on the card, similar to a debit card.

My suggestion is to process a list of foods based on nutritional value that are either covered
under food stamps or not covered. Items that contain high saturated fat, sugar, and trans fat contents can be excluded from the list. Guidelines as to what is considered high for each of these categories will be developed on the basis of a 2000 calorie/day diet. So items such as soda and chips may be excluded from the list and will therefore not be covered by the food stamps.

Now, I am not suggesting that people on food stamps can no longer have soda or chips. If they wish to have such items, then they will have to purchase them at their own expense. This will give incentives for people take full advantage of their food stamps by purchasing healthier more nutritious foods rather than junk food. Eating high fat and sugary foods will no longer just have health implications, but it will have financial implications as well.

The way the food industry is designed is one the main reasons why the burden of obesity is so heavy in our country. It is far too easy to have a poor diet. We need to reconstruct the way the food industry operates by making junk food come with a price and healthy food more available.

Jason Emrani
Letter to the editor
Secondhand Obesity?
LA Times
Re “Obesity: Like the new smoking,” March 7, 2011
In 2008, the WHO reported that there are 1.8 billion overweight Americans and from that, 500 million are obese. We all know there are health risks when it comes to obesity but as the author suggests very few know cancer is one of them. Cardiovascular disease, diabetes, and hypertension are associated most with obesity. This article suggests that obesity is “like the new smoking” but doesn’t discuss if the health consequences can be passed down from the obese to people around them just as secondhand smokers are susceptible to lung cancer.
I suspect that “secondhand obesity” is possible and most prevalent in lower income families. In the majority of American families, parents are tasked with buying food for the families. If the parents are obese then the food they buy is most likely not the healthiest and as a result, the rest of the family is eating these unhealthy foods as well. Low income families are more susceptible to “secondhand obesity” because they have less resources to buy healthier food and resort to cheaper, more filling (more calorie) fast foods.
Fatty foods are generally cheaper than fruits and vegetables because of the U.S. Department of Agriculture’s crop subsidy program for crops such as rice, cotton, soybeans and corn. These subsidized crops are used to make soybean oil and high fructose corn syrup, two ingredients commonly found in fatty foods such as, soft drinks, cheeseburgers and potato chips.
“Second hand obesity” is also spreading more in low income communities via the millions of fast food chains that are opening up in these neighborhoods. The target market for these franchises is lower income families so they place their stores in more densely populated low income areas which will result in increased sales.
I also believe that this trend is dominating America because Americans don’t directly internalize the costs of obesity right away and believe they have no incentive to stay healthy. Most Americans are enrolled in some type of employer based insurance where obese individuals and non obese individuals pay the same premiums for their health insurance. If health insurance
premiums reflected weight, more Americans would be healthier because they would have an incentive to be.

Paul Nam  
Ethics in Science - Editorial  
March 22, 2011

Dear NY Times,

My name is Paul Nam and I am currently a Nutritional Science major at Rutgers University in New Jersey. As part of a class that I am taking I was required to write an essay on a specific topic and submit it for publishing. My topic is about the reason and steps needed to reform the current food stamp program. My essay is shown below and I hope that it will be considered for publishing. I am hoping that this essay will reach an audience that will learn something about the topic that I discuss. Please review the article and notify me of any modifications to get it published on your website. My contact information is below. Thank You.

Telephone: 201-669-2826  
Email: paulnam87@yahoo.com

Editorial Sent to NY Times at oped@nytimes.com

The True Cost of Food

The obesity epidemic in the U.S. has been on the rise for the last decade. With so many options of fatty foods and at numerous convenient locations it is no wonder that obesity is on the rise. Combined with a decrease in the amount of physical activity in this country and we can expect a further increase in the rise of obesity. The World Health Organization also estimates that the prevalence of obesity is the highest in the United States. A survey taken in 2010 estimates that the prevalence of obesity in the United States is 80.5% for males ages 15 and up and 76.7% for females ages 15 and up (4). In every town there is a fast food restaurant and in every fast foods restaurant there is a limited availability of healthy options. There is a saturation of fast food restaurants in this country. The environment that many Americans live in promotes the development of obesity. The limitations of food production that were present centuries ago in this country are absent in today’s modern society. Food production is essentially unlimited. Production is now on a massive scale and the country’s need for food is fulfilled. In fact too much food is being produced. We also don’t need to forge and hunt for our food. The convenience of a food store makes it unnecessary to acquire ones food from the wild. With the invention of television, video games, and the Internet many young children do not get enough exercise. Tag is no more a game where you run around and catch your friends, but is something you do when you want to identify someone in a photo on Facebook. Even sports can now be played indoors thanks to the advancements of video games.
Essentially the cost of obesity is costing the people and the country. Obesity can lead to many health complications, such as type 2 diabetes and cardiovascular disease (2). Many people suffering from obesity develop such health conditions and seek treatment. Most Americans in this country cannot afford or choose not to pay for their hospital visits in full. They instead have an insurance plan that covers their expenses. Instead of paying a large sum of money for an unexpected health complication, many individuals pay a “small” fee to a health insurance company during the year so that their hospital expense will be covered. Whenever an individual gets ill the insurance company is able to pay for their cost because they have been collecting money from everyone who subscribed to the insurance plan. This system works because not everyone who is using the insurance company will be sick at the same time. If this were to happen the insurance company will not have enough money to pay for the health expense and would raise the rates. This is what can possibly happen if a large proportion of the people under the insurance plan develop a health complication. This will raise the insurance rates of everyone under the plan. Individuals must now pay more money for the same plan that they have been using. Public health programs can create an even greater problem. Many of the public health programs available in this country are funded by either the state, federal government, or both. The money that is needed for these programs essentially comes from taxes. The rise in obesity will create a rise in the prevalence of disease in the country. This will in turn lead to public health programs paying for the health expenses of these individuals. An increase in spending by the public health program leads to an increase in funding, which means higher taxes.

Luckily not everyone qualify for these public health programs. Most of these programs have an age or income requirement. Medicaid and Medicare are two such programs. Medicaid is available only to people with low income. Medicaid is usually offered only to the elderly, which is 65 and over. These limitations prevent the majority of the people in the U.S. to qualify for these programs. There a problem that arises when you examine the Medicaid program along with the Food Stamp program. The food stamp program is for low income families that cannot afford food. The program offers its participants a certain amount of money for food. With the money that these families get they often purchase unhealthy foods. Many individuals of a lower socioeconomic background are not properly informed about the effects of diet and health. They are also unable to afford the more healthier foods because they are more expensive then the “junk food”. Also most low income neighborhoods do not have a lot of places where healthy foods can be purchased. They are often littered with fast food restaurants and corner stores. Often children in the neighborhoods would go to their local corner store and purchase a bag of chips and a quarter drink. You will very rarely see a child walk into a corner store and purchase an apple (if the store even sells apples). Even the adults are going to their local supermarket and purchasing a liter of coke rather then water. The food stamp program only offers a limited amount of funds for an individual to purchase food. Many people that use this program will try to purchase to foods that cost less so they can buy more with the money that they are given. These foods are usually high in fat and sugar. Two things one must avoid if they do not want to become obese. As expected many people in theses neighborhoods are obese. They not only qualify for food stamps, but also they have access to Medicaid. This creates a system where money is being used to provide these people with junk food and more money is needed to pay for their medical expenses because of their unhealthy diet. A noble idea with undesired consequences.

The way the food stamp program operates needs to be revised. Certain limitations must be set to guide people into making healthy choices for themselves. The way to food stamp works now individuals can purchase any food product with their food stamp card. Foods high in
sugar and fats should be excluded from the list of foods that these people can purchase. The
American Heart Association recommends that an individual consumes no more than 7% of
saturated fat from their total caloric intake per day (3). The AHA recommends about 6 teaspoons
of sugar for women and 9 teaspoons for men (1). Foods that contain trans fats should also be
excluded. There should also be an incentive for individuals to purchase the healthier foods. Fruits
and vegetables should be given at a discounted rate for those individuals under the food stamp
program. It is unrealistic to think that people will stop eating these foods either way. Some
people enjoy these foods because of the way they taste and it might not be a matter of price. Such
limitations, however will decrease the amount of junk food that is consumed. This can then lead
to steps in reducing obesity in this country. With obesity on the decline the adverse health
conditions might also decrease and less money will be required to fund the public health
programs. This small step in revising the food stamp is required to convert the U.S. into a
healthier nation and to step down as the worlds fattest country.

Citations

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