

What a Summer Nutrition Benefit Program Could Mean for Clinicians and Their Patients

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In 1946, the National School Lunch Act was passed establishing the school lunch program and making meals a permanent part of schools. Congress declared it a measure of “national security” to ensure the health of the nation’s children by encouraging the consumption of nutritious foods.¹ Since then, the meals program has expanded, both in reach (including breakfast) and size (over 100 000 schools now participate).² The National School Lunch Program and the School Breakfast Program serve over 30 million and 12 million children annually, respectively, with free or reduced-price meals.^{2,3} Low-income children who participate have lower rates of food insecurity (FI), improved dietary intake, and higher academic achievement.^{4–10} Although the success of these programs is clear, there remains an important issue: What happens to families who rely on these programs during the summer, when school is not in session?

In this issue of *Pediatrics*, Collins et al¹¹ have published “Impact of a Summer Nutrition Benefit on Low-Income Children’s Food Security and Diet Quality,” which describes the Summer Electronic Benefit Transfer for Children demonstrations project. The US Department of Agriculture received funding to test a summer electronic benefit transfer (EBT) program for children receiving free or reduced-price school meals. Fifty thousand households at 16 sites were randomly selected between 2011 and 2013 to receive \$60 per month, \$30 per month, or no EBT over the summer. EBT is

a system that transfers government benefits to an account to purchase products, similar to a debit card.¹² Households that received a benefit via EBT had a lower prevalence of children with low FI, compared with households that did not. Children receiving the EBT also had improved nutritional outcomes, including increased fruit and vegetable consumption. The study is a rigorous, methodologically sound evaluation of the effect of a public assistance program on children’s nutrition. Although the results have clear policy implications, the findings also have important clinical relevance.

First, clinicians should be aware that low-income families are often vulnerable during the summer school recess or break. FI increases in the summer for families whose children receive free or reduced-price meals during the school year.^{4,13} The nutritional quality of the foods children eat in the summer also worsens.¹⁴ The US Department of Agriculture currently runs an existing program, the Summer Food Service Program, to provide meals in the summer. Approved sites, such as recreation centers, serve free meals and snacks. As noted by Collins et al,¹¹ only a small proportion of children participate. In 2016, 3 million children participated in the summer meals program, one-sixth of the children who receive free or reduced-price meals. Barriers to participating included the limited number of sites available and difficulty accessing sites because of transportation.¹⁵

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Second, this study reveals that when families are successfully connected with nutritional resources, they use them. As reported in the study, 90% of the households who were issued the \$60 EBT used the benefits at least once and the mean percentage of benefits redeemed was 77%. The American Academy of Pediatrics has recommended that all pediatricians screen for FI and other social determinants of health (SDH) to connect families to services.^{3,16} Increasing research has resulted in strategies to address SDH screening in pediatric practices, and providing referrals in practices increases the resources families access.^{17–22} In their study, Collins et al¹¹ add further support to the American Academy of Pediatrics recommendations by showing that once families are successfully connected to resources, they will use them.

Third, public assistance programs can improve children's health. To warrant screening for SDH, programs that effectively address families' needs need to be available. In the study, families who received the EBT benefit had a lower prevalence of child FI and improved nutritional outcomes. The study is one of the few randomized trials in which the effect of a public assistance program on children's food security and nutrition is investigated. Although the results may not be generalizable to other times of the year, populations, or programs, the authors of this study do provide support for the idea that successfully connecting families in need to well-designed programs can improve children's health and nutrition.

As funding for public assistance programs continues to be debated, it becomes increasingly important to provide strong evidence for how these programs improve the lives of children and families. The Collins et al¹¹ study is a welcome addition to the literature because it is one of the few trials in which the effect

of a public assistance program on children's food security and nutrition is evaluated. Although continued research and advocacy are needed to understand how to improve health outcomes by addressing SDH, the study's authors add important policy information about how programs can be effectively designed to address families' needs. As an increasing number of pediatric practices screen for FI, clinicians can connect families to resources, such as food pantries and the summer feeding programs highlighted in this study, to improve the health of their patients.^{3,17,20,21}

ABBREVIATIONS

EBT: electronic benefit transfer
 FI: food insecurity
 SDH: social determinants of health

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