

Hospitals and Healthy Food

How Health Care Institutions Can Help Promote Healthy Diets

HIGHLIGHTS

For decades, U.S. food and farm policy has been poorly aligned with public health objectives. But new opportunities, including an innovative federal program that provides incentives for low-income consumers to increase their purchases of fruits and vegetables, can now begin to address the problem. Hospitals and health insurers—long responsible only for treating diet-related illnesses, as opposed to preventing them—are part of the solution. By partnering with local organizations to devise and invest in healthy food systems, health care institutions can improve health and equity in their communities while reducing costs.

The U.S. health care system is the most costly in the world, accounting for 18 percent of the nation's gross domestic product (World Bank 2014). This is due in large part to increasingly high rates of chronic conditions, including heart disease, diabetes, obesity, and cancer, which are expensive to treat. According to the Centers for Disease Control and Prevention, about half of all adults have one or more chronic health conditions (Ward, Schiller, and Goodman 2014; RWJF 2010). And approximately 35 percent of U.S. adults suffer in particular from metabolic syndrome, a combination of risk factors that increase the likelihood of developing diabetes or cardiovascular disease (American Heart Association 2011). Total health cost for individuals with metabolic syndrome is 1.6 times that of those without it (Boudreau et al. 2009).

It is well established that metabolic syndrome and associated diseases are largely preventable through healthy lifestyle behaviors such as maintaining a healthy diet. Yet the typical American diet misses the mark. On average, Americans eat only about half the amounts of fruits and vegetables recommended by federal dietary guidelines, while consuming too much meat, processed foods, and added sugars. In addition, the U.S. food system that consumers must navigate daily is highly inequitable, making it more difficult for some to maintain a healthy diet than it is for others. That is,



Farmers markets, like the Crossroads Farmers Market in Takoma Park, MD, provide communities with direct access to fresh fruits and vegetables.

Many low-income Americans want to make healthy food choices for themselves and their families, but they confront accessibility and affordability challenges.

many low-income Americans want to make healthy food choices for themselves and their families, but they confront accessibility and affordability challenges. For example, Figure 1 shows that the fresh fruits and vegetables price index has risen twice as high as the composite food price index since 1947.

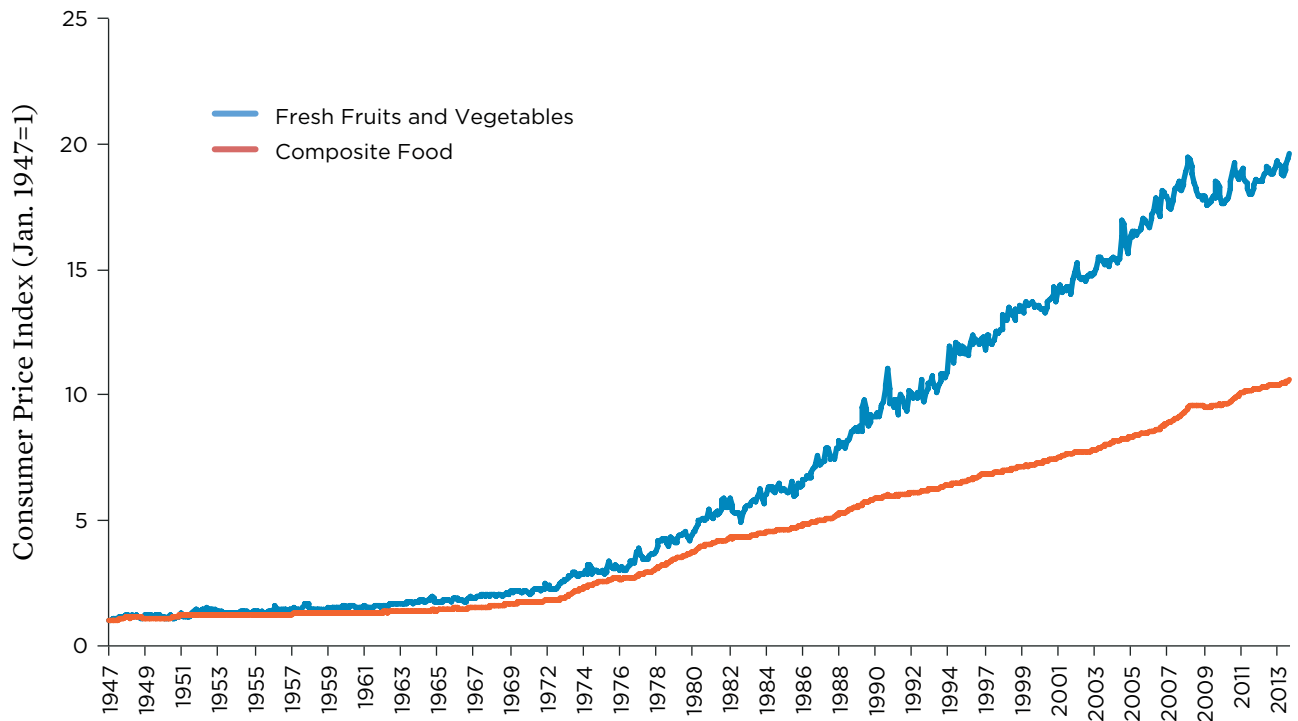
Improving community food environments and increasing demand for, and access to, more healthful

foods are essential components of driving down the long-term health expenditures from diet-related diseases. In particular, incentives for fruit and vegetable consumption could reap enormous health and economic benefits over time; a 2013 Union of Concerned Scientists report showed that if Americans increased their daily consumption of these foods to meet federal dietary recommendations, the nation’s costs related to the treatment of cardiovascular disease alone could drop by \$17 billion (O’Hara 2013).

A New Opportunity to Expand Access to Healthy Foods

One piece of federal legislation—the “farm bill” that Congress passes every five to seven years—plays an outsized role in shaping the U.S. food system, largely by using subsidies to influence what farmers grow. But the incentive structure in the farm bill is notoriously misaligned with public health objectives in that it subsidizes the corn- and soybean-based ingredients for processed

FIGURE 1. Prices of Fresh Fruits and Vegetables Relative to Composite Food Prices



SOURCE: U.S. BUREAU OF LABOR STATISTICS 2014.

foods and livestock feed while discouraging farmers from growing fruits and vegetables (O'Hara 2012).

Fortunately, there has been some progress. The current farm bill, passed in early 2014, included important new initiatives to improve health and nutrition. In particular, it established the Food Insecurity Nutrition Incentive (FINI) program, which will provide grants to organizations seeking to increase low-income consumers' purchases of fruits and vegetables at farmers markets and elsewhere. These grants provide a subsidy to shoppers who wish to redeem benefits from the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) for buying fruits and vegetables. Similar programs had been pioneered at some 500 farmers markets in at least 24 states (as of 2012), and grocery stores are now starting to pilot them as well (Community Science 2013).

Evaluations of these programs have found that they do increase fruit and vegetable consumption (Freedman et al. 2013; Lindsay et al. 2013; Young et al. 2013a). An example of such efforts—the Crossroads Farmers Market in Takoma Park, MD—is described in the box on p. 4.

In order to apply for these new federal FINI funds, program applicants must demonstrate that they have secured matching funding from other sources. For hospitals, health centers, and health insurers that want to improve health and reduce diet-related disease in their communities and patient populations, this FINI requirement is an opportunity to get into the act—that is, to form partnerships with community groups.

Leveraging “Community Benefits” Investments to Build Local—and Healthier—Food Systems

Financial support from hospitals and health insurers would be a valuable way for local-food projects to leverage resources, and such aid would simultaneously represent a strategic means for health organizations to establish prevention-focused partnerships with community organizations. A policy infrastructure, in the form of the federal Patient Protection and Affordable Care Act of 2010 (ACA), already exists to help enable these collaborations.

The ACA is better known for increasing access to health insurance, but constraining health care costs is also one of its major priorities (Koh and Sebelius 2010). For example, the law places restrictions on reimbursement to hospitals if Medicare patients are readmitted

within 30 days for some types of conditions, including heart attacks and heart failure. At the same time, the ACA encourages nonprofit hospitals to make investments to increase wellness in their communities; in return for

The Food Insecurity Nutrition Incentive (FINI) program will provide grants to organizations seeking to increase low-income consumers' purchases of fruits and vegetables at farmers markets and elsewhere.



Grow NYC runs a bustling farmers market outside Mt. Sinai Hospital in New York City, offering healthy food to patients and doctors alike. Shoppers receive a two-dollar voucher for every five dollars in food assistance benefits they use. FINI funds will expand programs like these across the country.

Maryland Farmers Markets Making a Difference

Located just over the Washington, DC, border in Montgomery County, MD, the Crossroads Farmers Market has served a multi-cultural population since 2007. Operating near a clinic where income-eligible families receive benefits under the federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), this market provides a convenient venue for participating families to redeem their benefits and purchase fresh fruits and vegetables from local farmers. To promote high attendance, the market also offers live concerts by local musicians and cultural heritage celebrations.

The Crossroads Farmers Market was one of the first farmers markets in the country to implement a matching incentive program for nutrition assistance benefits—which makes it a model for the new federal FINI program. The market’s “Fresh Checks” coupons double the value of WIC, SNAP, and Farmers Market Nutrition Program benefits redeemed there. During the first seven years of operation, the Crossroads Farmers Market has distributed \$243,000 in Fresh Check vouchers to 7,000 low-income families. The market’s operator, the Crossroads Community Food Network, has enjoyed support for this and other programs from a variety of federal, state, municipal, and private sources.

These grants also enabled the Crossroads Community Food Network to launch (in November 2010) “Eat Fresh Maryland,” a collaboration of diverse organizations that provides support and technical assistance for implementing nutrition assistance benefit incentives at farmers markets across the state. This program is now housed at the newly formed Maryland Farmers Market Association (MDFMA), an organization established to address the farmers market community’s needs, such as overseeing nutrition incentive programs at markets across the state.

The Crossroads Community Food Network and the MDFMA are examples of organizations eligible for funding through the FINI program. And local Maryland hospitals could offer needed help, given that the Centers for Medicare and Medicaid Services are requiring the state’s hospitals to achieve \$330 million in Medicare savings by 2019. Our review of community benefit reports from Maryland’s 46 nonprofit hospitals showed that 80 percent of them offer screening or education programs related to diet or a diet-related chronic disease, but none is significantly involved in food system efforts beyond its own campus.



Every growing season, Crossroads Farmers Market in Takoma Park, MD, serves thousands of people who receive food assistance benefits.

© UCS/Lael Goodman



© UCS/Ancelia Moore

The Harvest Home Farmer’s Market in East Harlem, NY, brings fresh produce into a community dealing with high levels of poverty and diet-related diseases.

the federal tax exemptions they receive, hospitals are required to report “community benefit” initiatives they undertake.

Nonprofit hospitals constitute 51 percent of all hospitals in the United States, and in 2002 these institutions received \$12.6 billion in tax exemptions (AHA 2014; CBO 2006). A recent study of select tax-exempt hospitals found that they devoted an average of 8 percent of expenses to community benefits (Young et al. 2013b). Actual community benefit expenditures by all nonprofit hospitals nationwide are not reported, but we calculate* that they total about \$33 billion (AHA 2014).

Until now, the vast majority of these total expenses—an estimated 85 percent—have subsidized patient care,

* To arrive at this figure, we assume that the ratio of nonprofit hospital expenses to total hospital expenses is equal to the ratio of the number of nonprofit hospitals relative to the total number of hospitals.

“Community benefits” requirements, combined with policies such as the new FINI program, offer an unparalleled opportunity for health care institutions to expand patient access to healthy foods and make lasting improvements to community health.

with just 5 percent directed toward prevention efforts such as screening, education, or immunization (Young et al. 2013b). But with the anticipated decline in the percentage of uninsured patients due to the expansion of coverage under the ACA, hospitals are expected to identify more opportunities to support community benefit initiatives that promote prevention. Specifically, the ACA requires tax-exempt hospitals to conduct public “community health needs assessments” every three years—with community input, particularly from the public health sector—along with a description of how targeted health improvements will be attained. And as Medicaid coverage expands, health program administrators may use programs like FINI to help lower medical costs and reach their prevention goals by incentivizing healthier diets, since 97 percent of SNAP recipients could qualify for Medicaid (Dorn et al. 2013).

The community benefits requirements under the ACA, combined with policies such as the new FINI program, offer an unparalleled opportunity for health care institutions to expand patient access to healthy foods and make lasting improvements to community

A recent study of select tax-exempt hospitals found that they devoted an average of 8 percent of expenses to community benefits. Actual community benefit expenditures by all nonprofit hospitals nationwide are not reported, but we calculate that they total about \$33 billion.



The Mt. Eden Harvest Home Farmer's Market in New York City provides fresh produce to a range of customers including patients of Bronx-Lebanon Hospital Center.

© UCS/Amelia Moore

TABLE 1. Examples of Food Policy Council Engagement with Health Sector Organizations

Food Policy Council (FPC)	Health Care Representation on FPC	Support Healthy Food Access Programs	ACA Enrollment at Food Pantries	Hospital Funding for FPC	Actively Discussing ACA Opportunities	SNAP Enrollment by Hospital Counselors
Kansas City (MO) FPC	●					
Ozarks Regional (MO) FPC	●	●		●		
St. Louis FPC	●					
Community Food Council for Del Norte and Adjacent Tribal Lands (CA)	●	●				
San Francisco Food Security Task Force	●	●			●	
Homegrown Minneapolis Food Council	●					
San Bernardino (CA) FPC	●					
New London County (CT) FPC	●		●	●		
Denver Sustainable FPC	●	●		●		
Worcester (MA) Food and Active Living Policy Council	●	●			●	●

health. In particular, directing community benefits expenditures toward matching FINI grants and similar programs would represent an extension of projects that some hospitals are already pursuing on their own campuses. These projects include sustainable-food procurement efforts such as the “farm-to-hospital” initiatives that 58 percent of hospitals in the Northeast have adopted (Smith, Kaiser, and Gomez 2013). Further, some hospitals have established on-site farmers markets for patients and staff, exemplified by Kaiser Permanente’s efforts in setting up farmers markets at 40 of its medical campuses (Crompton et al. 2012).

Around the country, food system stakeholders have established food policy councils (FPCs) as a means of collaborating on food policy opportunities at the local and state levels. When we asked subscribers of an FPC listserv for examples of existing collaborations with health care institutions, they most often cited these institutions’ support of farmers markets and nutrition incentive programs, funding of the FPC, enrollment of food pantry clients in the ACA, and regular participation in FPC discussions and planning. Table 1 summarizes the highlights from the listserv response. Other examples

that have emerged in the United States include the support of health center-based “prescription” programs (wherein patients with diet-related health problems receive vouchers from a doctor that can be redeemed for fruits and vegetables at the health center or at a neighboring farmers market), health insurers offering discounts to patients with healthy diets, and hospital investment in other food system infrastructure.

Conclusions

Recent policy initiatives in the health and food sectors have been structured around promoting wellness and preventing disease. As a result, hospitals and health insurers can become key advocates of food system reform. And while some exciting initiatives are under way, further engagement and actions are needed.

For more information, contact Jeffrey O’Hara (johara@ucsusa.org) at the Union of Concerned Scientists or Anne Palmer (apalmer6@jhu.edu) at the Center for a Livable Future in Johns Hopkins University’s Bloomberg School of Public Health.

REFERENCES

- American Heart Association. 2011. About metabolic syndrome. Online at www.heart.org/HEARTORG/Conditions/More/MetabolicSyndrome/About-Metabolic-Syndrome_UCM_301920_Article.jsp, accessed on July 8, 2014.
- American Hospital Association (AHA). 2014. Fast facts on U.S. hospitals. Online at www.aha.org/research/rc/stat-studies/fast-facts.shtml, accessed on July 1, 2014.
- Boudreau, D.M., D.C. Malone, M.A. Raebel, P.A. Fishman, G.A. Nichols, A.C. Feldstein, A.N. Boscoe, R.H. Ben-Joseph, D.J. Magid, and L.J. Okamoto. 2009. Health care utilization and costs by metabolic syndrome risk factors. *Metabolic Syndrome and Related Disorders* 7(4):305–314.
- Community Science. 2013. *SNAP healthy food incentives cluster evaluation*. Gaithersburg, MD.
- Congressional Budget Office (CBO). 2006. *Nonprofit hospitals and the provision of community benefits*. Washington, DC.
- Crompton, D., A. Cheadle, L. Solomon, P. Maring, E. Wong, and K.M. Reed. 2012. Kaiser Permanente's farmers market program: Description, impact, and lessons learned. *Journal of Agriculture, Food Systems, and Community Development* 2(2):29–36.
- Dorn, S., L. Wheaton, P. Johnson, and L. Dubay. 2013. *Using SNAP receipt to establish, verify, and renew Medicaid eligibility*. Washington, DC: Urban Institute.
- Freedman, D.A., S.K. Choi, T. Hurley, E. Anadu, and J.R. Hebert. 2013. A farmers market at a federally qualified health center improves fruit and vegetable intake among low-income diabetics. *Preventive Medicine* 56(5):288–292.
- Koh, H.K., and K.G. Sebelius. 2010. Promoting prevention through the Affordable Care Act. *New England Journal of Medicine* 363(14):1296–1299.
- Lindsay, S., J. Lambert, T. Penn, S. Hedges, K. Ortwine, A. Mei, T. Delaney, and W.J. Wooten. 2013. Monetary matched incentives to encourage the purchase of fresh fruits and vegetables at farmers markets in underserved communities. *Preventing Chronic Disease* 10:130124.
- O'Hara, J.K. 2013. *The \$11-trillion reward: How simple dietary changes can save lives and money, and how we get there*. Cambridge, MA: Union of Concerned Scientists.
- O'Hara, J.K. 2012. *Ensuring the harvest: Crop insurance and credit for a healthy farm and food future*. Cambridge, MA: Union of Concerned Scientists.
- Robert Wood Johnson Foundation (RWJF). 2010. *Chronic care: Making the case for ongoing care*. Princeton, NJ. Online at www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583, accessed on July 5, 2014.
- Smith II, B.J., H.M. Kaiser, and M.I. Gomez. 2013. Identifying factors influencing a hospital's decision to adopt a farm-to-hospital program. *Agricultural and Resource Economics Review* 42(3):508–517.
- U.S. Bureau of Labor Statistics. 2014. Seasonally adjusted U.S. city average consumer price index for food and fresh fruits and vegetables. Washington, DC.
- Ward, B.W., J.S. Schiller, and R.A. Goodman. 2014. Multiple chronic conditions among U.S. adults: A 2012 update. *Preventing Chronic Disease* 11:130389. Online at www.cdc.gov/pcd/issues/2014/13_0389.htm, accessed on July 8, 2014.
- World Bank. 2014. Health expenditure, total (percent of GDP). Online at <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>, accessed on June 13, 2014.
- Young, C.R., J.L. Aquilante, S. Solomon, L. Colby, M.A. Kawinzi, N. Uy, and G. Mallya. 2013a. Improving fruit and vegetable consumption among low-income customers at farmers markets: Philly Food Bucks, Philadelphia, PA, 2011. *Preventing Chronic Disease* 10:120356.
- Young, G.J., C.-H. Chou, J. Alexander, S.-Y. Daniel Lee, and E. Raver. 2013b. Provision of community benefits by tax-exempt U.S. hospitals. *New England Journal of Medicine* 368(16):1519–1527.

FIND THIS DOCUMENT ONLINE: www.ucsusa.org/hospitalsandhealthyfood

Union of Concerned Scientists

The Union of Concerned Scientists puts rigorous, independent science to work to solve our planet's most pressing problems. Joining with citizens across the country, we combine technical analysis and effective advocacy to create innovative, practical solutions for a healthy, safe, and sustainable future.



The Johns Hopkins Center for a Livable Future promotes research; communicates information about the interrelationships among diet, food production, environment and human health; and promotes policies that protect human health, the global environment and the ability to sustain life for future generations.

NATIONAL HEADQUARTERS

Two Brattle Square
Cambridge, MA 02138-3780
Phone: (617) 547-5552
Fax: (617) 864-9405

WASHINGTON, DC, OFFICE

1825 K St. NW, Suite 800
Washington, DC 20006-1232
Phone: (202) 223-6133
Fax: (202) 223-6162

615 N. Wolfe St., W7010
Baltimore, MD 21205-2179
Phone: (410) 502-7578
Fax: (410) 502-7579