INTRODUCTION

Nutritious food is essential to healthy growth and development and can prevent the need for costly medical care. Every year, the federal nutrition programs save the country hundreds of billions of dollars in additional healthcare costs. Socioeconomic factors such as housing, education, employment opportunities, and access to healthy food have a larger impact on health outcomes than medical care. Socioeconomic inequalities drive population-wide health disparities. The United States spends more per capita on health care than any other high-income country but compares poorly with others on key population health indicators such as life expectancy and child survival. The Affordable Care Act is moving the U.S. healthcare system to shift more resources into prevention to address the root causes of chronic diseases.

Launching Off Point

In the United States, the issues of hunger and health have been seen as two separate and distinct challenges. That is beginning to change as the system adapts to an ambitious reform agenda driven by the Affordable Care Act (ACA). The objectives (or triple aim) of reform are to improve the patient experience, improve health outcomes for the population, and adopt quality improvements to reduce per capita cost growth. All of these goals will be difficult to achieve as long as hunger and food insecurity rates in the country remain stubbornly high.

Hunger leads to poor health, and poor health contributes to descents into hunger and food insecurity, especially for people who must choose between paying for food or medicine. Up to one-third of chronically ill patients in the United States cannot afford to buy food, medications, or both. Many chronic diseases—the main drivers of cost growth and poor population health—are diet-related. For those who cannot afford it, healthy food is a cost-effective intervention compared to episodic hospital stays.

The ACA encourages healthcare providers to pay closer attention to the social determinants that drive health outcomes. There are many social determinants, and they include:

- Nutritious food is essential to healthy growth and development and can prevent the need for costly medical care.
- Every year, the federal nutrition programs save the country hundreds of billions of dollars in additional healthcare costs.
- Socioeconomic factors such as housing, education, employment opportunities, and access to healthy food have a larger impact on health outcomes than medical care.
- Socioeconomic inequalities drive population-wide health disparities.
- The United States spends more per capita on health care than any other high-income country but compares poorly with others on key population health indicators such as life expectancy and child survival.
- The Affordable Care Act is moving the U.S. healthcare system to shift more resources into prevention to address the root causes of chronic diseases.

“Of all forms of inequality, injustice in health care is the most shocking and inhumane.”

— Martin Luther King, Jr., Second National Convention of the Medical Committee for Human Rights, March 25, 1966
School meal programs remain one of the most effective means of ensuring children receive the nourishment they need to be healthy. Through the array of federal nutrition programs and a vast network of charitable organizations offering food assistance, the health system has an infrastructure to work with to support patients who face the agonizing choice of food or medicine, or who must choose between unhealthy food or running out of food altogether. It is a starting point for deeper coordination with a range of partners who are addressing different social determinants of health in their communities, unified behind a common appreciation of the catastrophic effects of poverty on health.

The Double Burden of Hunger and Poor Health

We’ve seen images of emaciated people, victims of wars, droughts, and famines. Most shocking are those of severely malnourished children, some of whom are brought back from the brink of starvation with therapeutic foods such as Plumpy’Nut. We understand the effects of hunger on human health at once, and there can be little doubt: hunger is deadly.

But these scenes always seem to be somewhere else—a long way from home. In the United States, the effects of hunger on health are not as vivid and striking. They are nonetheless real and harmful, from the feast-or-famine cycles that become a way of life for people trapped in poverty, to steady diets of cheap, manufactured junk foods rather than real nutrition. In zip codes less than a few miles apart, average life expectancies are sometimes worlds apart. One reason for differences in life expectancy is the ability to afford or gain access to the foods needed for a healthy life.

Households are food insecure when they do not have reliable and regular access to the foods they need for healthy living. Food insecurity and hunger do not mean the same thing, but they are indivisible. Food insecurity means the specter of hunger is always present, if not on the attack then lurking close by. Food insecurity forces low-income households into...
making painful decisions, such as paying for medications rather than food, paying the rent, paying to keep the heat on in winter, paying tuition, or paying to fix a car to get to work.\textsuperscript{2}

Hunger can damage one’s health at any point in life. In Chapter 1, we use a life course lens to show the effects of hunger and food insecurity from the womb through old age. Food insecurity during pregnancy is associated with negative birth outcomes such as preterm and low birth weight and even infant mortality.\textsuperscript{3} Food-insecure children are in worse health than their food secure peers, with higher rates of hospitalization, more developmental delays, and educational setbacks; they are more likely to have trouble with anxiety and aggression, setting up early and repeated contact with the criminal justice system.\textsuperscript{4}

Food insecurity in childhood is a predictor of chronic illness in adulthood. Food insecurity is associated with higher rates of depression, cardiovascular disease, high blood pressure, diabetes, certain types of cancers, and other physical and mental health conditions.\textsuperscript{5} People who are food insecure are more likely to be in poor health, and in turn, their poor health increases the risk of being food insecure. This bidirectional relationship of food insecurity and poor health passes from one generation to the next. Parents in poor health may not be able to earn enough income to provide the nutritious food their growing children require for healthy development.

Parents try to protect children from the nutritional impact of food insecurity, skipping meals to ensure children do not have to go without. It is more difficult to protect children against the psychological impacts of food insecurity.\textsuperscript{6} Contrary to what parents think their children perceive, studies show that children are well aware their parents are suffering. Dawn Pierce, a

\begin{figure}
\centering
\includegraphics[width=\textwidth]{trends_food_insecurity.png}
\caption{Trends in the Prevalence of Food Insecurity and Very Low Food Security in U.S. Households, 1995-2014}
\end{figure}

\textbf{Figure i.1} Trends in the Prevalence of Food Insecurity and Very Low Food Security in U.S. Households, 1995-2014

\begin{itemize}
\item \textbf{Food insecurity} = Limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.
\item \textbf{Very low food security} = At times during the year, the food intake of household members was reduced and their normal eating patterns were disrupted because the household lacked money and other resources for food.
\end{itemize}


\begin{itemize}
\item \textbf{3 percent} — the share of federal spending on nutrition programs.\textsuperscript{3}
\item \textbf{24 percent} — the share of federal spending on health care.\textsuperscript{4}
\end{itemize}
single mother in Boise, Idaho, struggled against hunger for 14 months after she lost her job as a nurse. See Box i.1. “If I could get three hours of sleep at night it was a luxury,” she explained in an interview. Pierce is diabetic and feared the poor quality of food she was consuming would land her in the hospital. Another parent interviewed for this report described how she stared at grocery store flyers left in her mailbox, trying to quell the hunger pangs with pictures of food.

Seniors suffer more severe health effects from food insecurity than younger adults. Food insecurity in older adults lowers resistance to infection, worsening the effects of chronic diseases and making it more difficult to manage their conditions. As the chief beneficiaries of the nation’s two largest social insurance programs, Social Security and Medicare, seniors as a group have lower rates of food insecurity than younger adults. Neither of these programs guarantees low-income seniors freedom from hunger, or the loss of independence and spiraling healthcare expenditures that come with it. Out-of-pocket medical costs are a heavy burden on seniors with multiple chronic conditions, and it does not take long to burn through savings to pay for health care.

Food insecurity in the United States, as in the developing world, is closely tied to poverty. The extreme poverty we find in the developing world is rare in the United States. But unlike countries in the developing world, the United States has achieved little progress against domestic poverty. The Millennium Development Goals (MDGs), embraced by all countries in 2000, have helped to spur unprecedented progress against global poverty and hunger, as well as improvements in health and health care. While much still remains to be done, the MDGs have shown that goal-setting works and that poverty reduction and improvements in health are inextricably linked. In 2016, the MDGs will be succeeded by the Sustainable Development Goals (SDGs), which call on all countries to end hunger and poverty by 2030 and to improve health outcomes for all. We will have more to say about these monumental initiatives in Chapter 3 and the Conclusion. As the global community embarks on the SDGs, it is time the United States commits to setting and achieving its own development goals.
“NO WONDER I FELT THE WAY I DID”

by Dawn Pierce

June 8, 2008, I remember the day vividly—the nurse practitioner told me I had Type 2 Diabetes. I argued with her that was not possible. I’m a nurse, I do diabetic counseling, and I don’t pig out on junk.

Once I came back to reality, I realized I had to have a plan to manage my condition. For a year and a half things were going well. I lost weight and was on oral medications. Then the recession hit and my employer laid me off: January 10, 2010, another day I remember vividly.

I did receive unemployment insurance, which was helpful, but not enough to replace what I was making—and yes, I was relentlessly looking for a job.

I had stopped seeing the nurse practitioner. She didn’t like that, and neither did I, but it didn’t seem like I had much of a choice. I couldn’t afford to pay her any longer.

I realized that to properly take care of my son, I was going to have to ask for help. When I went to apply for food stamps, I sat in the car for an hour and cried before going in.

I bought the most food I could afford for the $317 per month in SNAP* benefits we qualified for. I most certainly did not want to eat junk, but cans of chili, packs of frozen burritos and frozen pizza are a lot cheaper than a roast, ham, or pork chops.

It took about three months after we started receiving SNAP before I noticed I was feeling cruddy all the time. Eating processed foods is okay now and then. When you make a regular diet of it, they clog your whole body with sludge and drag you down.

I remember lying awake in bed one night, my thoughts scattered and my mind racing. When is the rent due again? I wonder if the power company will take $20 this month and let me pay the rest later? I hope Joel doesn’t need something baked or cooked for a school event. What am I going to do about Christmas?

I got out of bed to check my blood sugar. 279—Holy Smokes! I ran through everything I’d eaten that day: Coffee, muffin, pop-tarts, ramen, grilled cheese, and Diet Coke. No wonder my blood sugar was skyrocketing, and no wonder I felt the way I did.

$317 per month in SNAP benefits is $79.25 per week, $5.60 per person per day. Imagine someone handing you five dollars, two quarters and a dime and telling you to feed yourself three meals a day with that, and yes, make sure the food is healthy.

Dawn Pierce lives in Boise, Idaho, where she is currently employed full-time as a nurse. This reflection is an edited version of an interview for the Hunger Report.

* SNAP is the Supplementary Food Assistance Program, formerly known as the Food Stamp Program.
A Two-headed Pandemic: Food Insecurity and Obesity

The Great Recession of December 2007 to June 2009 was the worst economic slump since the 1930s, and it pushed the number of food insecure Americans to record highs, where they’ve continued to remain due to the anemic recovery. From 2008 to 2014, no less than 48.1 million people per year in the United States were food insecure. In 2014, 19.2 percent of households with children (7.5 million) reported being food insecure. In about half of these households, only the adults were food insecure. Many of these adults are employed. They are food insecure due to low wages, or they are paying too much for transportation or child care or other necessary costs to hold on to their jobs. The Earned Income Tax Credit (EITC) and the refundable portion of the Child Tax Credit (CTC) are the nation’s strongest tools to help working families escape poverty and food insecurity. Improvements to the EITC and CTC that were enacted during the Great Recession are set to expire in 2017. Allowing these to expire would force 16.4 million people, including 7.7 million children, to sink into poverty or deeper poverty than they already are.

The U.S. Census Bureau conducts an annual survey to collect national food security data. The Department of Agriculture (USDA) analyzes the data and publishes an annual report, Household Food Security in the United States. Since the year 2000, the number of people in the country who were food insecure has never fallen below 30 million. USDA groups food insecure households into one of two categories: “low food security” or “very low food security.” Households with very low food security are those experiencing the deepest levels of poverty. Low food security is prevalent in households with incomes two and three times the poverty level. (In 2015, the poverty threshold for a family of four was $24,420.)

Prior to 2006, households with low food security were categorized as “food insecure without hunger,” and those with very low food security “food insecure with hunger.” The change in the nomenclature was necessary, according to USDA, to disentangle the physiological state of hunger from indicators of food availability. The survey itself continues to ask respondents whether they experienced hunger. Experts analyzing the data may not like to use the word hunger, but it seems to be impossible to talk about it any other way with experts who know what it feels like to be hungry.
Not everyone agrees hunger and food insecurity are pressing problems in the United States. Skeptics contend the official data overstate the actual levels of hardship in the country.\textsuperscript{16,17} But according to Mark Nord and Alisha Coleman-Jensen, very low food insecurity may actually be \textit{understated} among households with children.\textsuperscript{18} In USDA interviews with families receiving food assistance, researchers found “adults in the study, including those who are food secure by our survey measure, have skipped meals so often and for such a long time, that it is not described as anything out of the ordinary; in fact, it is seldom even conceived of as a hardship.”\textsuperscript{19} Marianna Chilton and Jenny Rabinowich explain also, “Caregivers are often reluctant to admit that their children may not be getting enough food due to shame or due to the fear that their children might be removed from the home by authorities.”\textsuperscript{20}

Households with children are categorized as food insecure if they answer three or more of the survey questions affirmatively. The survey consists of 18 questions (or 10 questions for households without children). Questions include: “In the last 12 months, were the children ever hungry but you just couldn’t afford more food?” (Yes/No), and “In the last 12 months, did any of the children ever not eat for a whole day because there wasn’t enough money for food?” (Yes/No).\textsuperscript{21}

At the World Food Summit in 1996, the international community agreed on the following definition of food security: “when all people...
Surveys show food insecurity occurring in households with incomes up to two and three times the poverty level. The U.S. food security survey focuses on food deprivation due to lack of economic resources. The emphasis on nutritious food in the quotation above is ours. Only one question in the U.S. food security addresses diet quality, and it does so indirectly: “(I/we) couldn’t afford to eat balanced meals.” Respondents are asked to choose “often, sometimes, or never true.”

The National Health and Nutrition Examination Survey (NHANES), conducted by the Centers for Disease Control and Prevention (CDC), a division of the Department of Health and Human Services (HHS), reaches a much smaller population but provides the most in-depth analysis about the nutritional status of Americans. About half of the people participating in the survey are children.

NHANES is the nation’s primary data source on overweight and obesity. Like food security, obesity is associated with increased risk of chronic illness. In 2005, an article published in the New England Journal of Medicine reported that the current generation of U.S. children will be the first to have a shorter life expectancy than their parents, and the authors placed the blame directly on the dramatic rise in childhood obesity.

The stove piping of food insecurity data at USDA and obesity data at HHS may inadvertently be reinforcing the perception that food security is primarily about food availability and not a health issue. This could not be further from the truth. The Dietary Guidelines for Americans, a joint effort on the part of USDA and HHS, states unequivocally that food insecurity is “an independent risk factor for poor physical and mental health outcomes across the lifespan.”

The childhood obesity rate in the United States has more than doubled since the early 1980s. Low-income children and adults have higher obesity rates than their higher income peers, but the majority of obese children and adults are not low-income. Obesity is a complex problem, but one simple fact is that people in the United States consume more calories per capita per day than people in any other country, and diets are higher in saturated fats and lower in fresh fruits and vegetables than in peer countries. Except for young children, the majority of Americans do not consume the recommended daily amount of fruits, and an even greater majority fails to get the recommended amount of vegetables.

Calorie consumption has been declining since the early 2000s, both for adults and children, cutting across all the major demographic groups: whites, blacks, and Hispanics.
The early 2000s was when healthcare professionals in large numbers began to speak differently about obesity, reframing it as a public health crisis rather than a personal problem for individuals to deal with independently. In addition to the article in the New England Journal of Medicine, the surgeon general issued a report, Call to Action to Prevent and Decrease Overweight and Obesity, which was immediately compared to the 1964 surgeon general’s report on smoking and health. That report is credited as being a catalyst for dramatic changes in public attitudes about smoking.

Normally, healthcare leaders leave it for someone else to talk about food insecurity. But there have been prominent exceptions. Pediatrician Sandra Hassink, while president of the American Academy of Pediatrics in 2014-15, spoke out publicly about the triple threat to children of obesity, food insecurity, and malnutrition. It will once again take the healthcare sector speaking in concert for food insecurity to be reframed as a public health problem as obesity has been.

There is much confusion about the associations between food insecurity and obesity—even in medical, academic, and policy circles. The prevalence of obesity does not discredit the fact that the United States has wide-scale food insecurity: the same person can be suffering from both obesity and hunger. This is because conditions that are common in food insecure households—episodic food shortages, reliance on high energy-dense foods to stretch food dollars, stress and depression—are all risk factors for weight gain. We need to think of obesity and food insecurity as co-occurring health conditions.

The Dietary Guidelines for Americans states unequivocally that food insecurity is “an independent risk factor for poor physical and mental health outcomes across the lifespan.”

Poverty increases a household’s vulnerability to both. A healthy diet is the most effective intervention against obesity—and it is also inaccessible to millions of food insecure families.

The Nutrition Safety Net—A History of Safeguarding the Health and Well-being of Children and Adults

In 1946, Congress established the National School Lunch Program, the first food assistance program available to all of the nation’s children, following an investigation that showed malnutrition to be the main reason two out of five draftees had been rejected for military service during World War II. Today, 31 million elementary and secondary school children participate in the program, two-thirds of them qualifying for free or reduced price meals based on household income levels.

In 1961, President Kennedy’s first Executive Order was to launch a pilot food assistance program. Kennedy was appalled by the conditions he encountered in West Virginia’s coal mining communities while campaigning for the presidency. He promised the miners and their families to provide relief once elected. In 1964, with President Johnson in the White House, Congress enacted legislation to make the pilot version of the Food Stamp Program permanent, and it has been the country’s main safety net program against hunger and food insecurity ever since. In 2008, the name of the program was changed to the Supplemental Nutrition Assistance Program (SNAP).

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) was initiated in 1972 as a two-year pilot and became a permanent program in 1975. WIC
is available to income-eligible pregnant women, post-partum women with a child under six months, breastfeeding women with a child under 12 months, infants, and children under the age of 5. Presently, half of all children born in the United States qualify for WIC based on family income, and the program serves close to 9 million participants per month, most of them children.

The federal nutrition programs were established with the explicit aim of safeguarding the health and well-being of children and adults. In all, there are 15 domestic nutrition programs administered by USDA. One in four Americans participates in at least one of these programs at some time during the year. Descriptions of all the programs are included in Appendix 1. We don’t plan to review them all here, other than to note the major ones that serve the most people.

The school lunch program has a long history of improving children’s health and reducing food insecurity. The latest research shows the program continues to reduce food insecurity among low-income children who qualify for free or reduced price meals. All meals served in the program must meet strict nutritional guidelines. Multiple studies have shown that on average school lunches are healthier than home-packed meals. The lunches must include at least one-third of the Recommended Dietary Allowances of protein, vitamin A, vitamin C, iron, calcium, and calories. No more than 30 percent of a lunch’s calories may come from fat, with less than 10 percent from saturated fat. In 2012, schools began incorporating healthier nutrition standards into their meal programs, as directed by the Healthy, Hunger-Free Kids Act of 2010, and 95 percent of schools are meeting these new standards.

Research leaves little room for doubt that SNAP protects the health and well-being of children and adults who participate in the program. Several studies have shown that SNAP improves the nutritional quality of the foods they consume—and yet studies also have shown SNAP recipients consume less protein, less fiber, less calcium, and less of other key micronutrients than the general population. For reasons unrelated to the program, SNAP recipients tend to be less healthy than eligible non-participants. But this is not a surprise. Those most in need of the program are also likely to be in the poorest health. Adults on SNAP are much more likely than eligible nonparticipants to have chronic conditions such as diabetes, hypertension, and cardiovascular disease. Children are more likely to have been diagnosed with...
a learning disability or other developmental delay. And families are also more likely to have had to postpone medical care because they couldn’t afford it.  

In 2010, the Urban Institute analyzed close to a decade of data and found SNAP reduced food insecurity by roughly 30 percent and very low food insecurity by 20 percent. A more recent study of nearly 3,000 households with children published in *Pediatrics* found child food insecurity rates were one-third lower in households that had been receiving SNAP for 6 months or more than for households recently approved for SNAP but not receiving benefits yet. From 2011 to 2013, USDA conducted a pilot study giving a set of families with children $60 of additional SNAP benefits during the summer months when the children were out of school and no longer receiving free or reduced price lunches. Very low food security among these children decreased by 33 percent.

To study the long-term effects of the program, one group of researchers went back to the 1960s, when the Food Stamp Program was being rolled out county by county in rural Mississippi. What is interesting about this study is they were able to compare the effects in communities with nearly identical socioeconomic conditions, the only difference being that some communities had access to the program and others did not. Most studies of the program are not able to control for the inherent selection bias due to the fact that participation is by choice. The staggered rollout of the program provided a control group to overcome selection bias. In the communities where food stamps were available, researchers found the benefits to the children in the program were significant, particularly in areas of health. “Examining adults aged in their thirties to fifties who had differential access to the Food Stamp program during their childhoods in the 1960s and 1970s, we found that adults’ health—as measured by self-reported health status, obesity, and reported diagnoses of diabetes and other chronic conditions—was markedly improved if they had access to the safety net during childhood. In particular, we found that access to food stamps mattered most in early childhood, through ages three to five.”

Access to food stamps also corresponded with increases in education, earnings, employment and income, and a reduction in poverty.

Unlike SNAP and the school lunch program, WIC is not an entitlement program, meaning it does not have to serve all income-eligible families that apply. When a local...
WIC agency reaches its maximum caseload, vacancies are filled according to which applicants are determined to be most at risk nutritionally.\textsuperscript{48} WIC has been shown to reduce the prevalence of child food insecurity by one-third and very low food security by at least two-thirds.\textsuperscript{49} WIC has also been shown to improve birth outcomes.\textsuperscript{50} Pregnant women who experience food insecurity and malnutrition have a much higher risk of preterm birth and delivering a child with low birth weight. The average medical cost for a premature/low birth weight baby is $49,033, compared to $4,551 for a baby born without these complications,\textsuperscript{51} while it costs approximately $743 a year for a pregnant woman to participate in WIC.\textsuperscript{52}

Fighting hunger remains primarily the role of the federal nutrition programs. In recent decades, the mandate has broadened to include fighting obesity. Let’s Move, the program developed by First Lady Michelle Obama to fight childhood obesity, has moved aggressively to improve the quality of school meals. Changes to foods allowable in WIC occurred at least partly to fight obesity among low-income preschoolers. Those efforts seem to be paying off, with childhood obesity levels finally leveling off. The convergence of objectives around hunger and obesity was inevitable given how much obesity has increased in recent decades. The problem is that the nutrition programs are carrying a disproportionate share of the load to fight these twin pandemics.

In 2010, the Urban Institute analyzed close to a decade of data and found SNAP reduced food insecurity by roughly 30 percent and very low food insecurity by 20 percent.
Discrimination and the Determinants of Health

The Navajo Nation, the largest reservation in the United States, straddles territory in Arizona, New Mexico, and Utah: 27,000 square miles. There are a total of 10 grocery stores on the reservation, an area the size of West Virginia and home to more than 180,000 people. The food insecurity rate on the reservation is five times the national average, and the obesity rate three times the national average.

The Navajo Nation is a “food desert,” an area with limited access to affordable and nutritious foods that is most common in low-income communities. In urban areas, a food desert is defined as a Census tract where at least one-third of the population lives more than a mile from the nearest supermarket or full-service grocery store. For rural areas, that distance is 10 miles. The Navajo Nation may be an extreme example, but all hardships in Indian country are extreme. If we were looking for conditions in the United States similar to the ones we see in developing countries, such as families living without running water or electricity, we would go straight to Indian country.

Discrimination is a known factor associated with health disparities. Urban communities of color, regardless of income, have fewer supermarkets or full-service groceries than low-income white communities. Living in a food desert is just one example of how discrimination harms health. Racial and ethnic minorities living in urban areas not only have poorer access to healthy food, for example, but the air they breathe is of lower quality, making them more vulnerable to respiratory illnesses. African American children are more likely to be hospitalized for asthma than white children. Rates of low birth weight are highest among African Americans, and low birth weight babies have weaker lung capacity than heavier babies, thus making them more susceptible to respiratory illness.

In 2015, socioeconomic inequalities in Baltimore captured our attention. The tragic death of Freddie Gray, a young African American man held in police custody, highlighted issues of police violence in the community. A health lens reveals other life threatening inequalities. Gray was exposed to hazardous levels of lead paint as a child. Lead exposure is a housing-related hazard that continues to affect children in high-poverty urban areas. Approximately half a million U.S. children between the ages of 1 and 5 are exposed to toxic levels of lead every year. New research shows that low levels of lead exposure once thought to be safe are harmful to children’s cognitive development. In 1978, Con-
gress banned use of lead paint. Two decades later, when Gray’s exposure occurred, inner city Baltimore’s housing stock was still coated in lead paint. Statistically, the average child growing up in Seton Hill, one of the city’s poorest neighborhoods, is not expected to live long enough to begin collecting Social Security. Just three miles away in Roland Park, one of the city’s wealthier neighborhoods, the average child can expect to live to be 84. A color-coded map of food deserts in Baltimore does not look very different than a similarly coded map of areas with the shortest life expectancies. See Figure i.7. Fifteen Baltimore neighborhoods, including the one where Gray lived, have lower life expectancies than North Korea.

Cost-related medication underuse is a common problem in low-income communities. A number of studies have noted a relationship between food insecurity and underuse of medication. Lack of health insurance or underinsurance can put the price of the medication out of reach. A study looking at neighborhoods in Chicago turned up another factor to explain medication underuse: residents of segregated black communities had to travel longer distances to fill prescriptions than residents of mixed communities or segregated white communities. Approximately one million people in the city live in what the researchers describe as a “pharmacy desert.”

Until the places where people live are conducive to good health, we should not expect that health insurance by itself will be enough to reduce health disparities. Health insurance is necessary, but not sufficient, to ensure good health. Even in countries with universal access to health care, we find signif-
cant health disparities driven by socioeconomic status. Another limitation is that having health insurance does not mean people understand how to make healthy choices.

Researchers at the University of Buffalo School of Medicine and Biomedical Sciences studied the relationship between infant feeding practices and maternal education. Mothers with fewer years of formal education were found to be feeding their babies diets higher in sugar and fat than more educated women. The American Academy of Pediatrics recommends exclusive breastfeeding for the first six months after birth. College-educated mothers are much more likely to breastfeed the full six months. Many women in low-income households may not be able to breastfeed this long. College-educated women often can because their jobs allow longer maternity leave.

Good jobs. Good schools. Healthy food. Clean air. These are well outside the scope of what most healthcare providers do. A national poll of U.S. doctors found that 4 in 5 believe unmet social needs undermine their ability to provide quality care, and 3 in 4 feel the healthcare system should be supporting such services when a doctor determines these are essential to improving patient outcomes.

Health and Health Care: Swimming Upstream Towards Prevention

Life expectancy in the United States increased by 30 years over the course of the twentieth century. Five of these additional years were due to improvements in medical care, the remaining 25 to improvements in public health. The landslide achievements for public health include many nonmedical factors, such as new water and sanitation infrastructure, safer workplaces, safer and healthier foods, lower rates of tobacco use, and new technologies that made motor vehicles safer.

Life expectancy did not increase evenly for all. For example, whites live longer on average than blacks, the rich longer than the poor. A considerable body of research tells us that nonmedical factors play a larger role in determining health outcomes than medical factors do. See Figure i.8. Food insecurity, for example, increases a person’s chances of becoming a high-cost user of healthcare services within 5 years by nearly 50 percent.

The most consistent predictor an adult will die in any given year is his or her level of education. In medical jargon, education is a “social determinant of health.” Health literacy, as defined by the Robert Wood Johnson Foundation, “is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions and adhere to sometimes complex disease management protocols.” Virtually every encounter with the healthcare system is a test of a person’s health literacy skills, and health literacy is directly related to educational outcomes.
THE FOOD ENVIRONMENT IN LATINO COMMUNITIES

by National Council of La Raza

Healthy food choices are much easier to make in a supportive food environment—where healthier foods, such as fresh fruits and vegetables and foods that are less processed, are available and affordable. Too many Hispanic families do not live in a supportive food environment. Counties with large Hispanic populations have a greater proportion of people with limited access to grocery stores (29 percent) than other counties do (21 percent). Latino children and low-income people are at particular risk (see Figure i.9).77

In a national survey, more than 10 percent of Hispanics reported difficulty in accessing affordable fresh fruits and vegetables—a higher rate than any other racial/ethnic group. The survey also found that access to fresh produce is linked with better health: people who reported that they were in poor health were four times as likely to face access barriers as people who said they were in excellent health (20 percent vs. 5 percent).78

Research shows that larger chain supermarkets tend to carry more healthy food items, such as produce, at lower prices, while smaller convenience stores tend to carry less fresh produce and more snack foods that are calorie-rich but nutrient-poor. Thus, neighborhood convenience stores typically cannot compensate for the lack of a supermarket that offers healthy foods.79

Hispanic neighborhoods, particularly those in nonurban areas, have almost one-third fewer chain supermarkets but more convenience stores than non-Hispanic neighborhoods.80 Better access to chain supermarkets has been associated with lower adolescent body-mass index (BMI) scores and lower rates of overweight. Greater access to convenience stores, in contrast, has been associated with higher BMI and frequency of overweight.81 Latino children have high rates of overweight and obesity and are consequently more likely to develop largely preventable diseases such as diabetes.82 All signs indicate that any discussion of public health should include a look at the local food environment.

The National Council of La Raza—the largest national Hispanic civil rights and advocacy organization in the United States—works to improve opportunities for Hispanic Americans. Learn more at www.nclr.org.
In turn, educational outcomes are linked to the quality of schools one attended, and the quality of schools to socioeconomic conditions.

Nearly half of adults surveyed with less than a high school education have “below basic” levels of health literacy. A parent without a high school degree is statistically more at risk of raising a child in a hungry household than a parent who finished high school. Without a degree the parent earns lower wages and faces longer spells of unemployment. This means that the family’s housing options are limited, their neighborhood is less safe, and the increased stress caused by living under these conditions often creates strife at home. Hunger undermines a child’s ability to learn. Falling further behind with each hungry year, the child drops out like mom or dad. Now there are two generations with limited capacity to follow medical instructions.

Today, public health is concerned with the factors that perpetuate population health inequities. “Where people live, work, learn, and play has a greater influence on their health than what goes on in the doctor’s office, yet the healthcare system bears the brunt of these problems when they ultimately lead to poor health outcomes.” This statement appears in a 2015 report, *A Prevention Prescription for Improving Health and Health Care in America*, written by a taskforce of health experts under the aegis of the Bipartisan Policy Center. Their overarching recommendation is telegraphed right there in the title of the report: Invest in prevention.

Time and again research has confirmed the age-old maxim that an ounce of prevention is worth a pound of cure. Prevention strategies take place “upstream” and affect the social determinants of health. Public health departments and the social service providers they partner with work upstream. Medical care is “downstream.” By the time a person with a chronic illness arrives downstream, damage control is the best doctors can do. They may have little to offer but efforts to slow down the progression of a disease.

According to one study, a 10 percent increase in public health spending could achieve a 3.2 percent reduction in cardiovascular mortality. For the average metropolitan community, that would free up $312,274 in cost savings each year for other uses. Lowering deaths from cardiovascular disease by 3.2 percent through medical care alone would require hiring an additional 27 doctors, which would cost substantially more than a 10 percent increase in public health spending.
As the U.S. healthcare system evolved over the second half of the twentieth century, technological advances in medicine and an increasing focus on specialization drew attention away from the cost effectiveness of investments in public health. Roughly 80 percent of doctors in the United States are specialists, even though research shows that primary care physicians save more money for patients and the health system.87

Health care in the United States has been labeled a “sick care system,” overemphasizing treatment at the expense of prevention.88 This is reflected in the tiny fraction of government health spending that is dedicated to public health activities—in 2012, only 2.7 percent of federal and state health spending combined.89 The Institute of Medicine states, “The aims of public health agencies (that focus on the health of communities) and healthcare organizations (that typically focus on individual patients) are not aligned, nor are the resources and political visibility associated with them comparable.”90 Public health has none of the lobbying firepower of the pharmaceutical companies or medical-device manufacturers, not to mention that of the alcohol, tobacco, and less-than-healthful food and beverage lobbies, whose products are as severe a problem for public health as antibiotic-resistant disease strains are for medical care.

The ACA has authorized the largest expansion in federal public health spending since the 1960s. The ACA remains controversial, partly because the media fixates on the political and judicial battles, paying little attention to what the law has already achieved. The ACA has already reduced the share of the U.S. population without health insurance to unprecedented levels, and lack of health insurance has decreased most markedly for minority groups.91

In countries where healthcare costs are lower and health outcomes better, health systems typically place far more emphasis on prevention. The United States spends on average twice as much on health care per capita as peer countries.92 See Figure i.11. Reducing the rate of growth in healthcare spending will require changes in the basic model of how the U.S. health system has operated for the past half-century. This model is known as “fee for services.” Doctors are paid for the services they provide, and whether a patient’s health improves is immaterial. This is actually backwards—focused on providing health care rather than on promoting health. If a patient’s condition improves quickly and requires fewer services, the doctor receives no compensation for the improvement and the savings it brings both the patient and insurers.
Now, however, the incentive structure is changing. Rather than financial rewards for filling hospital beds, the system sometimes offers incentives to keep them empty. This is why doctors and other health professionals are beginning to pay more attention to the social determinants of health. Medicare and Medicaid are the proving grounds for the reforms in the ACA. Medicare covers 55 million people—predominantly seniors but also younger people with long-term disabilities. Medicaid covers nearly 70 million low-income children and nonelderly adults, dual-eligible seniors who are also covered by Medicare, and people with a range of disabilities. The ACA expanded Medicaid eligibility to low-income nonelderly adults in households earning up to 138 percent of the poverty level. Medicaid expansion has been concentrated in communities with the largest health disparities, so the health care systems that serve these populations have good reason to pay attention to the social determinants of health.

Access to health insurance is a key social determinant of health. At this writing, 20 states have chosen not to accept federal funding to expand their Medicaid programs. Medicaid, unlike Medicare, is a federal-state partnership, which is why the Supreme Court ruled in 2012 that states have the right to reject Medicaid expansion. More than half of adults who would qualify for Medicaid in these states are working full- or part-time. The most common
All people deserve the opportunity to reach their full potential—and part of this is being able to make choices that lead to good health and quality of life. But the United States has a widening gap between those who have a fair chance to make these choices and those who do not.

As the World Health Organization points out, large differences within countries in health outcomes are not only unnecessary and avoidable, but also unfair and unjust. Poverty, low socioeconomic status, racial discrimination, gender bias, disabilities, and mental health conditions all contribute to today’s significant health disparities in the United States.

An individual’s resources—such as money and power—most often shape the economic and social conditions he or she lives under. Another influence on people’s environments, though, is that of the policies and choices that decision-makers support. Policies that affect food security are one example.

In many states, people who have been convicted of a drug-related felony and have served their sentences are banned or restricted from participating in SNAP (formerly food stamps) and TANF (Temporary Assistance for Needy Families). These bans also apply to the formerly incarcerated person’s entire household, including children.

People with lower incomes are incarcerated at disproportionately higher rates, and many enter the prison system with chronic illnesses. Health problems are exacerbated by the prison environment, which can include overcrowded and unsanitary conditions, poor nutrition, lack of ventilation, and the impact of violence, trauma, and solitary confinement.

Ironically, people in correctional facilities are the only group in the United States with a constitutional right to health care. But when they return to their communities, they often do not have access to quality health care. It is not difficult to see that declaring people ineligible for assistance to get the food they need is also bad for their health. To a person with a chronic illness, going without food can lead to hospitalization (which, incidentally, costs much more than food assistance). A ban on food assistance for ex-offenders and their families works at direct cross-purposes to the goal of improving family and community safety and security.
The United States has a far higher rate of incarceration than most other high-income countries. Mass incarceration is now a public health crisis that has increased hunger and poverty. Health and human service providers and people of faith must view the problem through a social justice lens. This lens can help us see that often, people’s only “choices” range from bad to worse. In addition to enabling us to see situations as they are, a social justice lens can and should help find ways to expand the choices that are actually available to people!

Barbara T. Baylor is currently the Policy Advocate for Domestic Issues at the Washington, DC, Policy Office of the United Church of Christ. She holds a Master’s Degree in Public Health.
reasons for them not to have health insurance are that their employer doesn’t offer it or they cannot afford it.98 These are also states with some of the highest percentages of the population who report being in fair or poor health.

Medicaid expansion for adults has been associated with reduced mortality as well as improvements in access to care and self-reported health status.99 People with health insurance are simply more likely to receive timely preventive care. In 2013, only 33 percent of uninsured adults reported visiting a doctor during the past year for a routine check up, compared to 67 percent of adults with Medicaid.100 Access to primary care is an effective prevention strategy that also saves money.101 Access to affordable, nutritious food is another cost-effective prevention strategy.

Healthy Food: A Sound Investment for Everyone

1965: Bolivar County, Mississippi. Dr. Jack Geiger, director of the first community health centers in the United States, recognized that malnutrition was the root cause of many of the health problems he and his staff were treating. At the Bolivar County Health Center, they developed the innovative approach of writing prescriptions for patients to purchase food at local stores. The health center paid for the food with funds set aside from the pharmacy budget.

The Bolivar County Health Center and others around the country were established with funding for the War on Poverty. When the Office of Economic Opportunity, the Washington, DC-based agency in charge of directing the War on Poverty, found out what Geiger was doing, officials told him to stop prescribing food paid for with money set aside for health care. Geiger explained that the patients were sick because they were hungry, and the best medicine he knew for hunger was food.102 But this was not allowed under program rules.

Little has changed since then in practical terms. Doctors still cannot routinely prescribe food for patients with conditions related to hunger or malnutrition if they expect insurance to reimburse them. Meanwhile, though, medical researchers have produced reams of studies re-confirming the relationship between nutrition and health.

Researchers from the University of California, San Francisco, found that hospital admissions for diabetic patients were significantly higher at the end of the month than at the beginning.103 People with diabetes must manage their blood sugar by adhering to a strict dietary regime to avoid acute episodes that could land them in the hospital. Looking at the hospital discharge records of more than two million patients from 2000 to 2008, the researchers noted that the majority of the patients lived in the poorest ZIP code zones.

Anyone who has talked with families that participate in SNAP has heard how difficult it is to stretch the benefits until the end of the month. The California study was published in early 2014, about the same time that Congress and the president agreed on a farm bill that contained $8 billion in cuts to SNAP, making it harder still for diabetic participants to manage their blood sugar levels. Government pays nearly two-thirds of the cost of treating diabetes,
mostly through Medicare and Medicaid.\textsuperscript{104} The average cost of a hospital stay in the United States is $2,157 per day.\textsuperscript{105} In contrast, a key prevention strategy—SNAP benefits—costs the government about $4.50 per day per recipient.\textsuperscript{106}

Studies published in the British medical journal \textit{The Lancet} show that investments in maternal and child nutrition in developing countries are extraordinarily cost-effective, yielding long-term gains in everything from reduced health care costs to lower poverty rates to increases in productivity and Gross Domestic Product (GDP).\textsuperscript{107} It is no different in the United States. A 1992 report by the Government Accountability Office (GAO) showed that WIC cost $296 million a year but saved more than $472 million in federal and state Medicaid costs—a net savings of $176 million a year.\textsuperscript{108}

The economic arguments for closer coordination between health care and the federal nutrition programs are persuasive even without considering society’s moral responsibility to help people who are hungry. The biggest fiscal challenge for policymakers at the federal, state, and local levels is still the rapid growth of healthcare expenditures.\textsuperscript{109} As noted earlier, the United States spends more per capita on health care than any other developed country. But on most meaningful health indicators, the United States is doing worse than almost all of these peer countries.\textsuperscript{110} U.S. life expectancy is the lowest, infant mortality the highest.\textsuperscript{111} See Figure i.12.

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**Figure i.12 The U.S. Has the Lowest Life Expectancy at Birth Among Comparable Countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Life expectancy at birth in years, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland</td>
<td>83</td>
</tr>
<tr>
<td>Japan</td>
<td>82</td>
</tr>
<tr>
<td>France</td>
<td>82</td>
</tr>
<tr>
<td>Australia</td>
<td>81</td>
</tr>
<tr>
<td>Sweden</td>
<td>82</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>82</td>
</tr>
<tr>
<td>Canada</td>
<td>81</td>
</tr>
<tr>
<td>Netherlands</td>
<td>80</td>
</tr>
<tr>
<td>Austria</td>
<td>80</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>79</td>
</tr>
<tr>
<td>Germany</td>
<td>79</td>
</tr>
<tr>
<td>Belgium</td>
<td>79</td>
</tr>
<tr>
<td>United States</td>
<td>79</td>
</tr>
</tbody>
</table>

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**Infant Mortality is Higher in the U.S. Than in Comparable Countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Infant mortality per 1,000 live births, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>6</td>
</tr>
<tr>
<td>Canada</td>
<td>3.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2.2</td>
</tr>
<tr>
<td>Belgium</td>
<td>2.2</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2.2</td>
</tr>
<tr>
<td>Switzerland</td>
<td>2.2</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>2.2</td>
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<tr>
<td>France</td>
<td>2.2</td>
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<tr>
<td>Germany</td>
<td>2.2</td>
</tr>
<tr>
<td>Australia</td>
<td>2.2</td>
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<tr>
<td>Austria</td>
<td>2.2</td>
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<tr>
<td>Sweden</td>
<td>2.2</td>
</tr>
<tr>
<td>Japan</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Source: Peterson-Kaiser Health System Tracker, data provided by Organization for Economic Cooperation and Development.
For decades, in both the public and private healthcare sectors, costs have been rising faster than GDP has been growing. In 1965, healthcare expenditures accounted for less than 6 percent of GDP. By 2015, its share had ballooned to 17.4 percent. The rate of growth has slowed in recent years compared to the trend of past decades. This is not expected to last, however, in large part because of an aging population. Older people have higher than average healthcare costs. By 2030, people older than 65 will make up 21 percent of the U.S. population, up from 15 percent in 2014. More than 70 percent of all U.S. health costs are for people with multiple chronic diseases, who tend to be seniors. National healthcare costs would grow at a slower rate if more people were healthier in their senior years—and keeping people healthy has a lot to do with making sure they are eating well.

Beyond the strain on the national budget, rising healthcare costs also, of course, pose a burden at the household level. One in three households struggles to pay medical bills—even though 70 percent of these struggling households have health insurance. Premiums for employer-based insurance have risen by 212 percent since 2000, while wages have risen by just 54 percent over this period. One-quarter of privately insured people do not have enough savings to cover the cost of their deductibles. Medical bills are the leading cause of personal bankruptcy, and more than 11 million people in 2013 were driven into poverty as a result of out-of-pocket medical expenses. Finally, one-third of all chronically ill patients in the United States cannot afford to buy food, medications, or both.

Figure i.13  Adults Who Are in Worse Health Have More Difficulty Accessing Care Due to Cost

Percent of adults who reported delayed or going without care due to cost, 2013

<table>
<thead>
<tr>
<th></th>
<th>Better Health</th>
<th>Worse Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed care</td>
<td>8%</td>
<td>20%</td>
</tr>
<tr>
<td>Did not get care</td>
<td>6%</td>
<td>17%</td>
</tr>
<tr>
<td>Yes to either</td>
<td>9%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source: Peterson-Kaiser Health System Tracker, National Health Interview Survey
The Shared Agenda

The United States has two food assistance systems that respond directly to people in our country who struggle with hunger. The government system includes the nutrition programs administered by USDA. A private charitable food system, sometimes called the emergency food system, is led by food banks and the agencies they supply.

The two systems are by no means mutually exclusive. USDA provides food banks with millions of pounds of food every year. Charities prepare and serve meals funded by government programs, and they help people enroll in these programs. Earlier, we mentioned the main government programs; here, we briefly discuss the private charitable food system.

Food banks collect and aggregate food supplies from donors and distribute them to community partners, who serve people directly through food pantry and kitchen programs. It is estimated that charitable networks provide between 5 percent and 10 percent of the amount of food assistance supplied by the government. But the strength of the charitable food system goes well beyond the food it provides. In a typical month, two million volunteers dedicate more than 8.4 million hours of service.

Volunteers are the faces of the anti-hunger infrastructure in their communities, while government programs are virtually invisible. SNAP benefits are accessed with the swipe of a debit card; the transaction looks the same as any other involving a debit card. As important as it is to improve efficiency and reduce stigma by using debit cards, this strategy does obscure the magnitude of the problem, the sheer numbers of Americans who struggle to put food on the table. Without the visibility of the charitable volunteers, most people could fall into the trap of underestimating and minimizing the extent of hunger in U.S. communities.

Volunteers deliver boxes of food to homebound seniors, fill backpacks with food to help low-income schoolchildren and their families get through the weekends, and host summer meal programs. They organize anti-hunger fundraisers and enlist local politicians to speak at those fundraisers. When elected officials wish to show their concern about hunger, it’s not surprising that they prefer standing alongside volunteers, serving food, to visiting an office where people are signing up for SNAP and praising taxpayer-supported nutrition assistance programs.

Feeding America, a national network of food banks, is the largest entity in the private charitable food system and supplies food to 46,000 partner agencies nationwide. Faith-based partners make up 62 percent of agencies working with the nation’s food banks.
healthcare system in the United States is deeply rooted in faith-based mission work. Feeding programs are an extension of this work—another way of providing care.

The Feeding America network serves 46.5 million people every year, members of an estimated 15.5 million households. Healthcare reform has created new opportunities for Feeding America, since food banks could become important partners for healthcare providers in their communities. Feeding America is working with its partners to build their capacity to provide a range of health services, from conducting chronic disease screening, to preparing food boxes specially targeted to help manage diseases, to offering nutrition and health education, to referring food bank clients to primary care services.

The Oregon Food Bank offers an example of how this can work. It has created a staff position called a Screen & Intervene Coordinator. Lynn Knox was hired in March 2014. She travels across the state meeting with staff at clinics and hospitals, showing them how to develop protocols to administer a two-question food security screen to patients and then to enter this information into their electronic medical records. Knox has spent most of her career designing and implementing health programs in government, nonprofits, and health-
Responding to the social determinants of health will require the combined efforts and expertise of a range of community partners.

Of course, healthcare institutions need to go beyond screening for food insecurity to providing assistance to patients who screen positive. The other part of Knox’s job is working with healthcare providers to help connect patients to local resources. One of her strategies has been to work with nursing programs, integrating a practical learning module that places nursing students into clinics and hospitals so they can help connect patients with the resources available in their community. Knox believes that these modules will also help sensitize the next generation of healthcare workers to the relationship between hunger and health.

The Oregon Food Bank is not the only U.S. food bank to recognize that hunger and health are interconnected. What is unique about this food bank is how it has reached out to healthcare providers in the state and helped them understand the important role that anti-hunger partners can play in helping patients stay healthy and food secure.

Responding to the social determinants of health will require the combined efforts and expertise of a range of community partners. The ACA is a unique vehicle to bring multiple stakeholders to the table to coordinate their work around a common vision of improving community health. Hunger is a health issue, as is education, housing, job opportunities, and more. Policies tend to address social problems in isolation from each other. Holistic approaches are in short supply, which is what makes health reform such an exciting opportunity.
Water is essential to life. Humans require it for hydration and hygiene, and it plays a central role in agriculture, food preparation and cooking, and sanitation. Every person must have access to safe, sufficient, and affordable water to meet daily human needs.¹

The Unitarian Universalist Service Committee (UUSC) works to implement the human right to water and sanitation through support for grassroots partners, advocacy, and a legal strategy in the United States and across the globe.

Thus far, only one U.S. state, California, has enshrined the human right to water in law. In 2012, a coalition led by the Environmental Justice Coalition for Water, the Safe Water Alliance, UUSC, Unitarian Universalist congregations, and other faith-based activists helped make California’s human right to water bill, A.B. 685, a reality.

The majority of people living in the United States have a reliable supply of safe water. But that fact conceals serious disparities in access that fall along economic, racial, and ethnic lines. Too often, poverty intersects with race and ethnicity to deny people of color and indigenous communities their human right to water.

The main problem in the United States is the “affordable” requirement of the right to water. The international standard is that water bills should not exceed 2.5 percent of a household’s monthly income. A recent study by the U.S. Conference of Mayors found that under this standard, large percentages of the U.S. population face water bills that are unaffordable.²

By and large, municipal authorities have failed to create adequate affordability plans to help low-income residents maintain access to water. In 2014, the city of Detroit began disconnecting tap water service to about 35,000 residential accounts. City officials claimed that people were simply refusing to pay their bills. But in a city where 40 percent of the residents live below the poverty line, the reality was that poor households could not afford their rising water bills.

Detroit families brought a class action suit, Lyda et al v City of Detroit, to stop the shutoffs. The plaintiffs gave harrowing examples of the impact of the shutoffs on small children, elderly people, and people with disabilities. Plaintiff Nicole Cannon was a mother of three living with a chronic illness. Her unpaid water bill had reached $3,000 because of a leak in her rental home that her landlord refused to repair. As she struggled to pay her bills with a monthly Social Security Disability check of $648, Detroit Water and Sewer notified her that to avoid having her water shut off, she must pay $241 a month toward her balance. In her deposition, Ms. Cannon noted that this was unsustainable and that, despite seeking help from various sources, she had found no way to maintain running water in her home.³ She died in January 2015 at the age of 44.
Detroit Water and Sewer had scheduled another 30,000 shut offs for the summer of 2015. In July, the Detroit City Council passed a 7.5 percent rate increase, while establishing a blue ribbon panel to investigate “affordability” for low-income residents. At this writing, Detroit Water and Sewer has not carried out the scheduled shutoffs.

One measure cities can take is to create water affordability plans that align water bills with people’s actual incomes. The city of Philadelphia took a welcome step in 2015, enacting an ordinance that requires the city to research and establish an affordability plan that allows low-income water customers the opportunity to enroll in a payment plan based on their income and individual needs, while maintaining the financial sustainability of the utility. At the national level, the EPA must review its affordability guidelines and develop policies and plans that meet the needs of the country’s lowest-income people.

The insistence in the “right to water” language that water be “safe” is another problem in the United States. Communities are threatened by industrial and agricultural practices that treat water as a resource to be exploited—a commodity rather than a necessity or something everyone should have.

The international human rights community has taken note of U.S. difficulties in making the right to water a reality in practice. In 2011, the United Nations Special Rapporteur for the Human Right to Water conducted a mission to the United States and met with people across the country. In 2015, the U.N. Human Rights Council Universal Periodic Review of the United States recommended stepping up efforts to secure the human right to water, especially to avoid discrimination based on poverty, race, and ethnicity. Efforts such as the planning in Philadelphia offer signs of hope that our country can make progress.

Patricia Jones is Senior Program Leader for the Human Right to Water and Amber Moulton is a Researcher for the Unitarian Universalist Service Committee (UUSC). For more information on UUSC’s human right to water program, visit http://www.uusc.org/focus-areas/environmental-justice.