Reauthorization of WIC and CACFP

When it comes to a child's healthy development, there are many factors at play. Social, emotional, and cognitive growth all work together to build the architecture of the brain and start the child off with the best beginning in life. If healthy development is compromised, it weakens the foundation for that child and the prosperity of our community and our economy. Unfortunately, there are conditions – such as hunger and malnutrition – that can negatively impact healthy child development and lead to poor outcomes for very young children.

Two million infants and toddlers in the United States currently live in food insecure households (households which lack or have uncertain availability of nutritionally adequate and appropriate foods).[1] A young child who goes hungry or consistently lacks nutritious food or breast milk is less likely to grow and develop properly. In fact, infants and toddlers living in food insecure households are 76% more likely than those living in food secure households to be at developmental risk.[2] Food insecurity is potentially damaging to the development of children whether their households suffer from severe food insecurity or even mild food insecurity (households that may not surface in government statistics).[3] Not surprisingly, food insecurity in early childhood is linked to poor school outcomes, with hungry children being more likely to experience hyperactivity, absenteeism and generally poor behavior and academic functioning. If unaddressed, the effects of hunger and malnutrition can become permanently built into a child's immune system, cardiovascular system, and brain, causing risks to both the child and society at-large.

WIC

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), begun in 1974, is a federally authorized program providing economic supports to purchase nutritionally balanced foods, nutrition education, breastfeeding instruction and promotion, nutrition counseling, and referrals to health and other social services. WIC's target population is low-income[6] pregnant, postpartum, and breastfeeding women, infants, and children under 5 who are at nutritional risk.[7] WIC currently serves half of all infants in the U.S.[8] In February 2009, 2.1 million women, 2.2 million infants and 4.6 million children under 5 participated in the $6.86 billion WIC program, an increase of 52% in the past 6 years.[9, 10]

Fortunately, there are programs that can support child development by ensuring that all children are well-nourished and can grow healthy, strong, and prepared for school. This brief will focus on two of several federal nutrition programs, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Child and Adult Care Food Program (CACFP), as they are directly relevant to infants and toddlers. WIC and CACFP are proven remedies to food insecurity that promote healthy development.[4] The reauthorizations this year of WIC and CACFP offer critical opportunities for policymakers to ensure a positive future for our children and prosperity for our country, particularly at a time when the need for food assistance is currently on the rise.[5]

Policy Recommendations

1. Revise CACFP area eligibility to allow more food insecure families with infants and toddlers, particularly those living in rural areas, to receive access to nutritious foods. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 imposed a two-tiered, means-tested reimbursement rate for family child care providers participating in CACFP. This change reduced reimbursements to providers serving moderate-income children by nearly half. The result was an exodus of over a quarter of family child care providers from the program.[11] Currently, these providers are assigned to tiered reimbursement rates according to the income of the geographic region, the household income of the provider, or the household income of participating children, with the highest level of reimbursement for those with the lowest incomes.[12] Area eligibility allows family child care providers to receive the highest level of reimbursement if 50% of household incomes in that area are at or below 185% of the federal poverty level, as determined by free and reduced price school lunch data or census data.[13] Because poverty is often not as geographically concentrated in rural areas as it is in urban areas, this method of reimbursement unfairly affects providers in rural districts. In order to make CACFP more accessible and equitable for all children, the area eligibility threshold should be reduced from 50% to 40%.

CACFP

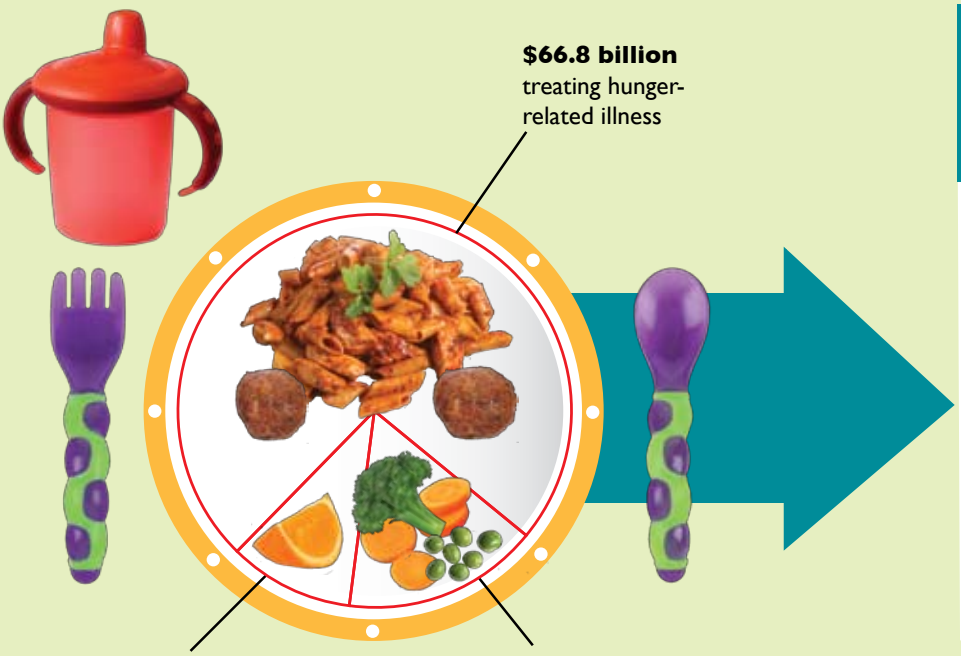
The Child and Adult Care Food Program (CACFP), established in 1968, reimburses family child care providers, child and adult care centers, Head Start and Early Head Start providers, and afterschool programs for the nutritious food served to eligible children, as well as meal preparation costs and training for staff on nutrition, child development as it relates to feeding practices, and implementation of the CACFP program.[14] In FY08, the United States expended $2.3 billion to serve 3.1 million children multiple daily meals and snacks.[15] CACFP serves 2.3 million children enrolled in child care centers and 849,000 in family child care homes.[16]

FAST FACTS

- **43%** of all children under the age of three in the United States (5.4 million infants and toddlers) live in low-income families (those making less than 200% of the federal poverty level or **$42,400** for a family of four).[17]
- Nearly **30%** of poor households with infants (those with incomes at 100% of the federal poverty level or **$21,200** for a family of four) are food insecure (lack of or uncertain availability of nutritionally adequate and appropriate foods).[18] Infants and toddlers from food insecure families are **76%** more likely to be at developmental risk than those from food secure families.[19]
- Underweight infants and toddlers are **166%** more likely to be at developmental risk as compared to normal weight babies and toddlers.[20]
- **14%** of children between the ages of 2 and 5 are considered obese due, in part, to the purchase of cheaper, less nutritious foods as well as insufficient access to fresh fruits and vegetables in many low-income neighborhoods.[21,22]

2. **Increase CACFP reimbursements to reflect the actual cost of providing food.** Between 1996 and 2008, while child care centers increased their participation in CACFP by 47.6%, participation by family child care providers dropped by 27.3%.[23] This reduction, despite the growing need for services, is particularly dangerous for infants and toddlers as they are more likely to be cared for in family child care homes than in any other setting.[24] The decline in participation of family child care providers can be partly attributed to the notable cost gap between the reimbursement level and the actual cost of implementing the CACFP meal plan, combined with the significant administrative time and knowledge required to meet the paperwork requirements.[25] Most likely, these providers now purchase cheaper, less nutritious food.[26] CACFP reimbursement rates need to rise in concert with higher food and fuel costs for all providers. Moreover, with the update to the food guidelines allowing for iron-fortified infant formula, fruits, vegetables, baby foods, and whole grains, the program will require more expensive food purchases. Reimbursement rates should reflect these rising costs and increased need due to the economic recession so that family child care providers are more likely to participate and to adhere to program guidelines.

Hunger and food insecurity cost the U.S. $90.5 billion every year.[41, 42]



Yet good health and nutrition, both prenatally and in early childhood, saves money now and in the future by lowering education costs and life-long health expenses for the child.

3. **Eliminate administrative barriers to participating in child nutrition programs.**
Administrative and other barriers often prevent low-income families from participating in programs such as WIC and CACFP. These barriers include lack of time and transportation, language and literacy barriers, programs' hours of access, families' lack of permanent addresses, missing documentation, and the costs associated with the application and participation processes.[27] Policymakers can work to eliminate administrative barriers for families by allowing longer certification periods, instituting a standardized application for multiple benefit programs that support working families (such as Temporary Assistance for Needy Families, WIC, Food Stamps/Supplemental Nutrition Assistance Program, Children's Health Insurance Program or means-tested early education programs such as Head Start and Early Head Start), and investing in technology that reduces administrative costs and improves access.

4. **Increase efficient use of resources by requiring collaboration between WIC agencies and early care and education programs such as Early Head Start.**
WIC currently requires State and local agencies to distribute information on the availability of program benefits to entities that serve significant numbers of potentially eligible individuals, including hospitals and clinics, welfare and unemployment offices, homeless and domestic violence shelters, and religious and community organizations.[28] Notably absent from the list of programs and services are early care and education programs such as Early Head Start. Although Early Head Start offers many of the same nutrition services provided in WIC, such as nutrition education, breastfeeding support, and referrals to health services, a lack of coordination between the two programs results in missed opportunities to efficiently utilize resources. Streamlining qualifying assessments and screenings, collaborating in recruitment, creating joint nutrition education materials, and integrating record-keeping systems could boost efficiency and reduce duplication of effort.[29] Early Head Start and WIC can also reduce costs and eliminate duplication by sharing a nutrition coordinator and/or facilities. In addition, both programs should conduct parent education and outreach efforts to ensure that families are fully aware of their eligibility and the services provided in both programs.

Access to nutritious foods and referrals to health services provided by WIC and CACFP can increase food security for a family, increase the nutritional value of the food, and increase economic security.

Research

Participation in child nutrition programs can prevent food insecurity and promote healthy development. Child nutrition programs are effective deterrents to food insecurity and unhealthy development. Mothers who participate in the WIC program are less likely to have low birth weight or preterm infants.[30] Reducing the incidence of low birth weight births is particularly important for healthy development, as underweight infants and toddlers are 166% more likely to be at developmental risk than normal weight infants and toddlers.[31] Furthermore, when compared to eligible children who do not receive WIC services, infants and toddlers who participate in WIC show increased rates of excellent or good health and decreased risk of developmental delay and anemia.[32, 33] WIC participation also reduces the incidence of overweight young children.[34] Likewise, children benefitting from participation in CACFP receive nutritionally superior meals, consuming more of certain essential nutrients, more milk and vegetables, and significantly less sweets and fat.[35] Participating children also have fewer educational absences due to illness.[36,37] Referrals to health services and programs provided by WIC and CACFP can increase food security for a family, increase the nutritional value of the food, and increase economic security.[38]

Child nutrition programs are an economically sound investment. Child nutrition programs, such as WIC and CACFP, benefit the economy due to the increased savings to society. For example, every dollar spent on WIC yields an estimated savings of $1.77 to $3.13 in Medicaid costs for newborns and their mothers.[39] Not only do child nutrition programs yield positive returns on investment, but the cost burden to society of hunger is enormous. In fact, hunger and food insecurity are estimated to cost the United States $90 billion annually in direct and indirect costs.[40] Of this amount, $66.8 billion is used to treat hunger-related illness and psychosocial dysfunction, $14.5 billion is spent in charitable efforts, and the annual societal cost burden of less education and lower productivity resulting from poor nutrition is $9.2 billion.[41] Promoting good health and nutrition prenatally and in early childhood, including breastfeeding, not only saves current-day costs, but also enables considerable future cost savings by lowering the life-long health expenses for the child.

Prenatal and early childhood nutrition have life-long impacts on health. A lack of nutritious food during pregnancy increases the risk of low birth weight babies; infant mortality; cleft palate; spina bifida; brain, neural, and physical defects; and adverse effects on long-term health, growth, and developmental trajectories.[42,43] Poor prenatal nutrition has the worst effects on children when it occurs during a critical period of fetal development or when malnutrition is severe, long-lasting, and continues after childbirth.[44,45] Healthy maternal nutrition after childbirth is particularly important for breastfeeding women and infants. When appropriate, breastmilk is an inexpensive and nutritionally rich food that reduces the risk of obesity by 7-24% and decreases the incidence of a range of infectious diseases, diabetes, asthma and other negative health outcomes, thereby reducing health care costs.[46,47] Research also shows that children from low-income, food insecure households suffer from a host of poorer health outcomes and experience more hospitalizations than children from food secure, low-income homes.[48] In fact, low birth weight infants from food insecure families are nearly 28 times more likely than their peers to be overweight or obese by the

age of 4 ½.[49] While seemingly incongruous, food insecurity can lead to both hunger and obesity simultaneously. Food insecure households not only purchase less food in general, but are also more likely to purchase cheaper, low quality food.[50] Reliance on a less nutritious diet and limited physical activity has resulted in an explosion of childhood obesity which has, in turn, led to a number of health impairments (diabetes, hypertension, asthma, anxiety, and hyperactivity) that can have devastating lifetime effects and carry substantial costs.[51]

Food insecurity in early childhood is linked to poor school outcomes. By the third grade, children who experience food insecurity in early childhood score 13% lower on reading and math tests than their food secure peers.[52] Hungry children are more likely to experience hyperactivity, absenteeism, generally poor behavior, and poor academic functioning often creating cyclical negative effects on academic performance and behavior.[53] Hungry children are twice as likely as non-hungry peers to receive special education services or repeat a grade. Thus, children who are food insecure and at higher risk of requiring special education services are approximately twice as expensive to educate per year.[54] The cost to educate a child who repeats a grade is four times the average per-pupil cost for each grade repeated.[55] Food insecurity not only puts children at risk for academic failure, but also carries a significant financial cost for society.

Poor nutrition can affect the social and emotional health of young children and their parents. The impact of food insecurity is not limited to just physical health and poor school performance; children who live in food insecure homes are also more likely to have mental health challenges during adolescence and young adulthood.[56] As young as preschool, children from food insecure homes have high rates of social and emotional problems such as aggression, anxiety, depression, and hyperactivity.[57] In addition, food insecurity can have an indirect but life-long impact on the child through the primary caregiver. Mothers in food insecure households are significantly more likely to report symptoms of depression and are more likely to exhibit inattentive or negative parenting behavior than parents in food secure households.[58, 59] Because early childhood development is facilitated by the infant's relationships with caregivers, depressed and negative parenting can and does have adverse effects on a growing child's development.

If, as very young children, we have positive, predictable relationships with our parents or other caregivers, we will feel safe from harm and secure that our basic needs will be met.

For more information about meeting basic needs, see ***Getting Back to Basics: Building the Foundation for Infants, Toddlers and Their Families***.
For more information about physical health as well as the effectiveness of child nutrition programs in preventing food insecurity, see ***Leading the Way to a Strong Beginning: Ensuring Good Physical Health of Our Infants and Toddlers***.

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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy.

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