Almost 90 years after the first food stamp program in the United States in 1939, there continues to be substantial food and nutrition insecurity, despite important gains and progress. In this age of perceived plenty, basic healthy sustenance eludes too many vulnerable hands. Thus, the increasing recognition of the tight interconnections binding food security, treatment access, and health equity together through threads of stability or precarity has the potential to play a pivotal role in improving cardiovascular outcomes. However, it is critical to ensure that programs that target food insecurity also incorporate interventions to improve nutrition security.

The Supplemental Nutrition Assistance Program (SNAP), signed into law in 1964 as the Food Stamp Act, primarily aims to address food insecurity. After unemployment insurance, SNAP is the most responsive federal program that provides additional assistance during and after economic crises. In 2021, 41 million persons in the US received SNAP. Among them, approximately 69% of SNAP participants have hypertension, and only 43% of SNAP participants are adherent to their antihypertensive medications. Whether SNAP can help improve hypertension medication adherence is an important question. Whether SNAP may be optimized to address adherence is an issue with significant public health implications that researchers and policymakers can prioritize.

Adherence to hypertension medication is an important determinant of cardiovascular health. Poor adherence to cardiovascular medications increases the risk of cardiovascular events by 20% to 35%. Of 119.9 million US adults with hypertension, only half (51%) of the 34 million adults who are recommended to use medications do so consistently. A related public health concern is food insecurity, which disproportionately impacts households with annual income below the poverty line compared with those at or above 185% of the poverty line (36.7% vs 6.8%). As with several determinants of health, there is a critical intersection between food security and medication adherence. For instance, people experiencing social marginalization are more likely to be subject to a “treat or eat” trade-off between prescription medication and household food. Individuals facing food insecurity often struggle to adhere to medical treatments yet shoulder undue blame for circumstances outside their control. Rather than judging individuals, addressing systemic barriers that limit basic health care access and nutrition could alleviate disproportionate disease burdens, especially among underserved populations.

This study by Islam and colleagues contributes to this body of work by highlighting the potential role of SNAP in improving medication adherence among SNAP participants. The study by Islam et al implies that SNAP could potentially mitigate the risk of nonadherence to antihypertensive medications due to food insecurity. Their study reported that persons who received SNAP, compared with nonrecipients, had a lower rate of nonadherence to antihypertensive medications among the food insecure subgroup but not among the food secure subgroup nor the overall population. Insight from the work by Islam et al may inform more extensive implementation and evaluation of interventions that leverage SNAP participation to address food insecurity and medication adherence through clinical-community partnerships. Research that systematically identifies barriers and facilitators of such programs has the potential to provide evidence-based guidelines for stakeholders interested in leveraging SNAP to address nonadherence to hypertension therapy and chronic disease management. Additionally, since sustained SNAP participation appears to be crucial to optimizing the impact of SNAP on health, interventions that seek to ensure SNAP enrollment should also target reducing SNAP churning, defined as disenrollment and enrollment into SNAP within 4 months. Team-based integration of community health workers could allow for continuity of care that will...
enhance the ability to provide navigation assistance that ensures continuous SNAP participation. There is also a place for advocacy that targets increased adoption of policies that enhance SNAP enrollment and reduce recertification burden, such as reduced recertification frequency and availability of online recertification.7

Despite these possibilities, there are important obstacles to be considered. Programs that promote food security, like SNAP, are underused, with the most significant barrier to SNAP being noted as the application process.8 This significantly contributes to the so-called SNAP gap, ie, the gap between individuals who are eligible to enroll and those who are actively enrolled in SNAP. Efforts to improve SNAP participation must be multilevel and move beyond the individual. It is also critical to address other access barriers, such as lack of transportation, through initiatives like mobile food markets. Universal food insecurity screening and streamlining SNAP enrollment within health care and social welfare systems could help boost SNAP participation and decrease food insecurity. Food-is-medicine interventions, which include produce prescriptions, medically tailored groceries, and medically tailored meals, also offer opportunities due to their characteristic multilevel approaches to bridging the divide between health care and nutrition. However, these programs are often centered within the health care system and systematically exclude individuals with limited health care access. This limitation could be addressed by improving the health care navigation system. Community health workers may be vital to improving navigation by connecting underserved populations to food-is-medicine programs while targeting medication adherence through community outreach and health promotion efforts. Integration of this workforce is feasible, since health system navigation can also be extended toward efforts to address food insecurity screening through SNAP application assistance, in addition to connecting to community members who are less likely to engage with health care through traditional methods. Nutrition security programs and interventions that respect individual food preferences and are culturally tailored are needed. The proliferation of digital health tools as a result of the COVID-19 pandemic also offers a unique opportunity for innovative strategies such as virtual food markets with deliveries. Extending efforts to promote access to programs to improve food insecurity will expand public health efforts to improve overall health.

Islam et al5 present interesting results; however, several questions remain unanswered. Estimates could have been strengthened if comparisons were made between SNAP participants and SNAP-eligible nonparticipants, using the available data sets. The analyses could have been further strengthened if SNAP disbursement was explored monthly rather than quarterly.8 Health care access is an intractable problem and could be a major confounder in this study, as health care access may impact both SNAP access and hypertension medication adherence. Health care facilities, as early as 2010, have been assisting patients in obtaining resources to meet their food insecurity needs, like assisting with federal benefits applications, including SNAP applications.9 Assessing health care access as a confounder may contribute to our understanding of the association of SNAP participation with hypertension medication adherence. Given that the Medical Expenditure Panel Survey data analyzed in this study contain measures for health care access, there may have been a missed opportunity to explore the role of limited care access in the study findings in how receipt of SNAP could improve hypertension adherence. More rigorous research is also needed to understand the pathways through which SNAP participation influences medication adherence and any variation across subpopulations. Research in this area should seek to reduce bias by accounting for the issue of self-selection bias, whereby SNAP participants differ on observable characteristics and potentially unobservable characteristics.6

Access to food, nutrition security, and medication adherence are interdependent factors integral to a healthy population and to achieving equitable health outcomes. Without reliable nourishment, related pillars of well-being, like medication adherence, quality medical care, and better health outcomes, all wobble under the strain of food insecurity. As highlighted by the research of Islam et al,5 to improve cardiovascular outcomes and overall health outcomes and truly advance health equity, prioritizing universal food and nutrition security is critical. With compassion and unified voices, public health policies that leave no child, family, or community without adequate resources
for realizing their human potential can be championed. Although the road stretches long ahead, each small growth in community nourishment and care pulls us step-by-step toward a society defined not by deprivation, but rather one where all can thrive with dignity.

ARTICLE INFORMATION
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