Food insecurity as a symptom of a social disease

Analyzing a social problem from a medical perspective

Federico Roncarolo MD PhD **Louise Potvin** PhD

Food security is "the right of every individual to have access to safe and nutritious food, consistent with the right to adequate food and the fundamental right of everyone to be free from hunger."[1] Despite the well-known association between food insecurity and type 2 diabetes, hypertension, cardiovascular diseases, mental distress, and poor health in general,[2-4] food insecurity is steadily increasing in developed countries such as Canada. Consequently, the effects of food insecurity are becoming relevant to family physicians. Family physicians should acknowledge the importance of food insecurity as a determinant of health and, moreover, be aware of the strategies currently implemented to address food insecurity. The objective of this article is not to medicalize a social problem, but rather to present food insecurity within a medical context that might give physicians a better grasp of this issue and help them understand their role in addressing food insecurity.

Increasing food insecurity in Western countries has its roots in the social and economic changes that have taken place during the past 30 years. Since the economic recession of the 1980s, welfare programs have not been able to efficiently respond to the increasing number of people in need.[5] At the population level, food insecurity and hunger have resulted from prolonged periods of high or increasing unemployment and underemployment, declining wages, lack of affordable housing, and the absence of adequate welfare policies.[6] From a medical point of view, food insecurity is a symptom of a complex and multidimensional social disease affecting a large proportion of populations in Western societies. In medicine there are 2 possible strategies to relieve a symptom: treat the symptom itself or address the causes of the symptom operating on the pathophysiology of the disease.

Treating symptoms

The most common strategy to address food insecurity in Western countries relies on food distribution—primarily taking the form of food banks. In Canada food banks are commonly administered through non-profit organizations, based on charity, wherein volunteers collect and distribute food donations to people in need. The effectiveness of food banks in addressing food insecurity is the core of a long-standing debate.[6-8] There are some researchers who argue food banks exacerbate rather than alleviate food insecurity by masking it, undermining social justice, and relieving governments of their duties.[6] They suggest that the increased social acceptance of non-governmental interventions as an appropriate way of dealing with food insecurity might contribute to depoliticizing household levels of food insecurity.[6] In contrast, other researchers underline the importance of food banks, affirming that food banks should be strengthened with collaborations to increase their role in addressing hunger and health issues, and recognizing the strategic position that community organizations could have in changing the approach to food insecurity.[9,10]

With food insecurity representing a symptom in the medical context, we liken accessing food banks to treat food insecurity to using a drug that acts as a painkiller to treat pain. Painkillers, although offering temporary relief, do not prevent the pain from returning. As such, they are useful when the symptom presents or while waiting for effective treatment of the disease. The chronic use of painkillers can lead to side effects that can worsen the health status of the patient in the long term or over time. In the same way, food bank use might have detrimental side effects. At an individual level, food bank users might face stigmatization because of their need to access charity organizations for food, or individuals might become dependent on the system, relying on food banks instead of improving or enhancing any of their own skills (eg, cooking skills, managing a family budget).[11] Food banks might provide the illusion that the problem disappears; however, the lack-of-food issue will return periodically, unless the reasons for the food insecurity have been addressed and more stable solutions are achieved. Nevertheless, having access to food banks might temporally improve the physical and mental health of patients[12]; consequently, referring patients to community interventions might be considered a temporary support while waiting for long-standing solutions.

Treating the disease

As we have defined *food insecurity* as a symptom of a "social disease," we suggest the solution to cure and prevent this disease includes policies that encompass both social justice and social and health inequalities. A comprehensive strategy to actively take charge of food

This article has been peer reviewed.
Can Fam Physician 2016;62:291-2

La traduction en français de cet article se trouve à **www.cfp.ca** dans la table des matières du numéro **d'avril 2016** à la **page e161**.

insecurity should include government commitments to living wages and welfare, taxation reforms, and new approaches to agricultural food and nutritional policies.[5] The reform of social policy to ensure all Canadians have adequate income to meet their right to food seems the only solution to steadily solve food insecurity in Canada.[13]

Family physicians support their patients by introducing them to the solutions that can affect physical, mental, and social wellness. In Canada about 80% of people with chronic disease have access to a family physician at least once a year[14] and some of these people are also food insecure. Family physicians have a role in addressing food insecurity at individual, community, and institutional levels.

At the individual level, family physicians can help patients find the "temporary relief" that they need by informing them about available community services. There are people who do not have access to food banks for reasons that include a lack of information, their perceptions about food aid, or their belief that they are not in extreme need.[8,15] Family physician clinics are an ideal setting to promote the help that these patients need,[16] and being referred to community services by family physicians might increase patients' willingness to participate in community programs. Health Leads, a non-profit organization in the United States that involves more than 9000 physicians, is an example of a health-promotion initiative that enables doctors to "prescribe" basic resources, such as food, which are provided by associated community organizations.[17]

At the community level, family physicians could influence community changes and improve community participation by taking active part in debates on social issues.[18] An interesting health initiative taking place in Massachusetts to address hunger and nutrition in communities is the co-location of health care and social services such as on-site emergency food boxes or other programs; co-location of health care and social programs in communities can increase accessibility and patient use of services and improve program efficiencies.[19]

At the institutional level, family physicians can advocate for political institutions to make changes in areas affecting the health of their patients such as guaranteeing food access or increasing minimum wage.[18,19]

Conclusion

Family physicians should acknowledge the importance of food insecurity as a determinant of health. Patients experiencing food insecurity need the support of their family physicians to improve their social, physical, and mental health.

Dr Roncarolo is a postdoctoral fellow in the Public Health Research Institute at the University of Montreal in Quebec. **Dr Potvin** is Full Professor in the School of Public Health at the University of Montreal.

Competing interests
None declared

Correspondence
Dr Federico Roncarolo; e-mail **federico.roncarolo@umontreal.ca**

References

1. Food and Agriculture Organization of the United Nations. *Report of the World Food Summit: 13-17 November 1996*. Rome, It: Food and Agriculture Organization of the United Nations; 1996. Available from: **www.fao.org/docrep/003/w3548e/w3548e00.htm**. Accessed 2016 Feb 24.
2. Vozoris NT, Tarasuk VS. Household food insufficiency is associated with poorer health. *J Nutr* 2003;133(1):120-6.
3. Che J, Chen J. Food insecurity in Canadian households. *Health Rep* 2001;12(4):11-22.
4. Carter KN, Kruse K, Blakely T, Collings S. The association of food security with psychological distress in New Zealand and any gender differences. *Soc Sci Med* 2011;72(9):1463-71. Epub 2011 Apr 8.
5. Riches G. Food banks and food security: welfare reform, human rights and social policy. Lessons from Canada? *Soc Policy Admin* 2002;36(6):648-63.
6. Riches G. Thinking and acting outside the charitable food box: hunger and the right to food in rich societies. *Dev Pract* 2011;21(4-5):768-75.
7. Emery JC, Fleisch VC, McIntyre L. How a guaranteed annual income could put food banks out of business. *SPP Res Pap* 2013;6(37):1-20.
8. Kirkpatrick SI, Tarasuk V. Food insecurity and participation in community food programs among low-income Toronto families. *Can J Public Health* 2009;100(2):135-9.
9. Webb KL. Introduction–food banks of the future: organizations dedicated to improving food security and protecting the health of the people they serve. *J Hunger Environ Nutr* 2013;8(3):257-60.
10. Wakefield S, Fleming J, Klassen C, Skinner A. Sweet charity, revisited: organizational responses to food insecurity in Hamilton and Toronto, Canada. *Crit Soc Policy* 2013;33:427-50.
11. Hamelin AM, Beaudry M, Habicht JP. Characterization of household food insecurity in Québec: food and feelings. *Soc Sci Med* 2002;54(1):119-32.
12. Roncarolo F, Potvin L. *Impact of traditional and alternative food security interventions on food security, health and social adaptation of new participants in Montreal, Canada*. Poster presented at: American Public Health Association 142th Annual Meeting and Expo; 2014 Nov 15-19; New Orleans, LA.
13. Tarasuk V, McIntyre L, Power E. *Report to Olivier De Schutter, the United Nations Special Rapporteur on the Right to Food Mission to Canada. Submission on civil society priority issue no. 1: hunger, poverty and the right to food.* Geneva, Switz: United Nations Human Rights Council; 2012. Available from: **http://nutritionalsciences.lamp.utoronto.ca/wp-content/uploads/2012/07/Special-Rapporteur-submission-on-household-food-insecurity-01MAY2012-final-copy.pdf.** Accessed 2016 Feb 23.
14. Ronksley PE, Sanmartin C, Campbell DJT, Weaver RG, Allan GM, McBrien KA, et al. *Perceived barriers to primary care among western Canadians with chronic conditions.* Ottawa, ON: Statistics Canada; 2014.
15. Loopstra R, Tarasuk V. The relationship between food banks and household food insecurity among low-income Toronto families. *Can Public Policy* 2012;38(4):497-514.
16. Goel V, McIssac W. Health promotion in clinical practice. In: Poland B, Green LW, Rootman I, editors. *Settings for health promotion: linking theory and practice*. Thousand Oaks, CA: Sage; 2000. p. 217-49.
17. Onie RD. Creating a new model to help health care providers write prescriptions for health. *Health Aff* (Millwood) 2012;31(12):2795-6. Epub 2012 Nov 21.
18. Gruen RL, Pearson SD, Brennan TA. Physician-citizens—public roles and professional obligations. *JAMA* 2004;291(1):94-8.
19. Gottlieb L, Sandel M, Adler NE. Collecting and applying data on social determinants of health in health care settings. *JAMA Intern Med* 2013;173(11):1017-20.