Food insecurity: What is the clinician’s role?

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Food insecurity, or food poverty, describes uncertainty in consistently accessing nutritious food in socially acceptable ways. Although food insecurity is only one of several important social determinants of health, it is a common problem in many countries, including Canada (where 9% of households experience it1), the United States and the United Kingdom. Food insecurity is associated with poor health, particularly cardiometabolic diseases such as obesity, diabetes and hypertension, as well as mental health disorders.2,3 There are few data, however, on its association with health care costs. In a linked research article, Tarasuk and colleagues4 help fill this important gap by examining annual health care costs by level of food insecurity.

Given widespread efforts to contain health care spending, and recognition that public policy programs may influence health indirectly, information about the costs associated with food insecurity is vitally important. Tarasuk and colleagues4 linked data on household food insecurity collected through the Canadian Community Health Survey to health expenditure data collected by the Ontario Ministry of Health and Long-Term Care. They found that annual health care costs in households with moderate or severe food insecurity were about $500–$1000 higher than costs in food-secure households. There was a “dose–response” pattern, with more severe food insecurity being associated with higher costs.

The cross-sectional design of the study precludes the evaluation of time ordering. The inability to determine whether food insecurity or health spending came first is an important limitation because of the strong potential for “reverse causation.” Worsening health can make employment difficult and increase out-of-pocket health-related expenses. This can lead to food insecurity. Because Tarasuk and colleagues did not adjust for indicators of poor health or disease severity, we should be cautious about concluding that food insecurity causes increased health care spending. The association between food insecurity and poor health is likely complex, bi-directional and self-perpetuating: food insecurity may lead to poor health, worsening health can lead to worsening food insecurity, and the cycle continues.3 For clinical management, however, untangling causality might not be necessary. Adhering to a healthy diet is the foundation for preventing and treating cardiometabolic disease. However, food insecurity promotes consumption of highly processed, energy-dense foods laden with saturated fats, simple carbohydrates and sodium, because these foods are often cheaper than healthier alternatives.3 Whether or not food insecurity and poor health are causally related, once they coexist, food insecurity is clinically relevant.

A common question is whether routine screening for food insecurity with a validated instrument5 should be done in clinical settings. If the purpose of screening for food insecurity in the context of clinical care is to make health care more patient-centred, addressing food insecurity can be justified as simply the right thing to do. If the purpose is to improve health, however, the answer is more complicated. As in most cases of screening for health promotion, whether one should screen for food insecurity depends heavily on how the information will be used. No evidence yet shows that this type of screening improves health. Nevertheless, if routine screening for food insecurity changes clinical management, then it seems reasonable, especially given its low burden and cost.

Will screening for food insecurity change clinical management? There are situations where it clearly should. Patients with diabetes, for example, experience increased risk of hypoglycemia when food intake changes (as money

**Key points**

- Food insecurity is common and linked to poor health outcomes.
- It is not known yet whether screening for food insecurity will improve health.
- Discussing food insecurity with patients is appropriate when it will change clinical management, and it may make care more patient-centred.
- In the absence of government-sponsored nutritional assistance programs, collaborations between community organizations and health care systems is a promising approach for addressing food insecurity.
that vulnerable patients face, such as intense demands on time placed by comorbidity, caregiving responsibilities and work, and knowledge of and equipment for food preparation. Future studies should determine whether medically tailored meals programs improve health, and if so, situations where they may be cost saving.

Food insecurity is a common problem, associated with both poor health and increased health care costs. Although we do not yet know whether these associations are causal, or whether routine screening for food insecurity will improve health, asking patients about food insecurity where it may change clinical management is appropriate. Studies to determine how best to overcome food insecurity will expand our ability to help patients who face this pernicious barrier to health.

References

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