More Than an Apple a Day: How Food Insecurity Tests the Boundaries of Medicine

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The patient's chart says *non-adherent*. Their blood pressure remains uncontrolled, their cholesterol is elevated, and previous recommendations for a nutritious diet were never followed. On paper, the problem appears straightforward, but the chart does not note that this patient must choose between groceries and rent each month, and the fight for groceries rarely wins.

This scenario is not an exception. In 2023, Statistics Canada reported that 25.5% of Canadians live in households experiencing food insecurity.[1] Food insecurity refers to inadequate or insecure access to food due to financial constraints, with experiences ranging in severity from worrying about running out of food to going whole days without eating.[2] While hunger itself may seem separate from medicine, its consequences are not. In exam rooms and emergency departments, food insecurity is not an abstract social issue but a clinical reality. It's no secret that lack of access to affordable, healthy food is directly associated with increased risk of cardiovascular disease, diabetes, and poor mental health, or even that individuals experiencing food insecurity are more likely to experience premature death.[2,3,4,5] When these preventable health consequences affect millions of Canadians, the impact goes far beyond individual patient encounters and pours into the healthcare system itself.

Food insecurity places an enormous and costly burden on the healthcare system. Individuals experiencing food insecurity are more likely to require acute care, experience longer hospital stays, and face higher readmission rates.[6] These patterns translate into higher costs for the healthcare system, as the average acute care expenditure for a Canadian facing food insecurity is $400-$565 higher per year than that of someone who is food secure.[6] Between 2011 and 2017, total acute care expenditures among adults in sampled Canadian regions were estimated at $155 billion, of which 4.4% ($6.82 billion) represented excess costs attributable to food insecurity.[6] Faced with this widespread impact, the question becomes unavoidable: who is expected to respond to this crisis? In the day-to-day, it seems that the finger points at physicians and frontline healthcare providers.

Canadian physicians are increasingly asked to treat hunger with stethoscopes, often managing the medical consequences of food insecurity rather than its root causes. However, this is not a failure of individual physicians, but rather a reflection of the systems that ask medicine to compensate for the gaps in social programming that it was never designed to fill. Repeated exposure to the health consequences of food insecurity without the means to meaningfully intervene creates a burden that is not only clinical, but also moral.[7] While treating the downstream effects of hunger remains possible, treating hunger itself often is not. This dissonance between recognizing a patient's unmet needs and the lack of tools to intervene can create an immense sense of distress that grows larger over time.[8] Unsurprisingly, physicians report barriers such as limited appointment time and feeling inadequately prepared to connect patients with appropriate resources to manage food insecurity.[7]

As this moral and clinical burden grows, healthcare provider burnout has reached an all-time high, with physicians increasingly expected to meet both rising clinical demands and unresolved social needs of their patients.[9] In the absence of effective interventions, physicians are left to manage problems they did not create and cannot resolve on their own. As current government programming falls short and local food banks are overwhelmed, atten-

tion has turned to a potential intervention situated at the boundary between healthcare and social need: prescribing groceries.

Food prescriptions are an emerging, evidence-informed healthcare intervention aimed at improving access to healthy foods while reducing burdens on the healthcare system.[10,11] In practice, these programs may involve physicians prescribing vouchers that enable patients to access nutritious food through participating retailers and community partners, or referring patients to dietitians and food literacy programming.[10] Research has shown that food prescription programs can improve affordability and accessibility of nutritious food, increase fruit and vegetable intake, and enhance household food security.[11,12] Additional benefits include improved food literacy, such as enhanced nutrition knowledge, greater exposure to healthy ingredients, and the acquisition of essential cooking skills.[12,13] Compared with emergency food provisions (e.g., local food banks), food prescription programs can be integrated into clinical care, enabling physicians to directly reduce patients' barriers to accessing food. These programs align closely with broader efforts to address the social determinants of health, ultimately advancing health equity.[14] While concerns about program costs are valid, these interventions may reduce healthcare utilization, yielding potential healthcare system savings alongside improved quality of life and reduced rates of premature mortality.[5,6]

However, food prescriptions are not a cure for food insecurity. These programs do not provide sufficient food to meet all nutritional needs and will not lead to lasting health benefits if the root causes of food insecurity remain unchanged.[11] Although food prescriptions cannot solve food insecurity, they may be seen as a harm-reduction tool: important measures that reduce preventable illness and alleviate the moral distress physicians experience when hunger is identified but left unaddressed.[14] They are not substitutes for social policy but provide temporary support when more substantial interventions are unavailable. Given these limitations, a broader response is needed. When physicians alone cannot solve food insecurity, collective advocacy within medicine becomes especially important. Medical trainees and healthcare providers can do their part by supporting the integration of food security screening and advocating for partnerships with community organizations that strengthen food access initiatives.[13,15,16] At the policy level, professional medical corporations may leverage their collective voice to advocate for income supports and social policies that address the root of food insecurity.[14]

Food insecurity is a health crisis that drives preventable illness, strains healthcare systems, and contributes to growing physician burnout.[1,5,9] Physicians cannot solve food insecurity on their own, but given their proximity to its consequences, they have a collective responsibility to call it as it is. Hunger is not a medical oversight, but a policy failure with profound medical consequences. Acknowledging this is the first step toward sustainable change in addressing food insecurity.

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Conflicts of Interest Disclosure
There are no conflicts of interest to declare.