

Food insecurity in Australia: Implications for general practitioners

Rebecca Lindberg, Mark Lawrence, Lisa Gold, Sharon Friel, Olivia Pegram

Background

In Australia, it would appear that food is abundant. For a proportion of people, however, accessing enough food to eat can be a daily or weekly struggle.

Objectives

This article provides a summary about the prevalence, causes and consequences of food insecurity that affects vulnerable populations in Australia, and discusses the implications for general practitioners (GPs).

Discussion

It is estimated that 4% of Australians cannot access sufficient, safe and nutritious food. Food insecurity can be both a precursor to, and a by-product of, chronic disease and poverty. Patients who are food insecure may skip meals, eat cheap food and experience stress. They may show incredible resilience and skills in managing and masking this issue. Identifying this vulnerable population is of high importance to GPs as it has an impact on the work-up and care of such individuals. Effective links between welfare and health services are required to address patients' material, financial and environmental barriers to food security.

Food security has been defined by the United Nation's Food and Agriculture Organization as existing 'when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life'.¹ Food insecurity exists when access to food becomes impossible and can impact individuals, households or whole communities in Australia.

Food insecurity is measured by a standard food insecurity question: 'In the past 12 months, were there any times that you ran out of food and couldn't afford to buy any more?'.² For those who experience food insecurity, it has significant health and social costs.³ In a climate of increasing nutritious-food prices, wider gaps in household income brackets and environmental resource pressures, food insecurity is likely to grow in prevalence and severity. The objective of this article is to provide an overview of the prevalence, causes and consequences of food insecurity, and discuss the implications for general practitioners (GPs).

Food insecurity – Causes and consequences

In 2011–12, 4% of Australians experienced food insecurity.² An understanding of the factors that increase the likelihood of individuals experiencing food insecurity will aid GPs in identifying this patient population when they present. A higher prevalence of food insecurity has been

reported among particularly marginalised communities, such as asylum seekers (71%),⁴ Aboriginal and Torres Strait Islander peoples (22%),⁵ disadvantaged urban households (25%)⁶ and people who are unemployed (23%).⁷

A variety of contributing factors can cause or perpetuate food insecurity. The cost of food and household income are the most consistently reported underlying determinants of food insecurity.⁸ Australian families that are welfare-dependent spend 40% of their disposable income in order to afford a nutritious diet, as opposed to 20% for the average Australian family.⁹ Households that are on low income are at greater risk for a number of chronic diseases and may live in regions where fast food outlets are 2.5 times more accessible when compared with affluent regions.¹⁰ Qualitative research suggests that for some people, their food budget is seen as discretionary and can be pushed down the priority line.¹¹ People who are reliant on a 'Newstart allowance' have as little as \$25 a week for discretionary spending (after fixed costs such as rent and utilities are met),¹² and are therefore unlikely to be able to afford a diet consistent with current recommendations.

Among urban populations, poverty, increased cost of living and poor housing were reported as playing significant roles in food security status.^{6,11} Various issues can have an impact on the food security of remote Aboriginal and Torres Strait Islander communities, including a

food supply that is irregular, culturally inappropriate or non-nutritious.¹³ People living in caravans, crisis accommodation or experiencing homelessness have a compromised ability to store and prepare food.¹⁴ Low educational attainment and/or poor food literacy can also compromise an individual's or a household's food security.¹⁵ Whole communities can be at risk of food and water insecurity in the wake of natural disasters such as bushfires.¹⁶

Several studies have highlighted the thrift, skills and nutrition-conscious behaviours displayed in households that are disadvantaged,^{17,18} and the capacity of people to develop resilience and use creative, coping mechanisms.¹⁹ A number of food and social programs are emerging to tackle the causes of food insecurity, including community gardens, school meal programs, advocacy coalitions and state-wide food policies.^{20–23} Despite this, food insecurity remains an important and often under-reported issue.

In Australia, Ramsey and colleagues found food insecurity was associated with lower household income, increased use of healthcare, poorer general health and depression (n = 505 urban households).⁶ A community report qualitatively examined how mothers who were on low income managed food costs, and found that they were anxious, needed to use food relief services and were concerned about their children's welfare.¹¹ A study of 185 households that are food insecure reported that children in the households had increased frequency of school truancy and behavioural problems.²⁴

A South Australian study found those experiencing food insecurity tend to consume less fruit and vegetables,²⁵ although this is not a consistent finding.⁶ Burns concluded that overweight and obesity rates were 20–40% higher among women who were food insecure.⁷ Food insecurity research highlights why groups that are vulnerable and on low incomes are more likely to display health risk factors such as poor nutrition.

Research conducted in other high-income countries provides further insight on the consequences of food insecurity. Negative health outcomes for children living in food-insecure households include higher risks of particular birth defects,²⁶ increased hospitalisation²⁷ and iron deficiency anaemia.²⁸ Among adults who experience food insecurity, the consequences include increased risk of developing kidney disease,²⁹ nutrient inadequacies,³⁰ mental health issues,³¹ and higher levels of risk factors for cardiovascular diseases³² and diabetes.³³ Geriatric people who experience food insecurity have been found to have lower self-reported wellbeing³⁴ and insufficient nutrient intakes.³⁵ Food insecurity, obesity and chronic disease coexist, although the complex association between them requires further research.³⁶

Implications for GPs

GPs are exposed to the issue of food insecurity in two main ways. First, GPs treat the consequences of food insecurity, which include physical, social and emotional ramifications, and increased risks for chronic disease. Second, GPs have the opportunity to identify food insecurity and work collaboratively with peers, allied health and the welfare sector to decrease its impact and monitor patient progress.

Food insecurity identification, treatment and referral

Patients who are experiencing financial or personal crisis, or are from a community that has been found to have an increased prevalence of food insecurity, should be identified as having a high risk for food insecurity. At the same time, there is no typical 'food insecure person' and people may move in and out of this state. The mischaracterisation of vulnerable populations as people who make poor food choices and have poor food knowledge unfairly prejudices affected households, and GPs are cautioned against stereotyping.

A person who experiences food insecurity is likely to present in a clinical setting with anxiety about their food or

household budget, have weight gain or loss, and nutrient deficiencies and/or the other health consequences described above. Such a patient may have run out of food and not had enough money to buy more. Regular foods may be substituted with cheaper foods, there may be instances of reduced food intake by adults or children, and periods of feasting and fasting between pay cheques. People who are regularly using emergency food relief are considered food insecure.

An Australian-specific household food insecurity questionnaire is in development, but in the interim, probing questions about diet, food budget and current stressors will help to identify this problem and offer appropriate support. Alternatively, an American screening tool could be used as a guide.³⁷

If GPs believe their patient is experiencing food insecurity, they could refer the patient to dietetic services, particularly those with nutritional or food literacy issues. Financial support for patients struggling to buy food can come from Centrelink³⁸ in the form of payments and services, or welfare programs that can offer vouchers, loans and case management support.

For patients who are homeless, or living in environments where it is difficult to store and prepare food, local council or community centres have details of Meals on Wheels³⁹ or emergency relief programs that provide free or subsidised access to pantries and meals. Local food cooperatives, gardens or markets can support patients to connect with their community and access healthy, affordable food. As far as possible, GPs should consider the home environment and cost of living in treatment plans and counsel patients on the importance of a balanced diet that is consistent with the *Australian guide to healthy eating*.⁴⁰ GPs have an important role to play in identifying and then monitoring this issue with their patient over time.

The following cases illustrate possible food insecurity scenarios presenting to general practice.

Case 1

Norm is 68 years of age and presents for his diabetic care plan. He is having difficulty controlling his blood sugar and is not accessing the food his diabetes educator has recommended. Norm finds fast food more accessible and much cheaper. He is on a disability pension and lives alone.

Norm needs ongoing support and monitoring. The issues with food affordability should be made known to his diabetes educator in order to see if low-cost options can be suggested and/or if he can be connected with a community food literacy program. Norm should possibly be referred to local services like Meals on Wheels or a community meal program in order to improve his social connections and diet. The GP or a dietitian should monitor his nutritional status.

Case 2

Selma is a mother aged 23 years. It is a Friday afternoon and she comes to see you for a minor ailment. At the end of the consultation, she expresses concern regarding her ability to feed her children over the impending long weekend. Her partner, the household income earner, has recently lost his job.

Selma needs emergency food relief. Through local welfare services, a supermarket voucher or access to a pantry should be provided. The GP could also recommend Centrelink as a place where her husband can register for an allowance while seeking work and also be connected with potential employers. Selma could also be assessed for a healthcare card or other social security support that may help to relieve any ongoing financial disadvantage in the household and prevent this issue re-occurring.

Case 3

Mrs Al-Mahdi, 43 years of age, presents to you to check her blood pressure. She and her family are new to Australia,

having recently arrived as migrants. She speaks very broken English, but from what you understand, she wants to know where she can access safe, nutritious food. It is her responsibility to buy and prepare food for her family.

Mrs Al-Mahdi needs short- to medium-term support in order to improve her food literacy for her new country. A referral to a local migrant or refugee support service is appropriate and, if possible, a food literacy program for culturally and linguistically diverse (CALD) communities should be identified. The Centre for Culture, Ethnicity and Health provides resources for practitioners working with CALD communities, and food safety and nutrition resources, developed for CALD people, are available online.

Food insecurity prevention and advocacy

There are opportunities for GPs to help prevent food insecurity. GPs can support peak national groups such as the Public Health Association of Australia⁴¹ and the Australian Food Sovereignty Alliance,⁴² which rally for healthy, equitable food policies; the Council of Social Services,⁴³ which lobbies to increase social security payments; or the National Aboriginal Community Controlled Health Organisation,⁴⁴ which advocates for improved health for Aboriginal and/or Torres Strait Islander peoples. Healthcare services could consider collaborating with groups such as SecondBite,⁴⁵ which provides free fruit and vegetables to the community sector; the Red Cross⁴⁶ and the Stephanie Alexander Kitchen Garden Foundation,⁴⁷ which support healthy food in schools; and other local health promotion and community food interventions. GPs can also share, as appropriate, their clinical experiences of this issue to lend weight and support to these important preventative approaches.

Conclusion

One in 25 Australians (4%) experiences food insecurity each year. A variety of determinants can cause or perpetuate food

insecurity, affecting the ability of a person to afford, store and prepare food. In the long term, strong social, food and health policies and interventions are required to give everyone in Australia the chance to enjoy healthy, sustainable and affordable food. In a clinical setting, GPs should be aware of the social and dietary behaviours of their patients and, if food insecurity is detected, it is vital that this issue is monitored and referrals for additional support are made. Food security will help improve patients' health in the long term, and is likely to reduce their need for clinical care.

Authors

Rebecca Lindberg BA, BAS (Hons), PhD candidate, Deakin University, Burwood, VIC. rlindber@deakin.edu.au

Mark Lawrence MSc, PhD, Professor in Public Health, Deakin University, Burwood, VIC

Lisa Gold PhD, Associate Professor in Health Economics, Professor, Deakin University, Burwood, VIC

Sharon Friel MSc, PhD, Director, Regulatory Institutions Network and Professor of Health Equity, Australian National University, Acton, ACT
Olivia Pegram MBBS, PGDipSurgAnat, General Practice Registrar, Kwinana Medical Centre, Medina, WA

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correspondence afp@racgp.org.au