Feed Opportunity
CENTRE FOR FOOD SECURITY

August 2, 2023

# Maple Leaf Centre for Food Security Dialogues on Food Prescribing, 14th June 2023

## Detailed Themes from Dialogues: Strengths, Challenges, Opportunities & Resources

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## Future Visions of Food Prescribing: By 2026…

- A food prescription program is rolled out in addition to other measures, including income supplementation, for individuals and families that are food insecure
- Prescription programs have been designed with input from people with lived experience of food insecurity
- Food prescriptions can be used flexibly between large retailers and smaller local markets, offer choice in what food can be purchased, and are provided in a way that fosters dignity and reduces stigma
- Food prescriptions are sensitive to cultural food needs and provide education and food skills support for patients who require it
- Food prescriptions are accessible to people who need them
- Food prescription programs have sustained funding from government bodies
- Food prescriptions are as legitimate as pharmaceutical prescriptions

## Strengths of Food Prescribing as an Intervention: What resonated with participants

### *Good food supports good health and other outcomes*

There was a general agreement among participants that good food is important for good health – physically, mentally, and emotionally. Participants agreed that food is medicine in that it provides nutrition, but that food can also be used to foster social connectedness and a sense of belonging within communities. Participants resonated with the idea that food prescriptions, in addition to providing

access to affordable food, could contribute to other outcomes including sustainable or local agriculture and local economic development.

### *Trust between patients and healthcare providers*

Participants shared that food prescriptions have the potential to foster trust between health care providers and patients and encourage patient-centred care. Social prescribing goes beyond a biomedical model of care to support patients with the social determinants of health. Participants noted that social prescribing could help patients feel comfortable asking their healthcare providers for help and allows providers to support patients with their food needs. As food is one of the most discretionary expenses available to households, participants felt food prescriptions could open room in the household budget for fixed costs like rent.

### *Potential to reduce healthcare burden over time*

Participants discussed the potential for food prescriptions and social prescribing in general to lower the burden of managing the social determinants of health within primary care. This burden was discussed in terms of the healthcare costs associated with poverty and food insecurity and participants felt there was potential for food prescribing to lower healthcare costs down the road. Participants notes that food prescribing could enable allied healthcare providers rather than just doctors (including dietitians, community health workers) to link patients experiencing food insecurity with a tangible service that could address their immediate nutrition and health needs.

## Threats and Challenges: Food prescribing in a 'sick care' system

### *Power and the 'sick care' system*

Participants discussed the reality of the healthcare system in Canada as being more of a 'sick care' system that is reactive to people who are already sick, rather than proactively addressing patient needs or preventing them. Participants discussed the structure of the healthcare system and how much power hospitals hold within the healthcare system. Participants felt that there were few hospitals actively investing in preventative models of care or incorporating programming to address the social determinants.

### *Funding*

This system is reinforced by insufficient funding for preventative health care and health promotion activities compared to acute health care in Canada. Participants expressed fear that the primacy of the pharmaceutics in Canada could prevent preventative interventions from reaching scale. Participants also noted scarce funding within the community food security space, which could pose a threat to scale food prescription programs, and the risk posed by philanthropic funding that often comes in 1-3 year cycles and makes it challenging to offer sustainable programming within community organizations.

Participants also acknowledged that food prescription programs tend to require significant upfront investment, while the potential for cost savings is there but not guaranteed. Participants believed strongly that patients should have choice over the foods they have access to, which could make it challenging to receive funding from health-related organizations or government departments who might want restrictions placed on food prescriptions so they can only be used for certain things. Since

responsibility for health is split between the federal government and the provinces with provinces holding the jurisdiction for healthcare, any prescription effort would likely need to be catered to the provincial funding context.

### *Overburdened healthcare system*

Participants acknowledged the strain within the Canadian healthcare system and in some cases, were grappling directly with the lack of capacity in healthcare institutions. Participants noted that this lack of capacity could make it challenging for healthcare to be a willing partner in these interventions and make it harder to collaborate. Participants with experience working with primary care providers noted that there is pressure to provide care within a small window of time and that this could make it challenging to get physician buy-in for food prescribing. Many noted that this is connected to a bigger issue of misplaced incentives within the healthcare system that encourage doctors to focus on quantity of patients served rather than quality of care provided. Others noted that physicians are sometimes not willing to have conversations with patients about issues they can't help with or that seem outside their scope. Some also noted that while prescriptions could build trust, they could also reinforce existing power structures between providers and patients and be subject to provider bias. Some participants make the point that these programs could exacerbate discrimination, racism, and paternalism that already exists within parts of the healthcare system.

### *Public awareness and understanding*

Many felt there is a lack of public understanding of what food prescriptions are and a lack of awareness that these programs exist. Participants had also struggled with public perceptions that some groups of people are 'less deserving' of support, particularly working age adults, and that this bias makes it harder to get sustained funding for programs to support this group of people. One participant described prescriptions for food as medicine is such a big and jargony idea that policymakers might not be able to "sink their teeth into it".

### *Scale*

Participants also discussed challenges of scaling. Participants discussed the intricacies of food distribution systems and that this could make scaling prescription programs challenging, particularly if they are fully reliant on non-profit infrastructure. Participants felt a centralized program could be helpful to reduce inefficiencies of food prescribing programs and reduce the administrative burden on individual partners but expressed concern that a centralized approach could ignore community context and the needs of particular groups. Finally, participants noted the importance of collecting detail data about prescription implementation and participant outcomes but acknowledged that data collection needs to be carefully designed in order to be ethical and respect patient privacy.

## Areas of Opportunity: Advancing food as medicine

### *Awareness of the social determinants of health*

Participants noted the importance of reframing of the focus in primary care to prevention. They discussed that the proliferation of public health programs and training on the social determinants of health in medical school could result in primary care providers with greater understanding and willingness to address these things in their scope of work.

### *Learning from community organizations and collaborating across sectors*

Many participants felt it was important for the healthcare sector to partner with community organizations in order to reach potential participants and learn from their experience supporting people with the social determinants of health. Participants agreed that community organizations play an important role as connectors and often know what their communities need. Participants noted a potential ally in this work could be the Canadian Red Cross, who has advocated for food security internationally and has credibility in this area. Participants noted the opportunity to reach people via different pathways – including through schools or non-profit housing providers.

Participants also noted that a partnership of diverse cross-sector stakeholders could present a united ask to government and make a case for investment in food prescriptions – and that this would likely be more effective than individual organizations making asks for individual programs. Participants acknowledged the need for governments and industry to be at the table to support the scaling of food prescriptions. Many participants felt that private sector partners being involved in the scaling of food prescription programs could broaden participant choice and improve accessibility. Participants noted that social prescribing programs would likely require a coordinator to support collaboration between cross-sectoral partners and to support health providers in the prescribing process. Others noted the opportunity to work with governments to target groups who are most vulnerable to food insecurity through existing government programs, such as provincial disability support payment programs.

### *Integrated models of care and incentives*

Participants noted the potential of integrated models of care for implementing food prescriptions. Participants suggested working with Community Health Centres to test and scale food prescriptions models, as they already operate in a way that seeks to support patients with the social determinants of health and are already integrated within communities. Participants with experience with CHCs noted that they are adapted to the needs of local neighbourhoods and could make sure social prescribing programs are meeting the needs of their patients.

Participants discussed incentive models that could trigger different behaviour among key actors, including healthcare actors, insurers, and patients. Participants noted creative ways to incentivize health insurers to care about the social determinants of health. Others noted certain healthcare models that incentivize physicians to treat the 'whole patient' – and that many CHCs are good examples to look to. A few participants shared the method of bundled payments to fund multiple providers and settings for a 'bundle' of care, which could open up space for preventative interventions and those that address food insecurity and incentivize providers to treat patients differently. Others shared ideas to incentivize patients to purchase healthier foods without removing choice from prescription programs – like providing extra subsidies for fresh fruits and vegetables.

### *Leveraging technology and data*

Participants discussed the opportunity to leverage technology throughout the user experience of a food prescription. Participants discussed the opportunity to include a brief food insecurity screening tool as part of electronic medical records to determine which patients might be most in need of food prescriptions. Technology platforms could fulfill some of the design requirements for a scaled food prescription program, including platforms like Instacart that link people with multiple different food vendors and provide a dignified way to transfer funds to people.

Participants felt that robust research and evaluation of food prescription programs would be needed to make the case for sustained government funding. They identified results of food prescription programs that demonstrate improved health and other outcomes connected to food insecurity and the opportunity to start sharing these with potential funding bodies. Participants also noted the opportunity for case studies of existing food-related programs with provincial health ministry support – like the B.C. farmers market voucher program).

## Resources Needed

- Immediate funding for small scale pilots that provide rapid feedback about what works and what doesn't for different communities and contexts to inform a scaling plan
- Sustained funding from government bodies, such as a dedicated budget line, to ensure programs can last over time
- Willingness from healthcare institutions to participate
- Spaces for further learning and knowledge sharing to take place between practitioners implementing food prescription programs
- Human capacity to coordinate between different cross-sectoral actors – including community organizations, healthcare institutions, governments, philanthropic funders, private sector food retailers, and farmers/producers
- Support from researchers and evaluators to capture the process and outcome metrics and data that will build a stronger case for food prescriptions

## Tough Questions and Areas for Further Discussion

- How can we advance food prescriptions while still pushing for better income supports? How can food prescriptions be advanced within further entrenching emergency food relief? How can we prevent governments and others from viewing food prescriptions as a silver bullet solution for food insecurity when other interventions are needed?
- How do we advance food prescriptions within the Canadian healthcare system when the dominant model of healthcare prioritizes pharmaceutical interventions and there are few incentives for prevention? How do we move food from an ancillary service to a medical intervention?
- How to incorporate place-based needs of communities while aiming for scale reach with food prescriptions?
- Is food prescribing meant to be temporary or long-term? How do we grapple with the idea that food prescriptions could end due to funding or other constraints, and how might that impact participants?
- How can we best to communicate and frame the concept of food prescriptions to government, when food security doesn’t neatly fit into a single budget line, department, or level of government? How should food prescription practitioners engage with political parties versus bureaucrats, and how should they communicate between siloed areas of government?
- How do we design a program that supports people who are most affected by food insecurity without stigmatizing them? How should food prescription programs be targeted or universal? Who might get left out?