Plenary 4 – Presentation by Steven Lewis

Comments captured below compliment the Power Point slides shown during this presentation:

- Form should follow function in the organization of health care
- Intellectual consensus and common recognition that there is a mis-alignment between resources and needs in health care
- Cost-control is also an agreed upon concern.
- Canada = rated as poor value for money in terms of work / outcomes. Consistently ranked as one of the bottom performers when compared to other countries.
- There is no question that primary care and public health are political concepts (both are about distributive justice / egalitarian values)
- Primary care and public health care are more collective in nature rather than individualistic
- The challenge in this forum is how do you make your point re: health care system change without coming off as being overly political.
- Vocabulary matters (primary health care is what we WANT). Primary care is what we have.
- We have to worry about the retreat to a primary care that is primarily physician centric – backlash against multi-disciplinary, community-focused health care.
- Difference between aspiration and commitment – How do you make an aspiration an actual priority. Necessity to reorient funding and policy to support and show commitment.
- Middle-classed concept of orienting health care planning and dollars does not support the needs of at-risk groups / vulnerable populations
- Currently, there is little to no accountability for achieving broad health goals or for meeting health care needs equitably.
- It is necessary to reflect upon the estimated statistics that the health care system alone is only attributable to approximately 20% of change to health outcomes.
- Real accountability is that organizations / staff are taking things seriously – concrete plans and values that are committed to the reduction of inequities – focusing on the social determinants of health in on the ground ways.
- Another necessary thing to recognize: The Health care system = A big part of our economy (12% of GDP).
- Our health care economy thrives on overstated risks, understated harms and overhyped hopes
- We are all preoccupied with the here and now – difficult to convince people to care about tomorrow (10 years from now) = prevention is undervalued – particularly if there isn’t any tangible short or medium term benefits that are recognizable at the individual level.
- Anonymous benefits are difficult promote when people don’t know where their work / giving is going to (need for a name and face).
- Example of this reality: Foundation dollars typically go to children’s hospitals, disease-oriented issues, etc. but not community health clinics.
• Technology often outweighs and is more sexy than preventative practice (diagnostic / treatment equipment vs. basic exercise).
• Public health / population health is only supported in crisis moments that are often affiliated with infectious disease outbreaks (SARs, H1N1, etc.). General public does not necessarily understand or appreciate what public health / population truly is in its broad scope.
• Opinion of Steven Lewis: Better to take the risk and initiate collaboration between primary health care and public health, rather than hold off because of cautiousness – fear that public health efforts will diminish over time. Collaboration has the potential to increase the number of people and $$ towards collective initiatives for public health strategies and visions.
• Necessary for public health to be inside as many tents / in as many different teams as possible – engagement and communication is the key to everything

What Can Be Done?

• Influence the indicators agenda. Those who have the power and influence to define success and failure will own the future. Example of a changing focus on indicators and what they represent (Eg. Valuing and quantifying lost human capital due to ill health versus wait times for health care.)
• Communicate well (social media, social marketing, creation of narrative, sexifying public health)
• Make connections with a variety of potential partners who are neutral and who might be convinced to become involved.
• Reframe the inequality agenda: Inequality is scarier than the flu. Poverty cripples the economy. Disparities breed conflict. (Use of the same advertising / language techniques as the corporate world)
• The evidence / stories are available to support the primary health care / public health agenda – It just comes down to how you package this evidence and present it.
• 3rd party advocates are gold .. engage the unusual suspects.
• We need population based funding that joins PHC, home care, community-based services.
• We need to be at the table with the BCMA and the Government to discuss fee for service – central issue to address. The current billing system is a huge barrier to more integrated care.
• Reform also needed re: health science education and health practitioners in training.
• Young practitioners today do want something different – are hopeful and are progressive. Things seem to change once they have entered the system – how to best support new practitioners with new ideas about how to do things?
• Need to be able to point out where health care is not effective (what is over-hyped)
• Try to monetize you case – Business framing is needed. (Emphasis on returns / estimate re: the cost of not acting and not investing in prevention)
• Promote real community ownership and governance. Ground up community development.

Optimism
• Current state world-wide = skepticism. Hunger for something different. Public health has an opportunity to gain new ground.
• Municipal governments / urban planners – they get this approach. Municipalities are more in touch with the issues close to home. Powerful place to begin to make positive changes.
• Research / evidence is everywhere!! Use this information to back up your arguments.
• Nudge – Very good book that looks at how to persuade people in small ways that are not overly intrusive.

Comments from John Millar

• Two complex systems that we are coping with (health care system within the broader economic system – both political in nature).
• Complex system change – You need to have a clear vision and distributed leadership, civil dialogue, taking action on best available evidence, monitor work to continuously improve
• Governance at a local level – We need structures in place so that community can take ownership and become involved in shaping health care
• How to convince late adapters to support collaborative PH & PC?: Provide infrastructure, training and support for collaborative practice, show ongoing evidence to support work and the positive outcomes that patients and families experience.
• Need to be very clear about what we support re: public health work – what is truly working / showing prevention results over time.
• Choose your battles and focus your energy – example of an easy argument to make = The importance of early childhood development – 6 to 1 cost benefit in the long term with investment in ECD supports.
• Boards of trade / business community - key starting points re: partnerships. How to initiate these partnerships? Examples?

Questions from audience

• What are the ‘tents’ that primary health care currently sits it and should potentially sit in? PHABC can potentially be the tent that can support and guide alternative forms of primary health care.
• Discussion re: Governance for health care – Co-op model. People who use the service are a part of defining it – setting up the terms of reference.
• Hospital governance is very powerful. Would be useful to look at what hospital leadership is doing right in terms advocating and securing dollars / programming.