The Power of Partnership Beyond Social Prescribing

Le pouvoir du partenariat au-delà de la prescription sociale

COMMENTARY

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ABSTRACT

This commentary focuses on the social determinants of health and how they may be more fully integrated into engagement-capable environments. In this commentary, the authors provide excerpts from their in-depth discussion that explored how the foundational principles of the Gattuso Centre for Social Medicine emphasize the importance of prioritizing care for populations that are marginalized and engaging communities to improve health outcomes. The article delves into some of the historic and current issues facing communities and individuals that are marginalized and describes how a large academic centre has leveraged its structures and resources to build partnerships with communities and community organizations to address these challenges.

RÉSUMÉ

Ce commentaire porte sur les déterminants sociaux de la santé et sur la façon dont ils pourraient être mieux intégrés aux environnements propices à la participation. Dans cet article, les auteurs citent des extraits de leur analyse approfondie des façons dont les principes fondateurs du Centre Gattuso pour la médecine sociale insistent sur l'importance de prioriser les soins pour les populations marginalisées et de mobiliser les communautés pour améliorer les résultats cliniques. L'article explore certains enjeux historiques et actuels pour les communautés et les personnes marginalisées et décrit comment un grand centre universitaire a répondu à ces enjeux en tirant parti de son infrastructure et de ses ressources pour établir des partenariats avec les communautés et leurs organismes.

Key Takeaways

- We must prioritize lived experience and leverage population health data to meaningfully address inequities in healthcare. For meaningful change to happen, we must be willing to confront the chronically unconscionable health outcomes facing marginalized communities.
- Partnership with communities during COVID-19 demonstrated that we can deliver innovations in the public system and we need to implement these lessons to ensure better health access and outcomes for all.
- The power of partnership beyond *social prescribing* demonstrates what health and social care integration can look like beyond the walls of the hospital.

Introduction

While the concept of social determinants of health is not new, increasing efforts to better link health and social care are emerging, with innovations seen in public and community health sectors, with increased focus on integrated care and in the design of systems and policies that support active connections between these previously isolated sectors. The recent COVID-19 pandemic revealed the stark realities of inequities in health and in care and has propelled efforts to bring together health and social care in more meaningful and relevant ways.

Prior to the COVID-19 pandemic, Canada's largest academic health sciences centre – the University Health Network (UHN) in Toronto, ON – created the Gattuso Centre for Social Medicine. This novel program, set within the traditional hospital sector, focuses on integrating social determinants of health (e.g., housing, food) into care delivery and supports better partnering with community organizations to improve access to care and improving the quality of care for structurally disadvantaged populations. Driven by a commitment to health equity, the centre underscores the need for policy changes to support integrated health and social care, advocating for a more universal and effective healthcare system. Underpinning this work are foundational efforts to improve population health. Collaborative work and partnership have been central to advancing the work of the centre, recognizing the importance of lived experience of those in diverse communities served by UHN.

This commentary provides excerpts of a discussion that one of the co-guest editors of this special edition, Maggie Keresteci (MK), and Andrew Boozary (AB), founding executive director of the Gattuso Centre for Social Medicine, had about engagement-capable environments. Throughout our discussion, the "leadership" pillar of the engagement-capable environments model stands out – leaders who not only value and seek out other forms of experience and expertise but also centre these lived experiences in the work; leaders who understand the strengths of community

wisdom and knowledge; leaders who seek to collaborate, listen to understand and act with humility; and leaders who make space for others to enable them to lead and set direction. Lessons embedded throughout this interview point us to areas where engagement-capable environments need to be more attentive moving from individual to community engagement and enabling others to lead.

MK: Why is the bringing together of health and social care so important?
AB: The idea behind social medicine has a solid foundation in Canada, rooted in the work of Minister Marc Lalonde, with the 1974 report entitled, *A New Perspective on the Health of Canadians* (Lalonde 1974). The report clearly outlined the need to address social factors and the social determinants of health if the health of all people in Canada was to be improved. The report meant that Canada became known as a leader in developing and then disseminating theory about the social determinants of health; however, upon reflection of the past almost 50 years since the Lalonde Report, we have not been a leader in putting the theories and principles into practice for patients and communities.

Prioritizing care for structurally disadvantaged and marginalized populations is of paramount importance if we are to truly claim a universal health system. The lack of awareness about these inequities in healthcare access and delivery became clear at the outset of the pandemic when the highest public health authority in the province stated that we do not need to collect health equity data because we have a universal healthcare system (Boyd 2020). I find it highly problematic that the highest levels of public health fall into the mirage of universality when it comes to healthcare in Canada. The mistaken belief that Canada has universally accessible healthcare and the neglect of long-standing health disparities in Canada have hindered reconsiderations of the root causes, the barriers and the potential solutions.

MK: What has been the impetus for engaging with communities in your work?
AB: One of the things reiterated early in the pandemic, in the COVID-19 vaccine response, is that rightfully, many communities have deeply rooted mistrust of hospitals and the healthcare system. There are plenty of good reasons for this mistrust as we consider the history of the healthcare system relating to violations and experimentation of Black and Indigenous populations and of how refugee newcomer populations have not been able to access healthcare. For a long time, hospitals and healthcare academia have held the view that only we hold the answers with all the basic science and therapeutic advances. This historical way of thinking and working relied on a unidirectional dynamic that did not invite or welcome the input and insights of the communities we serve. The COVID-19 community vaccine response underscored the need for a bidirectional approach to innovation, especially when it comes to healthcare delivery – and that is going to demand humility from those of us in hospital and clinical sectors.

MK: Can you provide examples of work you have done with and for communities that are underserved?
AB: We saw examples of how community coalesced to support each other and how we, at the Centre for Social Medicine, could support them in their efforts. There are many examples of innovations such as mobile clinics providing vaccines or testing in community spaces – community health ambassadors going door to door to answer questions and build trust. Vaccine clinics were set up and run on public basketball courts right beside apartment buildings to improve access for people

who did not have transportation or people who could not afford a day without paid sick leave. These issues continue to be barriers to healthcare for people today. We still do not have consistent paid sick leave for people in Ontario, and we do not consider or account for the broader indirect costs such as transportation or childcare imposed on people to see a physician or nurse in a clinic. All these factors must be reconsidered and integrated in how we deliver care as we reimagine a more equitable and effective approach to healthcare.

At the outset of the pandemic, there was a drastic shift that began in Toronto whereby within a matter of weeks, we saw Toronto Public Health ensure the collection of health equity and race-based data to better understand the needs and the disparities that were at play during this pandemic. This was really a result of strong community leadership and advocacy. It became clear, but not unsurprising to individuals working in health equity spaces, that racialized populations were three to five times more likely to be infected with COVID-19 with far worse health outcomes.

This health equity lens that was now better informed by data helped lay out the need for better policy protections for certain communities and neighbourhoods. Early on, it was also clear that unhoused individuals were facing dire risks and impossible situations when it came to physical distancing in shelters. This led to the creation of the first COVID-19 recovery hotel in Canada – an interim housing response in partnership with the City of Toronto, UHN, Parkdale Queen West Community Health Centre, Inner City Health Associates and The Neighbourhood Group (UHN 2020). The inclusion of peer support workers as part of the COVID-19 recovery hotel healthcare team really helped shape my own perspective on the need to see such a trauma-informed response in our own emergency departments at UHN.

The COVID-19 recovery hotel was created in recognition of the fact that there was a distinct gap in care for those with COVID-19 or for those at risk because they did not have access to housing as a human right. The data showed serious disparities and much worse outcomes for marginalized and structurally disadvantaged populations. The COVID-19 recovery hotel was an initiative put in place as a direct response to help mitigate these disparities. The hotel provided access to a hotel room that gave people the ability to physically distance and recover. From a care perspective, the secret sauce of the COVID-19 recovery hotel was truly the peer support workers. These are people with lived experience – many who either have used drugs or have survived homelessness – who were able to check in, provide supports for people, build trust and help in terms of navigation and provide accompaniment in the journey. Because of what we learned during this experience, the Gattuso Centre for Social Medicine worked to embed peer support workers as permanent, *bona fide* members of the UHN emergency department healthcare team. This means that people with lived experience, working as equal partners in the team alongside physicians, nurses and social workers, could help UHN bring a trauma-informed approach to care for people who have historically been stigmatized in healthcare settings.

MK: How have lived experience perspectives been embedded into the work of your program?
AB: Lived experience is core to everything that we do. My belief is that lived experience, coupled with other forms of data analysis, is the way to move more equitable and effective programs forward. So first, we interviewed people who survived homelessness as to what they wanted from the Social Medicine Housing Initiative (Bozikovic 2024). For

example, this was integral in helping inform the need for a community kitchen and inclusive pet policies. We also have a Social Medicine Lived Advisory Council that remunerates people for their time to help overcome any barriers in engagement. They are actively engaged in everything from strategic priority setting to program delivery with governance that helps keep us accountable. This is a crucial component to true co-design, and committing to this process informs all current and future interventions or initiatives taken together.

Diverse communities, especially those that are marginalized or disadvantaged, have, in fact, already established innovations in healthcare delivery that are needed to improve outcomes and to improve the system writ large. If we are to co-create a truly person-centred healthcare system, the system must approach communities with humility and respect. The pandemic lesson was clear: the healthcare sector needs to better acknowledge the wealth of knowledge and innovation that already exists within communities if we are serious about bridging and addressing long-standing health disparities. The delivery and implementation gaps across Canada have really kept us back.

MK: How does a large academic centre such as the UHN leverage any lessons or resources to advance this work?

AB: The lessons we have learned over the past four years continue to drive the strategy for the Centre for Social Medicine. We continue to gain a better understanding of the importance of the integration of social policy and health policy and believe this is desperately needed to improve population health. Integration needs to be happening on the ground for people and not just in the theoretical spaces of academic medicine. As we enter this new era, it is key that hospitals and other system leaders recognize we are not experts in everything. We must foster partnerships over prescribing. One example at UHN is the Food Rx program that the Centre for Social Medicine launched in Toronto. This initiative was launched in partnership with Food Share Toronto, an organization with deep understanding of food security and of the kind of community response that is needed to be successful. This resulted in significant improvements in health and well-being for over 200 people and families over the past two years of the pandemic (Kennedy 2022).

Another example is the housing initiative whereby UHN, in partnership with the City of Toronto and United Way Greater Toronto, has repurposed a former UHN parking lot to build 51 housing units with embedded health and social supports that will open this summer (Boozary et al. 2024). We also know that nobody wants a hospital as their "landlord." So part of the partnership includes a non-profit supportive housing operator, Fred Victor, that has deep expertise in this work (https://www.fredvictor.org/). The reality is that we need new coalitions to respond to long-standing disparities if we are serious about improving health for everyone. This is what I hope is the next evolution in health and social care integration. It requires co-design with patients and communities that have long been shut out of system decisions, and we are seeing concrete steps toward this aim.

MK: How can policy shape the care that is provided?

AB: Currently there are misaligned incentives and a siloed, fragmented system where you have various ministries, departments and organizations that are ostensibly responsible for the outcomes of that same one patient or one family. The same siloed approach at the policy level then plays out at the delivery

level. The reality is that numerous providers or ministries must collaborate for high-quality care delivery or to help create lower-risk conditions for patients and families. That is just not happening currently, and the price we pay is in how challenging it is for patients and health workers to navigate both health and social care systems.

From a public spending perspective, Canada spends fewer public dollars on health and social care than other OECD [Organisation for Economic Co-operation and Development] countries. Seeing these innovations in social medicine within the public system over the past few years, especially throughout the pandemic, gives us reason for hope. Where Canada has failed is in ensuring that such successful pilots are scaled up across the country. If we do not ensure the policy bandwidth and focus to see more delivery innovations, we are at serious risk of seeing medicare coming undone. This is a major health policy nightmare that doesn't need to happen.

MK: What is your hope for the future? Where are you seeing the bright lights now?
AB: Healthcare specifically, and society more broadly, has felt bleak recently. There is widespread despair, including significant moral distress among healthcare workers. But there are also some pockets where we can galvanize hope. Just a few years ago, the notion of what large academic health sciences networks in Canada should and could be doing in areas of poverty, systemic racism and marginalization was altogether new and untested. Yet, we are now seeing a clear articulation of the rationale for these kinds of partnerships and, more importantly, we are seeing them come into practice, changing the way care is provided. There remain very real challenges to this work, but my hope is that there are too many people working in healthcare who are unwilling to give up on progress and the moral arc of health equity.

What we were able to do in partnership with community health centres around the COVID-19 vaccine response is a source of hope. The experience of the vaccine response shows that we can deliver things differently in the public system with improved outcomes for people who have not been on the health system's radar for far too long.

The idea of re-imagining a parking lot in downtown Toronto and turning it into housing seemed impossible. Now, seeing true housing in place of a parking lot is a testament to the power of thinking differently and of acknowledging inequities head on. It has demonstrated the power of collective commitment over many years. What started as a dream in 2019 will now provide real housing options for people – not just transitional housing, but real homes for people. This is the power of partnership beyond prescribing. These 51 housing units are not going to end the homelessness crisis, but they do demonstrate, in very real terms, what is possible when we partner with communities and when we think about care in a way that extends beyond the walls of the hospital or clinic.

What gives me hope is the belief that these sorts of partnerships can hopefully be scaled elsewhere or used as a playbook of where other public institutions can mobilize these sorts of innovations in the public health system. The friendships and partnerships that went through a pressure cooker over the past few years now give me hope, given how dire and dark things feel right now.

MK: What advice do you have for others to ensure that all of us are putting lived experience perspectives at the centre?
AB: The work is never done. There are areas every day in our healthcare system where, I know, we are letting patients and families

down. But this is why I feel it is so important to build on the learned lessons of the pandemic – the first to me being the importance of prioritization. We have to be willing to confront the chronically devastating health outcomes of marginalized populations. Otherwise, nothing will change.

We cannot continue to buy into the mirage that a *universal health system* means that there is universal access. If we believe in improving the health of all in Canada, now 50 years after the call from Minister Marc Lalonde (Picard 2024), we have to centre the lived experience of people who have been pushed to the sidelines. This will mean hearing hard truths. It will also require new structures in the way we make decisions – from lived advisory councils to health equity data collection, something we do not do all that well in the Canadian system.

But there is hope here. It was not long ago that a chief medical officer of health essentially said that we did not need to collect health equity data because we had a universal health system. But within a matter of months, various public health agencies and healthcare organizations mandated the collection of this data. We still have lots to learn from communities as to how to do this well and how to ensure that we follow the best practices on data governance. And, maybe most importantly, when we identify that a patient is not taking their medications because they cannot afford it or do not know where they are going to sleep that night, we do something to help. We need to move beyond data collection exercises alone to meaningfully improve population health.

Many of us working in healthcare have the privilege of hope. Things may feel bleak, but there is strong evidence that as partners we can bend or will the system to a fairer place. In our experience, truly engagement-capable environments extend beyond the hospital or clinic walls. The partnerships we describe can be used as a guide to scale similar partnerships elsewhere so that the public health system can make meaningful strides in creating a universally accessible health system in Canada.

References

Boozary, A., C. Varner and A. Laupacis. 2024. Homelessness Is a Health Crisis: Why Hospitals Are Resorting to Building Housing. *CMAJ* 196(19): E666–67. doi:10.1503/cmaj.240649.

Boyd, A. 2020, April 10. Race-Based Coronavirus Data Not Needed in Canada yet, Health Officials Say. *Toronto Star.* Retrieved June 27, 2024. <https://www.thestar.com/news/canada/race-based-coronavirus-data-not-needed-in-canada-yet-health-officials-say/article_0ccacf74-43a3-569c-95bf-47c58b7518f2.html>.

Bozikovic, A. 2024, June 16. Toronto's University Health Network Aims to Treat Homelessness as a Health Issue. *The Globe and Mail.* Retrieved June 27, 2024. <https://www.theglobeandmail.com/canada/article-torontos-university-health-network-aims-to-treat-homelessness-as-a/>.

Kennedy, B. 2022, June 5. A Prescription for Healthy Food? Food Rx Program Gives People Access to Fresh Fruit and Vegetables on Doctor's Orders. *Toronto Star.* Retrieved June 27, 2024. <https://www.thestar.com/news/gta/a-prescription-for-healthy-food-food-rx-program-gives-people-access-to-fresh-fruit-and/article_8fae3e01-6f6b-5ed2-bde4-ed649de79d57.html>.

Lalonde, M. 1974. *A New Perspective on the Health of Canadians*. Minister of Supply and Services Canada. Retrieved June 27, 2024. <https://www.phac-aspc.gc.ca/ph-sp/pdf/perspect-eng.pdf>.

Picard, A. 2024, June 25. Some Sensible Advice on Health Spending, Still Ignored 50 Years Later. Retrieved June 27, 2024. *The Globe and Mail.* <https://www.theglobeandmail.com/opinion/article-some-sensible-advice-on-health-spending-still-ignored-50-years-later/>.

University Health Network (UHN). 2020, July 22. Hotels Offer 'Health and Human Dignity' Along With a Place to Recover. Retrieved June 27, 2024. <https://www.uhn.ca/corporate/News/Pages/Hotels_offer_health_and_human_dignity_along_with_a_place_to_recover.aspx>.