WORKSHOP HEALTH OBJECTIVES

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Health for the people

health objectives and local realities

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This is a personal record of the Crosstalks round table held in the framework of the long-term *Shake the Disease* project, started in 2018, which maintains an open dialogue on the future of health and healthcare. The workshop took place on 27 April 2022 and went looking for local projects that put the project's health objectives into practice. The workshop was chaired, introduced and led by **Jan De Maeseneer**, an (inter)national expert in general medical practice and primary health care.
Marc Noppen, pulmonologist and CEO of UZ Brussel, introduced the theme, arguing for modesty by hospitals, which, although important, are nevertheless just one small element in the complex jigsaw of health care. **Karen den Hertog**, head of the Healthy Living department of the Amsterdam-Amstelland Community Health Service (GCD), sketched out the way in which different disciplines work together in the Amsterdam region in their Amsterdam Approach to Healthy Weight (Amsterdamse Aanpak Gezond Gewicht) programme. **Mathias Neelen**, deputy coordinator of the Community Health Workers project presented the plans for these health workers and how they build bridges between healthcare and vulnerable people.

At the heart of the matter

A few days after the Crosstalks workshop, NRC featured an interview with Angela Maas. Since 2012, she has been professor of women's cardiology at the Radboud University Medical Centre in Nijmegen, Netherlands. In this interview she announced that she was holding her last consultation. Her consulting room has become too cramped for her, because "the social context is a vital determinant of health, and I can't do anything here within these four walls. I see women here with no pensions, without the money to pay the gas bill, with the heating turned off. There's mould on the walls, their lungs and skin are affected, the inflammatory values in their blood are too high and they have chronic stress. And then I start talking about their LDL [Low Density Lipoprotein or 'Bad' Cholesterol] that should be below 1.6? I feel I've become useless." This is a painfully realistic observation by someone who, as a doctor, is concerned about the health of her patients, but who hits up against the boundaries of medicine as a practice and an institution. She describes the harsh and sometimes frustrating reality of a health policy, which, even if now able to to formulate health goals, is unable to put them into practice. It is precisely in this area that Crosstalks wants to dialogue.

The headaches of care provision

The workshop opened with Marc Noppen's sobering observation that, in developed countries, health care only makes a small contribution to increasing life expectancy. He referred to Kaplan's 2019 study, which shows that health care contributes at best 20% to the prevention of premature death, with behavioural patterns and social factors having a much greater impact on citizens' life expectancy. This explains why life expectancy in the US contrasts sharply with very high health care expenditure.

In our country too, socio-economic factors are fundamental determinants of public health. Moreover, health care is a very inefficient system that is going to be put to the test in the near future: the great wave of ageing in our country will swell dramatically from 2030 onwards, while the number of people over 65 with at least one chronic condition is increasing sharply, driving costs up further. Just to be able to absorb the increased costs caused by population ageing, the budget would have to be increased by 2%, while that money is simply not there. We also know that the greatest health losses are the outcome of decades of high-risk behaviour, with smoking, alcohol, unhealthy food and insufficient exercise being the frontrunners.

Another threat lies in the demographics of care providers. In Belgium we have relatively few doctors (per 1000 inhabitants) compared to other countries, and the influx of new doctors is limited. Just under half of all doctors are older than fifty and will retire in the foreseeable future, while the new generation (rightly) pays more attention to work-life balance and wants to work less. You see the same phenomenon with nursing: we have more beds than people around them. In addition, patients are increasingly better informed and more critical, perhaps also more demanding and wanting a say in their medical treatment. Add to this the costs of highly innovative medical advances (medicines, imaging, technology) which, however, cost more and more (while profiting above all the industry that produces them), and it becomes clear that the model of medicine in which we have historically grown up is hitting its limits.

It is now clear to many how that model should change: the system must shift from supply-driven to demand-driven. Healthcare should deliver what people want, not what doctors or hospitals usually do to make money. In other words: how do we organize the best possible health for as many people as possible at the lowest price? In addition, you need an integrated care system in which integration (around the care needs of the citizen) is based on value and not on volume, on continuous, coordinated care, performed by various actors working together, based on current data about individuals and populations.

Networked care provision

To be able to offer care trajectories, it is important to set up broad, horizontal networks that are close to the patient. Including vertical, clinical networks that focus on specialist care and with hospitals providing the link between horizontal and vertical.

When it comes to financing this, we encounter, in our country with its nine governments and ditto fragmentation of powers, a very complex jigsaw. Superimpose the maps of the primary care zones on the maps of care regions and the hospital networks, you will immediately notice the almost total lack of any concerted approach. The Covid crisis (including the calamities in residential care centres) has brought to the fore the way in which a lack of cooperation in care between the various sections and actors is disastrous for health and life expectancy.

Forty years after the WHO conference in Alma Ata on primary care, it is almost shameful to see how little we have done with the insights of the past: primary health care is much more than good medical care, including as it does adequate concern for housing, food, living conditions, information and education. How this *health in all policies* is to be worked out in our country is still far from clear.

The consensus on this story is great, most noses are pointing in the same direction, but the reality gap is large. The horizon here lies several decades years away, while policymakers usually think in five-year periods. What does not help either is that the urgency of the problem is not really experienced by people in the street because they have the impression that things are being taken in hand, because the care is good (for those who know how to find it and can pay for it).

Care thus remains a problem child, with good intentions in stark contrast to the very unequal and unjust reality: in Belgium, a 25-year-old man with a higher education diploma lives on average 18 years longer in good health than a man with only a primary education certificate.

Healthier on the Amstel

It is a universal fact that poverty makes sick and sickness causes poverty. This is expressed in the poignant finding that your life expectancy is determined by your zip code. For several years now, Amsterdam has been working on a plan to

break this vicious circle of ill health in vulnerable families and neighbourhoods. As head of the Healthy Living department of the Community Health Service (GGD) Amsterdam-Amstelland, Karen den Hertog is ideally placed to tell that story. Her department is where health and prevention-related knowledge, advice and innovation are bundled together, and different disciplines work together to reduce health inequalities in the region. One of their projects is the Amsterdam Healthy Weight Approach, for which they received the EU Health Award for Cities in 2019.

Den Hertog's core message is that the causes of ill health are layered and complex and influence each other, which explains why single interventions focused on individual behaviour do not work. The iceberg metaphor is apt: the risk factors associated with lifestyle are just the tip of the iceberg. Beneath the water level are the other causal factors of ill health: housing, work, social support, crime and safety. In depth, all this is based on socio-economic structures, the local, regional, national and global distribution of power and well-being, linked to (un)fair relations in tax systems, including between gender and class. The individual sitting on the top of the iceberg cannot do anything about those underlying pathogenic structures. That is not a new finding. It merely confirms the forty-year-old rainbow model of Dahlgren & Whitehead: the context of a person's life, at all levels from proximal to distal socio-economic factors, determines, far more than age, gender or genes, one's health and life perspectives.

At first sight, this complexity is frightening, because unmanageable. Take one look at the diagram of the Obesity System Atlas that Philippe Vandenbroeck et al. made for the UK Government's Foresight Programme (subject of a Crosstalks workshop in 2017) and you realize how complex and multidimensional the problem of obesity is. Fumbling around with one of the myriad factors doesn't help. That is why the Amsterdam approach opted for a focus on behaviour and the environment. The rainbow was split into segments. A healthy food environment has many facets: from what a pregnant mother eats before and after birth, to the school meals of obese children, to the sports facilities for less fortunate young people or the number of fast-food outlets in vulnerable neighbourhoods. The big problem falls apart into many 'wicked problems', each with its own specific approach. The approach has never been static, but constantly evolving and *evidence-informed*. From fundamental understanding that you can generate an impact in all places and moments where children and their parents are faced with food choices, the project aimed to create a healthy food environment in addition to adjusting individual dietary patterns. The ways in which this can be done are many, including through imams, sports canteens, schools, welfare work, food banks, outdoor advertising or the policy of licensing fast-food outlets.

Den Hertog emphasizes again and again: this is not an approach that can be generalized and copied one-on-one in another city. As described in the 'cynefin' model, you can only partially understand causes and effects here, and then in most cases only ex post facto. The lesson is therefore to assess constantly and learn from emergent practices that prove their worth. Embrace the complexity. That also helps to keep the task exciting (and fun).

Urgent and ambitious

To push through the necessary changes, a sense of urgency and a tangible commitment are needed. It is important therefore to 'colour in' the problem so that it becomes a significant motivation driver for politicians and other stakeholders. In Amsterdam, the photo of Kimberley, age seven and obese, was shown at every presentation of this project. With the added message that there are some 27,000 children living in the city who will become obese adults with diabetes within 20 years, with all the health and socio-economic consequences that entails: "That's why we don't want a single overweight child in the city by 2030."

That's an ambitious challenge, a clear and urgent goal, which may seem too absolute to be attainable, but it sets the bar high and makes clear why something needs to be done. It's clear that "change is not a question of chance". And that equity takes precedence over equality, because if you give everyone equal support, the strongest benefit more than the weakest and inequality continues. The Healthy Weight projects deliberately target weak and vulnerable neighbourhoods and schools. Do not give food support to all schools (and therefore also the better ones), but to the schools that need it.

In this way, in Amsterdam and Amstelland, small steps are taken, time and again learning from what works, without losing sight of the distant goal on the horizon. More information and inspiration can be found at https://www.amsterdam.nl/sociaaldomein/aanpak-gezond-weight/.

Bridge builders

How can health care reach the most vulnerable and 'under-served' groups in the poorer neighbourhoods if they cannot find their own way to care, which only increases their care need? This is the pressing question of the effective,

local interpretation of the overarching general health goals. Community health workers are one possible answer. Mathias Neelen outlined their operation as it has taken off in Belgium over the past two years. Since the start of the Covid crisis, he has been part of the joint management and monitoring by the various mutual health funds of the Field Agents in the Flemish contact survey and since 2021 has coordinated the Community Health Workers (CHW) project.
The CHW project is a federal initiative of Minister Vandenbroucke. Its core objectives are: building bridges between individuals, communities and healthcare professionals, starting from culturally adapted health information; helping people navigate the health system; coaching and providing social support; advocacy of individuals and communities; improving health literacy; going out towards to people and providing material for evaluation and research.

These health workers have a recognizable profile. They have a feeling for, knowledge about, or a connection of trust with the communities or cultures they go to. They work from an interest or understanding of or personal experiences with the problems that vulnerable people can have with health care. They can converse with people easily and in confidence, have honest and open contact and can listen. For this they must be personally strong in order to deal with sometimes difficult or emotional situations. They pay attention to diversity and respect and are interested in other lifestyles and views. They provide information, help people find their way round the health system and direct people to general practitioners, dentists, health insurance funds or Kind en Gezin (child and families organization) offices, where they help find solutions tailored to the individual person. In this way they identify the care needs of those who turn to them, accompany them where necessary, remind them of appointments and follow up on them, thereby also strengthening their health skills. For this they receive a two-day basic course and permanent training from various partners (such as the health insurance funds). They give a sense of trust and offer a listening ear. At the same time, they can flag the structural accessibility problems, help strengthen the network and point care providers and governments to where the barriers lie for so many on the road to care.

Locally rooted

As a federal project, the CHW activities are adapted to the local Flanders, Brussels and Wallonia situations, grafted onto the local situations and the structure of the working field. In Wallonia, 18 CHWs and three coaches work in four urban centres, collaborating with the Réseau Wallon de Lutte contre la Pauvreté. In Brussels, the 13 CHWs and two coaches operate in six municipalities or districts, coordinated with Les Relais Action Quartiers (RAQ). In Flanders there are 21 CHWs with five coaches active in Antwerp, Genk, Ghent, Ostend and Tienen, coordinated locally as much as possible with local organizations such as WGCs (local health centres), OCMWs (social welfare centres) and CAWs (general welfare centres).
In Antwerp, extensive work is being done on specific areas, in collaboration with De gezondheidskiosk, Logo (Local Health Consultation) and the university. Dokters van de Wereld (Doctors of the World) also participate, with the CHWs present at their walk-in moments and able to direct the target group towards regular care.
In Genk, the city structure is strongly based on local neighbourhoods, in which the CHWS can be easily deployed. For each neighbourhood, agreements exist with neighbourhood managers, street-level social assistants (straathoekwerkers) and city supervisors.
In Tienen, a small team has a very focused approach, working together with Bezorgd Om Mensen and Erm in Erm, where they participate in the mobile teams.
In Ghent, the CHWs with their comprehensive, proactive approach complement the health guides, who are more demand-oriented. The target group mix focuses on fixed neighbourhoods and specific target groups, from New Ghent to the Bulgarian community.
In Ostend, the CHWs are closely linked with the city's poverty network, with lines to home counselling services, community development work, city services and smaller, local non-profit organizations. Agreements have been made with the FMDO health ambassadors project.

Signals from the field

Everywhere the CHWs are running up against a number of obstacles that hinder the accessibility of care for vulnerable groups. There is a shortage of dentists (additionally limited by patient stops), with the cost of dental care being an additional barrier. There is also a shortage of general practitioners, exacerbated by patient stops – even at community health centres. The is also a shortage of psychological care providers. Turning to private practitioners is sometimes a solution, but it is often not affordable for people on survival budgets.
In short: where can you direct people in the absence of a sufficiently framed offering? Right now, GPs spend a third of their time doing things for which they are overqualified. Where are the practical assistants to GPs, like those that exist in the Netherlands, for example?

Specific psychological problems (such war and displacement-related trauma) require corresponding psychological expertise, which is difficult to find. This problem is exacerbated because a lack of interpreters prevents people from telling their stories in their own languages. The digital sphere continues to pose a high barrier for many.

Nor does it help that certain groups are highly distrustful of major organizations such as the OCMW or CAW. It certainly doesn't help at all that the services of some organizations in some cities are inadequate and that services are increasingly difficult to reach via a counter, the telephone or even by e-mail.

The CHW project started in 2021, and the intention is to expand it to collaboration with, for example, the mobile psychiatry teams. For the time being, there will be no expansion to other cities, although it is already clear that the same needs also exist outside the five project cities. The University of Antwerp delivered a qualitative research report in February 2022, which will be followed by a more quantitative report in the autumn.

And again: the context

The experience of and with the CHWs clearly tells of the importance of a broader view of the analysis of care that is difficult to access for many. General living conditions such as housing, childcare, labour market and education, in addition to the ecological, social and cultural environment, play an essential role here. Better access to primary care is only part of the problem. Focusing on health literacy and prevention should be part of any effort to better guide vulnerable people to the care to which they are entitled.

It would help if policy makers realized that this is an essential community project, in which the care providers themselves, civil society and the health insurance funds have their own role to play – a role that they are not taking up enough at the moment. CHWs can build bridges between all these actors. It would therefore only be fair if this initiative, which now exists on a project basis and which has to wait and see whether it will be extended, becomes a structural part of healthcare in our country. Belgium now has (for the time being) 50 CHWs. South Africa has 25,000, who are also involved in prevention.

Food for thought

The stories from Amsterdam and the Flemish cities are very different and yet complementary, at the same time recognizable and challenging. The context-based, rainbow view of health and well-being is the only one that does justice to the complexity of the problem and offers tools for tackling it. At the same time, there is frustration that, despite the theoretical consensus, so little is being done about it on a structural basis.

Fortunately, there are local initiatives everywhere that show how it can be done. For example, GPs who have worked in a neighbourhood for twenty to thirty years know the (life) stories of the people who live there. They need only one word to understand a situation. They know the local residents and their lives. These doctors and care providers are in danger of disappearing soon, and with them knowledge and continuity will disappear. In a child they see the four generations that preceded it and how that history and context will shape that child's future. "The roots of many diseases were put down four generations ago," Den Hertog added.

Scientific, deployable knowledge in this area is scarce or non-existant in Belgium. That is not surprising, knowing that in Flanders we have no *public health physicians*. (In the Netherlands there are 2600 for 16 million inhabitants.) We have to make do with anecdotal wisdom (which unfortunately contains a lot of truth): in a poor neighbourhood there are many pharmacists and few doctors, in a wealthy neighbourhood it is the other way around – and it has been that way for 40 years. In other words, how can we ensure that people take fewer pills and better care of their health? Why are it the poorest who live unhealthily and as a result generate more health care costs and live shorter lives? Poverty burdens everyone in a society, including the rich. Every euro spent in the early years of a child's life to ensure good living conditions pays for itself later, and everyone benefits.

As beautiful as the formulated health objectives are, the challenge is broader than the healthcare sector can tackle alone. This is a redistribution issue in which a handful of actors and sectors must work together at all levels: healthy housing for everyone and an intelligent form of basic income, integrated into health-promoting urban planning on a foundation of health-promoting education.

Shooting for the moon

Reference was made in the debriefing to *Moonshot* by the economist Mariana Mazzucato in which she argues for an ambitious government that dares to aim high to make society more inclusive and sustainable. The government has shown that it, not the free market, has kept society on the rails during the Covid crisis. Mazzucato argues that if we can put people on the moon, nothing will stop us from transforming our

society into a system that makes and keeps people healthy.

The objectives are already more or less on the table. Their implementation, embedded in a broad social transition, is work for the coming years. This implementation must take place within a broad framework that includes all sections of society. Local initiatives play an important role in this. Within the framework of the objectives and geared to local needs, they can teach and enable people in a coherent way to take responsibility for their health. Then patients themselves are in control of their well-being and health trajectories. This will only be possible if health care, as Donald Berwick wrote in JAMA in April, is no longer a repair shop for dented bumpers and broken headlights. Healthcare must, rather, proactively provide good roads and more cycle paths and traffic education. We need to work on the socio-economic determinants of health. If not, we will continue to repair damage after the accidents have claimed their victims. We are now particularly effective in that (expensive) repair work, but there are many good reasons not to continue doing it.