



SALZBURG
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Hooked on Health Care: Designing Strategies for Better Health

Monday, January 18, 2016

From antagonist to ally: The role of business

While many of the Fellows in attendance at the Salzburg Global session *Hooked on Health Care: Designing Strategies for Better Health* are already convinced of the benefit of improving population health at large, not everyone – the business sector included – is. As one Fellow urged: “We have to get better at reframing the conversation.”

One way to do this with the business sector is to “make the business case for health.” This can start with convincing companies that investing in the health of their workforce – rather than viewing their workforce as a commodity to exploited – can increase their employees’ productivity and thus improve their profits. As the demands on the workforce change, requiring greater creativity and systems-thinking, employers wishing to improve their workers’ health (and productivity) will need to expand their definition of health beyond just physical health to encompass mental health and wellbeing. A stressed out worker is not going to be a productive worker. US companies that provide their own health insurance to their employees have even more reason to invest in preventative measures and their workers’ general wellbeing.

Improving the health of workers can have a knock on effect of improving the health of the communities within which the workers live. Some businesses have invested directly in their surrounding communities’ health, through corporate social responsibility initiatives but this was dismissed by one Fellow as “mostly a branding exercise.” “Never assume business will become philanthropic,” another warned.

As public health contends with not only “Big Tobacco” but also “Big Food, Big Soda, and Big Alcohol,” consumers, shareholders and even the staff of these contentious businesses need to be engaged to push for action to improve health not only of workers but everyone.



Susan Mende, Srinath Reddy, Leana Wen, Shirley Cramer and Felix Rosenberg

How did we get “hooked on health care” – and how can we get clean?

“We’ve created an illness system instead of a wellness system,” said one Fellow of the UK’s National Health Service (NHS) in a panel-led discussion on how we came to be “hooked on health care.”

Much of the UK government’s health policy is focused on the health *care* system and not actually on improving the UK population’s health and wellbeing. There is little joined-up thinking or funding. For example, the NHS and social care provision are funded separately, with the latter more vulnerable to cuts.

One Fellow expressed frustration that while governments (the UK is not alone in this) are able to make 30-year plans for major infrastructure projects, or even 90-year plans for a nuclear power station, policy on health remains notoriously short-sighted.

When the UK government’s health policy has taken a more long-term view, its five-year plan focused on diabetes prevention – because it was measurable and could show quick results, rather than because it was a health priority.

Two health priorities for the city of Baltimore, USA, have long been substance abuse and infant mortality. Baltimore had the fourth worst infant mortality in the US despite the

proliferation of services available in the city. It was only once the city adopted a coherent strategy for all groups – public and private – to follow that the rate began to improve.

One in ten adults in Baltimore has a drug or alcohol problem. Substance abuse is a bigger killer than gun crime or road accidents, but communities’ concerns about methadone treatment centers had led to campaigns to close them down. A far better policy is for the city to tackle the related issues such as crime surrounding the centers than to close down what is for many in Baltimore a vital service.

Brazil is also facing a dilemma of what to treat – the patient or the root cause – with the ongoing Zika virus crisis. Should public resources go towards treating those infected, or should the focus be on tackling the disease-carrying mosquitoes?

To move away from being “hooked on health care” a more integrated, less siloed approach is needed to improving health. This is an approach the Sustainable Development Goals (SDGs) hopes to promote.

As one Fellow remarked: “If we want to make a real impact on the public’s health we must tackle it at many levels – but in a coherent way.”



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From the Floor Tweets from Fellows

Leana Wen, M.D. @DrLeanaWen
“#sgshealth in 20 years, will we get to point that social determinants of health is known as just “health”!? #SDOH.”

Paul Streets @PaulStreets2012
“#SGShealth. Bottom up pressure influence business bottom lines - influence up via shareholders, consumers and staff.”

SusanMende @susanmende
“Businesses can screen for social determinants of health for own employees eg food, housing insecurity #SGShealth”

Tracey Cooper @tcooper321
“#SGShealth we should ‘go to where the people go’ in communities to provide more accessible health & wellbeing – partnering with industry”

Nidhi Khurana @nidhikhurana
“Crisis can trigger social cohesion with local businesses at the centre which can be sustained through social investment #SGShealth”

Richard Taunt @RichardTaunt
“Hadn’t thought of that, nice point. “H’care so wrapped up in politics; yet wellbeing not - that’s an advantage, let’s use it.” #SGShealth”

William Chilufya @wchilufya
“Child obesity on the increase, what does this mean for future workforce? #SGShealth @SalzburgGlobal”

Sight and Life @SightandLife
“#SGShealth Breaking down silos in #SDGs will help cross-sectoral collaboration to improve health - not expand healthcare”

Join the conversation and read many more tweets by searching for #SGShealth on Twitter, following @SalzburgGlobal and checking out our Twitter list: www.twitter.com/salzburgglobal/lists/SGS-559
If you or your organization is active on Twitter, and we’ve missed you off the list, please let Louise or Patrick know!



Hooked on health care in the UK

How can we design systems for better health asks the chief executive of the London-based Lloyds Bank Foundation

Paul Streets

We're hooked on health care in the UK because we design it from the healthcare institution and health professional perspective down rather than the patient up.

The organization of medicine reflects this: respect, expertise, prestige and research funding rise with specialization – rather than a whole person or community-focused approach.

Medical intervention and pharmacological investment reinforces it: with financial incentives geared towards intervention, activity and pills – rather than avoidance.

So the central question around our current funding “crisis” becomes: “*How can we reduce the burgeoning cost of our current health care services by providing better community care/other provision?*” Rather than: “*How we can support people, where they live, and how they live, to avoid the need for health care services if they can?*”

If we started to plan from the person/family and/or community up, rather than the hospital and profession down, we'd have very different services and spending. Necessity can be the mother of invention and, from my (admittedly long!) past experience, cash-strapped low-income economies can come much nearer to this. Whilst it might not stack up against a randomized controlled trial

or pharma RoI, it can work to provide basic services where otherwise there may be none.

That said the maths has to work – and it should if we take a whole economy cost perspective. We might not then be perplexed as to why community-based work saves money but not enough (health care) money to justify (finite) health care resource reallocation. If you start to look at whole economy costs and savings, the maths are more likely to stack up. And they'll likely lead you to Pareto's 80/20 rule – focusing effort on those with the highest costs. This same argument has almost won the day on chronic disease in the UK, but probably only in the last 15 years – the NHS Plan 2000 being a turning point. Applied in the context of community, it would have us focus on those with complex multiple needs and high levels of disadvantage who generate significant local economy costs – many of whom have been, or are being, failed by state actors and state led provision – but can be reached by trusted locally-based community organizations.

But the list of odds stacked against a rebalancing are long. Can we be sure that – even with a blank sheet and zero budgeting – we would end up with a different model?

Join in online!

If you're interested in writing either an op-ed style article or a personal reflection blog post whilst you're here this week, please let Salzburg Global Editor, Louise Hallman know or email your submission directly to lhallman@salzburgglobal.org.

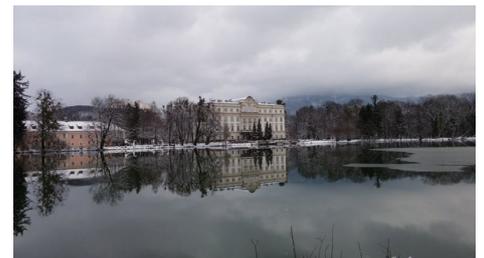
If you do intend to write for your own organization either whilst you're here or after the session, please make sure to observe the **Chatham House Rule** (information on which is in your Welcome Pack). If you're in any doubt, do not hesitate to contact Louise.

We'll be updating our website with summaries from the panels and interviews with our Fellows, all of which you can find on the session page:

www.SalzburgGlobal.org/go/559

We're updating both our Facebook page www.facebook.com/SalzburgGlobal with photos from the session during this week and also after the session. (If you require non-watermarked images for your own publication, please let Louise know.) We will also be posting photos to Instagram www.instagram.com/SalzburgGlobal

Share your Twitter and Instagram photos with us using the hashtag #SGShealth. Check out the photos below from @RichardTaunt!





Food for thought at the “Knowledge Café”

Patrick Wilson

Salzburg Global hosted a Knowledge Café this week featuring six table discussions offering specific expertise in promoting health and well-being as well as ways of lessening the burdens on health care.

Richard Taunt and Emma Spencelayh from the Health Foundation hosted a discussion entitled “**Health in all policies: what has been achieved, what more needs to be done?**” Some of the main themes that came through were issues that could go wrong, such as the lack of data and the lack of collective agreement between political parties in regards to intentions of what organizations are trying to accomplish.

Anna Futtero, senior economist with the World Bank led her discussion on “**Behavioral insights for policy design**” with the understanding that more time should be spent understanding the population and

recognizing the context in which they live to prevent new policies becoming counter-productive.

Clare Shine, Vice President and Chief Program Officer of Salzburg Global Seminar, moderated a discussion entitled “**Parks for the Planet: Nature, Health and a New Urban Generation**” which shared a large number of insights, including the concern that the public health community doesn’t “get the message” about the benefits of the urban population being more connected to nature and this needs to be better communicated.

Director of the Arnhold Institute for Global Health, Prabhjot Singh’s table talked about the idea of “**A new community health worker model: An example from Harlem/NYC.**” They unpacked the details of whether community workers should be more medicalized, socialized or become more like activists.

Al Mulley, Director of Dartmouth Centre for Health Care and Vama Jele, General Secretary of Swaziland Migrant Mineworkers Association, jointly hosted their discussion called “**Can the social determinants of health and wellbeing be addressed one person at a time?**” Fellows learned from examples of South African miners and the way they were encouraged to get tested frequently and not only when they become ill.

Finally John Lotherington, Program Director at Salzburg Global and Ngonya Mwaanga, Principal Education Officer for Colleges and Universities for the Zambian Ministry of General Education hosted “**Health and education: The often untapped potential of schools.**” Their discussion brought diverse opinions on the role of education in regards to health including examples from India and the UK about peer-to-peer education and the power of student health educators.