AMS - CM - EP10 – Dr. Andrew Boozary

Helen 0:00
Well, I've been looking forward to this for some time. I'm here with Dr Andrew Boozary, who is a family doctor, a policy advisor, a researcher, and you are the founding executive director of The Gattuso Centre for Social Medicine at the University Health Network. You were also just named as one of the 50 most influential people in Toronto - that's not in just healthcare, that's overall. So, what a thrill. You're also a friend, and so it's really just nice to see you and talk about your leadership journey. So maybe we'll start with, how do you get into this business and in social medicine and what motivates you? And then we'll talk a little bit more about your work and where are you going next?

Andrew 0:42
Yeah, well, thank you, Helen. It's so good to see you and be in this space. And, you know, been many years coming. I'm really honoured to be able to sit down with you and have this conversation. I mean, I think when you ask about sort of how this, all, you know, started on the journey piece. I mean, I have to give credit or kudos and take any of the blame myself, individually, but to my, you know, family, and especially, you know, my mom, who gave up a lot, sacrificed a lot for us. And we were born in St. Jamestown, which I think at one time, was the most diverse square kilometer in Canada. People all over, refugees, newcomers coming into that neighbourhood. And I think it's a big part, huge part of why I do what I do, why I believe what I believe, in terms of wanting to ensure that we can really enable and shape and spread opportunity, which is what I think social medicine is really about, is spreading the opportunity for health and well-being. And I think what I saw, what my mom, I think, has always enforced from the sense of pushing against, you know, injustice, pushing against a lot of these inequities that we've sort of allowed to take hold. And we'll talk about some of this through the pandemic, and obviously a lot of your leadership and trying to push against some of these really long-standing disparities, you realize that the cards are stacked against certain people, whether they're born into or various traumas and really just impossible conditions. But what I think we've done in healthcare for too long is we blame the individual with these supposed, quote, unquote choices, but really, these are system issues, and that's been really my draw to social medicine is, how can we start to be working both at the system level, but also right in front of the

individual at that patient level, which I'm really privileged to continue to see patients.

Helen 2:31
Why don't we talk a bit more about some of the social medicine work that you've been doing, and then maybe we'll pivot over to COVID, because that certainly was a shared experience. And, of course, I learned a lot, but maybe just give the audience a little better sense of what you're doing in the social medicine space. Because I think there's a bunch of different tranches, if I understand it correctly.

Andrew 2:53
For listeners who may be new to social medicine, really, I think the idea of this is, you know, hundreds of years old. So when you go back to some of the original social medicine physicians, one who's commonly cited, Rudolf Virchow back in the 19th century, really this idea that politics is medicine on a grand scale, the idea that these system choices really shape health outcomes, and what we mean by that is you know, the air people breathe, the jobs that people can hold, the human connection that people have, whether or not they're able to access, housing, food security, these are some of the most powerful drivers of health. And so that's really the discipline of social medicine. And for me, where I've been looking at it is, how do you integrate health and social care. So, it's still there really important fundamentals and the advances of healthcare and medicine.

But I think for too long, we've been disconnecting or neglecting the elements of the social aspects. So that's really the thrust of my work at the University Health Network, of how do you integrate many of these things that have been inextricably linked, but we just haven't taken that holistic approach in medicine. The example that I'll use is around housing and health. So really clear from the data that housing and health are inextricably linked. And again, what we mean by that is that people who are chronically unhoused, who cannot access housing for a number of years live half as long as the general public. So to me, that's one of the most powerful social determinants of health, and it's, you know, really more powerful than anything we can do in the operating room or the clinic setting. And if there was a drug that could recover 20 to 30 years of life, you know that that would be and should be a major investment and priority for any government policy maker, fund or investor. And an unfortunate

reality is, we're sitting here today, you know, coming through this polar vortex. The reality is, is that the wait list is eight to 10 years long for people and where we're sitting in downtown Toronto, and that means that people are unhoused, not only live half as long, but their healthcare experiences are far worse. So, they have these conditions, are not only waiting for housing, but their healthcare conditions and their healthcare experiences are far worse.

And some of the recent CIHI data, which is the Canadian Institute for Health Informatics, which does some really great research nationally, has been able to also put out a recent report that people are in hospital two to three times as long, not because of choice of their own. When they're unhoused, they have no real, solid discharge plan that's humane. And two, the healthcare costs are two to three times the general sort of patient population. Again, no fault of their own because of many of the compounding challenges. So a major part of our work the last five years has been to advance housing solutions for individuals who are unhoused. And again, really looking at driving the data as well as lived experience, the data was also really clear that about 234 UHN patients made up over 15,000 emergency department visits in a year. And again, that's because people had nowhere else to go, or their healthcare conditions were worsening. So just in December, we're able to launch Dunn House in partnership with the City of Toronto, the United Way and Fred Victor to see 51 individuals now moving in who previously have been unhoused, many for numbers of years. That's really, I think, a big lift to see, you know, these ideas and this critique in this research into some sort of tangible solution for people. And again, I'm always really adamant that 51 housing units is not going to solve the homelessness crisis. But the hope is, I know in this conversation today is, how can it help motivate push scale these solutions in various parts of the city and country, when we know that this is ultimately a housing issue and that we need to be thinking about this as a health care crisis?

Helen 6:55
Yeah, it's interesting. You're talking and thinking about my own career and maybe some of the areas where I wish I had been more successful. I started working in the ministry of housing when we were building not for profit housing, trying to house people who had mental health problems and physical disabilities and victims of family violence and others. So I had one kick at it, and second kick was really trying to start health links, which was

doing the same kind of analysis you talked about looking at people who were using a lot of healthcare, but really that was more symptomatic of not having other basic needs met, and working on housing as a solution. In some ways, the idea behind health links originally was that maybe we could substitute some healthcare for housing, and we could increase the sort of the fungibility of the money so that you could actually address the basic needs from within the health envelope. You've kind of done that on a sort of small scale in Toronto, an important scale, but scaling up is going to be a challenge. I certainly found even having my hands on levers of government. It was difficult, right?

Andrew 8:03
And, I mean, again, I think you deserve a lot of credit, you know, for the Health Links push. I mean, I think for many of us, it still the work is wanting. There's still, of course, so much more to do. But when you look at, I think even trying to put in the policy radar of, you know, the stories from, you know, Camden coalition or hot spotting, which I know informed the health links piece, that really we need to be integrating and thinking across ministries, across sectors. And to your point, that's really hard to do when it's really siloed in the structure. And again, you can see these pockets of the success were for you as a deputy minister or leading official to sort of say we need to be thinking differently but, also acting and engaging differently with how we're going to address these wicked problems. And I think that's something where, you know, all of this continues off previous success and iteration. So I'm happy to see Dunn House out, and I'm also, more, more importantly, I think, really excited and encouraged to see where, you know, other people take it in the coming months and years.

Helen 9:05
Yeah, it's the same. Let's talk a bit about COVID, because I found I learned a lot from the work of the science table and the descriptions that were put together on the neighbourhood deciles, right? And I remember looking at that those data, and basically we had an inverse relationship between where COVID had really taken hold and where we were getting traction on the vaccine rollout, and that required a whole rethink, but I think it laid bare some of the disparities that you're talking about, and My hope has been that that becomes some kind of permanent analysis and lens that we look at healthcare and look at health status through. But I'm not sure.

Andrew 9:49

Yeah, I was, I was hopeful at one time. I'm still hopeful. I try never to lose hope. I think you try to have everything we're doing and form hope without it. I think it becomes really bleak, but I do think it's been hard to watch in some respect, right, this sort of snap back or away from so many visible learnings. And I think one of the things that you know, working and engaging with the science table, but also, I think more fundamentally, with community organizations, who did heroic work mobilizing vaccine access, right? And I think beyond physicians and nurses, what I really saw was the importance of community health workers, community health ambassadors. That to me, and this is goes back some of the work we're doing, UHN, really informed my view and my thinking of how we need community health workers and social medicine navigators as part of the healthcare team. So that's something we've now lifted up in the past year that trying to hope and cling to whatever learnings from the pandemic, and also these ideas that we knew need new healthcare teams if we're really going to build trust with communities that have rightfully felt mistrust towards healthcare institutions, so that, I think again, on a local level, and what you can try to control and wrangle. I think we've seen some progress of trying to have that into how we approach chronic disease management, not just COVID, that there is a community health worker working with a nurse practitioner from a sort of health and social care perspective, the part that I do find hard is that what I felt was most effective.

To your point about, you know, neighbourhood decile, income, access, sometimes it gets really wonky. And what I felt, you know, when I was actually engaging with Steini at the time, Dr. Dean Brown, for folks listening, or Dean at the Donna Lana School of Public Health, you know, who's a tremendous leader, the way that I put it to him, and we started really, I think, try to communicate is, how many deaths are you willing to accept that are avoidable in these neighbourhoods? I think when that's posed as policy makers of the public, to me, it garnered a different response, because for, I think for a long time, we've accepted the inverse, which is, well, marginalized communities and racialized groups, low income folks will always have 20 to 30% less access to primary care, to housing, income, education. When you look at the averse and you say, Well, if this is resulting in avoidable death, what rate are you comfortable with? And it goes back, I think, the first question of you know, does a child born into a low-income postal code versus a high-income postcode? What different percentage or probability of living a full and meaningful life, are we willing to accept right? And I just think we haven't been as direct at those of us in

public health and public health research with the public about what we're talking about. Yes, there's really sophisticated epidemiology, yes, there's really social epidemiology. And colleagues do tremendous work in this area. But for me, as we're seeing, I think this polarization has to be clear of what are you willing to accept? And then sometimes people sort of get the Well, I'm not, we're not willing to accept higher rates of death in those neighbourhoods, but we have been so we just have to think, to be clear eyed about it. And I think that's one of the things that you know, working closely with Staney, but most importantly, working with amazing community leadership to try to articulate that for the public and for politicians and policy makers, I think alike.

Helen 13:24
I think it's a hard message. As you're talking I'm thinking about feeling probably a little bit inadequate, you know, working in this space, and yet, I live across from Dufferin Grove Park, right, and I have tents outside my window. Now, I'm told that actually, in the last few days, that most of the people have not been there, that they've actually taken there on a very cold day. We're recording this on a very cold day in Toronto in January, and so that gives me some comfort, but the failures of the system are visible from my living room window. What's interesting, at least in the discussion on the Dufferin Grove listserv, is pretty kind, actually. It's not very polarized. It's very much supportive of the individuals and trying to find a way through for them, but getting the attention of policy makers for the big systems issues that are really going to need to be addressed in order to have, you know, large scale impact. It's great that people like you are chipping away, but I also think there's another level of traction that has to happen. That's work, right? That's a lot of work ahead of us.

Andrew 14:37
Yeah, that's the work, you know. And it goes back to our conversation about Dunn House. I mean, the real hope is that this is taken up by policy makers, by, you know, the public, by officials who have some dominion over some of these decisions. And I think that's really where I continue to try to draw some hope. I mean, the other part of this that we haven't really talked about as much. Much. I mean, one, I think, from a social medicine perspective, the idea that you've laid out that you see the glaring policy failure from your living room window is that this is fundamentally about human dignity and human rights, right, the fact that we will want to pat ourselves on the back about having a universal health care system, we

won't get into that about how many, I'm sure you had folks talk about how many millions of people can access primary care. It's hard to keep to call it a universal health care system when people can't get into the front door. But when you look at these issues around how many 1000s of people in our city now, over 10,000 people living in a shelter system, that we've really failed on housing as a human right. We failed on housing for all, and I hope that I've laid out some decent arguments as to why this is also fundamentally a health issue when you continue to deny people access to housing. But there's also a really powerful economic argument right for the status quo.

So if those issues don't resonate with you, for whatever reason, when people ask, well, can we afford more done house, or can we afford to move people out of parks into housing, my response is, you can't really afford the status quo when it's over $30,000 a month for someone who would be admitted to the hospital that I work at, or any Downtown Hospital, it's close to $13,000 a month in the prison system, which my dear friend and colleague Lana Fredo, calls the de facto mental health system, because people cannot access mental health care, and it's roughly $6,000 a month in the shelter system, when we're now talking about 10s of 1000s of people in the shelter system and less than $4,000 for supportive housing. So whether it's human dignity or health economics, housing for all makes good sense, and I think that's the hope to your point around how we can best engage some of the policy makers who may straddle various ideologies or views or stakeholders, but I'm hopeful that more and more people realizing what the approach now is just failing on every front and most importantly, it's failing these 1000s of individuals that are faced with these impossible choices that's no fault of their own on a night like tonight, is there more imagination required on the housing options?

Helen 17:22
I think you know this is the solution. More den houses. Are there other ideas that we can get moving quickly? I'm just curious what your thoughts are on that. Because, yeah, you know, having grown up learning about the not-for-profit housing program, it was great, but it was hard to scale up for sure.

Andrew 17:53
And I think really, it's a myriad of things right for a complex problem, I would never be on here to say that you need to, you know, have 1000 done

houses, and that's our way out of this mess. But I think you need to look at, again, the populations having a tailored response. So some of it will be, you know, potentially modular housing, like Dunn House, with social supports and health supports that, you know, make it rather, relatively unique for really high, high needs patients, but there's also a lot of people who don't need a lot of health and social supports, but they're just without housing. And so I think we really need a response from both the public and private sector, I think, and there's going to be a number of different solutions that will emerge when you can really unlock the fact that this is a wicked problem we have to address. And I think the other part around the housing solutions piece is we've also allowed this atrophy to happen. You know, when we go back to look at the time in the 70s, 18 to 20% of all housing supply there was social housing, it was affordable. And when you look back at where we are now, or you look back at 50 years ago, at 18 to 20% we're now less than 3% amazing.

And it's so stark that Scotiabank, not exactly a left wing think tank, has come out to say we need to double the amount of social housing. So when the major banks in Canada are saying this is a major economic issue, this is an issue that investments here have real returns on investment. But Helen, even if we doubled the amount of housing supply, we would just come to the OECD average. So that's how far behind we are as a country. And so I think it's important to be clear, yes, it's not all going to be social housing are all done houses, but from a comparative lens, we're not performing that well as a country.

Helen 19:47
Yeah, that's really interesting. I think I'll go back to my neighbourhood. And you know, on Dover court, north of Dundas, there's actually a modular social housing project. And. Right beside the police station, which is pretty neat. And then, of course, you've got loft, yes, which has a building on Dufferin near me, which is also kind of and they're taking people out of alternative level of care beds and hospitals, and able to house them remarkably well. And this is an older apartment building, but it's been repurposed quite nicely, I think, for permanent housing. And they've got a, you know, some continued, I mean, I see some of the tenants I met when I was going through the building. I see them out on the on the street on Dundas, and they're part of the neighbourhood. It's fantastic, no. So we know how to do this, right?

Andrew 20:40
And as you mentioned, you've got, you know the neighbourhood group and loft and Fred Victor, you know so many, so many leaders in these spaces. And really, how we can, you know better partner and enable them to do the good work that they're doing? Yeah,

Helen 20:54
So I thought we might talk about how you lead in this work. And clearly, takes a team. How does that work for you? How do you bring people along? Obviously, your own personal profile is, is part of getting the message out. But how do you, how do you bring people along, and what does your team look like?

Andrew 21:13
Well, funny, you're saying that about, you know, earlier that the most influential list, you know, I had to sort of laugh because, you know, I think one to me, I mean, where it is really heartening is that it's a reflection of the work to your point, that you know, especially in some areas or mediums that have not really looked at social medicine, homelessness or issues around, you know, the drug overdose crisis that the idea that this there can be some influence, I think, is obviously why we want to do we do, I think how you do it in a way where you continue to bring in the collective is crucial, but it's also can be really challenging, right? I mean, they think the realities are, as we talked about a little bit earlier, that our system is not really structured for collaboration, and so it almost becomes, you know, eye opening and amazing when you hear that. You know, hospital systems working with community provider with the City of Toronto, the municipal government, the provincial government, the federal government, to build one housing complex, because that's just not how it usually works.

And so I think a large part of my work, especially when I started here, trying to figure out your orientation. Here we are in a leading global hospital network that does some incredible things around science advancement, things that are happening from transplant to frontline work, and how do you think about the partnerships beyond the hospital walls, and how do you maintain that trust with individuals? Because, as you know very well, it takes years to build trust, and you can also lose it in an instant. So, you know, I think it's something I take really seriously. I think it's one of the most important pieces of the work to be successful. You know, how a hospital could not launch a successful housing initiative alone? No one would want

the hospital to be their landlord. No one would trust hospital on how to manage and operate nonprofit housing. So I think really, the partnership with Fred Victor as an example is instrumental of how you really think of these new models of care. And with a number of, you know, community partners and leaders from Parkdale Queen West - Camille Centre to the Neighbourhood Group I mentioned, loft and Black Creek community health centers, far You know, so many that I think have actually really informed the way we try to do this work. And I think going back to the pandemic lesson, I think hospitals really learned a lot from community leadership, from partners outside the sort of typical day to day operations. And that's the part I'm actually really hopeful we stay on and so whether it's new models of care, maintaining those relationships in ways that you know there's going to be ups and downs and real challenges. And I think for a lot of us, looking at what's coming up the pipeline, there are going to be a lot of challenges about trying to keep people alive that have been marginalized in communities with a number of potential policy choices, and, you know, polarization that I think you know is coming. It's great to hear about your neighbourhood having a positive group chat on Dufferin grove. But as we look at across the city, that's not, you know, unfortunately, the reality for many neighbourhoods.

Helen 24:41
How do you kind of sustain yourself? This work is hard, you know, I'm going back in time, well, maybe 2030, years ago, and I was being, I was a project manager, and I was working on implementation of what was then the Graham report, which was a mental report. On how to improve community mental health, and it was the first effort to get patients engaged in the policy process and the implementation. And I remember your words about trust have a lot of resonance for me, and building trust with the patient advisors, including Pat Capone and others, we didn't always hit the mark, and the structures that I was working for in government had a hard time adapting. Imagine trying to get a check prospectively to a patient in order that for them to pay for their transportation, to go to a meeting and things like that. It was really hard. It was worth it, but it was, and it was hard on me personally, because I didn't feel like I had the support from, you know, government and others to really engage and be able to meet the expectations that had been created by working with them so closely. So I don't know how you how do you do it?

Andrew 26:00

I mean one, I think back on that point and also the previous question. I think you just have to acknowledge where you muck up, yeah, you know. I think all of us, you know, drop balls at various points. The you know to your point. I think you know, in some ways, the whatever kind of profile of the work also comes with its own pressure. It comes with its own expectations, and obviously for myself, personally, you always try to meet and surpass everything. You try to set out and you set it for yourself, and you set it for the team and people you work with. But I think the authenticity is a really big piece. I think you just have to be honest and open with your partners where you know, you may not feel you've done good enough where there continues to be work. And I think that level of openness with close partners, I think, really helps go through it. And it can be disappointment. There can be areas of where, you know, people get upset. But I think if fundamentally your belief in the why you're doing this work, and it goes back, I think, really to the why, and you can continue to remind yourself or re-energize yourself as the why. I think it helps on the sustainability. I think the other piece on this to from a compassion piece, or from the sort of you didn't say the word burnout, but you know, sort of how you continue without doing it is, I think, a few years ago and earlier. I think I sort of saw it as a individual failure when I was feeling sad or had grief in the work, you know. And I really privileged to work at sound times in Regent Park, you know, where I learn a lot from the patients that I get to see, and especially the leadership there, you know, and in talking to a close colleague there. You know, learning that it's okay to hold space for the grief. You know that this work is hard seeing you have. We have huge privilege as healthcare workers in that many of the dire circumstances are not ours or ours alone in those situations. It's really, you know, borne by the patients who have to go through these impossible conditions. But how do you carry that grief or help it inform your work? As opposed to saying, you know, this feels really dark, or this has been really sad, and you know what? I need, you know, to think of all the usual things of self-care. Part of it has been how you carry that and you also make space for the fact that there is suffering, there's pain, there's grief in this work. And I wouldn't be the last person to say I've completely figured it out, but I think being able to hold that with me more as I continue in this work I think has been really helpful.

Helen 28:44
I remember one point going into a Treasury Board meeting and telling the government officials, including the politicians, I was pissed. I was angry about something that happened in the health care system, and they all

stood up, including the Premier, and it, yeah, I don't know, I don't know that changed things, but made me feel better, and I felt like I was authentic to the situation. And it helped, it helped me.

Andrew 29:15
Yeah, well, again, we're lucky to have you, and have had you in many leadership roles. But I, you know, I think I find it, as I'm going on this journey, that the authenticity is key in whatever that is to you or whoever you know, the listener of whatever that speaks to you, to be able to speak out on it in a way that feels honest and legitimate to you. And I think it'll be different issues, different things and different times, but where I felt you aren't able to or you kind of duck away from it, it can feel suffocating. And I think these are the kind of things that in leadership positions, you know, demand a lot from you in various ways.

Helen 29:54
So what's next on your docket? I mean, you completed done has you've got this good. Incredible platform. Where do you see it going in the next 12 to 24 months?

Andrew 30:06
Lots, you know, lots more work, you know, I think, yeah. I mean, I definitely get, I think we got a lifetime of work, yeah, well, all of you know, every year, you know, and again, building off so much and with what people have done over many decades, you know, I think has been encouraging. But I think the other reality is, you know, as we said earlier, that Dunn House is not Mission Accomplished, you know, I think this is a huge, you know, just seeing what we've seen this week, you know, in terms of where there's just real challenges continue to be for people accessing housing, but fundamentally, going back to I think, How can we reshape the way that we're trying to deliver healthcare? I'd like to be able to spend more time on how we do that, you know, thoughtfully and in a structured and systematic way. You know, I think building some of these new teams, trying to think about new training programs to really enable and empower community health workers and social medicine navigators. I think our primary care teams are gonna have to look really different than the way we practiced in the 90s and early 2000s in 2025 and I think for me, I just from a journey piece. I just, I don't shy away from Wicked problems. So unfortunately, I think we have a number of wicked challenges. And I think it's, you know, trying to also go where you want to get ahead of it. But I think the other

realities are, we have no shortage of challenges that are facing many of our communities.

So, my hope is to get more and more and more resolved, try over the next 12 to 24 months. I think, you know, I'm always excited about new partnerships, but also, most importantly, the ones that, you know, what I'm in some ways most moved by in the work is that for many of these partnerships we've had, they've been for, you know, number of five years, you know. And to keep that in any relationship, you know, is a lot of work. It's a lot of trust, but to me, it's one of the most important deliverables in the work. And I know we get really focused on these KPIs, Key Performance Indicators and various returns on investment and outcomes. And I think we, you know, definitely do that in our work at the Gattuso Centre, where we have a strong, evaluative and rigorous lens. But you know, you and I have talked about this, the trust in the relationships really matter, and I think you just that, for me, is what you can't afford to lose. You know, in the coming future, fantastic.

Helen 32:32
It's just brilliant to spend time with you. Thank you very much. Thanks so much. Helen. I look forward to seeing what you're doing next, and if we can support you, we're there.

Andrew 32:41
Amazing. Thank you.