AMS - CM - EP11 - Andrew Bond

Helen 0:00
Well, welcome. I'm here with Dr Andrew Bond. As I was thinking about this, was thinking about the time when we first met. It's got to be back in 2017. That was about 2018 I wasn't quite as weary as I am today, because I was then an Associate Deputy Minister of Transformation at the Ministry of Health. And you were at Inner City Health Associates.

Andrew 0:26
I was brand new Medical Director, Inner City Health Associates. You got it.

Helen 0:29
And you were looking for, I think, some additional resources to do some work in hostels. Does that ring about?

Andrew 0:35
Yeah, we were looking to grow what we were doing fairly substantially. And we were trying to come out of the gates, and we heard you're somebody who thinks about systems in a big way.

Helen 0:47
So that's great. And now you're also a board member at AMS healthcare. Well, we will talk a little bit about that. So why don't we start with some of your work at inner city health, it's pretty unique organization, part of St. Mike's right? What does the Medical Director do? And let's talk about the leadership that you needed to do that work.

Andrew 1:10
Yeah, absolutely. So Inner City Health Associates. Short name is each is known in the community as is fascinating and fairly unique organization, increasingly trying to make it less unique, because we want to spread and scale the work that we were doing. But it was founded in 2014 / 2015 as an organization to solve a really big problem, which was for folks who are in large urban centers are not able to access healthcare effectively, meaningfully or with the specialty in care, the complexity that people experience, particularly around social adversity, what kind of models of care do they need to be able to actually get that access and get the kind of care they need? And I think one of the biggest challenges in healthcare systems is that we are designed around a model which is a come to the

provider model of care. And for many people, that does not work, and particularly for those who are unhoused. And so that was where Inner City Health Association grew out of us were unhoused communities, particularly in the shelters and folks were homeless. And increasingly realized that there's a lot of people for whom the design of health care, where you have to come to a center and come to your provider to get access and care does not work effectively. I think we're increasingly seeing that now more broadly.

And so Inner City Health Associates was designed around this model of, how do we design a community, embedded model of care that really gets to where people are and goes to wherever they are, to remove all the barriers that we possibly can and so whether that's in shelters, whether that's mobile on the streets, cars walking, whether that's within community centers, whether that's within churches in basements, with refugee agencies, community agencies anywhere where people are that they can't get from where they are to where they need to get otherwise for care. And how do we eliminate that those barriers with physical proximity, through technology and through the model of care that we provide.

Helen 3:06
Can you talk a bit about the model of care? Because I know you've tried some interesting approaches.

Andrew 3:11
Absolutely. So there's a few things, so one really building on that idea of going out and trying to figure out how to both use dispersed models of care. So we had over now 100 different locations across the city. We have over a couple 100 providers who are doing this, both interdisciplinary physicians, nurses, nurse practitioners, community health workers, public health, population health, full spectrum of care. So when you think of primary care, think very writ large. We have 40 psychiatrists on staff, for example, which were community based organizations, extremely unusual to see, to make sure that we can do both complex medical and mental health care, but do it in a way that works, in deep partnership with community agencies right across the city, so that we are coming not just as a provider of care to our space, but it's actually their space. It's community space, and we're guests there. And so that means that we have to operate on very different rules of engagement, grounds of trust, building those experiences together, making sure that we're actually not just personalizing to individuals, but also to the

communities in which they live and are working and living within their rules. And that really changes, particularly for vulnerable populations. The dynamics of power, respect, understanding, and really there's a lot of power in medicine. So it's not just coming to us, but it's also when you come to providers, it's often the providers space, their rules, their terms, their security. When you go to community space, it's theirs, and it changes the dynamic very substantially, and only not everybody wants to practice in that way, but for those who do, it creates those grounds of trust that allows us to get at some of the really difficult things that people are experiencing that they're not otherwise, are they able to get the support for in the healthcare system.

Helen 4:47
So how did you come to this work? I know you spent some time in the north, yeah, and talk about that, because not everybody chooses this path. The work that you're doing is rewarding, but it's also. So hard, right?

Andrew 5:01
So going through healthcare and going through my medical training, I think my approach was always to see just how much we did not have a universal healthcare system and haven't yet. It's an aspiration that I think I hold dearly, and I think we should continue to strive for, but we certainly for myself and many others see just how much that wasn't the case, and very much tried to orient my career and have and talk more about this, around looking at the structural gaps, and where are the structural fixes. So if anything, it's almost a structural medicine. And so one of the big, obvious initial gaps for me was around how we approach and treat our First Nations. And you would meet people, indigenous peoples in this country. Indigenous peoples in this country. And so I wanted to understand more, and to try to learn how to not just understand but actually do something about that. But that meant getting on the ground. After my initial training in Ottawa and Toronto, spent the first decade of my career with James Bay First Nations, Mustang Council, First Nations, working in fairly decentralized, very similar model to the work that was happening with inner city Health Associates, except it was a model of care that exists by virtue of necessity and lack of resources. But we're able to do some incredibly community, engaged and embedded, outreach, oriented work to try to learn how to do that.

Helen 6:16

It's amazing if you think of yourself and as I do think of you as a thought leader, you're kind of working on the ground, providing care to people, but you're also having influence on the rules of the game and the policies and the structures of healthcare. Did you learn that in the work that you did on the James Bay Coast, or was that part of your lifelong learning? How's that?

Andrew 6:46
Very much a continuing journey? I would say I learned an immense amount in James Van with First Nations, both there and also in Nunavut and with Haida Gwaii in Northern BC as well. Whereas out there for a couple of years, what I think I most have taken away always with this is that if one is going to both try to create change but also advocate, it's to really put in the time and put in those reps actually understanding what's really happening, understand that people, understand the relationships, establish trust, to really feel and understand where things are. And my goal has always been not to be a voice for others, but to be like just a translator between different spaces and so certainly, between healthcare and different communities, different languages and priorities and values and how to make things happen. I think that takes us a lot of time creating the density of relationships that really mean something, and to make sure that you're able to actually identify both those levers that need to be pulled, but also do that in a way that has community behind you and has people with you to be able to do that, and that just takes a lot of time. This is not a simple thing, and certainly none of the solutions I've thought of or worked on are things that are my own. These are things that evolve out of co creation, together with lots of people who are trying to struggle through and wrestle with how to change our systems of care.

Helen 8:05
Yeah, it's interesting. As you're talking I'm thinking about some experiences I had where sometimes you can get out ahead of the people that you're trying to serve. And I recall being chastised nicely by Pat Capone, and she was talking about “Helen, that's uninstructed advocacy, right?” You can sort of think of imagine her doing that.

Andrew 8:26
You have to earn the mandate, and that mandate has to come with lots of terms and accountabilities too, just like others. And I think it's particularly

true in the context of community, because the trust that goes into building that really matters a lot.

Helen 8:37
You know, AMS is an organization that thinks about compassion. And, I mean, I think you're kind of an archetype of that, but how do you think about compassion in the communities that you serve? And is that part of your sort of leadership toolkit?

Andrew 8:50
Absolutely. I think, like the push up against the walls of compassion and say, think we need to re own love honestly. I think love's a really powerful word, but people are fearful of owning and thinking it's vulnerable or weaker. Think love is one of the strongest words that we have. And I think when we think about both our work but our families and our community engagement, that's where the best parts of us show up. And so I think compassion is one manifestation of love, but I think love goes much bigger than that. And so not to but I do think it really is a big piece of connecting individual meaning, value and purpose to community and relationships. And I think it's, it's a word and a concept that we need to re own a lot more and feel comfortable exercising that in the work that we do. And it's not something that's sort of a fluffy piece, but it's actually the tissue of some of the best things that what we do in the world. And so very much see compassion for sure, but I think, you know, I almost think of love as an action and something that we actually it's not just a feeling that we have. It actually is something that is manifest and actually what we do and where that comes from. And so I think compassion is one dimension of that, and maybe it's a bit more of the feel. And the sort of more passive end of the continuum of it, which I think has the broader end to the active part of loving and giving and working to really create new things together in community.

Helen 10:11
And how do you build that into a team? Because obviously you can do so much, and then you've got 100 psychiatrists. I mean, it's just amazing yeah, the breadth and depth of team and how do you create kind of purpose, or do you just find people who are like minded and get them to come on the journey with you, but not everybody's going to be as evolved, necessarily in their thinking about these issues or their skill set as you are.

Andrew 10:36
There's a couple. One, you know, I was really fortunate where Inner City Health Associates, when I came into it had already been launched. Had amazing people involved who care deeply and very brilliant people to help build that. And so I got to sort of build on those shoulders of giants there. So we had something to work and build from. And I think that helps, because you're not building from zero. Building from zero is a very different proposition. But building from proposition, but building from something that actually already exists, and I think attracts people. People are very much attracted to that work. I think people are particularly now when you look at healthcare and workforce burnout, people are missing meaning, missing purpose, in really important ways. And I think that was something that really attracted a lot of people to the work that we do. But to my point earlier, it's, you know, love is not a mushy word where we have to get very concrete about what we're talking about when we're saying this. What does it actually look like? So yes, we need to name it and identify it, but along with other values that we've talked about, so we had a list of key values as an organization that we really took seriously and to make sure that we understand, like, how does that show up in the different programs, services, recruitment, onboarding, how we run our team, meetings, how we operate, and to make sure that we're actually living those and have them infused through the work that we do, and iterate them over time too, to make sure, because, as you know, values change or grow and emerge, and we want to make sure that we aren't just rigidly holding to those, but we put a lot of work into making sure that we're very intentional about that. I think that work that I think that work that we do, it also very much lends itself to teams who want to try and think through those, those challenges together.

Helen 12:08
And how do you teach others? Because at the beginning, you talked about scale up and hoping that the model of the Inner City Health Associates is not kind of a one off, you know, how do you think about replicating that, because clearly, we need more of that kind of imagination and care and thoughtfulness and feet on the ground, both in Toronto and beyond. Right?

Andrew 12:30
Certainly, the pandemic supercharged all of this and for everybody in so many different ways, particularly unhoused communities were greatly disproportionately impacted, just like long term care, anybody who had

either a were living in congregate settings or lived in under resourced settings really experienced the brunt of COVID. So that really propelled people to try to think creatively and to realize just how big of a challenge housing homeless was, I think, right now, with policy narrative and where we are right now as a country. Housing has gone from being barely on a policy agenda five to seven years ago to now being front and center, probably one of the top two issues that are going to decide elections in the next year or so, which is encouraging to see, because it's important to see that policy focus. But I think COVID helped to bring that into focus. The readiness is there. People are really wanting to do this building. So the number of organizations, municipalities that want to do this, the teams that are on the ground, healthcare providers, see it, and the idea of collaborating and doing care differently, I think, couldn't be more timely about where people are right now, that we know that there's a need for transformation of how we think about and deliver care. And so there's a real receptivity to this. And so certainly over the last year, we've had at least five or six different municipalities where we have actively helped them work through their business plans, their operating models, supported their teams, how to bring them together. So whether that was with Durham or Halton or Peterborough, for example, had conversations with Belleville. These are those who really are actively there, they will build and do their own version of this, because this work. The important thing with templating, I think, here, is the balance between the template and actually having the local meaning and integrability. And so they're going to have their own versions of this. But we've done a lot of work together to figure out what that could look like.

Helen 14:20
And I have to ask, are they doing this separate or in the context of their Ontario Health Team?

Andrew 14:27
I think a bit of both. Yeah, I think, as with all things Ontario health teams right now, there's still a one foot in, one foot out, and how do we get two legs into this thing happening? But absolutely, I think people are trying to figure how to do that. I think the part of it that is encouraging to me is that housing homelessness are the most vulnerable. They're not always going to be the priority of every Ontario health even there's only so much that any of them can do. And so what's really encouraging to me is that when it's not possible or it hasn't been able to obtain that pride of place in the priorities.

Is that those same individuals and organizations get together to figure out, okay, outside of this, how do we do this? And that's that, to me, is encouraging. Not everything is going to happen right away, all within the wait season, so the fact that it's critical of enough of an issue that they're still going to use the same relational tissue to make that happen is really great.

Helen 15:19
Yeah, I'm encouraged by the examples you're giving and the fact that you've got some spread what about up to the policy process? I mean, I agree with you. I think the challenges in the healthcare system and the visible challenges of housing are creating a platform for a policy discussion. But if you've got some thoughts about how to push it up even more, yeah, and make it more front and centre in the in the policy discourse, because we certainly still have a lot of silos and thinking

Andrew 15:49
There's probably two or three levels. So what the first is that certainly the ministry is commission health is certainly working with us and others to explore what it looks like to have other similar contracts for healthcare provider groups to do this work, and so that that's encouraging, that there is both interest and real commitment, I think, that has been shown from the Ministry about solving these challenges. We know that it's terrible for the for folks who are vulnerable in terms of their healthcare experience, but we also know that it's bad system design in that when folks have nowhere else to go, they end up in emergency departments for they don't get the care that they need, and it really doesn't help health systems actually run efficiently and effectively either. And so this is a win-win from both an individual compassion perspective health system design, but also cost efficiency perspective. So I think policymakers are seeing that part starting to which is really encouraging. I think the bigger thing that when I think about is we aren't still thinking about in the context of housing, both the social determinants side, but also, how do you bring together housing policy and healthcare policy to your point, around silos? And so the fact that we have a national housing strategy that had no health or health care providers or organizations thought of, let alone included anywhere in there was probably one of the biggest policy misses in terms of an opera, an opportunity for doing some really powerful work, because we know that this is exactly where you can have some of the most impactful change, both for individuals and communities, but also how we are able to actually sustain

housing when you actually have it? How do you make sure it's actually durable?

How do you make sure that health systems also work together really efficiently? At the same time? That was an opportunity lost. I'm hoping that it's something that can still be pulled into the policy mix, but, but certainly that was telling so I think that there's work for us to do, for sure, and seeing that happen at the level of, how do we think about housing policy and health care policy together? It's interesting in the States, for all the differences that they have, they have an interagency table, for example, that brings together most federal agencies that have to actually have to do with homelessness, to figure out, how does this particular challenge show up and refract across all the different portfolios? And I think that's an area where there's some learning for us to do.

Helen 18:02
Yeah, for me, personally, it's kind of the one thing I feel is left well, maybe not the one thing, but one of the most important things that was left undone. I started - I'm an urban planner by profession. I don't know whether you remember that. I started my career on something called supportive community living, which was basically trying to get support services and not for profit, housing kind of developed together so that we weren't developing housing solutions without the services to support living in the community and tenancy, you know, as well. And I had a couple of kicks out in my career, and I don't think we've solved it yet. Kind of dis Well, disappointing, I think having spent sort of 30 years in public service and wanting to see those two things come together, so it's clearly a difficult problem.

Andrew 18:52
Absolutely. I think it's easy to point of silos for many folks, I think to see homelessness as this, this awful tragedy that begets certain particular people, whether it's for life circumstance, whether it was from a health condition, whether it's from affordability, but it's a tragedy that affects just a few. And I think we don't think historically very systemically about this. To your point, we know that for every person who's unhoused, there's about 23 to 27 people who are just on the brink of homelessness, in terms of the high risk of housing instability, and that changes our thinking everything. This is a small segment where a tragedy happens as this episodic, containable thing to we're talking about something that's actually a tip of a

spear of a very big dimension of both financial and housing affordability, where now we're talking about millions of people in every single province who are basically in the same experience. They're just on the other side of that right now. And so it's actually a much bigger policy issue, I think to think about,

Helen 19:55
I would agree, and I will go back for listeners their first podcast was with Adil Khalfan, who runs Kensington, and of course, they're right beside the fort York Food Bank, which I walk by to come to the office here, and I'm just struck by the numbers of people lined up. Also, it's housing, but food security is also kind of part of that picture, right? And it's remarkable in not a good way. Just want to pivot a bit and talk about innovation. So within this context, you've been able to piece together bundles and packages of services and work with community, but you've also innovated. I'm just interested in how you've integrated because we're AMS, we're interested in technology and compassion, how you've integrated technology into some of the work that you've done in communities and where it's featured and where it's worked.

Andrew 20:55
Well, it's a big part of it. I think any time you think about how we are going to transform access to care. Experience of care technology has been an increasingly will be omnipresent in actually, how we achieve that there is not a way in which we transform healthcare through just increasing headcount and doing more of the same. And so that means reconfiguring the delivery of care. And that means, especially now, both in terms of analytics, but also now increasingly with AI with predictive potential and automation, how can we actually redefine what's possible? And so even in the context of working with communities who are either in house or refugees or indigenous communities within Toronto, for example, we had our entire network on a single electronic medical record communication system. We have entirely linked paging systems that are integrated into that, and we were one of the first in the province to use AI scribes, for example, before others were looking at how they might pay for it, we realized that the more that we can be efficient in our practice and be both efficient and mindful of administrative burden for our providers, we knew that they could actually do the hard work of actually being there, understanding their patients and finding better care. We started that right from the very beginning, for example, as a commitment within a an area in

health equity, where think there's a presumption that in the philanthropic or that nonprofit space, that there's not innovation, that somehow it's you do it on the shoestring budget and you make it happen, and it's not that it's not that it certainly is a high cost version, but it's we figure out where are those points of opportunity to do better with technology? I think that we are increasingly going to see what that looks like. So that's one in the context of the work we're doing there,

Helen 22:36
I'm not sure we have a choice. I don't know whether you've had a chance to look at the Dalai Lama/Ontario Hospital Association paper on the chronic diseases. I was in a meeting yesterday, and they were talking about like, we probably can't build the number of beds in time to be able to deal with those projections, but we also don't have the people to do the work, so we're going to have to innovate pretty darn quickly. Yes, on this one, right?

Andrew 23:04
Yeah. I think what we're seeing there is, there is the hospital compliment to the primary care crisis. That is, it's already here, but it is increasingly going to be obvious just how challenged we are. And so to that point, just like with primary care, we are going to have to fundamentally think about how we transform what a hospital is for. What are the different priorities? What are the different places in which we offer care and provide care? What does that look like? There is a fairly top-to-bottom rethink that is likely coming both from demographic but also from the fiscal side. Is that even if we had the potential is really that kind of capital investment the right way. So I would say, No, it's not the there's an opportunity to use some of the constraints to actually innovate, and that's often where that happens. We are also on the low end of beds in terms of OECD too, that we still have building to do as well. I don't think these are either our propositions, but it very much is. We're in a capability trap from a systems design perspective, and we need to be able to get out of that, which means resourcing the immediate but very quickly, also resourcing the intermediate to longer term, or we're going to be stuck here.

Helen 24:10
I keep saying the cavalry is not coming, right? It is not it is not coming. So we better seize the moment. I'm interested in your journey. Last I checked you were working on your MBA at the Massachusetts Institute of Technology, and how far in are you - pretty? (Three months left.) Three

months left. That's amazing. You must have a philosophy of lifelong learning to be able to and that, I mean, the challenges of the system kind of require us to tool up and hone our toolkit. But interested in your thinking about how you're preparing yourself to continue to have impact.

Andrew 24:46
So definitely committed to lifelong learning. There's no question that's been both with this, but also through, through my entire career. I think at different points though, it becomes critical to consider, to achieve where you're trying to get to. So do I have the capabilities? And then it's a question of, Do I need to have them, or do I just need to partner with people to be able to get there? What do I think I need to be able to be armed with what I need to go, where I need to go? I think increasingly, what I've realized, and this is connected to some of my career changes as well, is the ability to bring together understanding health systems at a granular level, but also at a more systemic level. How do you bring health systems design, policy and also the particularly about the point right now, but where we are fiscally and in health system financially is, how do we actually do this in a way that is mindful of cost efficiency, effectiveness and high performance? And the piece that has always been missing, for me, is actually understanding the actual business operations of an organization and how to actually make sure both organizations and larger budgets like you've managed is how do you actually think about and make sure that we are doing this in a way that is truly fiscally responsible and as efficient as possible, and increasingly with technology, that means working with different companies that have different priorities and a whole different value proposition that we're going to have to be able to think about as we do this. And so that was, for me, the point where MIT was about being in a place that has committed innovation, probably one of the most innovative places I've ever experienced. But also it's an engineering school. So this is not, you know, just a business school, of regular business schools. This is a place where most people you're with in class are engineers with big vision, big hearts, are trying to really build things, and they are in the weeds on all the details about how we get there, and how do we do that with technology, with biotech, with industry, and how do we actually think about public private partnerships in a very broad way to be able to achieve some of our big aims that we have to achieve.

Helen 26:44
So you've just made a career change. I'm pretty familiar with Green Shield. They did a lot of work with us back in the day when I was working in the

Ontario Drug Benefit Program. They were a technology provider for the provincial drug benefit program, and they are sort of unique in the landscape in Ontario. So talk to me a bit about the platform of a not-for-profit insurance company, and what the appeal was for you as a because it's a different platform than what you've had.

Andrew 27:12
Yeah. So Green Shield is the only national nonprofit health benefits company that really matters for me, I think from our conversation and from knowing me, you know that values alignment is really important, and where we're working from, and so as a nonprofit that is explicitly committed to health for all that's its mission, literally in the work that we do really mattered. And if you look at the arc of my career, I think as we know like understanding our life, you know the understanding comes in high in sight. You live it forward, but you understand it backward, right? It's and so when I look back on my career, the first phase was when I talked about structural medicine the beginning, and seeing myself as a structural medicine provider, really, the first was around the big gap around indigenous health, First Nations new at and the constitutional crisis in health and the lack of self-determination and health. And how do we work in that space and do something fundamentally different? Then the second phase was around and it's integrated forward. It's never just left behind. It's included. As I go, was around housing and social determinants. How do we think about integrating a much broader view of health and healthcare? The third stage now is seeing where we are as a healthcare system, to point around the OHA report and where we are with hospitals, but much more broadly, with 25% of people not having a primary care provider, and where we are fiscally 40 north of 40% of parental budgets going to healthcare. We are not on track to being able to think about how we're going to stabilize our healthcare systems.

And so as I thought about my next step, I'm thinking now not just about where are those segments that are a challenge, but now the whole system is a challenge. And so one of the biggest challenges and gaps, I think, that I've identified for me anyways, is just how much we have not thought about public private partnership in this country, that the private dimensions of healthcare, which accounts for about 30% of healthcare spending, but a significant amount of people's health care outside of doctors, hospitals and some drugs, is almost as if, as a health care provider, as a physician, it almost exists, exists in a different universe, and that that's baffling when

you think about how much we've created these silos, to your point of silos, but You have resources and people who are building at scale and at the intersection of technology, policy coverage and increasingly health providing as well. So we're certainly at Green Shield with 5000 mental health care providers, for example, have a large commitment to providing care as well as with chronic disease management. And so how do we bring these together? And so one of the big gaps for me is, and that I realize is, as we think about where we are in healthcare systems, I don't see a future that is possible without bringing these two dimensions of our healthcare system together as one of the wounds that we have to heal and to figure out what that looks like. And so for me, the move was, if and as. Think about doing that, where is the most values aligned place from which to do that, that we can operate at scale to try and figure out how to actually be a true partner with the public sector. And that's really the motivation for the movement. How do we work together to take everything that I've learned from public sector to try to bring that into some of the work that we're doing as well?

Helen 30:19
So you're a bit of a polymath. Is that fair?

Andrew 30:22
I have lots of interests.

Helen 30:25
You have lots of interests which make for an interesting life. And I'm really interested in, you know, you've just joined the board of AMS healthcare. You've expressed to me and other venues, your interest in in history and this is sort of one of the major programs that AMS offers. What do you think the influence of history is on that some of the contemporary challenges of healthcare that you've described so eloquently.

Andrew 30:52
Three things and maybe picking up on what we're just talking about. So I think one is, as much as there has been profound harm done to indigenous communities, both by healthcare organizations and institutions to solve and as a country and by history of our policies, there's also been some of the most interesting and impactful hopefulness as well and change that we've actually started to see, which I think is critical to call out, which is around the self determination of health and just how much can be achieved. Under

different models of governance and healthcare for indigenous nations. And so when you look at the First Nations Health Authority in BC, you look at some of the work that's happening with Southern chiefs in Manitoba, for example, we're similarly going to have the Health Authority and Sue Lookout in James Bay and Winnebago, having first nations led health authorities, that is so encouraging to see the swing from where we started 20-30 years ago, and trying to provide health care services and hospitals in very damaging ways to some of the most empowering and taking far too long to get here. But it is encouraging to see where that's going as I think that that's a lesson that I hope that we continue to learn and deepen right across the country. Second, I think you call that with respect to hospitals and their role. And I think Canada has, historically, as you know, through the Canada Health Act as predominantly had a focus on doctors and hospitals and some drugs, that certainly works from a perspective of cost containment. And I think, you know, I think we can be proud that, unlike our southern neighbours, bankruptcy due to healthcare is not the number one leading cause of bankruptcy personally, and in fact, it's nearly zero in Canada. And so that kind of approach to public insurance is critical at the same time it's the highest cost of care, which means that is gonna take up a lot of budget, and what that means is that that constrains what we're able to then do as a health system within fiscal sustainability. And so unfortunately, we also know that hospitals and doctors have the lower impacts on actual population health outcomes. And so it's the most costly. It's necessary because it's acute, but it also doesn't drive health. And so if we're trying to influence health, but all of our budget is locked up in doctors and hospitals, we have a structural problem. And so I think we have a lot to learn about how do we do that? I think the primary care shift right now is encouraging.

I do think, and I would stretch and push our thinking on primary care to say it's not just primary care, and it's not just the doctors within primary care. This is primary care within a broader community health lens. And so I wouldn't think of a medical home, for example, the language I think of as a community health home, where physicians respect, have places in that but a broader lens on what primary care really is. I think we're moving in the right direction, but we have a lot to pick up on there. I think the third for me, again, with, and I'll go back to this public private systems, is we need to learn to integrate in ways that actually work for Canadians, and what that looks like. And we have a lot of learning too. We know that most of the OECD high performing countries have identified some better and some

worse than how to do that, ways to be able to make sure that we actually have these systems work together, and by doing that, we can drive better population health. We can do it in a way that's more cost efficient. That is a big challenge for us ahead, and that's certainly where and why I'm positioned where I am right now, is to do that work, to try to do that in a way that is still committed to foundational commitments around health equity, access to care.

Helen 34:25
I'm excited for what you're going to achieve. Thank you very much. It's been a pleasure spending time with you, and until the next time.