Running title: REBOOTING THE SECOND GENERATION HEALTH STRATEGY

Manuscript title: Vancouver Coastal Health's Second Generation Health Strategy: A need for a re-boot?

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# Vancouver Coastal Health's Second Generation Health Strategy: A need for a re-boot?

## Abstract

In this commentary, we consider the motivations and implications of Vancouver Coastal Health's place-based population health strategy called the Downtown Eastside Second Generation Health Strategy (2GHS) in light of a broader historical view of shifting values in population and public health and structural health reforms in Canada over past three decades. We argue that the tone and content of the 2GHS signals a shift towards a neoliberal clientelist model of health that treats people as patients and the DTES as a site of clinical encounter rather than as a neighbourhood in its own right. In its clinical emphasis, the 2GHS fails to recognize the political dimension of health and wellbeing in the DTES, a community that faces compounding health risks associated with colonialism, gentrification, human displacement, the criminalization of poverty, sex work, and the street economy. Furthermore, we suggest that in its emphasis on allocating funding based on a rationalist model of health system access, the 2GHS undermines well-established insights and best practices from community-driven health initiatives. Our aim is to provide a provocation that will influence both the public health leadership at VCH and the wider community that it serves to consider the long legacy of community-based health leadership as well as the broader structural health determinants that are at the root of the present circumstances of the people who live in the DTES today.

## Introduction

On February 24th, 2015, Vancouver Coastal Health (VCH), released its Second Generation Health Strategy (2GHS), to "address changing health needs in the Downtown Eastside (DTES)".[1] After years of supporting numerous community health initiatives, often in a fragmented fashion and ostensibly with ineffective results, the 2GHS seeks to consolidate professional support using evidence based approaches that have been developed in response to community priorities obtained over two years of ostensible consultation. Yet, despite its seemingly progressive agenda, the 2GHS has been met with widespread criticism by leading voices from within the DTES community and beyond. The concerns of the community focused on a profoundly narrowed definition of health care to justify severe funding cuts to vital mental health community organizations.[2 3 4]

This gap between professional and community perceptions is an important concern for public health given the financial investment into population wellbeing that is at stake in the implementation of policies such as the 2GHS. In this commentary, we consider the motivations and implications of the 2GHS's plan to repatriate clinical services from its longstanding, albeit stretched, community partners in light of the broader historical view of VCH's status as an institution established amidst an era of shifting values in population and public health and structural health reforms in Canada over past three decades. In doing so, we point to some of the ways in which the 2GHS perpetuates a long pattern of health sector neoliberalization in Canada, reflected in an ideology of individualization, austerity, corporate governance, and a reassertion of a technorationalist biomedical model of health over a relational socioecological model of wellbeing.[5]

## Evidence based population health and neoliberal legacies

As with all regional health authorities in Canada, the circumstances surrounding the creation of VCH can be traced to the period of national health reform that began in the late 1980s through to the early 2000s. As a governmental response to the slow-motion financial crisis of Canada's federalist health system, most provinces undertook structural changes over the 1990s in response to a rising tide of austerity politics that led Health Ministries to embrace a neoliberal ideology as a way out of the fiscal crisis within the health care sector.[6 7] Regionalization was the mantra of neoliberal health reforms, and the newly implemented health authorities inherited a seemingly impossible task of delivering a more effective and affordable health care system simultaneously.

Particularly with regard to the re-structuring of British Columbia's health system from 18 to 5 RHAs, the shift towards a business-minded model of managing health care has often compromised the quality of health services delivery to members of the community with specific needs.[8] The ongoing unreconciled legacies of colonialism, deinstitutionalization, and the pattern of urban dispossession that has exemplified the DTES more than any other neighbourhood in Canada has placed VCH in a remarkably challenging position of implementing this wider austerity-driven health agenda within a jurisdiction that has been disproportionately impacted by neoliberal encroachments into its social and governmental institutions.

In its early days, the leadership within VCH has been credited with playing a critical role in implementing a philosophy of intervention that aimed at the root causes of chronic health inequities. Notable among its more successful efforts has been the continued support of the SMART fund, a lean but widely respected initiative named after the late Sharon Martin, a widely respected community developer who embraced a community driven model of health promotion that emphasized local control over the design and delivery of health services. Established in 1997, the SMART Fund has supported an enumerable number of non-profit agencies, projects, and residents throughout the lower mainland that has made lasting contributions to the ways that VCH and the wider community responds to systemic health inequities induced by homelessness, social exclusion, mental illness, colonialism, and other forms of discrimination. [9] Of particular significance, the SMART fund plays an integral role in supporting marginalized and vulnerable individuals who face barriers in accessing health services and exercising good health.[10]

On the other hand, the 2GHS follows a model that, on the surface, seemingly resembles the philosophy of the SMART fund, yet, underneath reflects a profoundly different approach to community health that is less consistent with the reality of the DTES and more a retrenchment of neoliberal influence within VCH corporate governance. The vision of the 2GHS is to "support the evolution of local health service towards the provision of client-centered, evidence-based and cost-effective care within a cohesive network of community based health services". [11] The vision is reflected in five approaches to health delivery in the DTES: "promoting coordinated partnerships, expanding care teams and staff competencies, integrating care, aligning services with client demand and recommitting to the achievement of performance excellence". [12]

The discursive tone of these approaches reveals a remarkable gulf between the progressive vision of health exemplified by programs like SMART and the clientelist vision of the 2GHS. Ironically, the 2GHS represents a consolidation of professional biomedical power within a city that is located on unceded Coast Salish territory, yet has failed to address unprecedented levels of

inequality and homelessness, a long history of racist and colonialist policies, and the lasting consequences of deinstitutionalization, all of which have contributed to a legacy of distrust in professionalized models of care, particularly among Indigenous people.

Amidst this environment, it is a common refrain among DTES inhabitants to see their community as a last refuge in a hostile city. This sense of refuge has been built up largely by the community, whose grassroots organizations have, often with VCH funding, supported those whose lives and wellbeing have been made all the more precarious by the failure of the health system. The story of Gallery Gachet provides a good case in point. A longstanding recipient of VCH funding, Gallery Gachet is a community-driven, grassroots, artist-run centre that advocates and educates the public about mental illness and social justice issues through artistic means and provides support to those who experience social marginalization and persecution. Gallery Gachet is significant because it is represented by community grassroots organizations to create safe spaces in response to violence and marginalization experienced by individuals with mental illness.

However, Gallery Gachet, as with many fundees, has fallen victim to VCH'S shift from a community health-centred focus to one of an evidence-based medicine culture. As VCH's $55 million funding package remain unchanged, new programs and services under the 2GHS will be funded by reallocating funds from existing projects. Therefore, "VCH contracts without a clear health mandate or those offering stand-alone services without formal connections to health *care* (emphasis added) services may not be renewed". [1] VCH's funding cut means that Gallery Gachet must seek alternate sources of funding and will likely not be able to offer the same level of care, support, and advocacy that it has long provided for the DTES community.

The broader implications of VCH's funding reallocation rest in its lack of recognition of community based organizations as bona fide health interventions in and of themselves. VCH efforts to expand the "potential of Drop-ins and Peer Support as a way to engage residents in the health care system",[13] means that recognition of the therapeutic benefit of peer support and community drop-ins are largely undermined and are rather justifiable only as gateways to health care access. We suggest that such repatriation by a large governmental institution is decidedly dangerous in a population whose members have endured a long legacy of distrust toward governments and health care professionals as a result of colonialism, deinstitutionalization, and the criminalization of the poor, racialized, and non-conforming.

In the view of a growing chorus of dissenters, the culture of evidence-based medicine that has typified the 2GHS is a covert intent to "depoliticize" the neighbourhood. Mental health is indeed a clinical condition, but it is also very much a political one whose present-day manifestations must be seen in light of their historical antecedents at the political and societal levels. Rather than avoiding politics, these dissenters argue that the political nature of health and its social determinants must be understood, and advocacy must be seen as an essential ingredient toward population health solutions for the DTES. In this view, organizations like Gallery Gachet are essential allies for VCH because of their unique capacity to create conditions for cultural safety and wellbeing among DTES residents and in pointing attention to the structural root causes of the mental health crisis in this country.

## Conclusion

While we support VCH's longstanding commitment to supporting health of most vulnerable Canadians and their ongoing efforts and investments in the DTES, we worry that 2GHS is inconsistent with current evidence and best practices in the tenets of health promotion. Rather, the 2GHS appears to extend a neoliberal model of health which has time and again proven incapable of attending to structural health inequities. The 2GHS signals a shift towards a professionalized, clientelistic, individualist, and authoritarian approach that treats people as patients, the neighbourhood as a clinical site rather than a community and a refuge, belying the huge impacts that the *in-situ* community of peer supporters have made for the wellbeing of people with mental health issues who live and/or seek care in the DTES. We suggest that VCH seriously consider a re-boot of the 2GHS consultation process and learn to draw on, rather than dismiss, the wealth of untapped expertise in dealing with the root causes of mental illness in informing the approach to holistic health care. A successful model of health for the DTES community must be people-oriented, not patient-oriented.

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