Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

"The Ethics of Equity and Sustainability"

Full Report

Local Health Involvement Groups

May 2016

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Section I

Report Summary

Background/Rationale

What is health equity?

> *Large gaps exist in Winnipeg between those experiencing the best and poorest health. People living in some areas of Winnipeg have nearly 19 years lower life expectancy than people living in other parts of the city. Many of the gaps arise from unfair, unjust and modifiable social circumstances. Health equity asserts that all people can reach their full health potential and should not be disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.*
>
> *Health for All: Building Winnipeg's Health Equity Action Plan*
> (Winnipeg Regional Health Authority, June 2013)

Reducing health inequities and building a more equitable health care system is a priority for the WRHA. For the last 3 years, more focused efforts have been made to realize this goal, most notably, a position statement on health equity from the WRHA Board and a discussion document, *Health for All: Building Winnipeg's Health Equity Action Plan,* 2013.[1]

The Local Health Involvement Groups (LHIGs) have been exploring topics using an equity lens for the past 2 years. During the topic selection process, LHIG members and members of the senior leadership team and Board all agreed that community consultations on equity would be very valuable to the region.

Choosing to look at equity considering ethics and sustainability
The purpose of the consultations was to bring the public into the discussion about equity and what building a more equitable health care system might involve, including the reallocation of existing resources to better align services with the needs of the population. Budgetary pressures on the health care system make it necessary to ensure that decisions regarding resource allocation/reallocation are sustainable for the long term.

Input from the consultations
Input from the consultations will provide an opportunity for the Board to hear broad public perspectives on equity using an ethical lens; areas of agreement and support; as well as questions and concerns about potential approaches to promoting equity.

Community members provided feedback on criteria for making decisions within health care that build equity. This will be helpful in the development of and application of a health equity lens to resource (re)allocation that will utilized to move equity forward in the Winnipeg health region. They also shared ideas for how to build understanding and support of equity in the

[1] For more information about health equity promotion at the WRHA visit: www.wrha.mb.ca/about/healthequity/.

broader public. This input will be utilized by the health equity planning tables and the communications department.

Process

The Director of Ethics Services and the Population Health Equity Initiatives Leader worked with the LHIG manager to develop the process and questions for the consultations. The first consultation took place in November 2015 with the Ethics Public Engagement Group. It was an opportunity to engage this group and get feedback and suggestions on the process and questions. (Their input on the questions is also included in this report). As a result of their feedback on the process and questions, a couple of questions were modified slightly and one slide was added to the presentation.

First Meetings of the Local Health Involvement Groups and Francophone Consultation

Meetings on equity with the Local Health Involvement Groups (LHIGs) took place from January to March 2016. Each of the six LHIGs held two meetings on equity. A consultation took place with the Francophone community at St Boniface University on February 22, 2016. This was part of the WRHA's effort to broaden engagement with linguistic, cultural, and vulnerable populations. Participants at the Francophone consultation provided input on the first set of questions, the same questions as those provided for feedback at the first set of LHIG meetings on equity.

At both the first set of LHIG meetings and the Francophone consultation, a presentation to provide background information about health equity and ethical decision-making in health care took place prior to the discussions. The purpose of the presentation was to share key information about what health inequities are, what causes these inequities to exist, and how to use an ethical lens to consider the question of moving health equity forward.

<u>Participants and LHIG members provided their feedback to the following questions:</u>

1. What obligation do we have as a society to address the differences in health outcomes that currently exist?
2. What obligation does the health care system have to address the differences in health outcomes that currently exist?
3. What are the ethical issues related to aligning health services to the needs of the population?
4. What would our health care system look like if we aligned health services to the needs of the population without adding new resources?
5. What would our health care system look like if we addressed the underlying causes of unequal health outcomes?

6. Equity is complex social issue that requires more than just health care system to address) Who do you feel the WRHA should partner with to address inequities? Brainstorm and then prioritize.
7. As we move towards a more equitable health care system, what is the most important thing that you feel that the WRHA should consider/keep in mind?

Second Meetings of the Local Health Involvement Groups

The members of the Local Health Involvement Groups provided feedback to 3 additional questions on equity at a second set of meetings.

Questions:

1. Identify the criteria that the WRHA could use to make decisions about resource allocation that reflect population needs? Imagine a "check list" for decision makers to use that would help address equity. What would be important to include? (Prioritization exercise followed)
2. When aligning health services to the needs of the population, what should we be mindful of? (principles, values, other considerations)
3. In order to build understanding and support for equity approach, what are your ideas for what and how the WRHA can communicate with the public?

Presentation of the Equity Report

This report was presented by Co-Chairs of the Local Health Involvement Groups at their year-end meeting on April 27, 2016 to LHIG members and members of the Board and Senior Leadership of the WRHA. It was formally presented to the WRHA Board on May 24, 2016, and then posted on the WRHA website. The report was also presented to health equity planning tables and program teams. Updates of how the recommendations are utilized will be included in LHIG feedback/update reports which are also posted on the WRHA website.

The Ethics of Equity – public perspectives, public support

What is the social obligation?

> *Disparity in health outcomes is a reflection of disparity within our society. Some groups are experiencing shorter lives and bigger health issues. It's a moral imperative to not just change the health care system to be more equitable, but to change society to be more equitable.* (Downtown/Point Douglas LHIG)

Conditions and opportunities for good health (like a reasonable income, good quality housing, education, good working conditions, and access to health services) are not shared by by everyone. There is an inequitable distribution of money, power and resources in our society which has resulted in large gaps in health outcomes and use of the health care system (for example, 16 - 18 year difference in life expectancy, the likelihood and length of hospitalization, and the incidence of diabetes, heart attacks, and teen pregnancy) between our most advantaged and disadvantaged communities in the Winnipeg health region.

As a result, the burden of poor health and health outcomes is experienced disproportionately by poorer populations. Given this, does society have an obligation to take action to improve health outcomes?

When this question was posed to members of the Local Health Involvement Groups, Ethics Public Engagement Group and at the Francophone consultation there was a range of responses. Many were very supportive because of a moral obligation, a "just society", and a duty to level out the great differences that exist. There were some, but not many, people at the other extreme as well. These perspectives were based on concepts like individual responsibility and that it isn't right to focus on the needs of the few versus the many. Generally those who participated in these discussions felt that there was a social obligation to take action but weren't sure about how far that obligation should go. And some of participants wondered how their neighbours or the broader public would respond if equity meant that some health care services would be redirected to those most in need/those who would benefit most from them.

Here are a few of the comments that illustrate the range of perspectives on social obligation:

> *I believe that we have an obligation to address inequalities and provide equal medical care for all individuals. We should be appalled at the differences in health outcomes.* (Participant from the Francophone Consultation)

> *We have a publicly funded system which reflects a societal obligation to providing health care and reflects our public values. Yes, we do have a strong obligation that speaks to how the system has been designed. We believe all should have access and therefore, they should have similar outcomes.* (River East and Transcona LHIG)

Probably yes, there is an obligation of society to act. But I don't necessarily know how it would impact your own family. If I have to lose access in order for someone to gain access, I'm not sure how I would feel about that. Society creates these disparities, so society has a responsibility to help fix the problem. (River Heights and Fort Garry LHIG)

There is definitely an obligation to address, but there is a big problem, unless you get rid of the bigotry, etc. first. (St James and Assiniboine South LHIG)

There are lots of factors that contribute to the gap in health outcomes, including personal choices versus access to resources. The health system has no opportunity to control personal choices, but could take some steps to equalize opportunities. Equal outcomes might not be realistic. (Ethics Public Engagement Group)

I agree that we have an obligation at all levels of government. Individuals need to understand and support the changes need to be made. There is a role for everyone.
(St Boniface and St Vital LHIG)

Society is much larger than the health care system. The heath care system is part of society and has a responsibility to contribute to health. The health system needs to partner with other areas, like housing etc. *(Seven Oaks and Inkster LHIG)*

What obligation does the health care system have to address inequities?

The question of the obligation of the health care system to address inequities was much more straightforward. There was very strong support of this statement; that the health care system is obligated to address the gaps in health outcomes. But, there was a range opinion about how far that obligation goes. Overall, LHIG members and participants of the Ethics Public Engagement Group and Francophone consultation feel that the health care system is responsible to address those factors within health care that contribute to inequity, especially how people are treated and experience discrimination.

> *These poor health outcomes are a barometer of how the system is functioning. It's a report card for the system to determine where it can be more efficient and look at allocating resources differently.* (St Boniface and St Vital LHIG)

What the level of obligation could look like:

- There is absolutely an obligation; there are inequities at every level and it's the very nature of our health care system.
- What's our obligation? We have to find out what people need to address barriers to good health.
- There is the data but that doesn't answer the question of what the specific barriers are that are being experienced by different populations. We need to go out and ask and find out how we can be most supportive.
- The health care system has a responsibility to advocate, to shine a spotlight on the societal problems that contribute to inequity in health outcomes. Who has better knowledge of the negative outcomes than the health system?
- The health care system has an obligation to lead the collaborative work with other government departments and community organizations to address the determinants of health like housing, food security, education, poverty, etc.

> *In principle, we have a universal health care system, which implies that health services are accessible to all. Is this actually the case? No. People in some locations (rural, northern communities) do not have the same access. When the language factor is added, the situation is even worse. We have to address these issues.*
>
> (Francophone Consultation)

Ethical issues in creating a more equitable health care system

Members of the Local Health Involvement Groups, the Ethics Public Engagement Group, and participants at the Francophone Consultation were asked to share what they felt the ethical issues would be if resources were reallocated to create a more equitable health care system; to align resources with needs of the population.

Some of the key ethical issues included not addressing the inequities, how reallocation of resources might impact other segments of the population and other areas of the health care system, proceeding without agreement/support from the whole population, how do you determine who receives what kind of care, and the challenge of consistency of approach.

Here are some of the ethical issues identified during discussions:

- What are the consequences of not aligning health services to needs?
- If we don't have additional resources, how would that impact other areas of the health care system?
- How do we build consensus about shifting resources? There might be some negative impacts like longer waiting times.
- Some people will not agree with aligning services to needs. Some people will think that everyone should just do their best with what they are provided with and that certain groups should not get more resources.
- You can provide additional supports to some people to help them but you can't force them to accept these supports. And, you can't overextend resources on a few people to the detriment of others. There needs to be a balance.
- How do we decide who receives what kind of care? How are we going to do this consistently? Develop criteria that are fair.
- Risks of making certain assumptions about the privileged and the under-privileged. People might look a certain way "on paper" but may actually need and/or want different things.
- Aligning health services with the population's health needs will involve working with other services. There will be issues involved in the sharing of responsibilities and interference between services. Who is ultimately responsible?

Visioning an equitable health care system

Community members were asked to imagine what the health care system would look like, how it would be functioning if inequities were addressed; if we aligned services to the needs of the population, without adding new resources.

What would an equitable health system look like?

The system would focus on client's needs rather than organization's needs, which would facilitate optimal health outcomes. The disadvantaged population would have better access to health care services currently provided on a fee-for service basis, like dentistry and physiotherapy. (Francophone Consultation)

In an equitable health care system, would caring for patients be different?

- Care would be more patient-centred – providers would spend more time with patients, interact and communicate better, and they would provide more compassionate care
- It would be a more stream-lined process and patients would be less distressed because their barriers would be addressed and they would have had better discharge/follow-up care.
- When a person comes into health care there be a unified process of assessment, addressing everything that impacts that person's health and their reasons for seeking health care. The health provider would then know where their needs are and be able to connect with them with appropriate resources.
- There would be increased services to those most in need and an increased focus on using evidence to improve care.
- There would be less visits/use of the health care system because patients' care issues would be better addressed the first time.
- Wait times might be longer initially if health care providers spend more time with patients who have greater needs.
- There would be case managers/community support managers is place who would work with patients who are vulnerable to provide the support that they need in order to access care and connect them to services after discharge from hospital, etc. Some of these positions could be volunteer positions.
- Staff and volunteers would take sensitivity and cultural competency training.
- Upstream versus downstream – resources would be shifted where we can work towards prevention or mitigation of illness.

In an equitable health care system, would planning for equity be different?

- Moving towards equity would involve re-aligning services to the needs of the population, allocating resources where they are needed most.
- More evidence-based research would be utilized to improve efficiencies.

- When developing new programs, we would learn from other successes in the area of equity and make the best of the limited budget we have.
- The WRHA would partner and work with other government departments, like family services, housing, education and community organizations that work on equity issues.
- The WRHA would implement policies regarding accountability of staff behaviour.
- New services would be located where they are most needed.
- Policies, guidelines, and processes that create barriers to access and care would be addressed.
- There might be shifts in community programs and resources from higher income community areas to core areas with higher needs.
- Gaps in the system would be addressed, like mental health services for youth.
- The focus of access centres would be to target the neediest populations.

The impact of addressing the root causes of inequity on the health care system

Members of the LHIGs, Ethics Public Engagement Group, and participants at the Francophone Consultation were asked to imagine what the impact on the health care system would be in the determinants of health (income, housing, food security, education, etc.) were addressed?

- A healthier population
- Centres for active living would be accessible and in place across the region.
- There would be more collaborative opportunities to address and prevent health issues. Prevention would be a priority – from early childhood through to senior years -- and schools would be more closely connected to their community and the health system.
- Communities would be moved into action as well, enabling individuals to affect and create the community that they want, building a greater sense of community responsibility among its residents.

Key partners to work with to build a more equitable health care system

Working to improve health outcomes requires partnerships to address the root causes and to engage and work with disadvantaged populations. Community members were asked for their input on who they felt the WRHA should partner with to build a more equitable health care system.

> *There needs to be more partnering with other government departments and organizations to address factors that contribute to poor health outcomes, especially in the area of food security. (Local Health Involvement Group Member)*

Priority partnerships identified during the consultations:

- Public
- Patients and families – feedback on how they were treated and input moving forward
- Private health sector stakeholders – fee for service doctors, other health care providers
- Community organizations /non-profits – that provide services for different populations – for example, seniors, newcomers, people with intellectual disabilities, etc.
- Francophone organizations
- Indigenous organizations
- Cultural groups
- Working across government sectors – education, family services, housing, etc.
- City government – recreation programs, community centres, transportation, etc.
- Service clubs
- Business

Key considerations to move equity forward

Members of the Local Health Involvement Groups, Ethics Public Engagement Group, and participants of the Francophone Consultation were asked to share what they felt is the key consideration to move equity forward in the Winnipeg health region.

The key to moving health equity forward is…

- Treating everyone with dignity
- Opening your eyes wider to include income, culture, everything that contributes to what influences us and our health.
- Asking the people experiencing poor health outcomes, having some process to ask the groups identified in the statistics -- what is the most important thing that would impact your health?
- Addressing systemic barriers in health care – those policies and processes that create barriers to access and care.
- Partnerships and collaboration with other stakeholders
- Involving patients and communities.
- Using evidence-based research -- decisions should be based on evidence, on what they data tells you and there should be continuous monitoring and evaluation to build accountability.
- Educating staff and the public and share strategies to build equity. This is what it would look like and how it would impact care for everyone.
- Acknowledging that there is no one solution; that it will take a lot of small solutions to bring about a bigger change.
- Drawing on what is already in place within the system and get feedback from professionals and staff to move it forward.
- Utilizing the knowledge that has been collected thus far and move forward now

Comments from participants:

Many people are distrustful of the medical establishment; they feel condescended to, minimalized. We need culturally-informed health services. Need to make it politically acceptable to invest upstream. (Ethics Public Engagement Group)

There must be a two-way exchange of information between the WRHA and the Francophone community to clarify the current situation and identify the needs. In short, we need better communication with WRHA as a partner. We must break down silos and stop placing clients in ghettos. (Francophone Consultation)

Ideally inequity will be addressed where it is occurring. Resources and initiatives will be targeted to the communities where the benefits will measurable. (Downtown and Point Douglas LHIG)

There needs to be follow-through with individuals. Need to make sure that people don't fall through the cracks, that the plan is followed and that people can get their services where and when they need them. (River East and Transcona LHIG)

Must focus on those most in need, even when that means reducing services to those least in need. How do you provide services to people who are disadvantaged while keeping the privileged people happy? Keep people informed about why this is important. Make sure people feel involved in this and give people alternatives so they don't feel like they're giving something up. (River Heights and Fort Garry LHIG)

Dignity is a big part of equity. If you are going to allocate resources to address need, you need to consider their dignity first. Identify needs and underlying causes; especially systemic barriers. (Seven Oaks and Inkster LHIG)

Find out what's working and what's not. Survey those people who are not using the system to get their feedback on why they are not using the system. Use the data you gather to make things better. (St Boniface and St Vital LHIG)

The goal should be that every individual is empowered with the responsibility to achieve good health to the best of their ability. (St James-Assiniboia and Assiniboine South LHIG)

Community Criteria – for health care decision-making that builds equity

At the second meeting of the Local Health Involvement Groups, members participated in an activity to develop criteria that the WRHA could use to ensure that decisions that move the health care system towards equity; that every decision must demonstrate how it builds equity.

Some members suggested that the criteria may be weighed differently, some being more important than others. Across the six LHIGs, there was definite agreement in the importance of strong evidence, that outcomes be identified, that resources be used efficiently, that the decision increases accessibility, that disadvantaged populations be empowered and engaged, and that there is a strong monitoring, tracking, and evaluation of outcomes.

Overall ranking of criteria for decisions that build equity (across all LHIGs):

1. <u>Evidence, target population, etc.</u>
   - Is there strong evidence to support the decision? For example, data that identifies huge gap in health outcome, research, staff and patient input on the issue, etc.
   - What are the consequences if we don't do it? What are the consequences if we do it?
   - Based on need, not size of population
   - Use proven approaches – evidence, data, and demonstrated results. Utilize best practices.
   - What is the urgency of the need? Does this issue need attention now? (like a suicide crisis)
   - Feedback and observations from staff and population that is targeted is engaged and provides input as well.
   - Target population – thorough assessment, why targeted? Chronic needs identified over time. Current interactions with health care system. Clear understanding of why they are underserved and/or why there is a huge gap in health outcome. Readiness and interest of targeted population.

2. <u>Efficiencies, sustainable, strong financial case</u>
   - Cost benefit-analysis informed by equity and ethics – how will it impact equity issue? Most benefit for the least amount of resources
   - Potential return on investment, savings to system (upstream versus downstream)
   - Potential reallocation of existing resources – staffing and tools. Trained, ready, and interested staff.
   - Good case for long term financial benefit
   - Is sustainable
   - Utilizing partnerships/collaboration with other organizations, government departments, business, etc.
   - Efficient use of resources
   - Phased in approach
   - Use of volunteers
   - Accountability

3. Increases accessibility and addresses barriers -- social, physical, time/location, etc.
   - Does it address social access issues that are barriers to people receiving care, using the health system? Like – discrimination, language/cultural/class barriers – people who are poor are discriminated against.
   - Geographic access – easier for community, especially vulnerable community members to get care – proximity, people feel welcome
   - Physical accessibility of buildings
   - Timely access to service
   - Financial barriers – like cost of parking, medication, other
   - Structural barriers – like policies and procedures that create inaccessible care – often experienced by newcomers
   - Does this decision, policy, or initiative increase access to the service for a vulnerable population?

4. Empowers and engages population, individuals, communities
   - Innovative and educational component
   - Encourages community involvement, feelings of ownership
   - Resources in community, opportunities for employment, to be part of it

5. Potential Outcomes – works to address root causes, structural barriers
   - Set measurable goals – i.e. shrinking gap in health indicators
   - Treating cause or symptoms? Upstream versus downstream
   - Addresses root causes, background issues
   - Prevention-oriented
   - Long term investment – takes longer – impacts will take some time
   - Are there negative impacts to a population? Who might be disadvantaged or negatively impacted by the decision? How will they be impacted?
   - What are the short term and long term outcomes?

6. Strong monitoring, tracking of outcomes – evaluation component
   - Are we getting the results that we were hoping for?
   - Evaluation – how will you monitor outcomes and successes?
   - Time-line to see results
   - Evaluation/feedback – 3 months, six months, etc.
   - How do we know if it's working? How do we know when it's working?

7. Culturally inclusive, prevention
   - Addresses discrimination
   - Cultural sensitivity
   - Training for staff, volunteers
   - Diversity of staff and volunteers – culturally appropriate for initiative.

8. Ethical, not political
   - Should not be strictly politically motivated. Use ethical decision making framework.

Top 3 criteria prioritized by each Local Health Involvement Group:

Downtown and Point Douglas LHIG
1. Social accessibility (describe)
2. Evidence
3. Efficient use of resources

River East and Transcona LHIG
1. Evidence
2. Efficient use of resources
3. Track, monitor, evaluate

River Heights and Fort Garry LHIG
1. Evidence
2. Accessibility
3. Track, monitor, evaluate and potential outcomes

Seven Oaks and Inkster LHIG
1. Accessibility
2. Evidence
3. Empowers and engages

St Boniface and St Vital LHIG
1. Evidence
2. Efficient use of resources
3. Potential outcomes

St James-Assiniboia and Assiniboine South LHIG
1. Efficient use of resources
2. Accessibility
3. Potential outcomes (negative consequences if we do not take action)

Values/Principles of Equity

Members of the Local Health Involvement Groups were asked what they felt the WRHA needs to mindful of when aligning health services to the needs of the population. LHIG members suggested values, principles, and approaches.

LHIG members identified staff and process issues that they felt were necessary to improve access, respect, compassion, empathy, dignity, and the empowerment of patients:

- That care and approaches to care be flexible and adaptive to address needs of patients;
- That the target population be engaged about what could help them, what they would like or need;
- That staff and volunteers be sensitive and respectful of all cultures;
- That staff and volunteers reflect diversity of population;
- That language barriers are addressed;
- That prejudices and biases are addressed; and
- That there is necessary training and investment in staff, including additional training on compassionate care.

LHIG members shared that the WRHA needs to understand patients and what their needs are, not make assumptions.

- Importance of listening
- Full knowledge of real needs versus perceived needs
- Proactively addressing barriers

Building public awareness and support of moving towards a more equitable health care system

In order to build public awareness and support to build a more equitable health care system, LHIG members were asked what they felt the key messages should be and how those key messages should be communicated.

> *We need to inspire change. It will be easier to allocate more equitably once people understand the implications.* (Ethics Public Engagement Group)

What would the message be?

- That equity is like triage for the health care system – making those with highest needs a priority (use MASH television show)
- Share facts to build awareness and support (the public will see the unfairness and the dramatic differences)
- Health equity is a better way to respond to different population needs
- Build the case, talk about what we've already done (like quick care clinics), this is our vision, what we've already done towards this, and how can we bring you in? A community development approach
- Storytelling – personal stories of people who have had good outcomes as a result of equitable care
- Draw on what is already in place within the system and get feedback from professionals and staff to move it forward.

How would we share this message?

- Engage staff, public, community organizations, those most impacted – to increase awareness and bring them on side
- Meet and great at community centres
- Conversation café approach to use with partners and staff who are more invested in the issue of equity
- Use engagement volunteers (like LHIG members) as ambassadors on equity – sharing information with community organizations, cultural and community centres, etc. to promote equity work
- Devote part of website to equity
- Use social media campaign -- health equity awareness week/month -- tweeting a stat a day for a month and get people involved virtually
- Have printed materials at health care sites
- Train staff from community organizations to share information about equity
- Use WRHA staff members and volunteers as equity communicators
- Hold information sessions and workshops in community
- Start with younger people at schools and get equity into the curriculum

- Use personal stories as part of the campaign
- Have updates on progress on equity – how peoples' lives are improving
- Communicate in different languages, have printed material in different languages
- Educate community leaders and get well-respected community members to deliver the message
- Team up with other organizations for campaign
- Communicate with staff to build understanding and support
- Get stories in Canstar and Metro newspapers

Recommendations to the WRHA Board and Senior Leadership

The LHIGs, Ethics PEG, and participants from the Francophone consultation recommend the following:

1. That disadvantaged populations targeted be engaged about what they would like or need in order to improve their access to health care, their experience in the health system, and their health outcomes.

2. That the WRHA is aware of the risks in developing equity approaches to make certain assumptions about people with higher incomes and people with lower incomes. While they might look at certain way “on paper” they may actually require or want different things.

3. That social, geographic, physical, systemic policies and processes to that create barriers to access and respectful, compassionate care be addressed.

4. That there be a unified process of assessment when patients seek care that includes everything that impacts their health and their reasons for seeking health care.

5. That care and approaches to care be flexible and adaptive to address needs of patients.

6. That the WRHA engage and partner with patients, Indigenous, Francophone, and cultural organizations along with organizations that provide services to vulnerable populations to move equity forward in the health region.

7. That the WRHA play a leadership role in the collaborative work with other government departments and community organizations to address the determinants of health like housing, food security, education, poverty, etc.

8. That there is the necessary investment in training for staff and volunteers in the areas of compassionate care and cultural competency.

9. That the WRHA utilize the equity criteria for decision-making as a community lens for equitable resource allocation.

10. That a staff and public awareness campaign on health equity be developed using social media, workshops, and staff and volunteers that act as equity ambassadors.

11. That the WRHA draw on what is already in place within the system and get feedback from professionals and staff to move equity forward in the region.

Section 2

*Notes from LHIG Meetings

*All comments made by LHIG members are included

Downtown and Point Douglas
Local Health Involvement Group

Meeting One (Member Comments)

What obligation do we have as a society to address the differences in health outcomes that currently exist?

- Past federal governments have publicly stated that they don't have an obligation
- Different levels of support (because of policies in terms of what is covered) can have drastic consequences – 2 parents able to support a child receiving chemotherapy versus a child whose parents were unable to support him (from First Nations community)
- Yes – it's the right thing to do
- Yes – it would be wrong not to address these differences
- Responses will be individual – there will be a range of views about this
- As a society I think that we do have an obligation to make things different
- Why are there such huge differences in health outcomes? Failed decision-making? – political interest
- People who have power make the decisions. Those gaps still exist. When the decision is made to narrow the gap – needs to be evidence-informed, provide care in a way that will narrow this gap – i.e. location of where health care services. Decisions need to consider cultural component always. How can this be looked at in a cultural context?
- Political decisions about where decision-making lies within Manitoba – like having Churchill become part of the Winnipeg health region
- We are obliged as a society – focus on health system and all members of society – growing together even with the differences, like in where we are from – all in this together
- Gap in health outcomes – for many reasons, very complex, many factors – when policies are developed, policy makers need to understand all of those factors that are contributing to the gap – housing, etc., addressing the root causes
- Fundamentally a question of justice – virtue – an acid test for the deserving, undeserving
- Cost-benefit for good health – not just an economic question, but a moral imperative
- As a society, we deem all people to be equal under the law, shouldn't we all have the same access to health care – this isn't the case – look at issues of paramedic care and cost
- With the values of our society – there is an obligation
- Part of the inequality has come from the culture – Western – now we are addressing equality in many ways, if we turn our back on this opportunity, we will be going back – in terms of privileged/un-privileged, morally obligated – very complex
- Disparity in health outcomes is a reflection of disparity within our society – groups that are experiencing shorter lives and bigger health issues – it's a moral imperative – not just changing health care to be more equitable, but changing society to be more equitable – if we did this, health outcomes would become more equitable
- Yes, we have an obligation to address differences in health outcomes – from an immigrant background – much has to be deconstructed – structures that have created disparities – but

others have benefited from these structures – class systems – some have benefitted from entrepreneurial opportunities and better health care

- As a society we have to recognise that not all people will have the same health out outcomes, some will succeed very well within the current system, although our aging community and the low income communities, especially those that would be considered shut ins or folks that don't have any form of outside resources such as the homeless. clients have difficulties working within the structured Health care environment. It's these folks that I refer too. We have an obligation to ensure that this demographic is not lost in the bureaucratic process, as they seem to now.

What obligation does the health care system have to address the differences in health outcomes that currently exist?

- There is a more effective way of using the same amount of resources – providing according to need.
- Yes – as a health care system there is an obligation to address differences in health outcomes – understanding the impact of unequal treatment, therefore there should be more equal treatment of all people
- This should be part of the mission of the health care system
- Equitable care for all – need to define this – be clear about what it means
- Won't be equal resources for all
- Health care system as is promotes equal access/opportunity to use the system – but no accountability for how people are treated – should be monitoring and evaluation of staff so that they are accountable for how they treat their patients, etc.
- If there were more processes in place to make staff accountable, wouldn't have to address inequities in other areas - -has that much of an impact on inequities
- All people need to be treated with equal respect, care dignity – some people may need additional supports in order to have the same/good health outcomes – in order to equalize the outcomes
- How people are treated is very impactful
- Day surgery and the pressures placed on family to provide care during recovery – what about others who don't have family to help them? (4X higher re-admittance to hospital)
- Some care processes are not the same – biases and differently treated
- It is not just how you are treated, but the method of treatment – to address the inequities – identify where those inequities exist and how they can be addressed

What are the ethical issues related to aligning health services to the needs of the population?

- We pay into the system and now you're saying that we will get less.
- Based on an assumption that we know what they need

- How do we decide who receives what kind of care?
- Is there any time for doctors, specialists, etc. to spend with patients in order to figure out what people need?
- Would that mean that we would need more doctors, etc.?
- Would be right to be making decisions and allocating resources based on evidence, based on need
- If we don't have additional resources, how would that impact other areas of the health care system
- Percentage of taxes across the population not equal – if you can afford additional kinds of support – maybe you should pay for it. Wealthier people would not be happy with this, would not consider it fair.
- Toughest ethical issue will be the ethics of rationing – for all of the short comings we are having re: access, treatment, racism, homophobia, etc. – we are moving forward
- We do know that income is fundamental to good health – cannot impact this
- Means always being pragmatic about what is achievable – sometimes multi-generational interventions
- How do we build consensus about shifting resources – might mean longer wait times, different access to diagnostic procedures
- Choices around where staff work – could be an issue – resources are allocated to where they are needed
- Is working in health care about a service to people?
- Waste in terms of staffing, top heavy – could reallocate some of those resources
- Previously dominant Western culture – are we serving the cultural needs of the population?
- How the perspectives on health care are changing because of the changing demographics – is the system reflecting these changing values?
- Culture of medicine different than how some populations view it (Aboriginal, for example)
- We need to be looking at all of the other sources of viewpoints around us
- Important to understand the cultural context for these values.
- The ethical issues related to aligning health care issues to the needs of populations of community; I think the idea of ethics has to start with educators of health care providers of all fields. People see someone, and that first perception, will almost certainly be, unintentionally influencing on any care provider. New form of training and educating those working in health care is critical to make. The debate about what is ethical and what's not needs to be a continuing dialogue for all concerned. Each separate but no less important population of people should have the confidence in knowing that they are being treated ethically and transparently and understandably by their health care provider.

What would our health care system look like if we aligned health services to the needs of the population without adding new resources?

- We would start allocating resources where they are needed
- People working in their community/with their community will provide care that meets their needs

- People receive care within their community, environment that they are comfortable, cultural context
- Would be making decisions and allocating resources based on evidence, based on need
- Should be a way to address the contributing factors – working with other organizations to address underlying causes – housing, homeless organizations, etc.
- End result, we maintain peoples' dignity; treat with respect – regardless of culture, background, origin, etc.
- Implementing policies that provides for accountabilities of staff's actions within the system
- Being innovative – society is changing – policies should also change – if you don't have additional resources, need to be innovative
- Develop parameters of what a person needs, ultimate criteria that meets the needs of the population – this is ethically sound – look at many factors - -not just income - -family support, etc.
- Just because there is a policy, it's not that simple – higher income means less needs - -many other things going on
- Shift might already have started to happen – like location of quick care clinics, new women's hospital, etc. – see the system moving in this direction
- Community clinics – Meet the needs of the local area
- Access centres with social services – integrated
- Health care providers during early intervention in the community
- The closer health care providers are to the community – more trust, feeling of safety, etc.
- Home visits for those who can't leave their homes (doctors)
- "Care" – building relationship with health care provider – family doctor who knows you and your family – critical to well-being of family
- Barriers – legislative framework (PHIA) –separates people from their family members – difficult to support in meaningful ways
- Costs associated with files, etc.
- Health Links/Info santé
- Dial a dietitian
- We'd have the older model of health care, Doctors making house calls. That model would not work today without newer and better resources. More community based WRHA clinics, with more community emphasis, Get out to the community's homes, make more information available to communities. As you can tell I have somewhat of a theme.

What would our health care system look like (what would be doing differently) if we addressed the underlying causes of unequal health outcomes?

- Should be a way to address the contributing factors – working with other organizations to address underlying causes – housing, homeless organizations, etc.
- Issues of food security
- The health care system shouldn't be responsible for addressing those factors because it is not making the decisions around allocating resources to health

- Whose responsibility is it to address food security – the band, the store, government?
- Health care system would have more input on allocation of resources
- Different sectors, businesses, government departments, bands, etc. would be working together on issues that impact health and addressing those issues
- More effective health care system – resulting in healthier community
- More housing first, harm reduction processes
- Everyone would have a doctor
- Address poverty factors that impact health – food security, nutritional food, healthy activity – might be beyond health care system, should be supportive of initiatives to address
- Realistic income assistance, better education - -shifting resources
- More space for advocacy – health care advocating for better income assistance rates, for example
- Address underlying causes – health outcomes will be positively affected, change the health care system
- It would look like we've decided that all people deserve equal health care, northern communities, low income communities and segments of senior populations feel left out or are being left out. If we had equal health care in practice our province would be a model to emulate and we'd be one step closer to universal health care.

Who should the WRHA partner with to address inequities? (Those identified as priorities have been bolded)

- All levels of government
- **Community boards – seniors, etc.**
- Different civic, regional groups
- Non-profit organizations
- **Working with families -- input**
- Educational institutions - -school system
- **Working across government sectors – working together to address issues**
- Religious organizations
- Private businesses that provide health care services, equipment, supports
- Large employers – consult them
- Insurance companies
- Focus – depends on the kind of service/program
- Social services/family services/EIA
- Organizations that specialize in nutrition – organizations, universities
- How much of the health resources should go into partnering? Engage yes, depth of relationship – not sure want to spend a huge effort on this.
- Canadian centre for policy alternatives, etc.
- Aboriginal organizations
- **Organizations and networks working on equity issues**
- **Organizations that provide services for different populations – seniors, newcomers, people with intellectual disabilities, etc.**

- Education
- **Priority – to take health system deeper into the community**
- Equity is as you point out, hard to address in the health care system. All of the community based front line services would benefit from partnerships of one kind or another. As a list of the top of my head; the 5 United Church community drop-ins, we all do front line work in some fashion EIA, Housing, health and we're daily, looking for those partnerships with WHRA independently. It would be life changing for our community that we serve to know that WRHA is willing to make that partnership with their interests in mind.

As we move towards a more equitable health care system, what is the most important thing that you feel that the WRHA should consider/keep in mind?

- Need to look at the cultural component of equity –
- Policy should be based on evidence, on what the data tells you – continuous monitoring and evaluation to build accountability and important to work with different sectors – communities, etc.
- Oversight of system outside of health care system bureaucracy – totally independent
- Need to be looking at the actual needs of individuals based on income, family supports, etc.
- Base health care services on need and not on political alignment.
- Need to open your eyes wider to include income, culture, everything – that contributes to what influences us, our health
- Need for a continuing monitoring and evaluation of the system – policies and processes – and adapt to changes in need, societal changes
- When you look at flattening hierarchies, understanding that people have roles within organizations – in terms of freeing up resources, you have to take money from somewhere – creating new jobs that can directly and positively impact equity
- Love that the health authority is looking at health holistically, prevention – focus and pragmatism is critical – maintain holistic focus but don't try to do too many things – where partnerships will add value, opportunities for accomplishing something
- Ideally inequity will be addressed where it is occurring – resources and initiatives will be targeted to the communities where the benefits will measurable
- There is no one solution – it will take a lot of small solutions to bring about a bigger picture/change
- Utilize the knowledge that has been collected thus far – move forward now
- The most important things to be mindful of, is that, we are sets of different populations of people and the adage; What's good for the many, is good for the few, is out dated sociologically. We live in a society that's so far divided in some cases that people will inevitably be lost in that systematic approach.

Meeting Two

When aligning health services to the needs of the population, what should we be mindful of? (Principles, values, other considerations)

- Human rights
- Humanity
- De-colonization
- Foundation in justice

- The needs of the patients come first
- Dignity of choice
- Lack of knowledge about a patient does not allow for lack of respect or support
- Principles – dignity of choice
- Option to decline service only when evidence is given of alternative support options
- Dignity of the person – their needs and culture

- Response of staff to unwelcome behaviour
- Staff – harm reduction approach
- Accountability

- Staff training on respect of identity
- Becoming mindful, compassionate
- Change the patient experience with care
- Listen, hear what the person is saying
- Flexibility

- Change the silo mentality
- Work on a horizontal plane to ease patient access – freer flow of care
- Conveyor belt medicine
- Problem-solving

- Health is wealth
- Change in demographics
- Knowledgeable of area and people

- Stewards of resources

- Prevention is a must and needed

In order to build understanding and support for equity approach, what are your ideas for what and how the WRHA can communicate with the public?

What is the message? What information should we share?

- Awareness of equity – what is it, what do you want to see in your community with health care?
- Transparency within the equity message
- Exploring equity with staff and partners
- Equity is triage for the system
- All people have value
- Disparities exist
- Health care is for all people – it's universal
- Equity is providing better health care service
- PSA – rooted in popular culture – like "triage" – allocating resources to those most need – like triage in MASH and ER TV shows

How can we communicate this message to build understanding?

- Meet and greets at community centres – like Rossbrook House, Spence neighbourhood association, etc. malls, health expos, seniors, Manitoba housing, libraries
- Making organizations aware of services and provide training to build skills – like – how do you recognize depression?
- Town halls – population specific – like seniors, etc. youth
- Education on equity, transparency through media, on-line
- Signage at clinics – also as a tool to build equity – and understanding of equity
- When you develop a strategy – participatory approach – in community settings – engage to help build the equity approach – bottom-up approaches
- Town hall meetings – with community groups – different cultures, etc. – invite, share info on strategy
- Share with industrial sector
- Conversation café approach – to use with partners and staff groups – who are more invested in the issue
- Equity is a dialogue – begin with meet and greets, then town halls, then dialogue with community groups – will have opportunity to hear consistent messaging, get more detail, etc.
- If we think of ourselves as a group of citizens invested in health care – we can be spokespeople on equity – to share with our own networks, etc. – ambassadors – can share with staff how people respond, questions, etc.
- To schools, social media

River East and Transcona
Local Health Involvement Group

Meeting One

What obligation do we have as a society to address the differences in health outcomes that currently exist?

- In a country that is as rich as ours, we absolutely have an obligation to level the playing field
- Because we are a social democracy, yes, but as a free market democracy – we are still individualistic
- We have an obligation on a macro level – if someone is sick they deserve to see a doctor, but when you go beneath to the underlying social conditions – we don't necessarily have an obligation
- Fixing preventable problems costs so much money, if we want to be a prosperous society it makes sense to prevent those problems – there could be an economic argument in favour of this as well
- We have an obligation, but to what extent? There has to be some accountability in all aspects of life
- We have a publicly funded system – reflects a societal obligation to providing health care – reflects our public values
- Depends on our values
- As a society, I would like to think that everybody is going to get equal outcomes – in a perfect world – but might not happen any time soon
- Yes we do have a strong obligation – speaks to how the system has been designed – believe all should have access – should therefore have similar outcomes
- If so, based on value of caring for one another – we all share some values – how our government system was formed – to share resources
- Duty to help each other – in return hopefully we would be helped as well in times of need
- To what extent do we help each other in society? Outcomes are different – we aren't doing this well now
- Many differences are based on choices – some outcomes are dependent on personal choices
- Different outcomes are a societal responsibility – society has a role to equalize outcomes

What obligation does the health care system have to address the differences in health outcomes that currently exist?

- Hard to just look at the health care system – many of the reasons that people are in the he system have to do with other socio-economic/contributing factors – socio-economic, etc. – these lay outside of the health system
- Equitable health system – speaking of those who don't have access to the same resources

- If not the health care system, then what other system? If there are other systems that aren't stepping up, (because they feel it is not their mandate, etc.), then who will?
- Health care can be a leader, look at how other departments can work on this as well – work in collaboration
- The health system obligation to put people in contact/link them to the right resources
- Whether people use those resources is not up to us – personal decision
- How do we determine who needs more support and who doesn't?
- Same thing – it is the obligation of the system to make it accessible for everyone – everyone gets a turn at bat
- Health care system needs to look at underlying health conditions – e.g. diabetes or cancer – need to be able to treat illness and the causes of them
- E.g. MS is rising – why is that?
- Obligation of health system – invest in outcomes that should reduce costs in the end – purely financial sense; there is an obligation
- Prioritize preventative health care – if we invest upstream, it will save money down stream
- Bring services to people/communities – make sure people in a community feel welcome to access the services
- Even some of the ACCESS centres are not easy to access geographically – bus is not convenient, taxi is expensive – set up services close to people
- Obligation is to match up with the society values – reflect on the health system – demonstrate through actions of the health system in terms of preventing some of the outcomes – there is a disconnect between data and action – we have information but need to align values, research and actions
- Obligation of hospital system to support people when they leave the hospital – some things are in place – people don't always know about them – e.g. home care liaison – if you don't know to ask, it might not be offered – not the fault of the individual if they don't know – need to have good communication to ensure it is easy to navigate the system

What are the ethical issues related to aligning health services to the needs of the population?

- How do you determine who gets what?
- Risks of making certain assumptions about the privileged and the under-privileged – might look a certain way "on paper" but may actually need/want different things
- How much stock or weight do we give to an individual's own assessment of their need? How much choice do we give the individual?
- What if the uptake (after shifting resources) doesn't make a difference to the population that is more in need?
- Need to be tracking/monitoring to evaluate the impact of shifting resources
- Value of solving problems for all people in one area (where there will be 100% uptake) versus a smaller percentage in another area of greater need?
- Are the programs being utilized by the populations that it is targeting?

- Who isn't getting served – if we are switching where resources are targeted, who is not going to benefit?
- Can be a vicious circle – if you have no home/income/etc., you may not need the services
- People who can't speak for themselves – not all homeless by choice
- Ethical issues related to health services – people being able to make decisions for themselves – not understanding diagnosis, sometimes can't even find a doctor – walk-in clinics don't have your history – should not be expected to announce health condition in front of a room full of strangers – need to monitor for and prevent privacy breaches
- We have a right to health and health access – who is not receiving – why are they not receiving it? How can we bridge gaps?
- What are we doing with data? When will we see action based on data?
- Where does the health care system stop? i.e. not in the business of housing or income support – will need to make partnerships
- What level of government is responsible? E.g. on reserves – who covers what – clarity around who is responsible for what? What role might the city play? How much does the federal government transfer to provinces for health?

What would our health care system look like if we aligned health services to the needs of the population without adding new resources?

- Equitable resources for everyone to start with
- Would see shifts in community programs and resources moving from higher income community areas to core areas with higher needs (not one in each community area anymore) – combining some and providing more in other community areas
- Better use of private resources (like medical benefits) to free up for others
- If higher income individuals had the ability to pay for certain services, would free up for others who couldn't afford
- Systemic change in how we fund programs – not just health care – like physiotherapy for everyone – so that recovery from surgery, etc. will be across the board – not just for those who can afford
- Forward thinking – what will it look like in 10 years – not just in 6 months
- Some people would fall through the crack – especially if there are no new resources
- Lower wait times – including emergency, specialists
- Communication is key – need to understand health condition – sometimes there are language barriers – need translators
- Education campaigns – make people aware of healthier life choices – may be less costly than illness care – other interventions like fitness classes, bike lanes
- Looking at the whole structure – collaboration with other systems – partnerships need to be more efficient – more evidence-based research that shows more efficient ways of doing things – learn from other successes – develop new programs or borrow from others – make the best of the limited budget we have – streamlining, communication, technology – technical piece in terms of how to better manage services and information

- Bringing back a city design that reduces isolation and increases connections – need to bring back supports and community – ACCESS centers have played a role – lots of resources in one place – ways to individualize services to the community – design systems so they respond to the needs
- Doing well – community based programs – e.g. mental health in the community – prevents Emergency visits and reduces costs
- Another example – proactive programs like those that go into downtown hotels to assess the needs in the area – being flexible and changing how home care is delivered – citizen centric
- Bringing more services on reserve so people don't need to fly in to Winnipeg – mobile nursing stations, teams of travelling providers
- Subsidize ambulance costs

What would our health care system look like (what would be doing differently) if we addressed the underlying causes of unequal health outcomes?

- Public private partnerships – it would benefit everyone
- Mandatory gym programs, play time, recess
- Mandatory fitness – with incentives and disincentives – across the board – like junk food tax, higher cigarette tax, etc., recreation tax credits
- Employers would be supporting longer breaks to attend gym programs, etc.
- Seamless integration of all stakeholders – housing, social services, etc.
- Healthy public policy
- Money would be spent differently – to make it fair – i.e. employees – instead of a large hospital with one home care liaison they would have more – a better match between need and resources – make sure people are aware of the resources available – won't ask questions - ensure we do a good needs assessment so we understand what the needs are and that the resources are available to address issues
- A lot of outcomes relate to poverty – need to look at roles of the health systems to address food insecurity – e.g. bag program in Elmwood – can be delivered – fresh vegetables that are available for a reasonable cost – developing partnerships between health and non-health systems – bulk buy, churches, other community groups (Rotary)
- Breakfast programs
- Subsidize food costs for rural and remote communities
- Community programs like Healthy Baby – early interventions – parenting programs for pregnant moms
- Need to make sure that everyone knows about what is available – there are lots of programs available, need to match people with needs to services available
- More healthy interactive inter-relational collaborative opportunities to address and prevent health issues – prevention would be a priority – from early childhood through life – schools connected with community and health

- More Indigenous people working in the health system – addresses systemic racism, would also help with relationships between system and people – may help to have programs to support more Indigenous people in health careers
- Sensitivity training, cultural competency
- Need to be sure the services connect – ensure communication processes are working well
- Need to be sure that people have advocacy especially if they can't advocate for themselves
- Being truly inclusive and making sure needs are met especially in terms of what they are entitled to
- Reasonable wait times
- Learn from other successful systems

Who should the WRHA partner with to address inequities? (Those identified as priorities have been bolded)

- **Education system**
- Family services
- Housing
- Federal government
- Recreational services
- Other organizations - community-based
- **City, communities**
- **Private sector (pharmaceutical, health equipment/suppliers, research and innovation, grocery stores)**
- Aboriginal and Northern Affairs
- Subsidize ambulance costs
- Governments – all levels
- Other government departments
- EIA
- Priority depends on the need
- Local resource centers – other agencies and programs -
- Food initiatives – farmers or food co-ops
- Homeless shelters – offering more services on site – increase comfort levels
- Non-profit organizations
- Business community
- Working together – need better collaboration – people are excluded from the conversation now –
- Connect service groups to needs

As we move towards a more equitable health care system, what is the most important thing that you feel that the WRHA should consider/keep in mind?

- Start at the beginning when children are born to address inequity at that point – early intervention – be exposed to better options
- There is no quick solution and there is no one solution – solutions should be results-driven not budget-driven
- Collaboration with other stakeholders is key – government departments work in silos - - need to work as a team – work together to come up with solutions that will benefit society as a whole - -not just the health care system – the changes would need to happen in other systems too – breaking down the barriers of communication
- Who is not included right now?
- And why not?
- It isn't going to be smooth.
- WRHA should be more hands on in terms of interacting with the community – e.g. communicating about what is out there, what is in the community – navigating what is out there, connecting to needs
- Individual follow-through – make sure people don't fall through cracks – need to be sure the plan is followed – make sure that people can get their services where and when they need via follow through on individual health care plans

Meeting Two

When aligning health services to the needs of the population, what should we be mindful of? (Principles, values, other considerations)

- Equality
- Realistic
- Keep it simple
- Ethical
- Good communication
- Determination
- Passion
- Dynamic
- Fast acting
- Transparency
- Rewards in prevention

- Empathy
- Empathetic re: patient's situation
- Patient-centred
- The needs (holistic) of the person

- Client's own perception/assessment of need
- Believing the patient
- Dignity of the person
- Client's perception (what do they perceive their problem is)
- Must meet the needs of all members of our society
- Cultural sensitivity/awareness

- Accessibility and availability
- Accessibility
- Proactively address possible barriers to access when talking to client
- Communicate in client's language
- Access to health services – accessibility
- Waiting times must be lowered

- Wise and efficient use of money and time
- Cost considerations but not above health
- Values – cost effectiveness of care in the system
- Addressing mental health needs, not just physical health needs

- Keeping the future in mind – changing demographics
- Age of the population (community, city, and surrounding area)

- Staff to be educated about change

In order to build understanding and support for equity approach, what are your ideas for what and how the WRHA can communicate with the public?

<u>What is the message? What information should we share?</u>

- Provide real life scenarios – individual storytelling
- Visual representation – quick and effective ways to explain the concept
- Keep it simple – language and approach
- Not wordy
- Depth of material/info based on targeted population
- Why is it relevant?
- What do we want to achieve by building understanding of equity?
- Be sincere and honest
- Powerful statistics
- Appealing to peoples' sense of fairness – most people want a fair society – appeal to that sense, as a Canadian

How can we communicate this message to build understanding?

- Finding ways to engage the public about the issue
- Free press, newspapers, community papers
- Website
- Billboards
- Word of mouth
- Part of website/mini website devoted to equity
- YouTube videos
- Social media
- Printed materials at health sites – handed out by health care providers – distributed through community centres, schools, etc.
- Mass mailing
- Share at events in community/city events
- WRHA staff members identified as equity-communicators
- Community organizations
- Training staff from community organizations to share info about equity
- Train WRHA staff/volunteers
- Information sessions/workshops in community – town hall meetings
- Health fairs
- Doctors' offices

River Heights and Fort Garry
Local Health Involvement Group

Meeting One

What obligation do we have as a society to address the differences in health outcomes that currently exist?

- Probably yes – don't necessarily know how it would impact your own family – if I have to lose access in order for someone to gain access, not sure how I would feel about that
- I do believe that we have an obligation – for every one of us – blindly go through life believing that if someone needs attention from a health care facility – we will get care – if we face an issue – we think that we will get the care that we need, but then you don't – not equal across the board – this should change
- See things from a needs and outcomes perspective/approach – big difference between someone who needs a medical service – others have barriers – transportation, etc. – I don't need the same supports that someone else needs – I don't have a problem that my tax dollars may go towards someone else who needs it -- they have an opportunity to have an equal outcome, may become more successful, contribute to society
- Focusing on obligation – very much a value question – in terms of Canada, Winnipeg – very much open to question – range of perspectives – don't think that a majority of people would support it
- For me – I would support 4 main obligations to address differences in health outcomes
    - a moral one (do the right thing),
    - consider distribution and re-distribution of services, evaluate every aspect
    - most in need
    - Funding - support directing resources to the areas where need is highest – we should be doing this
- Good theoretical concept, but in times of practicality and in how it might impact me – not that certain
- Other things other than funding that could be done need to be considered
- Will have to pay for it now or down the road
- What can society do to influence individual life style choices?
- As a society – more than just about health – fostering a sense of community - -I would give up something for others
- Need for follow through – connectedness – some using the system more than needed – not just about poverty and other barriers, using the system more appropriately
- Focusing on obligation – very much a value question – in terms of Canada, Winnipeg – very much open to question – range of perspectives – don't think that a majority of people would support it
- Support directing resources to the areas where need is highest – we should be doing this
- We have a huge obligation – it's what being a society is all about
- Broad question

- Could argue why it is not just up to individuals to take care of their own health – society should be part of it
- Could substitute "individual" for "society" – but charity begins at home
- Individual responsibility is only part of the story – not everyone has a choice about where to live
- We are Canadians – as a Canadian I have a problem saying that health is all an individual's responsibility
- Society creates these disparities – e.g. housing, racial discrimination, misogyny – society has a responsibility to help fix the problems
- We've had 50-60 years of socialized medicine to get this right, so what have we done wrong? If we don't know what we did wrong, we won't be able to develop successful solutions
- We have more knowledge now about the differences and why they exist – we have a huge responsibility to address - need to hear all voices

What obligation does the health care system have to address the differences in health outcomes that currently exist?

- The system definitely has an obligation to address the differences – when you interact with the system – it is about health – not looking at other issues that may impact your health – like barriers that you may face – obligation to address service and care related issues – barriers, how you are treated, etc.
- Follow up after surgery about donating to hospital but not about how your recovery is doing is inappropriate
- Better follow-up could address some of the differences in health outcomes that exists
- Have to advocate for yourself for care – at ER – no process to sign out, give up on receiving care – a lot of problems within the system
- Kinds of obligation:
  - Entrance into the health care system/access – questions to patients in day surgery
  - Across the different facilities
  - Follow-up and discharge – can't discharge everyone the same way
- Obligations of health care system – open to question –
  - Moral obligation – to focus on those most in need – to not give preferential service to those least in need and to link with other departments, etc. to address social determinants of health
  - Health care system has to find a way to increase emphasis on prevention, health promotion and to increase mandate on social determinants of health
- Supports – obligation to provide – like transportation – address barriers -- language barriers, cultural barriers/practice,
- Major institutions (education, justice, etc.) have a class struggle going on – includes health services – servicing their peers – elites
- Need to preferentially service the needy
- The health care system exists to improve outcomes

- What is "the system" we are talking about? – all of it affects outcomes
- The health system is in charge of delivering health but not in charge of housing, education, social services, food, etc. but it's the government that can make changes in the big picture but government's job is to get reelected, has a short attention span – equity is a systemic problem that can't be solved in a 4-year window – government needs to be responsible for the overall plan
- Without the high level strategic vision, it's highly unlikely we will solve this but inequities will be slower to change
- Child poverty stats – Manitoba's are appalling
- There may be systemic issues with treatment of some conditions – e.g. diabetes – push to treat people with drugs – symptoms - and not the cause – e.g. obesity. Need to be a refocusing on dealing with symptoms or root causes. Physicians are the front line when it comes to outcomes – have a responsibility to treat causes more than symptoms
- Maybe more effective services – changing existing structures
- Need to consider the obligations of the individual as well – especially when we are thinking about whether to put resources upstream
- Need to ensure that care providers have time for professional development to ensure they stay up to date – gap in ability to keep updated on current techniques and approaches – need room for more than giving medications
- Fee for service fosters this culture of rushing – need structural changes to change focus from treating symptoms to treating causes – give time for other kinds of questions

What are the ethical issues related to aligning health services to the needs of the population?

- What would a good person do? We think we would act like that – if it comes down to a change – it won't be what we currently have – would we share those resources, be okay with getting less?
- Fairness – debatable – to take from someone who needs it less to give to someone who needs it more?
- Ethical values of health care workers – do no harm, "we care", do the right thing – does doing the right thing work against the fairness or not?
- Neglecting the minority within the population – the evidence is generic, not very specific --- who are most in need in my community, who needs extra
- Social justice – downstream versus upstream – need to understand why health outcomes are poor --- caring for priority population ahead of others because they need it more
- Individual vs. collective – do we decide to redirect resources to individual needs especially if they opt not to take their own responsibility for their health?
- Limited finances – how to move them around to ensure resources are distributed according to need without disadvantaging others

- Moving boxes – in order for one to come up, another needs to come down – I'm on the box and would like to see others come up to my height, but not sure how willing I am to give up some of my access
- What if the tallest person has the resources to build their own box? Means 2-tier – still need support for access
- What if we lowered the fence? – no boxes required
- Some family physicians are able to provide the kind of comprehensive services that will help level the field
- It's not right or fair, but at the same time, it's not my fault that I am who I am
- Remember sustainability – remembering demographics when deciding how to build the fences – could it be that we are setting it up this way because we know we can't afford to do it right?
- I'm proud of the system we have in Canada
- If there are these differences, there is something wrong with the system

What would our health care system look like if we aligned health services to the needs of the population without adding new resources?

- Can our health care system look different than our society? It will mirror society. Without changing society, how can we change the health care system?
- If it was more of a streamlined process – you would notice it when you walked into a hospital – less distress from patients who frequently visit (because their barriers would be addressed, they would have had better discharge/follow-up) would only be distress from the health issue that they are facing
- Less visits - -handled it well the first time, no secondary issues
- Might be longer wait times initially because you want them to take longer with each patient (linking with other resources, etc.) -- over time it will improve
- Better care the first time will decrease number of overall visits
- Better organization – not more money
- More transparency
- Decline in outcome differences
- If we allocate resources to those in need, outcomes will improve for some and decrease for others – not fair but may be a sound economic model
- Add other resources – work with schools, social services – open up collaborations
- Focus on prevention approaches more
- Involve more people in shaping what health care looks like
- E.g. Norwest Co-op – all services together – including food, settlement workers,
- More comfortable to go to ACCESS centres or places with multiple services in one place – can also avoid stigma
- Challenge is to bring people up to the high end of, for example, life expectancy – want a system where no one is worse off for the changes – realignment of existing services to integrate and work together better

- For 50 years – maybe we need a 2 or 3 tier system, and really focus on those with the lowest life expectancy, without reducing services to those with highest life expectancy
- Need to be able to give people who need the time with a health care provider access to enough time, with the right person – e.g. maybe don't need a doctor but a social worker would be able to solve the problem more easily – match need to skills – e.g. more appropriate to see a social worker or counselor than a doctor for anxiety
- From a political point of view – want a quick fix but may not see results quickly
- Money into early childhood education on health
- Expanding scope of practice for people already in the system – like Nurse Practitioners and pharmacists

What would our health care system look like (what would be doing differently) if we addressed the underlying causes of unequal health outcomes?

- Public health would be getting more resources
- Increased services to those most in need, increased focus on using evidence to better deliver services
- Increase emphasis on determinants of health – partnerships – would involve taking some money from other parts of the system
- Less prejudice, more equal outcomes despite the starting part
- Positive impact on society overall
- Can't remove the fence altogether- it would mean moving the fence somewhere else
- We all have our own differences – need to understand culture, background, how these factors/values affect outcomes – can't ever have a one-size-fits-all solution because of individual values
- Need early education – e.g. nutrition, exercise
- Addressing one factor such as life expectancy may cause other problems – may replace problems with other problems – will always need a health care system – e.g. if everyone lives longer, will need to shift resources into elder care
- Does equal mean the same?
- More radical solutions – like a certain allotment of health care dollars per person and when it runs out, you are out of health care

Who should the WRHA partner with to address inequities? (Those identified as priorities have been bolded)

- **Partner with Assembly of Manitoba Chiefs** – health program
- Multiple (100's) of committees working on this – across the region
- **Partner with patients** – feedback on how I want to be treated – how I was treated – good and bad
- **Community partners** – non-profit organizations/charities – support those groups – groups in place doing this work – provide them with more support
- Look at what other provinces are doing – what can we learn from each other?

- Who are the lead organizations looking at determinants of health, addressing inequities – are they health?
- What does inequity look like? What does equity look like? What is the goal – going into the middle?
- What is the inequity – will inform the partnerships that should be forged
- **Like ACCESS centres – government – education, social services, housing, EIA, social assistance, other relevant government agencies** - integration
- Set up like Service Canada? Partnerships with all levels of government – may help to share costs
- Universities
- Reh-fit centre, Wellness Centre, Pan Am Clinic
- **City** – Parks & Rec programs, transportation programs – layout of cities determine access – transportation, bylaws and zoning for housing
- **Private sector** – education, better health care plans, we could do way better keeping people healthier – better insurance coverage for employees – maybe ask the corporate sector to shift compensation from wages to benefits – private sector has the money
- Concepts such as Superstore where all the services are in one place – doctor, pharmacy, etc.
- Need to be careful with those to be sure the social concept does not move toward the private for-profit concept
- Non-profit – non-governmental such as YMCA, Aboriginal, cultural, newcomer organizations, Folklorama

As we move towards a more equitable health care system, what is the most important thing that you feel that the WRHA should consider/keep in mind?

- Empower people to have a voice, to give their opinion, and to look for ways to help themselves
- Focus on those most in need, even when that means reducing services to those least in need
- Think back to your last hospital visit – what bothered you that you saw, did you get preferential treatment – certain characteristics that put us ahead of others
- Go and sit in a ER waiting room – listen to what patients have to say
- Health is not about one particular issue – there are many factors impacting health – take the time to ask questions to find out
- I don't think that the general population would look favorably at reducing services to those least in need
- Start with the kids – early childhood – kids, kids, kids (like location, location, location is to realtors)
- Take short term "politics" out of the decision making
- Vote for what you believe in.
- Be mindful of how you spend our dollars.

- How do you provide services to people who are disadvantaged while keeping the privileged people happy – keep people informed about why this is important. Make sure people feel involved in this – give people alternatives so they don't feel like they're giving something up
- Being open to new information – e.g. TRC – need to be willing to adapt to research – need to be willing to review policies with new evidence-based research findings
- Respect for clients – ask for input, demonstrate respect at an individual level and a system level.
- Advocate for national health/equity strategies

Meeting Two

When aligning health services to the needs of the population, what should we be mindful of? (Principles, values, other considerations)

- Access to services at various times to accommodate different schedules
- Availability, access, cost, time of day
- Accessibility
- Simplicity – the health care system is so complicated we need "navigators" – can we make it simple?
- What aspects of the service are accessible, inaccessible?

- Aging population
- Different cultural values, health needs
- Different age group and specific health concerns, needs
- Cultural diversity – how is this being addressed?
- Inclusive – sensitive to gender, culture, religion

- Appropriate, affable, kind, culture
- Capable, skills
- Agents – staff, volunteers, individuals

- Full knowledge of real needs versus perceived needs
- Relevance of tools, processes to the needs
- Why people/specific groups are not using certain services – i.e. young mothers not using prenatal class, using walk in clinics versus family clinics, etc.
- Focus on low-income marginalized populations
- Subcategories – e.g. not all ethnic minorities will use the same resources in the same way
- Specific group needs – i.e. LGTTQ
- Include the audience in any discussions to help that population
- Is it collaborative or paternalistic? (has the targeted population been consulted?)
- Needs versus wants
- When are the services needed?

- What is the best mode of delivery for this population?
- Everything should reflect the determinants of health
- How it measures need? Need measurement tools

- Sustainable
- Are the decisions/choices going to be long term/short term?
- What objective is the service intended to fulfill?
- The future – a long term solution for now and for later
- It would be better to fix a minor issue than have that minor issue explode into a major issue
- Vertical services (free standing) or horizontal (integrated, done through permanent health care institutions)
- Cost of taking something away from the privileged group (in their mind)
- Political considerations – as decision makers re-allocate resources to level the playing field – may not be favoured politically
- Consider change resistance – what might make the change fail?

In order to build understanding and support for equity approach, what are your ideas for what and how the WRHA can communicate with the public?

<u>What is the message? What information should we share?</u>

- The message is that we can provide services in a fair and equitable way and communicate this to the public – ensure staff training and education is up to standards – will know that they are getting the services that they need – demonstrating through day to day actions in the system
- Take more of a social role in approach – advocacy, activist role – to challenge current economic model
- Identify stakeholders – who we are targeting to get the message to – clients, public, health care providers, staff, politicians – based on who were targeting, message will be delivered differently – message will also be different –
- Share outcomes – build understanding, in a way that people can understand the needs, the facts – data that shows the gaps
- Why are these health outcomes happening, why do we need to communicate them?
- Demonstrate need
- Possible solutions – generally – looking at other countries, examples of what's been done
- It's not a brand new thing
- Culture – creating a community culture, inclusivity, getting people involved and ways to build a good environment, positive culture

How can we communicate this message to build understanding?

- Start with younger people – in education, get them to know what equity means – empowerment – include research, behaviour change models, etc. – then it is an upstream versus downstream approach – will start to build healthy community
- How – by describing the inequity in the city, get people to get together – share data –
- Change name – to Winnipeg health services – "authority" is overbearing - role is to be a service, not an authority
- Dialoguing with the public – everyone knows someone with a need - -so it does affect everyone
- Ferocious/provocative/in your face promotional campaign using health care providers (MPI)
- Social media – large campaign – awareness week, tweeting a stat a day for a month – involved virtually
- Spokespeople (like Clara Hughes for mental health week)
- Personal stories – personal connections more effective than just numbers
- Selling these ideas as a gain to everyone – shifting privileges – gain, part of larger community
- Constant update on the progress – how peoples' lives are improving
- Winnipeg needs and rural needs as well
- Need for a province/city partnership – province wide campaign

Seven Oaks and Inkster
Local Health Involvement Group

Meeting One

What obligation do we have as a society to address the differences in health outcomes that currently exist?

- I believe that we have a moral and legal obligation to address – legally – charter of rights and freedoms – states that all people should be treated equally
- Agree – Charter of Rights, Canada Health Act
- Financial obligation to use our healthcare dollars the best way possible – if there is an area of more need – we should be spending our health care dollars there
- Agree with both
- Economic – under the 2017 federal health care spending – health care dollars tied to GDP –
- Obligation to reallocate where people will be more productive – bring populations' health baseline up – more productive society, more equitable
- The more we balance out inequities, down the road we will spend less overall
- Prevention should be part of this
- Could have a greater lasting impact in with dollars spent in the community vs. in acute care
- We have to make informed decisions when it comes to electing our representatives who make decisions about where and how are tax dollars are allocated
- Society is much larger than the health care system. The heath care system is part of society and has a responsibility to contribute to health – need to partner with other areas – e.g. housing etc.
- Society and Health Care have a relationship – give a voice to each other, especially for those who can't speak for themselves
- Health Care system has a responsibility to advocate, shine a spotlight on societal problems that contribute to inequity in health outcomes – who has better knowledge of the negative outcomes than the health system – e.g. homelessness is one of the biggest contributors to visits to ER
- Once you see problems that exist there is an obligation to address them
- Need a clear understanding of "outcomes" – better definitions, better indicators – e.g. life expectancy is not a health outcome but a socioeconomic outcome – risks deviating health dollars to non-health areas rather than dealing with larger societal issues

What obligation does the health care system have to address the differences in health outcomes that currently exist?

- Some individuals (politicians) who have vested interests, etc. – some who see health care as important
- Issue, some who don't – we should be more informed, engaged about who we elect

- Issues of diversity – related to health outcomes – aspects that impact the ethical question – need to consider issues of diversity – making choices about who gets what kind/level of care – all of these have ramifications – need to attempt to balance – recognizing that we have finite resources
- There is the data, but doesn't answer the question – what are the specific barriers experienced by populations - -we need to go out and ask and find out how we can be most supportive – totally agree with this – comes down to this. What's our obligation, we have to find out what people need to address barriers to good health?
- Have we looked at other health care systems to see how they are doing related to issues of inequity? How do we measure up to other countries, provinces?
- Why does healthcare look different across the country?
- Poorer populations often need to compromise – e.g. work or seek medical care
- Societal obligations are different from health system outcomes – not a good question – should separate these
- Need parameters of the health care system – e.g. defining what is "health care" - do people have access to medical care, vs. do we need to be responsible for housing, etc.
- Defining the "health services system" is different from the obligations of the health system
- Health system is not 100% of health – need to define what we're talking about
- Health is the health of the nation, not the health system
- Limited resources – if we involve too much in the definition of health care services (i.e. including housing, etc.), we will not be able to meet all needs
- Health includes food security, housing etc. but services are different depending on the needs. Equity is responding based on the societal factors that affect the person's ability to access the system
- Access in one place is important to minimize effects of (for example) poverty
- Different needs mean different models
- Flexible approach
- Problem still to define the parameters of the health system – e.g. the health of the nation or the health of one aspect of the nation. If we include too much in the definition, we risk not having enough resources
- As taxpayers we are paying for this – we should have checks and balances to be sure money is being used well.
- There is data to show that if you reduce homelessness, you reduce the cost to heath care
- Need parameters/definitions because it affects the task of the health system – many things that affect health care require partnerships with others

What are the ethical issues related to aligning health services to the needs of the population?

- In a perfect society, all diversity would be accommodated – we should align health services based on needs of population
- What are the consequences of not aligning health services to needs – in case of Joe/Harry – re-admittance, death, etc.?

- Risk management – what are the risks associated with not aligning health services with needs?
- Who determines what the needs are? How are we going to do this consistently? Levels of complexity? Develop criteria that are fair. Goes back to fairness
- Health care issues need to be integrated into other elements – in the community, social services, etc.
- What would the fallout be – those who are wealthy would see it as getting less – they would want those services available to them
- If we want to be truly equitable – it's about making things fair, not necessarily equal
- What would be cost to the health care system about developing a means test --- more layers of bureaucracy – takes you down the road of a two tiered system
- Need to partner with many other areas – can't place all the onus on the health system
- E.g. recognition that homelessness=poor health=increased health costs – need to work with other areas
- If we take money from one area, we may be short in other areas
- Need to make sure reallocation does not negatively affect services
- Need to make sure that moving resources are going to a place that is clearly needed and clearly within the system
- Is any negative impact ever ethically appropriate? E.g. is it ethically appropriate to reduce PHN visits to new moms in high income areas, and allocate those PHNs to inner-city/poor areas? In this case, there may be no negative impact
- Some resources may not be missed and reallocation might make things in other areas better
- There may be political and social questions – which might have a problem with changing the resources – how do we guard against the squeaky wheel? How do we manage a sense of entitlement?
- One responsibility of health care is to educate people about what is available/needed
- Just because you come from a wealthier area doesn't mean you don't need the services – we can't allocate just on the basis of geography and ensure the system can respond
- There is entitlement on both sides – ensure that the question of need is balanced against the question of contribution
- E.g. in education – some know how to ask and get what they need, where others don't
- How to talk about entitlement without knowing what there is to be entitled to, what expectations there are and need to be considered
- Need a redefinition of health so we can understand all the things that contribute to health – will also help with entitlement
- Once we have defined "health system", we can educate on what is available

What would our health care system look like if we aligned health services to the needs of the population without adding new resources?

- Look at previous question feedback
- Leveling the playing field – moving towards equity – would involve re-aligning services to needs
- Would overall costs go up – not enough staff, higher demand for prescriptions, etc.?
- More clinics using younger doctors – to gain practice experience in low income areas
- Ideal system – well planned, well programmed, well thought out
- Address gaps in the system – like mental health services for youth – possibly adjusting the population served by existing organizations, depts. – need to have conversations to look at where those adjustments could be made
- Depends on who defines what the needs are
- Entitlement, expectation, actual requirement
- In certain areas, there are lots of people dying of things related to their socioeconomic condition – if resources were more available, they may have better outcomes
- Acute care delivery might be the same (e.g. reactive) but prevention/promotion could prevent need for acute care – e.g. prevent diabetes means preventing need for amputations
- Need a long term look at the system

What would our health care system look like (what would be doing differently) if we addressed the underlying causes of unequal health outcomes?

- Early child development – child care, public health, other prevention work – best bang for your buck in early years
- Prevention would decrease demands on health care system if it was more preventative in nature
- Would be more proactive – not just putting out fires
- Would have more education – so that people would want to do the things that they need to do to be healthy
- More effective education
- Address motivation issues
- Look at other successful health behaviour change campaigns
- Free therapy; free counseling – not having to pay for – other ways to access mental health resources easily – on-line, etc.
- Identify at-risk/high risk – more attention
- Person centred questions
- How we offer individual services to clients – where do we factor equity in those services?
- Health care system would be robust (if we addressed the underlying causes of unequal health outcomes
- Less need for acute care
- Less need for reactive care
- Need more accessible testing/diagnostics
- Better access to needed care

- If prevention was a priority, there would be significantly less need for acute services
- Health education
- E.g. Access to birth control to prevent teen pregnancies
- An ounce of prevention is worth a pound of cure
- Still can't really be answered until we can understand the parameters of the Health Care system

Who should the WRHA partner with to address inequities?

- Family services
- Schools
- Child and family
- Social services
- Therapy and counseling services
- Manitoba Housing
- Education
- City of Winnipeg
- Non-government organizations
- Housing
- Family services
- Education
- Transportation
- Food security
- Ethnic groups – cultural proficiency – especially if affected more by a particular health condition
- Need to create new groups that address the whole person together rather than segmentation – need to make services seamless
- Partnering with cultural organizations – seamlessly meeting the needs
- E.g. access centres – is this well understood by the community? May need to be communicated better, better education for communities about what is available
- Sometimes criticism of system is valid, sometimes not. Sometimes it is a case of what is offered is not effectively conveyed to the public – need public education
- Local communities
- Cultural groups – partnership is not just working together but includes communication (many people in this area don't know what access centres are and what they are for)
- How do we ensure services meet the needs of groups like refugees
- Need to be careful about turf wars – need to ensure cooperation as much as possible and guard against a return to protecting turf – make sure procedures align
- Need internal education to ensure all services understand what all others do and how best to work together
- Social services
- Need to ensure we are communicating what services we offer to the public so they know what is available at access centres

As we move towards a more equitable health care system, what is the most important thing that you feel that the WRHA should consider/keep in mind?

- Need to concern themselves with those things that they can control – how to make health care services more equitable – would go a long way to giving patients quality care
- Dignity is a big part of equity. If you are going to allocate resources to address need, you need to consider dignity first.
- Importance of partnering with other agencies and groups.
- Identifying needs and underlying causes – addressing systemic barriers.
- Staff training and buy-in – front-line workers especially.
- Systemic barriers in health care – informal policies/processes that create barriers, communication barriers between health care and schools/social services – cannot work as a team to help that individual.
- Health is a very personal thing which results in very personal responses – need a global strategy to deal with the impacts
- Needs to be flexible – it is a moving target
- We judge the system by our interactions with it (usually in acute care context/urgent/tragic situations) – not always a fair assessment
- Need to consider asking multiple people – survey on this question would be important to get more input
- Communication to all stakeholders – use social media, TV ads, etc. when something is changing, makes sure everyone knows.
- Might be helpful to link previous LHIG report on communication
- Make sure information is in other languages
- Other ethnicities are not always visible – people don't always know about Interpreter Services

Meeting Two

When aligning health services to the needs of the population, what should we be mindful of? (Principles, values, other considerations)

- Cultural bias
- Cultural differences
- Sensitivity
- Diversity of staff and volunteers
- Culturally appropriate
- Cultural sensitivity -- how to make people aware and informed
- Cultural awareness
- Language barriers
- Communication in first language – both spoken and written
- Language barriers – how to deal with this and provide adequate resources

- Changing demographics
- The reality that the population itself is changing in terms of age, ethnic and cultural backgrounds, understanding of our system and trust of our system – it is a moving target that the system has to be aware of and adjust on an on-going basis

- Prejudices and biases
- Preconceptions and assumptions
- Respect
- Acknowledge and accept responsibility
- Honesty
- Transparency
- Consistency

- Contacting for follow-up through multiple avenues – i.e. face to face, texting, email, in first language
- Follow-up to ensure complete care/if further care is required
- Support network
- Links with support groups
- Ensuring clients understand their diagnosis, needs, and their medication

- Long term commitments
- Multi-year program needs
- Research
- Program evaluation outcomes
- Training
- Training gaps

- Whose needs are being met?
- Address issues with prompt response
- Economic situation
- Available tax dollars
- Fiscally appropriate

In order to build understanding and support for equity approach, what are your ideas for what and how the WRHA can communicate with the public?

<u>What is the message? What information should we share?</u>

- Let people know what's available – how they are available equitably – what does that mean?
- Positive impact on health care delivery for everyone if we address inequities X2
- Everybody wins – the simple message

- Difference between equality and equity – and the message that “we care”
- Open and honest acknowledgement of issues – about the inequities – this is not working – not fair for everyone – transparency - state the facts
- Be clear about cost-benefit
- Pay now or pay later – long term solutions benefit everyone
- Be mindful of the lack of understanding that exists – to show how it benefits the whole population to get buy in
- Tie the initiatives to the strategic plan
- Health equity – better response to different community needs
- Provide examples – of what is equal versus what is equitable – to build understanding
- Will result in the creation of more meaningful relationships/partnerships that will better address the needs and should result in reduced financial costs

<u>How can we communicate this message to build understanding?</u>

- Website
- Focus groups
- Public forums
- Getting into the schools, getting into the curriculum – making it a focus
- Cultural and community centres
- Educating community leaders
- Need to communicate in different languages – community/cultural newspapers
- News media
- Better access to health -- for example “411” for Health Links and health service information
- Social media
- Presentations to Newcomers – Welcome Place, etc.
- Aboriginal organizations – teaching about equity
- Organizations that the WRHA has partnerships with
- Printed material in multiple languages
- Ensuring that there is communication with all of the groups that would be targeted in equity – seniors, Aboriginal, other cultural, newcomers – delivering the right message in the right way to the different populations
- Tailoring the message

St Boniface and St Vital
Local Health Involvement Group

Meeting One

What obligation do we have as a society to address the differences in health outcomes that currently exist?

- Yes we have an obligation – if we see this as important to us as a society – we have a total obligation to address the differences and to ensure that the system is a public one
- Agree that we have an obligation - at all levels of government, everyone, that includes that individuals understand and support/see that changes need to be made – role for everyone
- Legal and moral obligation for society to protect every citizen – core of the responsibility of the state/government – owe every citizen – duty of everyone
- Part of the charter of rights and freedoms
- Agree with all of the statements – it is a legal and moral obligation of Canadian society – these are our values
- If it doesn't happen, someone should be responsible – accountability
- Example of discrepancy in funding of children's services between the rest of the population and Aboriginal communities
- Some of the things that have happened are so insidious we didn't even know it was happening
- Should be part of a larger scope of open budget allocation, transparency of government – to share outcomes and where the money is being spent
- Some obligation – you provide resources to people to help them but can't force them and can't overextend resources on a few people to the detriment of others – it is a balance
- Need to ensure that every area has the access to equal health care opportunities – if available it should solve some of the problems – getting better but some communities still lack
- Need access to personal health (e.g. hygiene) – not available to everyone (e.g. homeless)
- We do have an obligation as a society to address bigger picture issues – housing, addictions – obligation to provide more of that
- If we're going to spend the money and identify differences – should be prepared as a society to deal with the differences – need a plan for the results – if we assess, we are on the hook to follow through
- Have an obligation to get the most bang for our buck – spend resources on what will give the best impact
- Need a reciprocal relationship – some role for individual health choices – some individual responsibility
- As a society there is an expectation that individuals will take some responsibility too
- There may be some expectations that things will be provided when it may not be reasonable
- City government should consider free transit for low income to help address some of the access issues

What obligation does the health care system have to address the differences in health outcomes that currently exist?

- Those outcomes are a barometer of what how the system is functioning – it's a report card – for the system to see where it can be more efficient – and look at allocating resources differently
- Needs to be communicated/shared with the public – of the vision - -need to understand what it is that you're trying to do
- Obligation to address and adjust to improve the outcomes – in terms of what the data is telling us – obligated to change things that are obviously not working
- WRHA should focus on equality of access to services – the other determinants of health – would be challenging to address as well
- Build something with other organizations that should be responsible in other areas – determinants of health
- So many people doing so many things, the health system cannot do it all – how do you bring it together, the vision, everything that organizations are doing – there are lots of things happening, how do you make it interesting/hopeful/engaging for members of the public?
- Gaps – differences in health outcomes – other determinants are very impactful – but they lie outside of the health system
- Account for the variables that are outside of the system – if changes are made, then the benefits will be clear – inside of the health system
- Health care system has an obligation to lead this work
- Demonstrate how money spent impacts on the health of a population – prevention versus treatment costs
- System needs to be able to provide required services – personal responsibility to access services – need to know services are available
- Education is required – to ensure that people know what is available – need to account for cultural requirements, differences in cognitive abilities
- When the system is looking at outcomes, need to ensure the determinants of health are assessed – e.g. look at housing, transportation, etc. Triage to areas that can help, even if not a health care provider
- Advocates – how many people come into system and are unable to advocate for themselves – especially upstream related to determinants of health – ensure not just language specific but help with culturally appropriate decision-making

What are the ethical issues related to aligning health services to the needs of the population?

- Public perception will be the main thing – how people see this – the bureaucracy –
- Some people will not agree with aligning services to needs
- Some people will think that everyone should just do their best with what they are provided with – not that anyone group gets more
- There would need to be criteria to determine if someone should get services – more or differently?

- I would feel comfortable – there is a responsibility of the health care system to explain this – and to build consensus in society – and then to communicate
- Extremely sensitive topic – WRHA should pick a certain issue/area that won't impact higher income population – to get people on board – communicating as best as possible
- Ethically cannot do things that would alienate a group of people – not alright to just proceed if a group of people will be unhappy – need to work with the people that will be most affected and try to get their buy in
- To not address/rectify what is not right – that is not ethical
- The people who can pay need to want to see resources distributed equally – may be difficult to get buy in for redistribution
- Need to ask disadvantaged people to divulge private or personal info about their needs
- How can we predict where resources will best be used? Difficult to know whether the action will impact outcome
- Health is very complex – decisions may not make the difference you want them to
- How do you align all the services to improve health
- Social isolation – often happens in hospital – may not be optimal for health outcomes
- Who gets to make these decisions – may determine outcomes
- Triage – look at bigger picture – align people by social groups?
- Are ethical issues the same at all age groups? How do decisions affect people in their 80s vs. 20s
- What is likely to have the best outcome? Age may be a factor – how to determine who deserves an intervention
- Is it possible to look at reduced outcomes? Arrange so that people are not so greatly affected?
- Is it best to bring the lowest up to the highest, or can we tolerate reduced outcomes for some to improve outcomes for others?
- Possible actions that would bring everyone up, rather than taking away from some
- How can we ensure people continue to receive services according to need, even if they can't afford them?

What would our health care system look like if we aligned health services to the needs of the population without adding new resources?

- Doctors and other health care professionals spending some of their time delivering care in targeted areas – lower income, cultural/linguistic community
- Access centres – health and social services together, working inter-disciplinary approach
- Role of volunteering for health care professionals? Evening clinics
- Case managers for people with chronic conditions – vulnerable people with few resources, supports
- Case managers/community supports – to work with patients who are vulnerable and assist with connecting to services after discharge from hospital – health, etc. – could they be volunteers?

- Consider Winnipeg Harvest as an example of people helping people – their approach – engaging people, schools, etc.
- Health care system would communicate/promote services more
- Communication is critical
- Responsibility of the health care system to "draw" this picture – to figure out the linkages, relationships that need to happen – and to draw/engage people in – to see their role/responsibility in this
- Advocacy for patients who don't have family and others to support themMany things that can be done together – ACCESS centres – one location, all necessary services
- Coordination between doctors, specialists, pharmacies, etc. – no conflict between services and meds (if being treated by more than one doc)
- There is an opportunity for alignment of services
- When a person comes into health care, there should be a unified process of assessment – all addressing determinants of health – e.g. who cooks, do you have enough money – all to identify the reasons for seeking health care – need to know where the needs are to be able to connect with appropriate resources
- Coordinated programs – such as milk programs in schools – all part of the overall picture of healthy lifestyle
- Increased services to those who need more services
- Holistic care – well rounded approach to health – asking the right questions
- Taking time, having time
- Building relationships to assess and address needs, for information and services, within community (e.g. within housing unit)
- Need a bank of information available for people with particular needs e.g. health care people connecting patients with employment or housing to prevent need for health services

What would our health care system look like (what would be doing differently) if we addressed the underlying causes of unequal health outcomes?

- System is so complex – technology driving health care, prescriptions that are very costly – losing sight of equitable distribution of resources
- How do you balance expensive acute care with preventative programs?
- Create social support networks – environments where people can have connections with others
- Centres for active living
- Go and provide care where people live
- Approach would be different – right questions, coordinated system, all things connected (e.g. employment, housing, etc.) – universal coordination, needs addressed more quickly, more holistically, before illness care is needed
- Focus on prevention
- Not so much health care as lifestyle changes to augment the health system
- Health care system would be working more closely with other government areas to address societal issues that impact health

- Prevention, holistic care – use of resources to provide health, it would be more all-encompassing instead of focusing on treatment only – think of health system more broadly – current system is reactive – not efficient use of health dollars – might improve outcomes by spending resources differently
- Quick access to resources if no time available

Who should the WRHA partner with to address inequities? (Those identified as priorities have been bolded)

- **Housing**
- Social services
- Schools, school boards
- Non-government organizations
- **Professional associations**
- **Philanthropists**
- **Community organizations**
- Community clubs
- Cultural associations
- Canadian Forces
- Government departments
- **Housing**
- Employment
- **Transportation – basic need**
- Social aspects of health – social services
- Schools – education about what a healthy lifestyle looks like
- Anyone and everyone
- Find out what people need – ask affected communities – e.g. Board committee for First Nations, Inuit, Metis – do we need to hear from other specific disadvantaged groups such as homeless population?
- Salvation Army
- Community clinics like, Youville, Centre de Santé,
- other **community organizations**, Health Links/Info santé, church organizations
- **Food banks, affordable healthy food sources –** need to be able to meet basic needs

As we move towards a more equitable health care system, what is the most important thing that you feel that the WRHA should consider/keep in mind?

- Communicating the need for equitable health care and sharing the stats – and communicating the plan to address
- Build the case, talk about what we've already done (like quick care clinics), this is our vision, what we've already done towards this, and how can we bring you in? A community development approach

- Draw on what is already in place – within the system, get feedback from professionals and staff to move it forward.
- I'd like to see them ask the people – have some process to ask the groups identified in the stats – what is the most important thing that would impact your health?
- To be able to do more with the resources we currently have – make sure it's efficiently spent
- Maximum and wise use of the resources that are available – there will always be more need
- A coordinated approach to health care using all health care providers
- Focus on holistic approaches to health and prevention
- Find out what's working – and what's not – survey people who are not using the system to find out why – use the data you gather to make things better

Meeting Two

When aligning health services to the needs of the population, what should we be mindful of? (Principles, values, other considerations)

- Cultural sensitivity
- Culturally appropriate resources – i.e. language, religion
- Mindful that different ethnic groups respond different – may have to tailor approach
- Treat/respect everyone equally
- Patients being treated with dignity and due diligence regardless of their understanding of the health care system
- Holism – look at mental/emotional/spiritual physical aspects of people when delivering health care
- Emotional state of patient

- (be mindful of) areas for that need improvement
- Recipients included in development of program – gets buy in
- Respectful of the populations' wishes
- Meeting recognized needs of population
- The desired end result – what is the specific goal of the program/policy change?

- Does everyone still have access to health care? After the equity adjustment?
- Balance to all groups
- Is everyone served? (given the equity adjustment)
- Public perception
- Ethical

- Barriers that impact users/or those needing the services
- Follow-up opportunities – how can questions be answered after/between appointments
- Time – allowing time for questions and proper explanation
- Educating patient and family – do they truly understand procedure/next steps?

- Necessary training and investment in staff
- Provide additional training around compassion

- Resources appropriate to need (i.e. babysitting)
- Fairness in resource allocation
- Mindful of resources that are available to the users
- Are resources sufficient to ensure best possible outcomes?
- Historical data – will it make a difference?

- Customer satisfaction surveys for all recipients of services
- Feedback from staff consumers of process, tool, etc.

In order to build understanding and support for equity approach, what are your ideas for what and how the WRHA can communicate with the public?

<u>What is the message? What information should we share?</u>

- Culturally sensitive messaging
- Concrete examples – like the 19 year diff in life expectancy – what healthy inequity really means
- Build on positive things going on – like the Bannock lady and impact that she's having, community gardens
- Try and focus on the recipients – not about the WRHA – engaging them on the programs – to develop the messaging – using their own language
- Facts and data – show how prevention is better than acute care – how equity approach is better for all – there won't be negative impacts on others
- Using examples of equity approach – and what cost-benefits are – some need the financial data to get on board
- Need to change peoples' perception
- Provide justification for changes proposed – plain language – using examples
- That it is progressive
- What is the impact of equity on other programs, services

<u>How can we communicate this message to build understanding?</u>

- Call out to volunteers, engage – saved resources
- Town hall meetings – food, transportation, babysitting, interpreters, notify employers (to get time off), door prizes, testimonials – take message into communities
- Share with younger population – targeted populations for younger population
- Well respected members of the community to deliver the message – celebrities, engaged, advocates, to get message across
- Team up with other organizations on campaigns, advertising blitz – same key message
- Communication with staff is also important

St James-Assiniboia and Assiniboine South
Local Health Involvement Group

Meeting One

What obligation do we have as a society to address the differences in health outcomes that currently exist?

- Definitely an obligation, but there is a big problem, unless you get rid of the bigotry, etc.
- Tough question
- Impact of rising prices on fruits/vegetable
- Society's role – different people need different things – some people have a support system and are still urged to use the system
- Gardens – publicly funded – for those who can't afford healthy food – involve children as well
- Using the organizations, people who are already involved in this work, individuals affected by this, living in Manitoba Housing, etc.
- Engaging both internal and external stakeholders – you'll need to get buy-in – need to educate and through increased understanding will get their buy in
- Transparency
- Engaging both internal and external stakeholders – you'll need to get buy-in – need to educate and through increased understanding will get their buy in

What obligation does the health care system have to address the differences in health outcomes that currently exist?

- Personal choices re: doctors – female, foreign trained
- Should get the same treatment, but it's not happening
- What if you don't need the same treatment? May need more wrap around services to affect the same outcome. Differences in terms of supports people have/don't have at home.
- Choices between types of treatment – because of income related issues, etc. For example, choice between radiation and surgery – choose radiation because you miss less work
- Yes I believe that we do – if we have more information about proper nutrition we wouldn't have a lot of the health issues that we have – good nutrition should be taught in the school – what we put into our body effects our health – there would be financial support needed in order to support better nutrition
- Where does the obligation come in – re: family role to support where they can
- Ability of anyone to use services – even when they don't necessarily need to
- Absolutely an obligation – there are inequities at every level – the very nature of our health care system – even how doctors view patients, lack of empowerment of patients
- How do you begin to deal with inequities if the system in and of itself is inequitable, and who is responsible for health/their own good health? It's always been someone else in charge

- Need to acknowledge the inequitable structure of health care
- Choices between treatments – some you can't get here – some aren't offered as options – how do you get the same outcome – if you can't get the same treatment?
- Inequities in terms of how services are offered right now – like private versus semi-private rooms – optics that you would get better care in private room
- Empathy for each and every patient
- Transparency
- Every individual should have a family doctor so that they don't have to go to a walk in clinic
- The goal should be that every individual should be empowered with the responsibility to achieve good health – to the best of their ability
- The impact of having a family doctor – the same throughout their whole life – continuity of care to an entire family – would prevent many issues that we have today – help people achieve their best health outcomes

What are the ethical issues related to aligning health services to the needs of the population?

- May do more at the front end – for example prevention
- Align health services through the whole life cycle – big picture
- Challenge will be addressing those who know how to get the services but don't necessarily need them – there would be a rebalancing
- Over the long term – if you align to needs, health services will go down in one or two generations and those resources will be redistributed
- Risks if you don't align services
- Dramatic difference between seniors with a lot of resources and those with none – no money for medication or groceries versus those with extra private care, regular home care, etc.
- The "even playing field" equal care has done us a disservice overall – maybe we need something more like a two-tiered health care system – basic line of health service that people are entitled to, then based on income – you could receive other services – for free or at a cost – how would that change outcomes?
- Just because we can doesn't mean we have to (achieve equity)
- 80/20 rule – are we building the system for the 80% or the 20%? If we build it for the 20%, the 80% get ignored… same services for everyone means some get more
- In farming, we "cull the herd" of sick or weak
- Where does the majority of the funding end up?
- These are political questions –
- There is a tension between societal and individual responsibilities
- Do we need to ensure everyone has the same opportunities, or do we create a system that meets the majority of the needs and hope most of the people get what they need?
- It depends on the outcome you want – even if it doesn't benefit one personally, some are in favour of spending the money to prevent some negative outcomes

- Harder to justify intervention for people who have made choices that have affected their own health (e.g. smoking)
- If a choice needs to be made – would rather pay for the health care of someone who was in an accident before someone who got lung disease from smoking
- Impractical to have all services in all locations (geographic alignment)
- What makes Canada good is that we strive for equity including in health. We need an equity lens in all decisions and that will create better outcomes.
- Do not want to set up a system where equity is worsened
- What is equity? Is it equal access or equal outcomes?
- Poverty is related to access – minimum income is a good idea – would help to improve outcomes – would like to see health system advocate for this
- Lots of things don't happen in a poor household when they have to make a choice between medication and food and rent

What would our health care system look like if we aligned health services to the needs of the population without adding new resources?

- Should be looking at other services – housing, etc. – all are inter-related –
- How do we expand – by taking limited resources, get synergies through partnering with housing, etc. –
- Change the profile of expectations – certain people providing services – can provide more ? by using all providers
- Hardest sell will be those who feel that their fair share is being taken away, what they feel entitled to
- Need to get the rest of society on board – includes housing, social assistance, etc.
- Getting society to be responsible for itself. System should role model what the greater society should be.
- Housing development in Toronto – looked at determinants of health related to housing – dealt with environmental issues within the buildings, developed nutrition programs, and had health advocate staff in the development – could directly access them when they had issues, questions – created a healthier community
- Centralized – so that people can phone in to get information about different supports available to assist them – to get to doctor's, etc.
- Role of access centres to target the neediest populations? Need to do more coordinated work – be more effective and efficient.
- Have staff to assist people to connect with programs, etc. and provide the support that an individual needs in order to access care
- Proctor service in mental health is an example
- Child care for those stuck in cycle – people want to be doing something – need direction, a framework, be seen as part of the solution, not just in the system
- Helping each other out needs to be supported
- Needs to be really good communication – tell the stories about what is currently happening, then they would be more understanding of moving in a different direction

- It is less costly to make sure everyone has what they need (minimum income)
- Resources on prevention – would not need so much intervention at the end
- Challenge – much of the prevention is outside of the purview of the health system – e.g. housing first
- Education from health system to society – not getting through – the people who would most benefit from the info available may not be in a place where they will be
- E.g. better hours for clinics, better access to primary care (nurse practitioners), make it easier to access – more within each community
- Quick Care Clinics – expand the ability to provide preventive care – support alternative service providers
- More front line services and prevention access points
- Triage system makes less urgent patients wait – more resources at first point of contact. Expand scopes of practice
- Re-evaluation of the role of primary care physicians
- Upstream services to prevent downstream waiting lists
- Would like to see more diagnostic testing (e.g. MRI)
- Judicious use of diagnostic tests and more use of low-tech interventions and diagnosis
- System should be more diverse in early contact points (example – Brian Sinclair – assumptions and stereotypes resulted in a pattern of behaviour and choices) – more options for managing people of different presentations – need each encounter with the system to be considered as a new encounter each time – don't rely on history assumptions
- If you are a sick person it is very difficult to take full responsibility for your own situation – especially if you don't have an advocate
- When you are sick you have diminished ability to hear, understand, remember, and may as a result end up costing the system more
- If we spend our resources upstream it will prevent the need for as much downstream intervention
- In EIA, we offer participants a Rewarding Volunteer Benefit, whereby they can receive a monthly "reward" for volunteering at not for profits in the community. I was thinking something similar for the WRHA...by way of a federal or provincial tax credit for volunteer services performed within the WRHA, or other community programs (list of "approved" organizations determined by the WRHA) – Put people where we need them instead of using homecare or other paid support staff (when possible) or health nurses etc. I think that for some of the issues we discussed, this is a viable solution to the resource problem, not only that, but it moves the community into action as well – putting individual people in a position to affect and create the community they are a part of....maybe even building a greater sense of communal responsibility among its residents

What would our health care system look like (what would be doing differently) if we addressed the underlying causes of unequal health outcomes?

- People who need greater support networks – currently live in the same areas, close to each other – "cluster model" –more coordinated care within apartment type context

- Advocates for those who don't have supports – have these in place and supporting individuals who need it
- Different funding models – different sources of funding – how do you reallocate funding to help people – broad range of services – may be some services that those who can afford to pay for some services
- If the focus was more on wellness than on illness – invest more in keeping the population well – what would we be doing? Healthy eating – what would we need to do?
- Support system for seniors living below the poverty line to assist with paying for medications
- Public health nurses with a different scope – other work beyond visiting moms and babies? Broader scope for community health.
- Volunteers providing (from health professions, etc.) assisting public health outreach
- Most of the problems are outside the purview of the health system
- There needs to be more intervention of other agencies
- If we were to do this, we would be spending less on downstream interventions
- If we addressed underlying causes for unequal health outcomes,we could replace more knees; could reduce wait times
- Health system should influence other agencies if there is evidence of effectiveness – encourage government to prioritize
- Need research and publicity

Who should the WRHA partner with to address inequities?

- Indigenous organizations
- Service organizations – those who provide wheelchairs, for example
- Service clubs
- Not for profit organizations, including Fort Whyte, Museums, etc.
- Recreation/community centres
- Education system, schools
- Business – wonder where business fits into this discussion – what are the responsibilities/expectations of large companies who benefit from seniors, etc. – to give back?
- Insurance companies
- Faith organizations
- Main Street Project, shelters, etc. – strengthen and provide more funding
- Manitoba Housing
- Other support agencies – Turning Leaf, community mental health groups, community living disability services (they decide what extra supports those with mental health needs, developmental issues receive)
- Residential care, group homes
- Government
- Medical profession
- Education system
- Community health

- Pharmaceutical companies (ensure medications are affordable – need a national pharmacare plan) – lower/lowest priority
- Experimental treatments?
- Non-governmental groups – private organizations e.g. better eating, housing, economic improvement, skills training, health education groups, schools
- Dissemination of health information
- Ensuring health care professionals' education takes place in all areas including low-income and inequity-affected populations

As we move towards a more equitable health care system, what is the most important thing that you feel that the WRHA should consider/keep in mind?

- Using the organizations, people who are already involved in this work, individuals affected by this, living in Manitoba Housing, etc.
- Empathy for each and every patient
- Engaging both internal and external stakeholders – you'll need to get buy-in – need to educate and through increased understanding will get their buy in
- Transparency
- Cost-benefit analysis – is it worth it? Careful consideration of options
- Health professionals should treat the whole person and have equity as one of their values – think of how the person is living their life – what education, prompts, support they need to achieve a good outcome
- Take an interest in the person – look at whole context
- More home care for the disadvantaged – including providing food, cooking, support for healthy living on a budget
- Keep in mind the aging population – great big whopping thing that is facing the system – will hit hard
- Need ability to move people upstream (e.g. personal care home beds, home services)
- Staff appropriately

Meeting Two

When aligning health services to the needs of the population, what should we be mindful of? (Principles, values, other considerations)

- Use plain language
- Clear communication (timely)
- Provide accessibility and assistance to complete forms so that they will access resources

- We should be mindful of leveraging/using technology and advancement in technology
- We should be mindful of utilizing/creating cost effective and efficient tools and processes

- What can be done to positively affect the greatest number of people?
- Ensure fewest problems as a result of decisions
- Does this affect another person or population negatively? Are there any losers?
- How much do people access the system versus pay into the system?

- Ask the target group how help could be implemented
- Ask the target group what they would like/need from the WRHA
- Services should be given by priority of needs
- Evaluation of needs

- Follow-up methods to ensure success?
- We should be mindful of accessibility
- Is the client able to access the system by conventional means? (i.e. someone who does not trust health care professionals may not go into a clinic or hospital but may meet in home or at a church

- Better training by people who are at the triage desk, cross cultural training
- People will help if you give them options
- Clear view of the waiting room to ensure equitable treatment of all visitors to ER

- No patient left behind
- No patient too unimportant to ignore
- We should be mindful of cultural differences
- Treat each person as if they were your family – i.e. with respect
- Respect
- Remove all barriers of discrimination – you should look at the person as a human first
- Sensitivity to past trauma that affects a person's decision to access the health care system
- Look at and treat the whole person (be aware of all relevant factors, not just the illness)

In order to build understanding and support for equity approach, what are your ideas for what and how the WRHA can communicate with the public?

<u>What is the message? What information should we share?</u>

- Share data – that's dramatic "wow" factor – difference in life expectancy – eye opener
- Start at an early age – can also be teaching about how to use the health care system
- What the community could look like if we addressed equity – difference?
- How do we bring the issues of equity related to how it could potentially impact different populations- -- negatively, positively?
- Share values – room for everyone in the system?
- Important to start at an early age – to build understanding of values related to equity
- In Canada our values include that we all help one another through our taxation system

How can we communicate this message to build understanding?

- Free television channels
- Websites and social media
- Partnering with community organizations, faith groups, etc. – newsletters
- School divisions – curriculum ideas
- Leisure guides, other ways to get info to mail boxes
- Active, inter-active approaches to take advantage of "captive" audiences – like waiting rooms
- Simple languages
- Other languages, translated
- Useful info – it's relative
- Location of area clinics with info on staff, hours, etc.
- Free newspapers – like Metro – Canstar publications
- Advertise on buses
- Partner with faith groups
- Groups going to community groups where they can assist with targeted group
- Promotion of health equity to younger age groups
- WRHA staff to talk to community groups (like a PR person)
- Target groups who are experiencing poorer health outcomes with info about how to access services, etc. – engage them in the process, support with bus tickets, etc.
- Volunteers

Appendix A

Background

- Delivering health care services equally across the entire population has not resulted in equal health outcomes across the population.
- The WRHA is committed to address these inequities and to building a more equitable approach to delivering health services – so that all people can reach their full health potential
- We must ensure that the health care system is sustainable, and that decisions made about spending health care budgets make sustainability of the system a priority

Why are we asking for your feedback and ideas?

- It is critical to hear from community members about how you see this issue.
- Building a more equitable health care system may require a reallocation of resources. So, it is very important to get public perspectives and feedback on this.
- Your ideas will be shared with the Board of the Winnipeg Regional Health Authority and programs and committees, such as the Coordinating Committee of Health for All
- We will let you know how your input has helped us move forward in ensuring that all members of the community have an opportunity to be healthy

Health is greater than healthcare

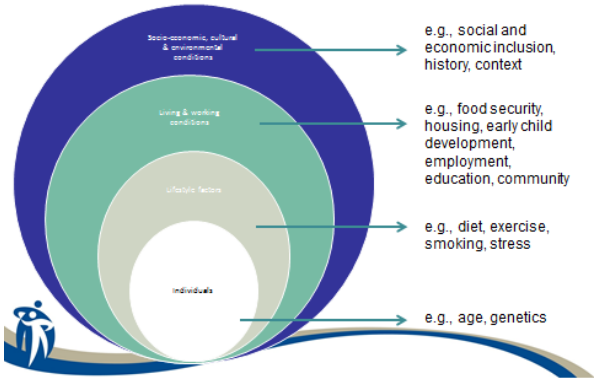
- Conditions and opportunities – determinants of health – are not shared equally by everyone
- Inequitable distribution of money, power and resources

We're all in this together…

…differences between advantaged and disadvantaged communities:

- Life expectancy
- Likelihood of hospitalization
- Length of hospitalization
- Diabetes
- Heart attacks
- Smoking
- Teen pregnancy

Why do we have health differences?



In real life…in the hospital

Joe and Harry are both 55 years old and have just had a heart attack. Both men had procedures to unblock their arteries. Are their needs the same or different? How should the health care system respond?

Joe

- Homeless
- Has lost touch with his family
- Struggles with addictions
- Spends most nights in shelters

Harry

- Lives in a bungalow in the suburbs
- Has a wife and two teenagers at home
- Job with sick leave benefits
- Already signed up with Wellness Centre

In real life…in the community

Alana and Jane are both 27 years old and just had babies. Both women are at risk for post-partum depression. Are their needs the same or different? How should the health care system respond?

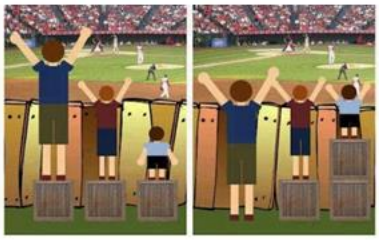
Alana

- Has three other kids
- Recently left abusive husband
- Living on social assistance
- Uses walk-in clinics

Jane

- First child
- Married two years, supportive spouse
- Plans to take her full 1 year maternity leave
- Has a good connection to a family clinic

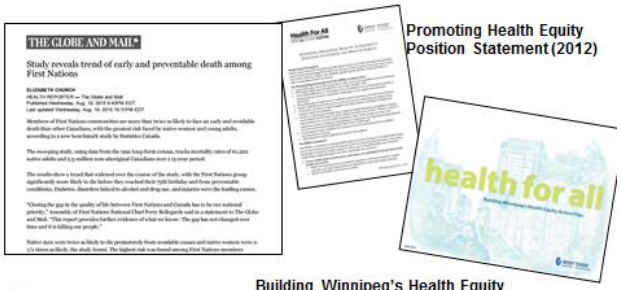
What is fair?



An equal share? According to effort? According to contribution? According to merit? According to free market exchange? Or, according to need?

Health Equity

http://www.wrha.mb.ca/about/healthequity/



Promoting Health Equity Position Statement (2012)

Building Winnipeg's Health Equity Action Plan (2013)

What would you do?

You need to mail a form that requires your spouse's signature. Your spouse is out of town for a week. Do you forge the signature?

You are driving home at 2 am. There's no one around, but the traffic light is red. Do you stop?

Source: "Scruples"

Ethics

... is about doing the right thing.

Ethics in health care

- What do we do if the ICU is full and someone needs a bed?
- How do we decide who gets a donor kidney?
- Where should we open a new clinic?

Ethics in population health

- What is the more fundamental right -- equality of access, or equality of outcomes?
- What is the health region's role in supporting population-level health interventions like affordable food, housing, development of walking/biking paths, etc.?

Ethical Guidance

- Virtues – what a "good" person would do
- Rules – policy, law, social convention
- Consequences – what could happen?
- Relationships – what else is going on?
- Values – dignity, care, respect, equity, accountability… choice, truth, access…

Appendix B

Notes from Ethics Public Engagement Group Meeting

What is our obligation to address the differences in health outcomes that currently exist? (as a society, as a health care system)

- Human rights, we all have rights; we have an obligation to help. Need to do something about lack of equality (e.g. Joe and Harry). Need a system.
- Lots of factors that contribute – including personal choices vs. access to resources. Health system has no opportunity to control personal choices. Could take some steps to equalize opportunities. Equal outcomes might not be realistic
- What is the relationship between the things we can control and things that we can't
- Education as a whole – is key to understanding outcomes – sets values
- Now that we know, there is an obligation, but the challenge is how you set up resources. Once people are knowledgeable, it is easier to bring points of view together – need education of the public to ensure they all understand the implications
- Being humans, we need to think about equality and fairness – it is an obligation. Education is a key factor. But change is difficult – need to inspire change – will be easier to allocate equally once people understand the implications
- Yes there is an obligation – we would be spending less if we invested in primary health – need to be able to show the broader public that investing in these interventions will save the system money in the end – needs to start early – prenatally – try to address differences before birth
- Obligation is tremendous – commonly held value that we care about each other's quality of life – not individualistic in economics – challenge – by the time a disadvantaged person seeks healthcare, they are already on a difficult trajectory – will be difficult to have a prophylactic approach without integrating health policies and other determinants of health – hard to isolate the obligations of health versus society and other services – need education with purpose – other things are more determinant than education (you may know to eat healthy but unable to afford/find healthy food)

What are the ethical issues related to making the change to align health services to needs?

- We can't do everything for everyone, not realistic
- How much in terms of resources can we justify to even the field? Insome situations it makes sense to pour more resources into situations where more people are affected
- Interesting that we separate health and social services – Access Centres good resource – need good coordination to make sure needs are met efficiently
- Ethical consideration – can't push people out of hospital – need to make sure there is a safety net – need to determine right amount of resources and where they are placed
- Do you have a higher obligation to younger people or older people? What about situations where people are unlikely to change? Need to be able to offer anyway
- Are we comfortable with providing more to people who need more? Is it an ethical issue to not be equal?

- Ethical consideration – how do you allocate the resources? Every situation is different. Some people will have a problem with equity-based allocations – e.g. physician says they won't treat smokers, yet the health care system still has to provide services.
- Partnering has to happen, advocacy. We as a society can't operate in isolated silos – solutions come from everywhere
- Example of Joe and Harry – both get same prescription – can one afford it vs. the other one needs more help?
- There needs to be a willingness to participate
- Education on consequences of what might happen if we don't
- Ensure people appreciate the implications of their choices
- Allocation of resources – tension between what meets population immediate needs vs. future needs – sound policy related to population health vs. policy related to how we spend tax dollars

What would our health care system look like if we aligned health services to the needs of the population without adding new resources? And, if we addressed the underlying causes of unequal health outcomes?

- More neighbourhood access centres so people don't have to travel as far – other services in addition to health services – so the most appropriate person is looking after the client's needs – easy to access
- Need to shift care where we can work towards prevention or mitigation – might mean taking money out of hospitals – shift away from tertiary care – more expensive to provide services at HSC than it would be at an access centre – no bang for the buck
- Education ties everything together – need connection, outreach,
- Difficult problem to solve without transitional funding – allow for people to adjust for new availability of preventive services – need to go in stages and ensure people understand what is available – change attitude
- ACCESS Centres – how well are they used? Years ago, health care was in the community – around family doctors – then we got specialists – need to go back to basics – ACCESS Centres with family doctors and Nurse Practitioners and Well Baby Clinics – used to have this and have lost a lot of it – models like Mount Carmel Clinic
- Address social determinants – need further resources – more prevention, more screening, better diabetes screening and care, more outreach, early childhood health care
- Many people are distrustful of the medical establishment – feel condescended, minimized – need culturally informed, health services – need to make it politically acceptable to invest upstream
- What is the role of the health authority as an advocate of change? There is a will to work with other departments, responsible for determinants of health – provincially and nationally – look to other jurisdictions for good examples of how this could work – pool resources

- Need conversations with health, education, social services, any ministries that have an impact on health – reduce duplication – e.g. redistribute education funding to lower income neighbourhoods – can't be health alone – ministry of environment
- This is not new. Political will is difficult to achieve – e.g. floodway happened because of a political risk that paid off
- Economy of scale, trying to avoid duplication
- Every little piece helps - Little programs are drops in the bucket if they are not connected

Who should the WRHA partner with to address inequities?

- Government departments – education, social services, environment, transportation, housing, water, food,
- Organizations at community (geographic, ethnic, refugee etc.) or neighbourhood levels – have trust relationships with individuals
- Assembly of Chiefs, Other Aboriginal organizations
- Immigrant groups and organizations – help with understanding of what is available, how to access
- Collaborate with other provinces – need permissive policies so they can share information and collaborate – common platform
- Charitable foundations

As we move towards a more equitable health care system what is the most important thing that you feel that the WRHA should consider/keep in mind?

- Maybe population you need to reach doesn't know what they're missing – not necessarily asking for it
- Need to do this with people – collaboration – information – collectivity
- Need to ensure providers are also educated – need to be sure they understand that this is the philosophy – need commitment from staff as well – interdisciplinary teams
- Need to determine ow to reach people, understand them and empathize
- Be careful not to be forcing something onto a society that doesn't know anything about it – how to approach is really important. Don't make prior mistakes again.
- We need to understand the people and their needs – not about assumptions – need good understanding of what people need
- Need empathy and compassion, maintain respect for clients, positive and trusting relationship between patients and health system – need engagement
- Feedback on how changes to system are working – good evaluation to ensure we are moving in the right direction
- Avoid analysis paralysis – need a leap of faith and get started – don't want to be talking about this in 10 years

Francophone Consultation Notes (February 22, 2016)

What is our obligation, as a <u>society</u>, regarding differences in health outcomes?

- We have an obligation to address inequalities and provide equal medical care for all individuals, including French-speaking people. A discussion followed on the term "unequal" – the group agreed that it was not possible to provide equal service, for example for Manitobans living in rural versus urban areas. It was more likely that services could be provided equitably. As a society, our duty would be to provide equitable services for all.
- In principle, we have a universal health care system, which implies that health services are accessible to all. Is this actually the case? No, people in some locations, such as rural communities in the north, do not have the same access. When the language factor is added, the situation is even worse. We have to address these issues.
- The current service offering is not even equitable.
- We have an obligation to promote disease prevention through education to reduce inequities.
- We should be appalled at the differences in health outcomes. We should be aware of this knowledge.
- We should help disadvantaged people access services because others have the means to pay for certain services and have access to transportation and other resources.
- We have to treat people to prevent health problems.
- We must treat the determinants of health.
- The Winnipeg Regional Health Authority (WRHA) and society need to learn about the differences in health outcomes and advocate for change.
- The Francophone community can work in partnership with the WRHA on French-language services.

What is our obligation, as a <u>health care system</u>, regarding differences in health outcomes?

- The health care system has an obligation to provide French-language services in hospitals, clinics and pharmacies to ensure the safety and quality of care.
- There must be direct consultation with clients regarding hospital and medical care.
- The health care system is not working. The system has to be streamlined to meet the needs.
- The health care system must treat everyone equally regardless of their situation.
- Equity must also be taken into account. As shown in the diagram, we have to take the steps and provide the necessary support to people who need help to stay healthy.
- We must ensure that people are aware of the full range of health services and that they select the best options: by visiting Quick Care Clinics instead of emergency rooms, for example.
- The WRHA has to find out what is being done in the Francophone community, for example, in terms of mental health.
- We need an open discussion to study and explore new options for health service structures different from those currently in use.

- There may be ways to "debottleneck" the system by making it more flexible.
- The health regions should work together to ensure clients continue to receive seamless services even if they move from one region to another. A respondent cited the example of a health care centre that serves only clients who live within certain postal codes. Client transfers should be facilitated.
- RHAs should cooperate to provide French-language services.
- We must continue efforts to increase the number of professionals able to provide French-language services.
- Professional associations must demonstrate more flexibility in order to meet client needs. They must be more willing to adopt recommendations to make services more equitable. This issue must be addressed by the system (provincial government, RHAs).
- Clients must be educated to use services more wisely. Consulting the doctor is not always necessary. Clients also have to change their way of thinking. For example, we could rely more on nurse practitioner services.
- Client or patient needs must come first.
- We must remove barriers, not work in silos.

What ethical issues are involved in aligning health services with the population's health needs?

- Some people could fall between the cracks: for example, a person living in an affluent neighbourhood could still have needs that have to be addressed. So we have to be flexible.
- We run the risk of overlooking people who are currently "healthy," but may present with health problems if they do not receive medical attention.
- It is difficult to assess needs, and decide who will have access to what services.
- Decisions must be based on current data, the current situation. However, the data used in the most recent *Community Health Assessment* were ten years old. What is the reality now?
- We were told that access to palliative care for our mother depended on who we knew. Access to health services should not depend on who you know.
- Some clients may feel the system is not fair – people will experience this when they are sick.
- Aligning health services with the population's health needs will involve working with other services. There will be issues involved in the sharing of responsibilities and interference between services. There is therefore the risk that responsibility may not be assumed. Who is ultimately responsible?
- There are ethical issues involved in all decisions and actions. This should not stop us from acting for the common good. Ethics is a lens through which all decisions are assessed.
- Not working in silos makes it easier to manage ethical issues and promote shared responsibility.

What would our health care system look like if we aligned health services with the population's health needs, without adding new resources?

- Nurse practitioners would provide ambulatory care in various seniors' facilities such as retirement homes and residences.
- There would be mobile clinics to serve people who are disadvantaged, homeless or living at home.
- There would be more people on the ground, e.g. home visitors from the Families First program, professionals who make home visits to people not familiar with the health system, such as newcomers.
- There would be seniors' facilities to avoid making seniors wait in hospitals. There would be more home care services.
- Resources would be allocated to ensure we have bilingual staff in place.
- There would be foreign credential recognition to help qualified newcomers resume their health care careers.
- Are there too many managers in the WRHA? Who could be reassigned to service delivery?
- There would be sound allocation of resources.
- For years, we have been talking about computerizing medical records, which would produce efficiencies by avoiding duplication (e.g. in terms of test requisitions). The computerization of medical records must be completed.
- We would have access to ambulance services or other forms of free transportation.
- Health professionals would be trained in teams and adopt a more holistic approach (experts from different disciplines working collaboratively to improve client outcomes).
- Teams should become more multidisciplinary, especially in hospitals.
- Home care is truly client focused.
- Community-based care would be preferred, because it focuses on promoting healthy lifestyles, which can have a greater impact on general well-being.
- We would focus on mental health, which has a significant impact on overall health.
- Health professionals would provide services to disadvantaged people in their communities.
- The client's choice to make or not make, lifestyle changes would be respected. Regardless of their decision, we would continue to treat clients and continue to educate them.
- Our health care system would focus on education. We will continue to find ways to help clients even if they adopt unhealthy lifestyles.

What would our health system look like (what would we do differently) if we addressed the root causes of unequal health outcomes?

- The system would focus on client needs rather than organizational needs, which would facilitate optimal health outcomes.
- There would be an educational component. We must educate people on health issues, and what they need to do to be healthy and live better, e.g. community gardens. We must promote disease prevention.
- The health care system would talk to its partners, for example, to identify Francophones and refer them to French-language services. The health care system would allow public

health nurses to identify and refer young Francophone families to French-language services as they do in rural areas.

- People also need to become responsible for using the services they need.
- We must encourage and promote bilingual greetings within health services.
- It would take into account factors that impact health, and work with appropriate partners depending on the circumstances, e.g. the education system (primary, secondary, university and adult education).
- It would take into account the special needs of Francophones, immigrants, etc. To find solutions, the health care system would work with departments whose responsibilities include resolving the issues to be addressed.
- The disadvantaged population would have better access to health care services currently provided on a fee-for-service basis (dentistry, physiotherapy, etc.).
- The system would ask who is really entitled to services. This is a difficult question, but should the wealthy contribute more financially?
- It would promote open communication between the various levels of society (the three levels of government—would not lose sight of the municipal level that deals with infrastructure for physical activity and well-being—the social services, health care, and education systems).
- It would encourage society to function horizontally. When individuals work together, they create a whole that is greater than the sum of its parts.

Who should the WRHA work with to correct inequities?

- Francophone organizations such as Plurielles, the Coalition francophone de la petite enfance du Manitoba, Early Childhood and Family Centres, schools (primary, secondary, and postsecondary), daycare centres, and the Fédération des aînés francophones du Manitoba.
- Various government departments such as interdepartmental committees on health and early childhood.
- Private sector stakeholders such as medical clinics, chiropractors, and physiotherapists.
- The three levels of government: *1st choice for 7 participants and 2nd choice for 2 participants.*
- The health care system should associate itself with the education system, including researchers, such as those working on best practices: *1st choice for 1 participant, 2nd choice for 2 participants, and third choice for 3 participants.*
- Professional health associations or organizations: *2nd choice for 2 participants and third choice for 3 participants.*
- The private sector, particularly with regard to food and housing: *1st choice for 1 participant*. The Centre de santé Saint-Boniface and Accès–Access Saint-Boniface.

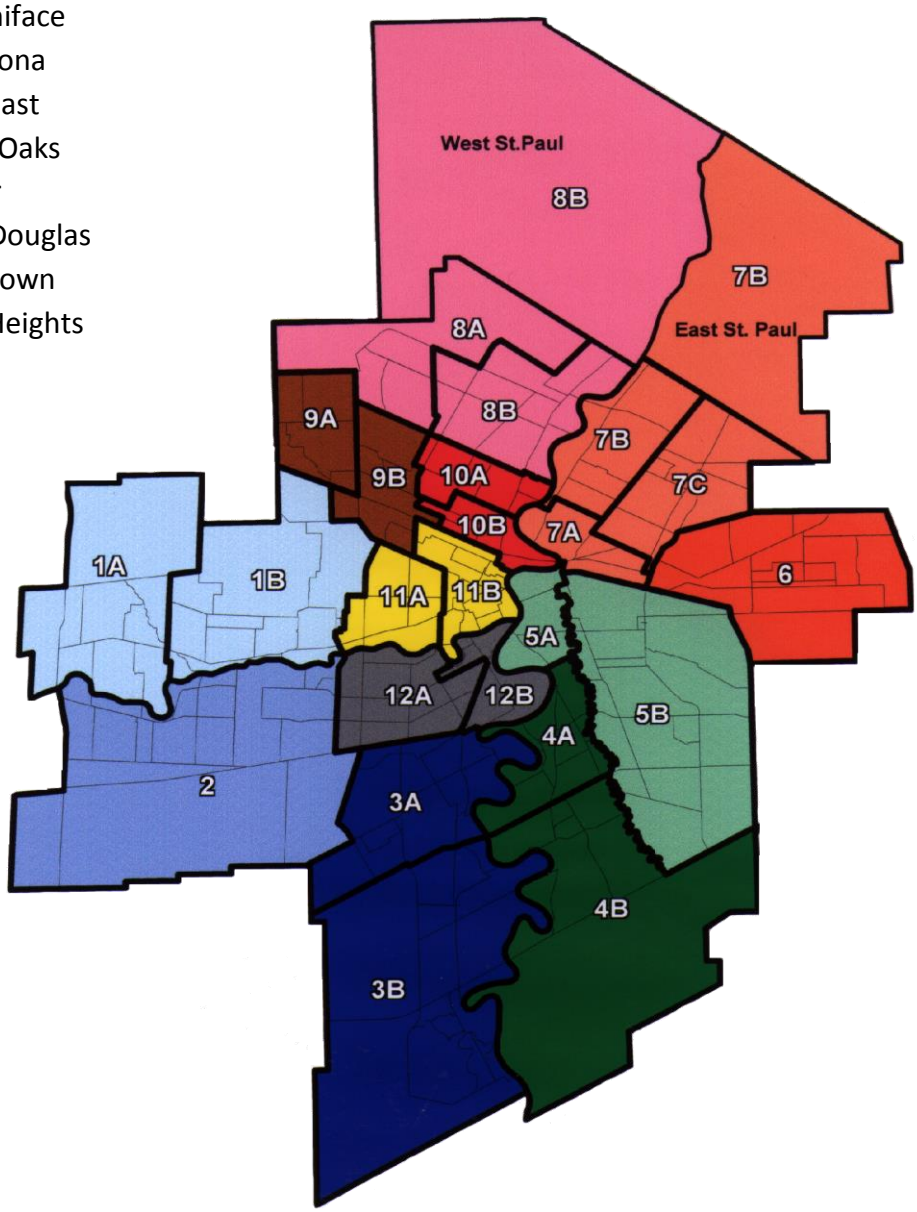
What do you think is the most important thing for the WRHA to consider / keep in mind when introducing a more equitable health care system?

- People's social class and income must be taken into account.
- There must be a two-way exchange of information between the WRHA and the Francophone community to clarify the current situation and identify the needs. In short, we need better communication with WRHA partners.
- We must continue to conduct community consultations.
- WRHA officials should be encouraged to re-educate themselves/become more aware and develop an effective action plan based on the results of this consultation.
- We need more assisted-living facilities for seniors.
- We have to think outside the box.
- We all hope our life expectancy increases.
- The health care system must take into account the needs of Francophones. For example, while respondents acknowledged efforts to conduct the consultation in French, they said the presentation preceding the group discussion was delivered in English.
- The speaker must listen to the views of Francophones and other minority groups.
- We must break down silos and stop placing clients in ghettos. If appropriate, we will be happy to consider clients holistically.
- Do not forget the client.
- Treat the whole person.

Appendix C

Map of the Community Areas in the Winnipeg Health Region

1 St. James – Assiniboia
2 Assiniboine South
3 Fort Garry
4 St. Vital
5 St. Boniface
6 Transcona
7 River East
8 Seven Oaks
9 Inkster
10 Point Douglas
11 Downtown
12 River Heights



Appendix D

Acknowledgements
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