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"

Summary 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.

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

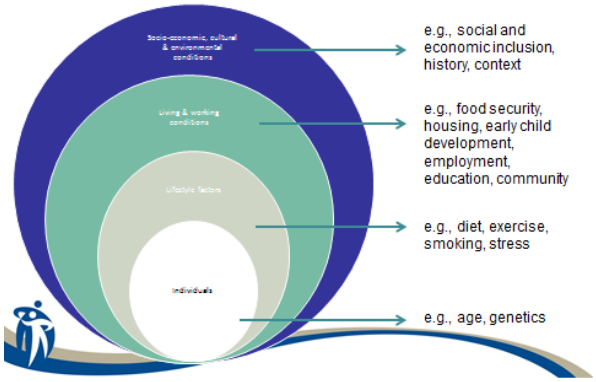
- Conditions and opportunities – determinants of health – are not shared equally by everyone
- Inequitable distribution of money, power and resources

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?

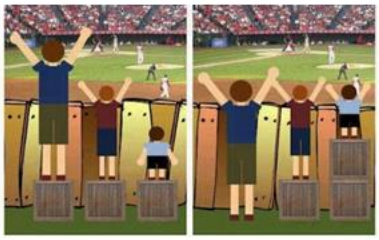
Alana

- 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

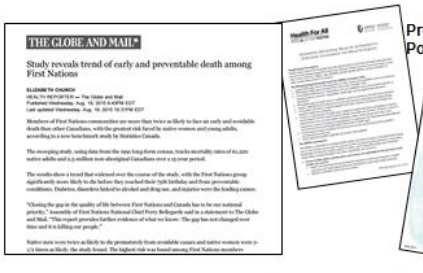
What is fair?



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/


THE GLOBE AND MAIL

Study reveals trend of early and preventable death among First Nations

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.?

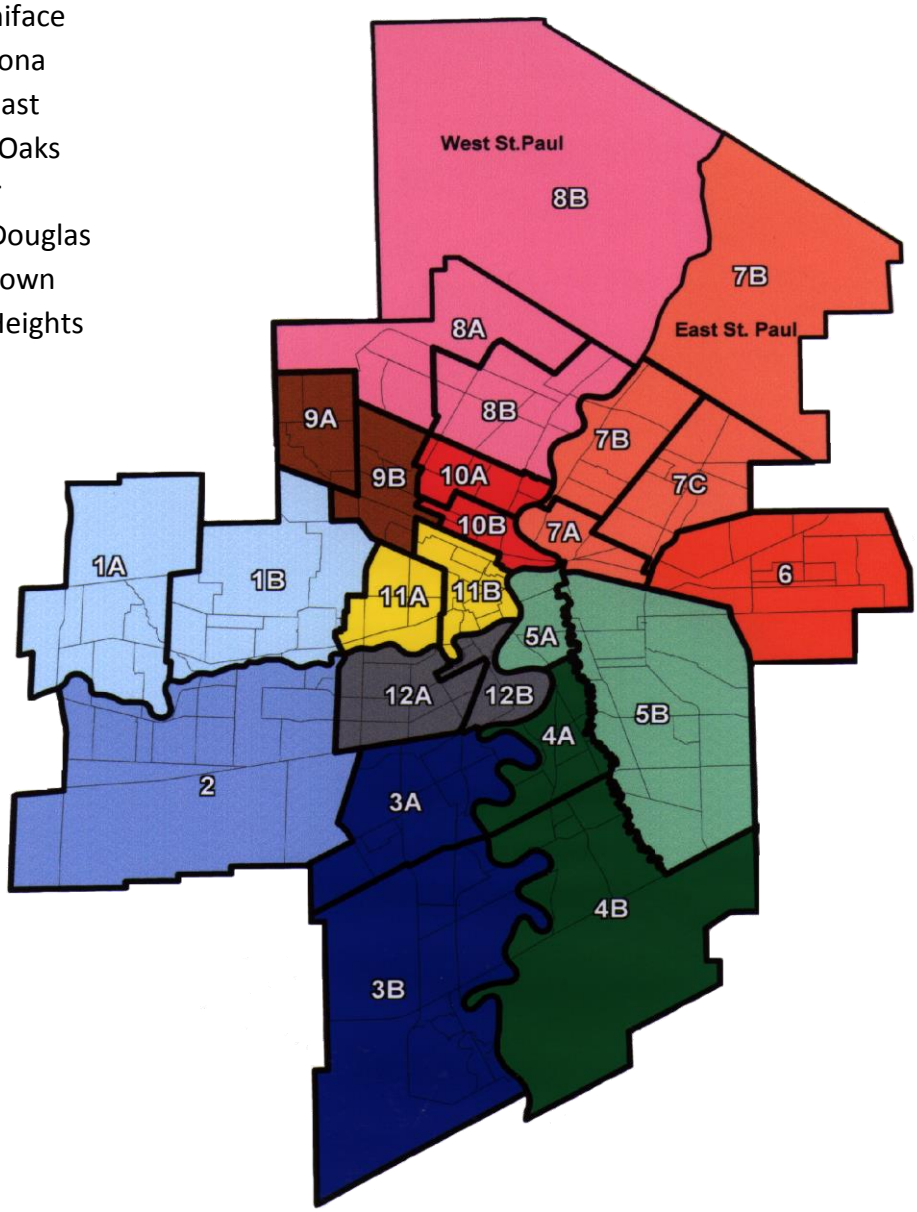
Ethical Guidance

- 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

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 C

Acknowledgements
Members of the Local Health Involvement Groups
Board Liaisons to the Groups
Support Staff for Groups

Members of Local Health Involvement Groups
2015-2016

Downtown/Point Douglas Group

Dennis Ballard
Kim Calder
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Todd Donahue
Blair Hamilton
Cari La Riviere
Kendra Huynh Williams
Dessalegn Melesse
Christine Nijimbere
Lissie Rappaport
Wayne Sandler
Alberto Sangalang
Carey Sinclair
Aimen Syed
Carla Veldkamp

River East/Transcona Group

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Emma Durand-Wood
Beth Fernandes
Donald Grier
Jonathon Lloyd
Darlene Karp
Maureen Peniuk
Judy Posthumus
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Brenda Rocchio
A.D. Zallack

River Heights/Fort Garry Group

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Sharon Dainard
Subas Dahal
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Meryle Lewis
Natalie LoVertri
Melaine Matte
Roni Dhaliwal
Lana McGimpsey
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Emmanuel Ro Timi Ojo
Amanda Rozyk
Pete Sarsfield
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Seven Oaks/Inkster Group

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Susan Burko
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Len Offrowich
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Ashley Saulog
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Diana Szymanski
Jagdeep Toor
Jacquie Tucker
Carolyn Wiebe
Valerie Williams

St. Boniface/St. Vital Group

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Mona Audet
Helene Beauchemin
Bathelemy Bolivar
Tim Church
Howard English
Andrea Kwasnicki
Debbie Lokke
Rose Marsden
Elsie Nabroski
Gisele Toupin
Kathleen Williamson
Linda Wilton
John Wylie
Derek Yakielashek

St. James-Assiniboia/Assiniboine South Group

Sangeet Bhatia
Brian Clerihew
Dennie Cormack
Danita Dubinsky Aziza
David Friesen
Wendy French
Alison Hoogervorst
Ken Howell
Lawrence Klepachek
Diane Lonergan
Georgette Martin-Couture
Roberta Novel
Christine Portelance
Kathryn Thornton

WRHA Board Liaisons (non-voting members of Groups)

Elaine Bishop and Connie Krahenbil	Downtown/Point Douglas
Doris Koop	River East/Transcona
Bruce Thompson and Jeff Cook	River Heights/Fort Garry
Stuart Greenfield and Myrle Ballard	Seven Oaks/Inkster
Rob Santos	St. Boniface/St. Vital
Joanne Biggs and Jean Friesen	St. James-Assiniboia/Assiniboine South

Community Area Directors/Staff (non-voting members of Groups)

Sharon Kuropatwa	Downtown/Point Douglas
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Dana Rudy	River Heights/Fort Garry
Carmen Hemmersbach	Seven Oaks/Inkster
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Kellie O'Rourke	St. James-Assiniboia/Assiniboine South
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Support Staff for Groups

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