

“Whatever Job I’m In, I’m Going to Find a Way to Make a Difference” – A Black Community Leader’s Perspective on Engagement and Advocacy

« Quel que soit le travail que je fais, je trouverai un moyen d’apporter des changements » – Point de vue d’une leader communautaire noire sur la mobilisation et le plaidoyer

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Abstract

Camille Orridge is a patient and community-focused healthcare leader who has passionately and tirelessly worked for more than 50 years to address systemic barriers in the healthcare system, creating innovative equitable health solutions for underserved populations. She has founded a number of key initiatives, including Pathways to Education, the Canadian Home Care Association and the Black Coalition for AIDS Prevention (Black CAP) and has served on numerous boards, as a volunteer and in her capacity as the CEO of the Toronto Central Local Health Integration Network. In this oral history narrative, Camille reflects on her extensive 50-year journey as a healthcare advocate, identifying victories but also areas that continue to be barriers for historically marginalized communities, such as Black communities. In so doing, she discusses the complexities that she has encountered while pushing boundaries and reimagining a more equitable healthcare system in Ontario and reveals key historical touchpoints in the health equity and advocacy space.

Résumé

Camille Orridge est une dirigeante des soins de santé axée sur les patients et la communauté qui travaille avec passion et sans relâche depuis plus de 50 ans pour éliminer les obstacles systémiques dans le système de santé, créant des solutions de santé équitables innovantes pour les populations mal desservies. Elle a fondé un certain nombre d’initiatives clés, dont

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Passeport pour ma réussite, l’Association canadienne de soins et services à domicile et Black CAP (une coalition de personnes noires pour la prévention du SIDA) et elle a siégé à de nombreux conseils d’administration en tant que bénévole et à titre de PDG du réseau local d’intégration des services de santé (RLISS) du Centre-Toronto. Dans ce récit, Camille évoque son vaste parcours d’un demi siècle en tant que défenseuse des soins de santé, s’arrêtant sur les victoires mais aussi sur les secteurs où on observe encore des obstacles pour les groupes historiquement marginalisés, comme les communautés noires. Ce faisant, elle aborde la question des situations complexes qu’elle a rencontrées, en repoussant les limites et en réimaginant un système de santé plus équitable en Ontario, et elle révèle les principaux points historiques dans les domaines de l’équité en santé et de la défense des droits.

Doors, Suits and Hoops: Being Black in the Workforce

I was often the only person of colour and the only woman of colour in a group. In these settings, our voices get erased. For your voice not to be erased, you have to get more aggressive and more forceful. Then you become the “angry Black woman” very quickly. I did a lot of stuff to jump through hoops: I made sure I wore the right suit, all the stuff you do in order to enter and belong. But I was blessed in a way that many of us are – especially when you come from countries that are Black countries, you have a different sense of self. But also, I have a family network, and although my mom did not have a lot of money, I was always secure because she’d always say, “You can come home.”

I never felt the need to be liked. You see people in spaces that feel the need to be liked, so they turn themselves into a pretzel to be liked. I had more of a need to be respected, and that allowed me to do the work I needed to do. So, for government and for policy folks, they knew that I delivered, I got work done. It was hard for them to dismiss me when I was a good worker that they could rely on.

I learned from others – I saw people who dedicated their lives to community and activism, but got burnt out, and then became mean and destructive to the very same community. I knew I did not want to do that. So as difficult as it was for me, I always had my friends, colleagues, like-minded staff, who I could call up and say, “You can’t believe the shit that has happened.” And I had my family. And in my family, we do not talk about work. We eat, we laugh, we talk. And striking that balance was always important for me.

Whatever job I am in, they are going to pay me and I need to feed my kid. But whatever job I’m in, I’m going to find a way to make a difference. I do not always have to promote or talk about making a difference, I just need to find a way to use that job to make that difference.

Working Toward Big Wins: Collaborating on Policy Change

It is a known fact that your best chance of influencing policy is before policy gets made and

it's harder to change policy once it is done. But that sets up significant barriers. The Black- or minority-focused organizations doing the work are usually so stretched and so underfunded that they do not have the time or resources to be doing this policy and advocacy work ahead of time. Other more established groups have staff and resources that monitor, keep ahead of and provide input into policy; we sometimes do not even have the time to go to the meetings to talk about the policy. So Black organizations or community-based agencies serving their communities are at a disadvantage from the outset.

If there is any inkling that what you are advocating for takes money or services away from mainstream communities, policy makers do not like to go there. There is a sense that the pie is small, and that by asking for something, it takes resources away from other people (from people who vote, or from people who have a voice). It is a way of thinking, "We don't have enough for people who currently need services, but you're asking to extend the policy for more people." And I have to say, "Yes, because the people who are not getting care are people of colour. We need to talk about how nobody has enough resources, but we cannot continue to leave people of colour out because there isn't enough money."

The people who are writing policy usually come from particular perspectives – an educational background or training – and are often disconnected themselves from communities. Even when you get Black people doing policy, their education and life trajectory removes them from being continually integrated in communities. This disconnect means that, often, steps to ensure the impact is consistent across communities are missing from policies.

For example, when I was at the Toronto Central Local Health Integration Network (LHIN), some partners from Toronto Public Health and I formed a group called the Toronto Health Indigenous Advisory Committee, which we funded as a side project. We wanted to focus on St. James Town [in Toronto, ON] – it was dense, with no park, no healthcare, nothing. It is a city by itself, without all the amenities of a city. We hired a community-based firm that then hired community members – a lot of whom were unemployed or on social assistance – and paid and trained them. These community members did all the interviews with the community – essentially a needs assessment for the community. What came out as their number one need was dental care for children. The LHIN did not do dental care for children, but we could not walk away from that community need. So, we focused on what else was needed. We found it – Health Commons needed a space in the community where the health providers could come together. Ten years later, Health Commons is still going and because Toronto Public Health is a partner, we could ask them what we could do about the dental care. Toronto Public Health was able to use what they were already doing and adjust it to this community. Making change is not always about brand-new programming; it can be about adjusting existing delivery methods to meet the needs of people not being served. I consistently got around policy barriers by creating pilots and using existing resources in order to gather the data to inform and push policy forward.

Pilot research was the way I found to do a lot of policy shifts: every time we were told we could not do something, I would find another way to gather the data, and evaluate it, to

show our approach was more efficient. Policy does not change without hard data. Sometimes you can make the argument for good care, but very rarely do you get the policy change you want if you ignore the economic argument. When we started Pathways to Education, a stay-in-school program for high school students, we got a consulting firm to do the economic analysis about why we should work hard to get our kids graduated from school. We argued that otherwise the workforce in the future will not be available for our businesses, and if these businesses do not have students taking jobs, they will lose business on the international front. Those kinds of arguments held up.

When I was on the AIDS Advisory Committee to the Minister of Health, the AIDS medication was really expensive. The committee wanted to go to the minister to ask for money to support people with AIDS. And I said, “I am not going to the minister to ask them to fund AIDS that way.” Instead, I said, “Let’s talk about other catastrophic illnesses with expensive medications, let’s join up with heart and lungs organizations.” That was hard, because then we encountered homophobia in those groups. But we could not walk away because the ultimate goal was too big. We will walk into spaces where we experience anti-Black racism, but you still stay in that space to do the work, to get where you want to go. You do not always have the privilege of walking away if the goal is what drives you. Together, we reframed the ask to, “Let’s say \$200 is a reasonable amount anybody should pay for drugs. And anybody whose drug bill is above \$200 will get government support, regardless of the medical condition that requires that drug.” That policy went through, and that is how we have Trillium drug support. Because it was the cost of drugs that the government was supporting in this policy; it included AIDS drugs, but it was not limited to AIDS. Sometimes you need to work together with others to get policy change for your people.

Co-Designing and Advisory Committees: Who Is at the Table and Who Is Missing?

Co-design drives me crazy. When people talk about wanting people with experience on their committees, it usually means having one or two people there. These people with lived experience are usually highly educated, and it is one dimensional. I do not have a problem with co-design, I have a problem about how it really is only always focused on the people who are at the table who invariably come from a particular race or class. Sometimes this is because other voices are not sought out, other times it is because there are too many barriers to participate. People living in poverty often do not have time to come sit down in meetings for hours. So, it is not that I’m objecting to co-design, I’m objecting to co-design as it is currently structured. Because we are left out, other people are left out, poor people are left out.

Everybody in healthcare wants advisory committees, they want to hear patient voices. Well, most of the people who participate – even if they are people of colour – have status and education. You are not really hearing from the other half of the people who are not in the room. I sit on the advisory committee for arthritis because I have bad arthritis, and I’m really clear: I do not represent poor people or all Black people with arthritis, you need to go hear

from them. I can tell you what my experience is, and my experience comes with privilege and knowledge. Anything I'm bringing has nothing to do with the immigrant experience now. I can no longer fulfil that role as an immigrant, I'm too far removed. I cannot speak for that community and I will not. I will say, let us form a focus group and let us reach out so we can connect with people from those communities so that you can hear their voices.

COVID-19: Lessons in Designing Systems for Equity

I think COVID-19 has exposed for the mainstream what Black and Indigenous communities have always known. Nothing about COVID-19 should have been a surprise because we knew from SARS who is at risk from every infectious disease that comes. I'm always a bit cautious about making health outcomes a Black community issue, as if it is because of your skin colour that this happens. It is not. Our health outcomes have a direct relationship to anti-Black racism, which then puts us in certain living conditions, in certain jobs, under certain working conditions. We are the people who work in places like community care where you do not get full time jobs, where you do not get benefits, where even if you are sick, you have to go to work or else you do not get paid. Those jobs are what exposed us to COVID-19; it is racism that put us in those jobs, in communities where we cannot afford housing. It is not a surprise because given that combination, we were prime candidates to get sick.

We are left in the same place post COVID-19 if we, as a society, do not do anything about community care, about benefits, about employment, about housing. Any new dollar should have conditions attached to it: we need to see that you now address the needs of the people you are not serving. That is where the opportunities are. So that is my hope for the post-COVID-19 era: taking a funding and equity approach to making sure that people who are not currently getting care, get care. Attach conditions to money. Do that analysis as to who will be negatively impacted and put strategies in place to address that.

This is a time where we have to stay strident and firm on change.

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