INSTITUT C.D. HOWE INSTITUTE
Trusted Policy Intelligence | Conseils de politiques dignes de confiance

VERBATIM

October 15, 2020

COVID-19: A Catalyst for Change in Health and Healthcare?

By Don Drummond and Duncan Sinclair

A joint submission to the C.D. Howe Institute Conference "Change Accelerator: A Post-COVID Healthcare Reform Agenda," held on September 30, 2020.

Don Drummond is Stauffer-Dunning Fellow, Queen's University.
Duncan Sinclair is Distinguished Fellow, School of Policy Studies, Queen's University.

Overview: After discussing the economic devastation brought by efforts to contain the spread of COVID-19, we then address the consequences for health and healthcare and how approaches to both in the provinces and territories of Canada must be revolutionized.

The Economic Hit from COVID-19

Many economists and policymakers were slow to realize that the economic hit from COVID-19 would be much deeper than had been thought. Losing 3 million jobs over March and April and seeing hours worked plummet 27.7 percent caught everyone's attention. Most are starting to realize that the recovery will be slow and uneven. Yet many economic forecasters put out a single scenario, typically with a start date for the recovery to begin and a linear path back to the pre-pandemic level of activity. Such estimates are useless given the enormous uncertainties about the post-pandemic economy and also about the course of COVID-19 and how it will affect us.

A basic problem is an apparent gulf between economic forecasters (and investors) and epidemiologists and infectious disease specialists. Most of the latter are clear that COVID-19 is far from over, that it will almost certainly re-emerge in waves, and that the options for much more strategic responses to virtual economic lockdown are compromised by insufficient testing, contact tracing, and isolation/quarantine of those infected. Add in the uncertainties relating to the timely discovery, manufacture, and world-wide distribution of safe and effective vaccines and/or treatments and the possibility none might work all that well for everyone, and the implication is clear. The economic damage from COVID-19 and its impact on health and healthcare are going to persist for some time.

Such uncertainties call for the use of scenarios to inform our anticipation of the future. We can easily contemplate a favourable one wherein the economy begins to recover in the third quarter of 2020 and, with considerable luck, makes its way back by the end of 2021 to the level of real GDP at the end of 2019. The dip in GDP over the two years 2020 and '21, plus the growth that would have occurred in its absence, would constitute the economic cost of the pandemic.

We must also consider a less favourable scenario in which COVID-19 lingers and re-surges in a second and then subsequent waves. The Bank of Canada,[1] the OECD[2] and the Canadian law firm Bennett Jones[3] each recently released such scenarios, referring to them as "pessimistic" and "less favourable"; an epidemiologist or infectious disease specialist might have suggested "realistic." In each, by the end of 2021, the levels of real GDP are down relative to the end of 2019 by 7 percent, 6.8 and 5.4 percent, respectively.

The Government of Canada's Economic and Fiscal Snapshot of July 8, 2020 used the average of private-sector economic forecasts to derive a near-term fiscal outlook. That average shows real GDP declining 6.6 percent in 2020 and increasing 5.5 percent in 2021, leaving the level of output in 2021 below that of 2019. Finance Canada correctly notes that the results of the survey of private-sector forecasts "are most consistent with slow, steady and relatively low levels of ongoing community transmission of the virus. As a result, risks around this outlook are elevated and tilted to the downside." The presentation of alternative scenarios is to be applauded, but the details of the assumptions and results are vague. In an "uneven and gradual" recovery output declines 9.6 percent in 2020; there is no mention of prospects for 2021. Under "virus resurgence" output declines 11.2 percent in 2020; the only reference to 2021 is that the level of output at the end of that year would be below even the most pessimistic of the private-sector forecasts.

Worse, we must also consider the possibility that the economy's potential growth rate will be depressed for some time. The hit to corporations' balance sheets will compromise their ability to invest. A good part of new investments will be needed on ways and means to make workplaces and transit safer; they may not necessarily enhance productivity. As many as 40 percent of pre-pandemic jobs will not return, a dislocation in the labour market that could further delay the return to normal growth.[4]

Although the economic news that 40 percent of the jobs lost in March and April were recovered in May and June struck an optimistic note, it is sobering to realize we are still down 1.8 million jobs from February. We may be off the bottom, but we are still deep in the well.

The Fiscal Hit from COVID-19

Federal, provincial and municipal balance sheets are all being hit hard from the combination of lower economic activity and unprecedented attempts to mitigate it. The July 8, 2020, Government of Canada Economic and Fiscal Snapshot estimated the federal net-debt-to-GDP ratio will hit 49 percent this year,

1 https://www.bankofcanada.ca/wp-content/uploads/2020/04/mpr-2020-04-15.pdf.

2 http://www.oecd.org/economic-outlook/june-2020/.

3 https://www.bennettjones.com/Spring2020EconomicOutlook.

4 https://bfi.uchicago.edu/wp-content/uploads/BFI_WP_202059.pdf.

up almost 20 percentage points from recent years (but still below the previous high-water mark of 66.8 percent in 1995-96). Provincial debt burdens, many already very high, will also soar and stay high. Ontario, for example, will also go to around a 50 percent net debt-to-GDP ratio, up from just under 40 percent last year, the deficit nearly quadrupling to $41 billion, 5 percent of GDP, in 2020-21.[5] The debt ratio of Newfoundland and Labrador, already 83 percent, could hit 100 percent, especially if oil prices remain depressed, and after factoring in the Muskrat Falls hydroelectricity project to account for its inevitable write-down. We must also recognize the ongoing liability of provincial residents through taxes and persistently high electricity prices. With limited economic and hence revenue potential, it is hard to imagine how that province can continue to pay its bills, including for healthcare. Newfoundland and Labrador may, essentially, be insolvent. New Brunswick and others are not far behind.

At some point in the not too distant future there will need to be a fiscal reckoning of the current expansion of deficits and debt. We cannot grow out of the debt as Canada did post-World War II. Canada's potential real output growth rate is likely to be but 1½ percent over the next few decades, a rate that could well be lower for a while due to the effects of COVID-19. The potential growth rate is much lower in the eastern provinces with their older populations. Inflation is much lower now than after the war and will be under further downward pressure as long as the economy remains weak. Labour productivity has averaged 1 percent growth since 2000, a fraction of the brisk pace in the '50s and '60s.

When should fiscal redress begin? It should not begin until the economy has recovered and that, in turn, is dependent on achieving substantial reduction in the risk to the health of the population, an objective still on an uncertain horizon. We must avoid repeating the dramatic shift to austerity and the ensuing recession in 2011 when the economy was still suffering the after-effects of that preceding financial crisis. The Bank of Canada already has its 'pedal to the metal' and could do little further to offset the additional drag of fiscal retrenchment.

Governments are in the swing of doling out large and costly programs without too much concern for the resulting deficits and debt, a practice appropriate in the heat of the pandemic but a behaviour to be resisted as the threat of COVID-19 is brought under control and the economy recovers. There is the danger that the 'rescue programs' may linger too long. History suggests the longer fiscal reckoning is put off, the harsher it will be.

Crises Highlight Pre-Existing Problems and Accelerate Change

Crises not only demand solutions to the immediate problems they create. They also highlight pre-existing problems in the fundamental policies and structure of the situation affected and accelerate their necessary change. COVID-19 has shone the spotlight on several problems of long standing in health and healthcare, including:

- Inadequate support of the most vulnerable. This runs the gamut from yawning gaps in social assistance programs like Employment Insurance, lack of income support, acceptance of large and persistent pockets of poverty, lack of affordable housing, and barriers to access to some forms of healthcare, prescription drugs, dentistry, and physiotherapy among them.
- Inadequate co-ordination of healthcare services resulting in, among other things, many hospital beds occupied by people who should not be there, "warehousing" of elderly people in long-term care

5 https://www.fao-on.org/en/Blog/Publications/EBO-SP2020.

facilities, and the relative separation of primary care both from such facilities and from hospitals.

- Overly rigid protocols applying to the provision of many healthcare services, an example being those that obstructed expansion of virtual care prior to the crisis-induced introduction of applicable billing codes.
- Greater community co-ordination of care that moved ALC[6] people out of hospitals to safe alternatives (where they existed) to create 'surge capacity' to deal with serious COVID-19 cases.

The COVID-19 spotlight has accelerated talk about other fundamental issues, including the social determinants of health, such as filling gaps in social assistance by a Guaranteed or Basic Income and, more generally, coming to grips with poverty as a major threat to health and well-being.

Perhaps the best example of the pandemic's accelerator effect has been the almost lightning speed with which the federal government introduced the Canada Emergency Relief Benefit and the Canada Revenue Agency processed 11 million applications. The speed with which governments have shown they can act is a potential 'game changer.' Never again should it be accepted that a problem is too large, too complex or will take too long for governments and their bureaucracies to solve!

Healthcare Was Already Heading for a Fiscal Crunch Pre-Pandemic

The COVID-19 pandemic has delayed and will ultimately intensify the fiscal crunch that has been coming in healthcare for some years now.

Some have been lulled into complacency by the moderate pace of healthcare's spending growth since 2011, thinking there is no need to curb it. Healthcare spending grew at an average annual pace of 3.5 percent from 2011 to 2019, ranging from 1.9 to 4.4 percent. Nominal GDP growth followed a similar path, so the ratio of healthcare spending to GDP did not stray far from its 11.6 percent in 2019. This figure is high by international standards; the OECD average is 8.8 percent. Canadians think we are doing well because in America the spending ratio is 17.1 percent of GDP.

Another dimension of healthcare spending often misunderstood by Canadians is the public dimension. Public spending accounts for 70 percent of total healthcare spending in Canada; the remaining 30 percent is private. The OECD average of public spending is 71 percent, an average brought down significantly by the U.S. public portion at less than 50 percent.

Not only is the Canadian share paid out of the public purse not particularly high, we have a unique structure whereby almost everything in primary care is covered but less than half of pharmaceuticals and only about 10 percent of everything else, including mental health outside a hospital and physician care-giver setting. This narrow definition of "medically necessary"[7] care that qualifies for public support is an important contributor to how far we leave exposed the most vulnerable Canadians to charges for healthcare services that would be paid for publicly, at least in part, in other developed countries. It is a stark reality that many Canadians lack access to essential health/healthcare services because of their inability to pay for them!

The moderate growth rates of healthcare spending since 2011 should not be grounds for complacency because their moderation was accomplished largely by non-sustainable means like cut backs in capital

6 Alternative Level of Care.

7 *Canada Health Act*; https://laws-lois.justice.gc.ca/eng/acts/c-6/.

spending that in many jurisdictions have now become urgent as a result of capacity constraints in hospitals and elsewhere. Ontario unilaterally cut physicians' pay; arbitrators have now reversed it; this lesson seems to have eluded Alberta, which is still trying to do the same. The 2011 to 2019 period was benign for pharmaceutical spending as few new and expensive drugs came on stream and several high-priced ones came off patent. That period is over and we can expect, barring policy action, higher growth in spending on drugs.

Absent the pandemic, healthcare spending in Canada would likely have reverted to a higher growth rate of at least 5½ to 6 percent per annum, driven by demographic and inflation pressures. Population growth accounts for 1 percentage point per annum. Ageing adds another, with the contribution at 1.2 percentage points in places like Newfoundland and Labrador with their older populations. General inflation adds 2 percentage points, if the current Bank of Canada-Government of Canada target is met. Because inflation in healthcare tends to run higher than general inflation, that will likely add another ½ point. As well, over time there is a tendency for the intensity of healthcare to increase as new interventions become possible. The intensity factor is highly variable but will likely add 1 percentage point or more to growth annually. The sum is a conservative estimate of the "status quo" growth rate of 5½ percent. Added to this will be the catch-up pressures from past actions like deferred capital spending and, more recently, eliminating the backlog of hospital and other services delayed by the pandemic. To that long list must be added long-term care; whatever the results of the reviews that are being launched, their implementation will be expensive and although there will be debate over who should pay, someone will have to foot the bill.

The growth in healthcare spending of at least 5½ percent per annum must be put in the context of longer-term nominal GDP growth of around 3½ percent (made up of 2 percent inflation and 1½ percent real GDP growth) prior to consideration of any ongoing, depressing effects from the pandemic.

A fiscal crunch, even absent any effect of COVID-19, is apparent. There is nothing inherently wrong with healthcare spending rising faster than GDP. It is the number one priority of Canadians. But there is a limit to the resources that can be devoted to healthcare given the vital contributions to health of its social determinants and their dependence also on funding from the public purse. The "status quo" funding of healthcare runs afoul of any reasonable interpretation of that limit. For provinces where healthcare is half of program spending and revenues grow at 3½ percent, simply to retain their already precarious fiscal positions they would need to restrict all non-health spending to 1½ percent growth per annum if healthcare spending grew at 5½ percent. It is unlikely voters would accept the consequences of spending on all non-health public services shrinking by 1½ year by year on a real, per capita basis.

Tax increases do not offer a feasible way out of this box. It would take large, persistent increases in taxes to narrow the growth rate differential between "status quo" healthcare spending and government revenues. That too would likely be unacceptable to taxpayers, especially considering the relatively high personal and corporate income tax rates Canadians already pay.

The crunch will hit the provinces hard. As fiscal protection, the federal government limited the Canada Health Transfer to a moving average growth rate of nominal GDP, with a floor of 3 percent of annual growth. Without relaxation of this rule, the crunch to be felt by the provinces will be higher because in addition to covering growth rates of healthcare spending greater than nominal GDP growth, they will have to fill the hole left by the limit on the federal contribution.

Stakeholders Should Not Let the Fiscal Crunch Dictate What Changes to Health and Healthcare Should be Put in Place

A fiscal crunch is often the catalyst for policy reform but if that reform is solely or primarily to relieve the crunch, fiscal austerity is often undermined later by inadequate attention having been paid to preservation of the quality of programs and achievement of their objectives. We seem to be re-living the experience of the late 1990s when many provinces made cuts to health spending that led subsequently to reversals that launched a period of quite rapid growth in spending; the moderate restraint in spending between 2011 to 2019 has resulted in pressures of the same kind and intensity.

A better way is for stakeholders, both the people who are the recipients of health and healthcare services and their providers, to set out a vision of what the ultimate outcome should be, how things should be done and then to factor the fiscal parameters into that vision – get the horse and cart in the right order. By virtue of their central role in both health and healthcare, doctors and other providers of health services should take a leading role in initiating discussions with representatives of the populations they serve in all their diversity of how best to optimize the health of the people of their communities. In the result of those discussions the views of the people served should prevail to the maximum degree possible.

The fiscal parameters will dictate bending the cost curve down from the "status quo" trajectory of 5½ percent plus per annum. There is no way of simultaneously achieving this imperative and those of appropriate outcomes in terms of health, high-quality care, and ready access to services without increasing the effectiveness and efficiency of how, when, where, and by whom services are provided. Such a holistic approach is not the forte of "bean counters," as demonstrated by the experience of the late 1990s and again since 2011.

Leadership Wanted!

What needs to change? Almost everything. This should not come as a surprise. The "system" we now have in place has evolved through glacial incremental change from that put in place in the 1950s and 1960s to serve a young, less unequal population whose principal health problems were acute illnesses and injuries. Its focus was quite rightly on acute, curative care. Then, some 60 years ago, 7.6 percent of Canadians, but one in thirteen, were over 65. Now, Canada has an older population with a large and growing number of people with multiple morbidities, rarely curable, who need management and continuing care. Seniors now represent one-sixth of the Canadian population. The last of the babyboomers turns 65 in 2031 and, by 2036, seniors will account for 23 to 25 percent of the population. Despite Canadians' fairly high average incomes, in absolute terms and relative to other developed countries, Canada now has prevalent socio-economic conditions, income and opportunity disparities, outright poverty and other vulnerabilities among them, that put the health of too many at risk.

A question is whether healthcare's providers and the communities they serve will rise to the challenge of creating a new vision for health and healthcare for the remainder of this first half of the 21st century and make the transition to the new vision quickly. The extraordinarily decisive and quick governmental policy response to COVID-19 offers some reason for optimism that health and healthcare's stakeholders can and will do the same.

The Objective is Health

The starting point for any policy is to define the objective. Our "system" has been pursuing, measuring, and incentivizing a subsidiary rather than the

primary objective. We focus on healthcare; patching people up after something goes wrong, a need that continues but is far from the only one. Rather than health outcomes, our measures are interventions and dollars spent on the treatment of ill health. If the objective is to optimize the health of individuals and the population the focus should be on the promotion and maintenance of good health. But we have only rudimentary measures of health, such as longevity or health-adjusted longevity. The common fee-for-service payment scheme incentivizes interventions, not better health as their outcome. Because a healthy patient would not be a revenue-generating one now for his or her provider, shifting to the right objective would have ramifications throughout the so-called "system."

The transition could start with defining health in much more ambitious terms than the "absence of disease." It should feature multiple dimensions of life's quality and address its physical, mental and social dimensions. Against that definition, measures of health should be developed, the health of individuals and of populations served, both in absolute terms and relative to comparable measures in other jurisdictions. And from those measures it would be but a short step to incentivize the work of the spectrum of healthcare's providers, including physicians, to promote and preserve the health of the people and populations they serve. To be fair, that's the predominant reason why physicians, nurses, and other providers of health and healthcare services entered their professions in the first place.

It would mean also giving public health the prominence it deserves. Perhaps that will be another lasting effect of the COVID-19 pandemic. There remains much to do on that front given that, for example, smoking, alcohol, physical inactivity and obesity account for 36 percent of men's and 27 percent of women's hospital bed-days.[8]

A focus on health would require bringing into alignment and co-ordinating a number of policy fronts that promote health, including the reduction of poverty and strengthening others of the social determinants of health. The current discussion of a Basic or Guaranteed Income illustrates the point.[9] The focus needs to go beyond income support, however, and delve into the fundamental determinants of income and the equality of its distribution. To a large extent that means turning to education and equalizing opportunities for all Canadians. It also means more effective connections across education, training and work.

The vision should be mindful of the numerous reports highlighting the importance of "non-healthcare factors," those so-called social determinants of health. The 2009 Keon/Pepin Senate report, for example, broke down the determinants of health as 25 percent healthcare system, 15 percent biology and organic make-up, 10 percent housing, and 50 percent socio-economic.[10] The latter included early childhood development, education, income and social status, employment and working conditions and culture and gender.

Health and Healthcare Should Finally be "Public Goods"

The pandemic has sharpened attention to the fact that many healthcare services are not in the public domain and how the most vulnerable suffer the consequences. As with the issue of a Basic or Guaranteed Annual

8 https://www150.statcan.gc.ca/n1/daily-quotidien/200305/dq200305a-eng.htm.

9 https://www.cbc.ca/news/canada/manitoba/coronavirus-pandemic-basic-income-1.5552388.

10 https://sencanada.ca/content/sen/committee/402/popu/rep/rephealth1jun09-e.pdf.

Income, discussion of this issue must become more sophisticated; there are choices to be debated. On pharmaceuticals, one option is a "Big Bang" to replace all existing public and private plans; another is to fill the gaps left by those plans. To a considerable degree, those falling through the cracks are the same people most exposed to those in Canada's existing social assistance supports. The core point is that if the over-arching objective is to optimize the health of the population, everybody, rich and poor, secure and vulnerable, advantaged and disadvantaged, must have access to the whole spectrum of healthcare and social services they need to achieve and maintain their good health and well-being. The country has a way to go to achieve that goal! Discussions, led by Canada's governments, should proceed on how best to achieve it.

Health should be Governed and Co-ordinated by Health Teams

Health Teams should be patients' "medical homes" but peoples' health homes. Their services should be co-ordinated and delivered by the appropriate range of personnel and in the appropriate places. In many cases, this means by teams of providers. This too has implications for funding which, together with the incentives and accountability for health, should be provided to and managed by such teams, rather than by individual providers or centrally.

Health Teams should include family doctors, specialists, nurses, physiotherapists, pharmacists, and others as required to meet the needs of the populations served. Consistent with the notion of bringing in various arms of the public sector to promote health, they should also include counsellors and social workers. Their governance must also include representatives of the populations they serve.

For the continuing care of seniors, wherever feasible, the right place is primarily and for as long as possible in their own homes and communities. There is a reason Denmark generally ranks at the top in the care and quality of life for seniors. They have not built a long-term care bed since 1987; those in use since then have decreased by 30 percent. Instead, they have created a co-ordinated system of continuing care based on the home and community, where most seniors say they wish to remain. A lot of care can be provided in peoples' homes and in supportive housing and still be lower cost, with higher satisfaction, than the alternative, the long-term care and retirement facilities so prevalent (and so dangerous for their vulnerable residents) in Canada.

We need governance of a real system of health services that will facilitate the use and accountability of Health Teams and provide them the financial and operational flexibility to meet best the local and/or regional needs of the population each serves.

Strike Down Other Barriers to Health Reform

Expanding "scope of practice" could be an important component of improving the effectiveness and efficiency of health promotion and care. Nurse practitioners could do some of the functions of physicians and so on down the line. Re-examining the scopes of practice of health professionals, however, is often taken off the table when and where it is presented as a thinly disguised attempt to reduce the compensation of physicians. But scopes of practice should, have, and will continue to change in relation to the educational qualifications and practice competencies of the whole spectrum of health professionals. Procedures once the exclusive province of the sub-specialist physician, soon become routine to the specialist and before long equally so to the generalist; that's the way knowledge and experience should evolve. The rate of recompense for its application is an important but very much secondary issue that would be considered as a win-win whereby physician compensation is preserved but shaped in a manner to reward activities where doctors or nurses or pharmacists or others have a comparative advantage.

Clinical Evidence Should Inform Protocols

The base of knowledge underpinning health and healthcare is already vast; it continues to grow faster than the capacity of its providers to remain aware of new developments much less incorporate them uniformly into clinical practice. But the same technologies that, in part, have facilitated that growth of knowledge have also made possible the widespread communication of experience in its application. Most recently, so-called artificial intelligence/machine learning offers the potential to pool the world's knowledge to inform practitioners of the most effective and efficient ways of applying new knowledge to improve every aspect of the human condition.[11] In all health professions, accumulated clinical evidence should be used to establish the relationship between the benefits (outcomes) of all health and healthcare interventions/procedures and extend it to analysis of their cost relative to the benefits produced. Care must be taken to ensure that clinical guidelines and protocols derived from collective experience or imbedded in algorithms remain guidelines and do not evolve into rigid rules or instructions that inhibit clinical judgement and the intuition critical to experimentation. There is evidence to suggest that as much as 20 percent of interventions in healthcare are of no or little value;[12] some 30 percent of medical interventions are reported to be contrary to clinical guidelines and orders for tests unwarranted and potentially dangerous.[13] The application of, and adherence to, sensible clinical guidelines could do much to reconcile continued enhancement of the quality of health and healthcare with the economic realities we face post COVID-19 and beyond.

The Human Resources Approach Needs to be Changed

The vision for the future should also address pressing human resources issues including planning its supply in relation to the need for its services. With the ageing of the population, it is hard to make sense of there being only 304 geriatricians and 471 rheumatologists in all Canada, many of them near retirement. There are 11.7 geriatricians per 100,000 Canadians 75 years of age and over; by contrast, there are 48.8 pediatricians per 100,000 Canadians 15 years of age and under.[14] There is no way Canada could train or import an adequate number of geriatricians based on conventional protocols. Instead, almost all physicians, especially family doctors, will have to adapt in training and in practice, as they have been doing, to orient a great deal of their practices to the care of seniors. And Canada's few specialist geriatricians will become consultant members of Health Teams serving populations with very high proportions of elderly people.

The explosive growth of knowledge in the last century has spawned the growth of specialties and sub-specialties in medicine and to a lesser degree in other health professions. These practitioners' knowledge and experience is narrower but much deeper than those of the generalists who predominate in front-line family medicine/primary care. Training programs (in medicine particularly) are long and

11 Topel, Eric. 2019. *Deep Medicine. How Artificial Intelligence Can Make Healthcare Human Again*. Basic Books, New York.

12 https://www.cdhowe.org/intelligence-memos/rosalie-wyonch-%E2%80%93-low-value-care-and-covid-19.

13 https://www.cihi.ca/en/unnecessary-care-in-canada

14 https://www.cdhowe.org/intelligence-memos/wyonch-drummond-%E2%80%93-caring-elderly-health-human-resource-problem.

it makes sense for society to put in place a robust planning mechanism to match to the maximum extent possible the supply of both generalist and specialist providers of healthcare services to the need for their services so far as that can be predicted in a fast-changing future.

Another pressing human resources issue that must be solved is the desire of many contemporary professionals, both young women and men, to work in ways different than those of their predecessors. Those ways tend more to an employee-type relationship with benefits and membership in a team of providers, rather than as owner-operators of independent businesses, working excessive hours that often lead to 'burn-out.' These desires are positive and align well with needed organizational change to Health Teams, making healthcare more effective and efficient, and the optimization of individual and population health as the systems' very goal.

Address Health of the Indigenous Population

Any vision for the future of health in Canada must also pay greater attention to the needs of Indigenous people. The 2016 Census reported 1,673,785 Indigenous Canadians, 4.9 percent of the total population; with a high birth rate and greater tendency to declare Indigenous heritage, that share could easily rise to 6.1 percent or higher by 2036. Indigenous people on average suffer the worst socio-economic conditions in Canada and suffer poor health. Their life expectancy is 5 to 7 years less than non-Indigenous Canadians; the incidence of tuberculosis on reserve, to cite just one of many examples of ill-health, is 31 times the national average. One-in-four children in First Nations communities lives in poverty, creating the prospect for health outcomes to deteriorate further as the large, young cohort ages.

Many things could and should be done to promote health for Indigenous people, primarily to improve the housing, education, socio-economic conditions and others of the social determinants of health, together with the healthcare services available in their communities. The establishment of Health Teams charged with ordering the priorities that should apply in the communities they serve would be a useful initial step.

Complete Finally the Task of Consolidating Health Information

Despite large expenditures having been spent federally, by Canada's provinces and territories, and by individual and institutional health service providers, health information systems remain fragmented, incomplete, incompatible, unstandardized, and only rarely accessible by the very people to whom the information in them refers. Simply put, their utility for clinical, managerial, planning, or accountability purposes is marginal at best and then only with the expenditure of considerable money and effort to overcome the absence of coherent planning since the beginning to direct their 'willy-nilly' development. Originating several decades ago as the then new technology's status symbol replacement of paper files and the desire of governments, institutions, and individuals to 'do their own thing', reform remains a long way off despite widespread recognition of its need and on-going efforts to achieve it. The Canadian Institute for Health Information[15] was established in 1994 and Canada Health Infoway[16] in 2001 by the

15 https://www.cihi.ca/en/cihi-a-history.

16 https://www.infoway-inforoute.ca/en/about-us.

federal and provincial/territorial governments acting together. Many provinces have also made strenuous efforts independently to foster greater coherence of health information systems to provide the reliable and comprehensive data virtually all enterprises of every kind now depend on totally to operate with the efficiency and effectiveness the modern world requires. The challenge of achieving comparable coherence in health or even the subset of medical information is compounded by the sensitivity of the personal information the records contain and securing its privacy. It is a problem made especially 'wicked' by the fact that many hospitals and other institutions and legions of individual health professionals have grown accustomed to their 'own' systems and don't want to change. Ironically, the principal beneficiaries, the people who pay the bills, and to whom the records refer, remain deprived of access to them! A concerted effort across Canada is necessary to complete cleaning up this long-standing mess. Perhaps the COVID-19 pandemic will be the catalyst to finally make it happen.

A Strong Vision for 2040 Can Be Realized – and Must Be Long Before Then

Healthcare is approaching a critical juncture. Will it follow the path of yesteryears where fiscal expediencies drive a cost-cutting agenda that tramples over outcomes, effectiveness and efficiency? Or will the nation come together and develop a consensus about a more sensible way to promote the health of the population and take better care of vulnerable people in need? For both to win out, health and healthcare's stakeholders must step forward, none of them more credible or with as much at stake as healthcare's providers, the health workforce. It is time they stepped up collectively together with representatives of the people they serve to lead the process of reform.