

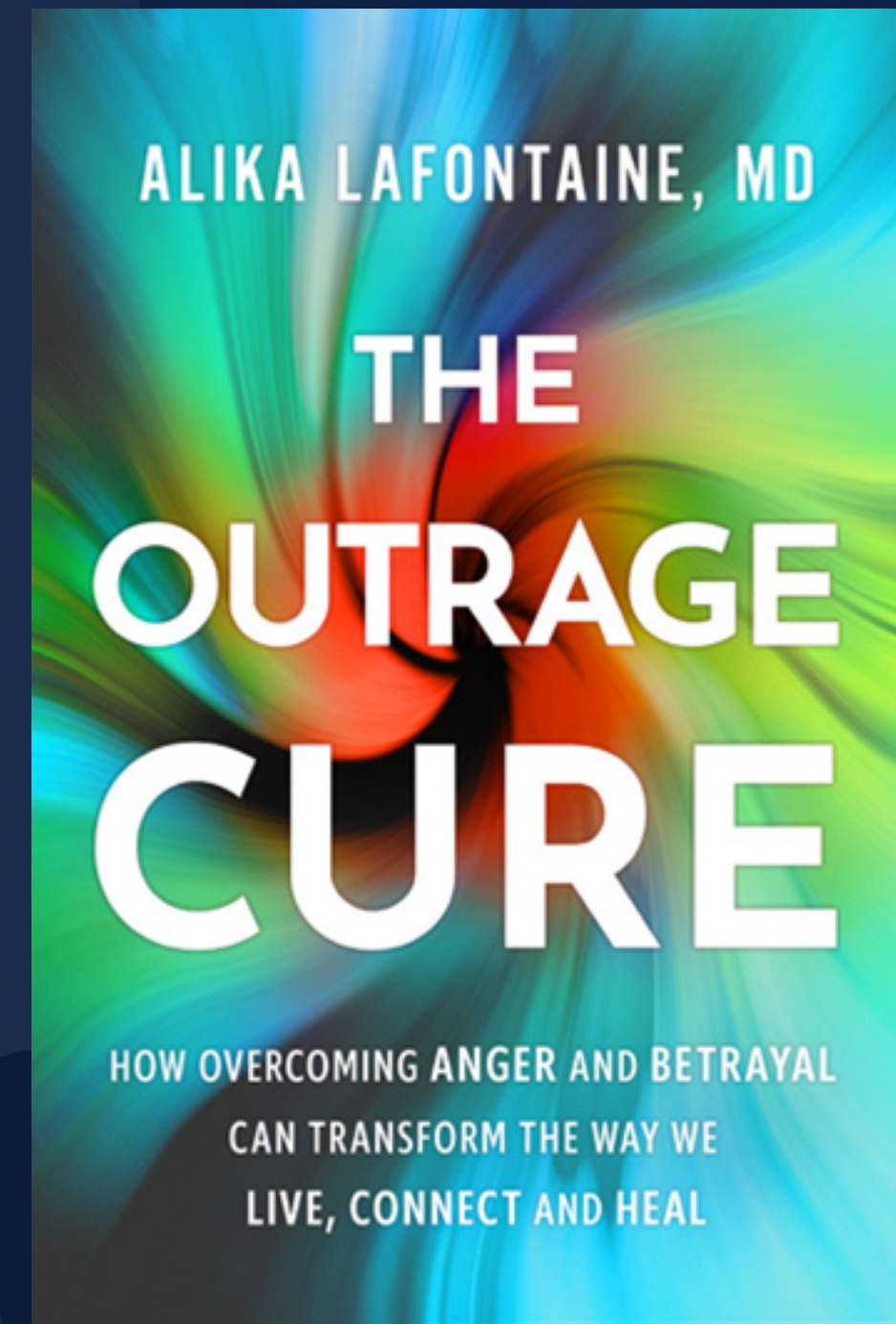
How to Change a Social Contract

Lessons from Reconciliation in an Age
of Health System Upheaval

Alika Lafontaine, MD

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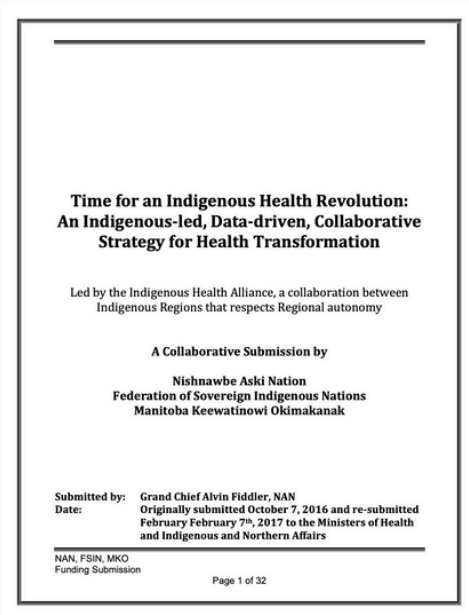
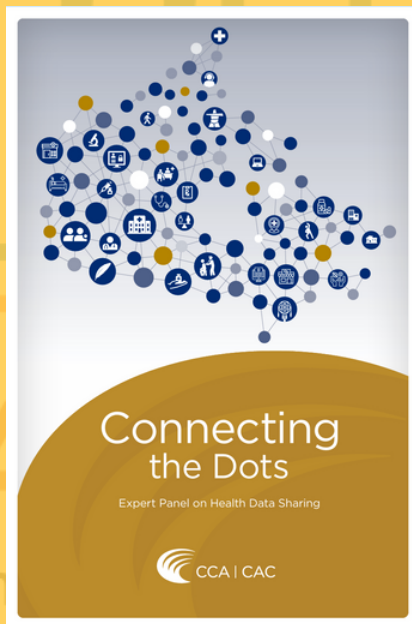
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The Outrage Cure will be published by
Harper-Collins in April 2026 and is
available for pre-order on Amazon

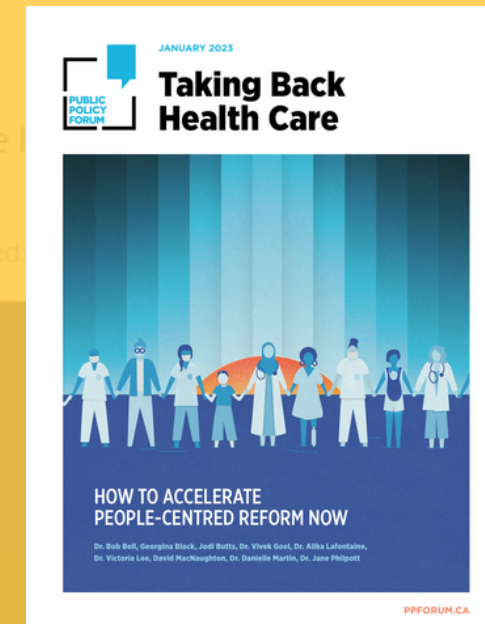


Our future is written in the stories we choose to
believe and **pass on**

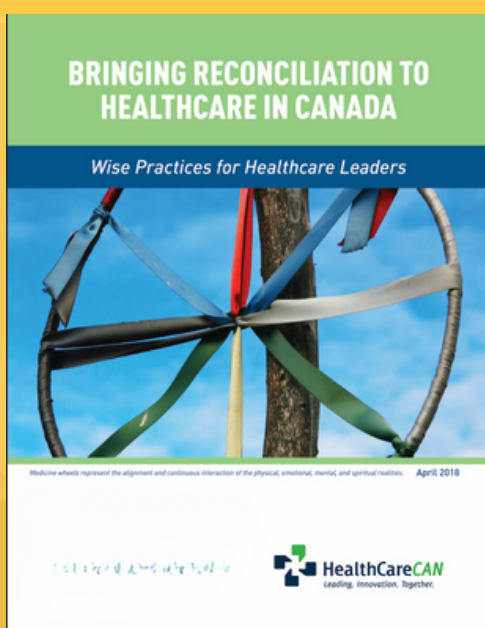


'At one time, I had no voice. At one time, people
Alika Lafontaine

CBC Radio · Posted: Aug 20, 2022 · Last Updated



I've been at the epicentre of observing and creating healthcare stories for 20 yrs

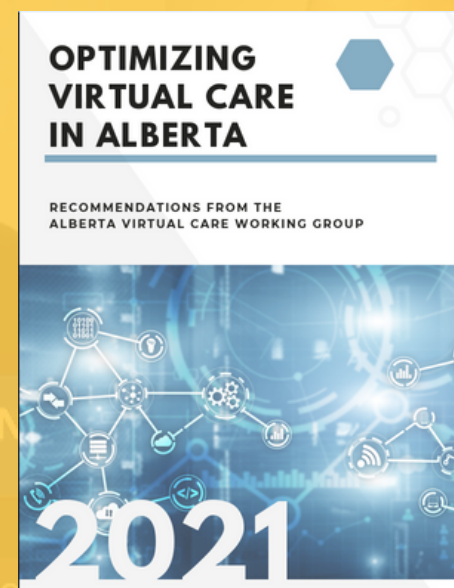


OPINION
A summer of hubris has led Canada's health systems to the verge of collapse

ALIKA LAFONTAINE
CONTRIBUTED TO THE GLOBE AND MAIL

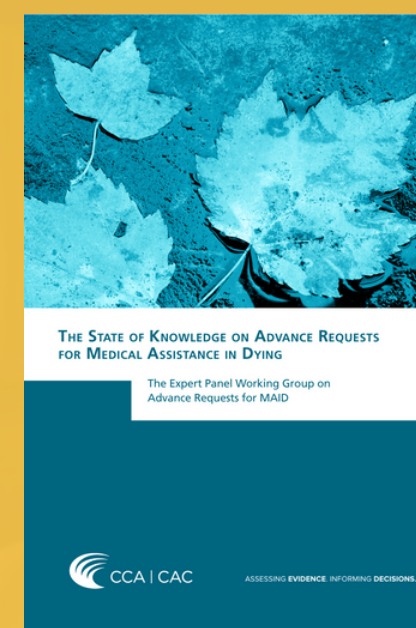


FIRST NATIONS UNIVERSITY OF CANADA
PRESIDENT (2022-2023)



OPINION
Canada's health care system is stuck firmly in the past

ALIKA LAFONTAINE
CONTRIBUTED TO THE GLOBE AND MAIL



CCA | CAC
ASSESSING EVIDENCE. INFORMING DECISIONS.



Dr. Alika Lafontaine

GRANDE PRAIRIE, AB



225+
interviews

4,470+
mentions in media

6.6B+
online impressions



THE NEW REALITY

Dr. Alika Lafontaine: Top doctor on how to fix a health care system in crisis

Posted October 8 2022 08:00am

- *Globe & Mail* - Oct. 29, 2022

"There's stuff at high levels we talked about for years. If we did it, it would transform the way the system works," Dr. Lafontaine said. "We have these conversations and

He was told he'd never graduate. Now this doctor is the CMA's 1st Indigenous president



'At one time, I had no voice. At one time, people looked at me as broken,' says Dr. Alika Lafontaine

CBC Radio - Posted: Aug 20, 2022 5:00 AM ADT | Last Updated: August 20, 2022



DR ALIKA LAFONTAINE
CMA PRESIDENT (2022-2023)

Devalued and dismissed.



optn
face to face

Dr. Alika Lafontaine



GRANDE PRAIRIE, AB



1st Horizon

3rd Horizon

Stories come and go in **patterns**

2nd Horizon



1st Horizon



Weight of
the Past

2nd Horizon



Push of the
Present

3rd Horizon



Pull of the
Future

1st Horizon

Weight of
the Past

The history that a person, organization or system carries with it. It is the inertia to change that exists due to sticky values, ingrained belief systems, legacy programs and infrastructure.

These might include:

- Physical and digital infrastructure
- Cultural beliefs and behaviors
- Systemic constraints

What are Mental Models?

Beliefs that...

...come from personal lived experiences. Over time these get rooted in personal identity.

Beliefs teach us how to act...

...what is desirable, undesirable, acceptable, or unacceptable; these are social norms.

Social norms do not have to be true, logical, adaptive or realistic...

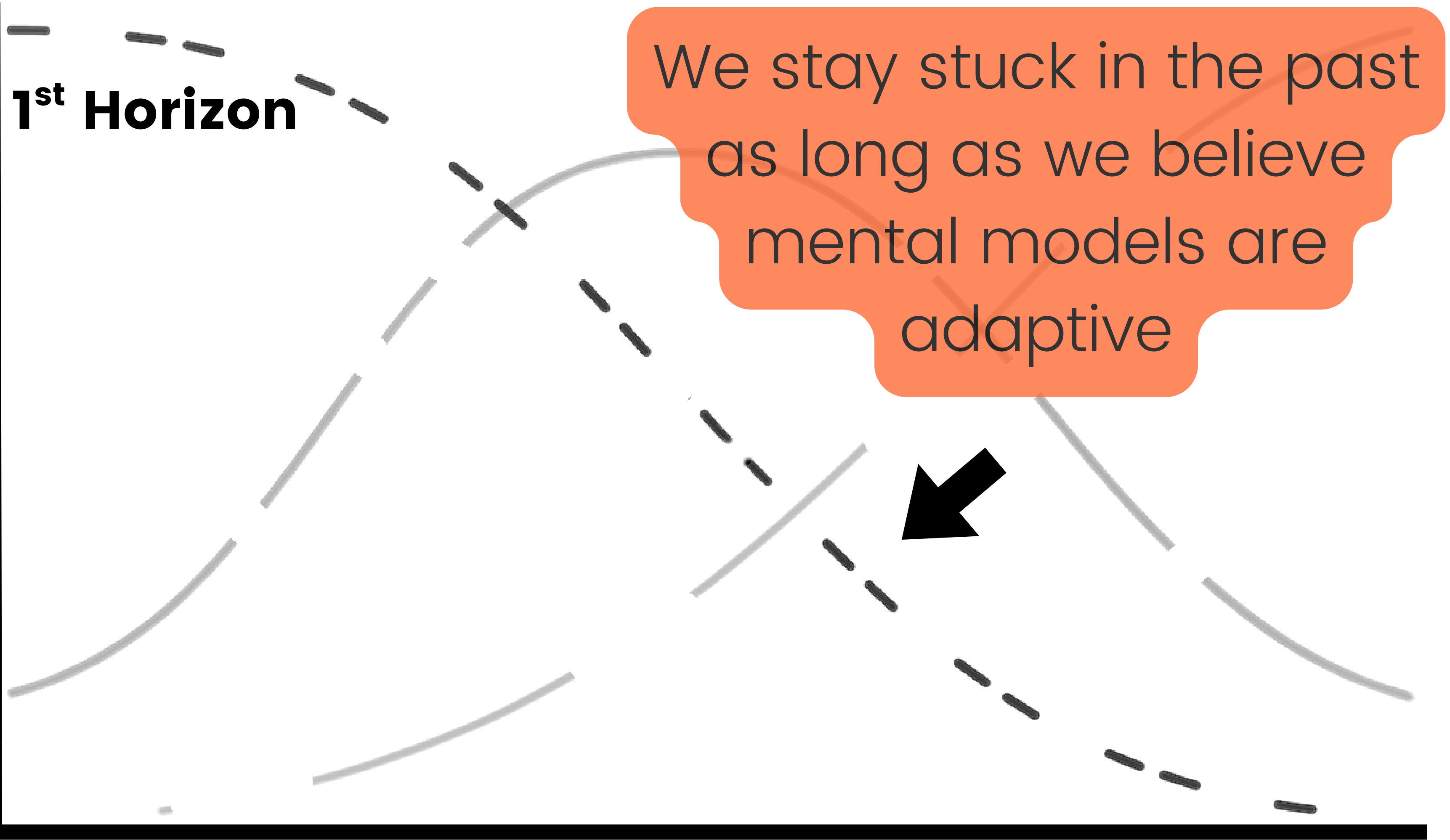
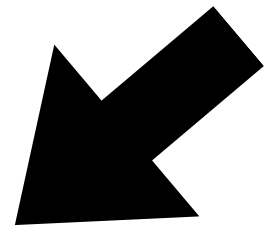
...but they still set our expectations for what comes next.

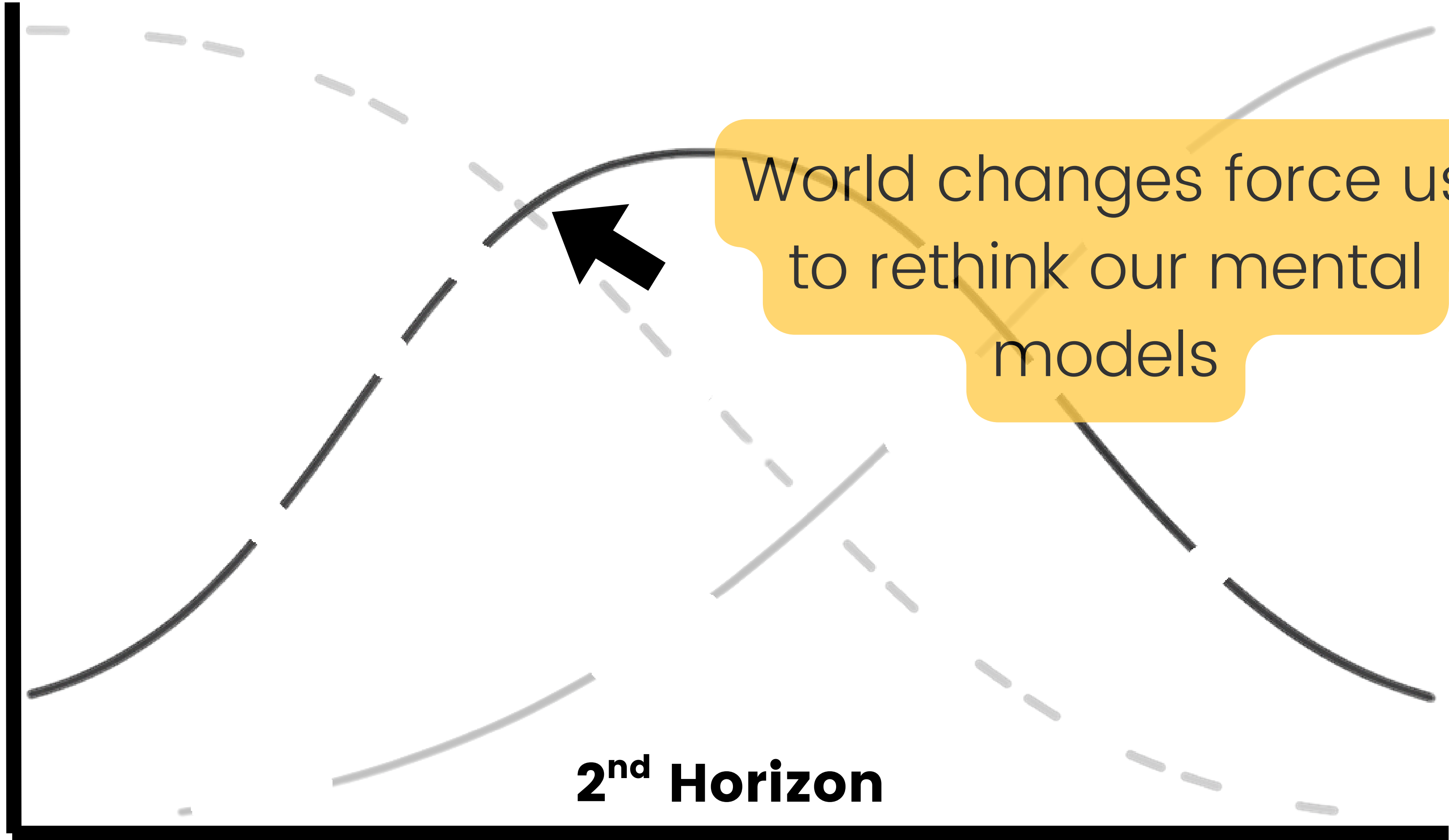
Our expectations are rooted in shared social norms...

...and shared social norms are rooted in our shared beliefs. Change one, you change the other.

1st Horizon

We stay stuck in the past as long as we believe mental models are adaptive





World changes force us
to rethink our mental
models

2nd Horizon

Changes in the world fit into broad categories and include:

- Social drivers
- Technological drivers
- Economic drivers
- Environmental drivers and
- Political drivers

These STEEP factors push us away from the past into an emerging future



2nd Horizon

Across history, STEEP factors have always shaped Canadian Healthcare

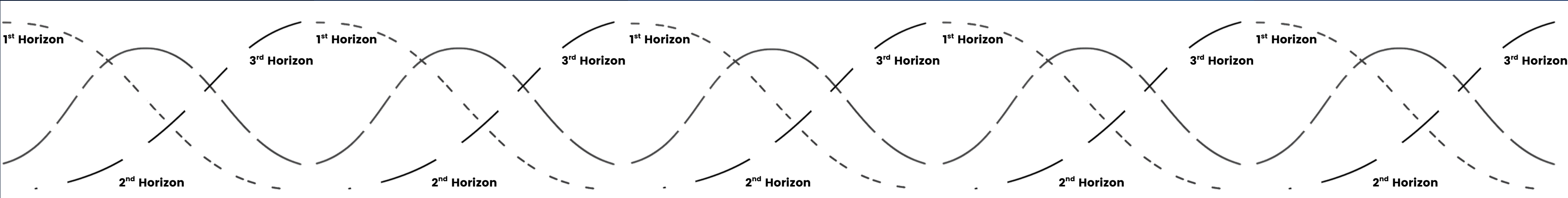
Era 1
Pre-1950s

Era 2
1950s-1970s

Era 3
1970s-1990s

Era 4
1990s-2010s

Era 5
2010s-Present



Era 1: Charity & Out-of-Pocket Care (pre 1950s)

Historical Context

- Health care was private, local, and largely unaffordable
- Most Canadians paid out-of-pocket or relied on charity or company doctors
- Federal Department of Health focused on sanitation, not direct care
- The Great Depression revealed catastrophic gaps in access
- Life expectancy > 60 years; infant mortality ~1 in 10
- Hospitals existed but were not universally accessible

STEEP factors driving change

- Social: class and job determined access
- Technology: House calls, rudimentary diagnostics
- Economic: Widespread poverty, high medical costs, charity care commonplace
- Environmental: Infectious diseases, unsafe work, poor sanitation
- Political: Provinces held jurisdiction, minimal public funding or insurance

State of Primary Care

- Patchwork access, variable availability and accessibility
- Almost 2/3 of Canadians went without care due to inability to pay
- Patients trusted their local providers who lived next door
- Primary care face-to-face and generational
- Trust is high, continuity is solid, but access is exclusionary to those with well paying jobs or high socioeconomic class

Era 2: From Hospitals to Publicly Funded Healthcare (1950s–70s)

Historical Context

- No health, no wealth; gov't had an existential choice
- 1947 Saskatchewan hospital insurance → national by 1961
- 1962 Saskatchewan medical insurance → strike, then success
- 1966 Medical Care Act → national physician coverage by 1971
- Public insurance became part of national identity
- Excluded services: drugs, dental, long-term care

STEEP factors driving change

- Social: wartime solidarity, demand for fairness
- Technology: antibiotics, hospitals, diagnostics proved transformative
- Economic: prosperity, tax base enabled funding
- Environmental: sanitation and vaccines improved survival
- Political: Saskatchewan leadership, federal cost-sharing, national adoption

State of Primary Care

- Hospitals and diagnostics publicly covered, followed by community physician care
- Universal, pan-Canadian coverage of hospitals and doctors
- Primary care remains independent but now publicly funded; care shifts from private access to civic Right
- Trust and continuity are maintained as access is expanded, government maintains a light touch outside of payment

Era 3: Universal Access, Gatekeeping and Cost Control (1970s–90s)

Historical Context

- Patchwork P&L means uneven user fees, extra-billing
- 1984 Canada Health Act bans extra billing and enshrines 5 principles of the Hall Report; public administration, comprehensiveness, universality, portability and accessibility
- Private care is nationalized
- Efforts to bring care to rural/remote communities
- Outcomes: life expectancy improves; infant mortality plummets

STEEP factors driving change

- Social: expectation of equal access solidified
- Technology: imaging, ICUs, chronic care expanded scope
- Economic: spending balloons as demand rises and services nationalized
- Environmental: chronic disease prevention gained ground
- Political: Support for Canada Health Act unanimous across all parties, healthcare becomes a growing cost concern but remains shared burden between Provinces and Feds

State of Primary Care

- Universal coverage stability; family medicine formalized as a profession and social pillar
- Family doctors become gatekeepers to specialists
- Fee-for-service dominates; solo practice remains common
- Pilot reforms—Community Health Centres (ON), CLSCs (QC) and other inconsistently defined team care
- Bureaucracy and cost pressures start to shift focus from the patient-provider to provider-system/patient-system

Era 4: Reform, Cost Focus and the Widget Economy (1990s–10s)

Historical Context

- Deep 1990s budget cuts under the Canada Health and Social Transfer (1996); fiscal crisis leads to waves of reform (lean, six sigma, evidence-based management, scorecards)
- Hospital bed closures; capital projects deferred
- Aggressive Provincial approach to physician compensation
- 2000 & 2004 Health Accords renew funding; “primary care reform” becomes mantra
- Continued care coverage expansion, culture shift to M&T

STEEP factors driving change

- Social: aging populations, rising patient expectations, reframed as consumers vs patients
- Technology: EMRs, data systems, and performance dashboards proliferate
- Economic: Efficiency and accountability dominate; volume prioritized over impact, growing part of Provincial budgets
- Environmental: Wait-times, SARS highlight system vulnerabilities
- Political: Feds step away from cost sharing, Prov chase value for money, managerialism grows

State of Primary Care

- Reform promises reconnection but instead delivers metrics and monitoring
- Team models multiply but relationships thin—care becomes quantifiable, not personal
- Funding rises, but intent narrows: volume > impact, cost > compassion
- Primary care re-engineered into a widget economy; corporate, assembly-line HC grows
- CMA and AMA begin documenting alarming rates of stress, workload dissatisfaction

Era 5: The Social Contract is being Renegotiated (2010s–Today)

Historical Context

- Longest wait times ever; burnout
- Infrastructure gaps exposed (Hospital capacity, LTC, IT systems, infrastructure)
- “Once in a generation” pandemic shock → virtual care 10% → 60% visits
- AI tools enter practice (voice recognition, imaging, triage)
- Healthcare misinformation spreads, corporate interests lean in; health is a “growth” industry
- No longer arms-length, governments now dictate health systems

STEEP factors driving change

- Social: trust eroded by misinformation, MD burnout and low morale, public loses faith in access and continuity
- Technology: Telemedicine and AI scale, data monetized by private intermediaries
- Economic: health at ~11% GDP, deficits, debates on private role, entrenchment of corporate players
- Environmental: COVID shocks, climate threats to infrastructure
- Political: politicization, promise of reform, ideology > pragmatism

State of Primary Care

- Aging population, chronic illness, underinvestment drive high demand
- Waitlists grow, chronic staff shortages and workforce gaps
- Fragmentation at scale; walk-ins, apps, and ERs replace continuity
- Care commodified; physicians treated as interchangeable labor despite clear differences
- Patients gain convenience but lose connection, advocacy and in some cases expertise
- Patients and providers are left to navigate a system hostile to both

Across history, STEEP factors have always shaped Canadian Healthcare

Era 1
Pre-1950s

Local, relational care limited by ability to pay

Era 2
1950s-1970s

Relational care scales with new investments

Era 3
1970s-1990s

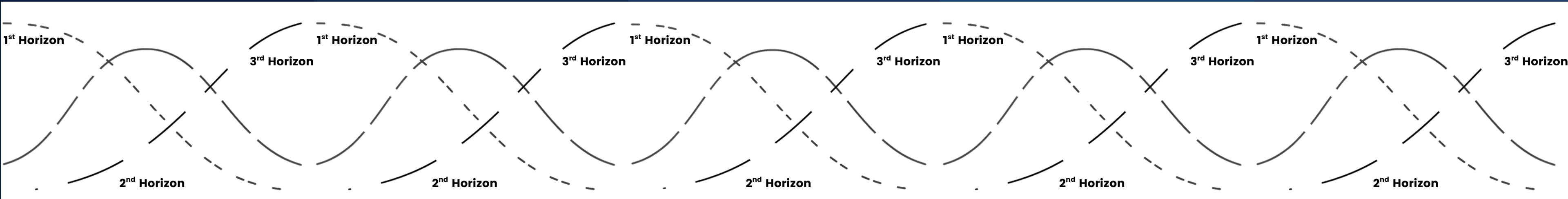
Management paradigm grows but relational care persists

Era 4
1990s-2010s

Managerialism expands and incentivizes transactional care

Era 5
2010s-Present

Transactional medicine and the return of out-of-pocket care



STEEP Factors have also shaped Indigenous Health

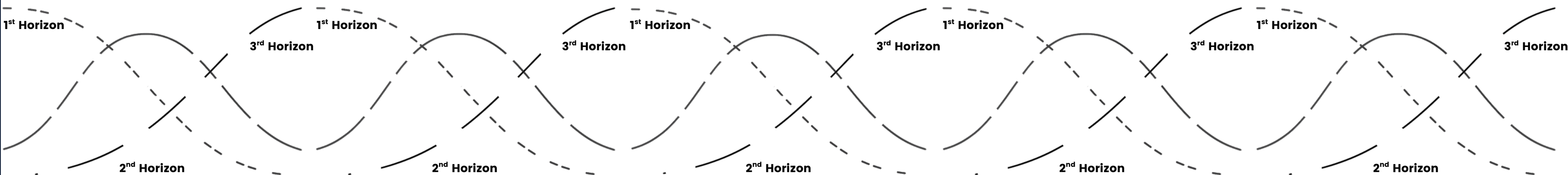
Era 1
Pre-1950s

Era 2
1950s-1970s

Era 3
1970s-1990s

Era 4
1990s-2010s

Era 5
2010s-Present



Era 1 Pre-1950s

Historical Context

- Segregated HC
- Founded on “charity”
- Traditional medicine criminalized
- Epidemics devastate communities, response minimal
- Complicit providers

Unique STEEP Factors

- S: Assimilation policy
- T: Limited use
- E: Manufactured poverty & dependency
- E: Poor sanitation, overcrowding
- P: Indian Act Control

Era 2 1950s-1970s

Historical Context

- Indian Health Service (1945) transferred to Dept. of National Health and Welfare
- Network of 22 Indian hospitals built for TB and chronic illness
- 1951 Indian Act amendments soften restrictions but retain paternal control
- 1969 White Paper proposes ending federal responsibility

Unique STEEP Factors

- S: Intergenerational trauma, growing political resistance
- T: X-rays, antibiotics, experimentation, vaccination
- E: Modest funding increases, status Indians excluded from prov healthcare services
- E: Trickle down advances
- P: Treaty Rights ignored

Era 3 1970s-1990s

Historical Context

- Land claims accelerate in early 1970's
- Political action leads to 1979 Indian Health Policy reform
- “Health Transfer” pilots devolve authority over local programs, still limited
- 1982 Constitution repatriated and s.35 recognizes Aboriginal and treaty rights
- Political action across FNIM

Unique STEEP Factors

- S: Civil-Rights movement
- T: Medevac, nursing stations
- E: Emerging FN managed programs
- E: Resource projects cause both economic help and environmental harm
- P: Shift from assimilation to self-determination

Era 4 1990-2010s

Historical Context

- 1987 Elijah Harper says no to Meech Lake Accords
- 1990 Oka Crisis
- 1991-96 RCAP
- 1996 Nunavut established
- Feds take responsibility for residential schools, provinces for health, land claims
- Residential school class-action, government settlement

Unique STEEP Factors

- S: Cultural revitalization
- T: Telehealth, social cohesion
- E: Funding grows, nation funded HC
- E: Boil water advisories, housing and health crises
- P: Self-government, reconciliation begins to go mainstream

Era 5 2010s-Present

Historical Context

- Truth and Reconciliation Commission (2015) and Calls to Action #18-24
- 2017 Indigenous SC
- First Nations Health Authority (BC) operational; others develop regional models.
- Brian Sinclair, Joyce Echaquan and “In Plain Sight” expose systemic racism

Unique STEEP Factors

- S: Cultural safety, trauma informed, language revival
- T: Virtual care, digital sovereignty
- E: Multi-year block funding
- E: Land-based healing, restoration
- P: UNDRIP, ongoing health devolution, health reconciliation, CMA apology

Comparing Canadian and Indigenous Eras

Era 1
Pre-1950s

Local, relational care limited by ability to pay

Managerialism dominates

Era 2
1950s-1970s

Relational care scales with new investments

Managerialism confronted

Era 3
1970s-1990s

Management paradigm grows but relational care persists

Push-back against transactional care

Era 4
1990-2010s

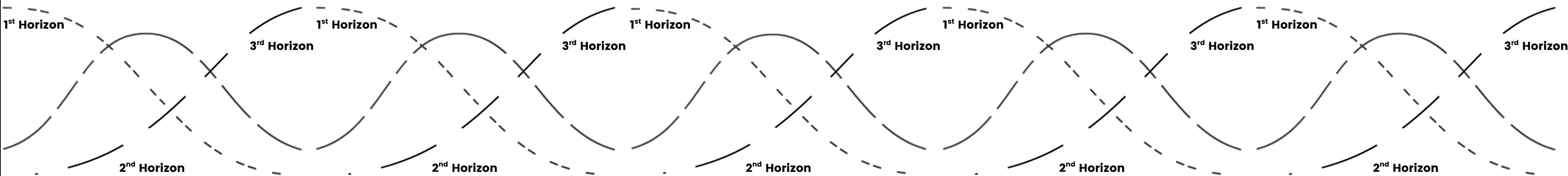
Managerialism expands and incentivizes transactional care

Relational care movement grows

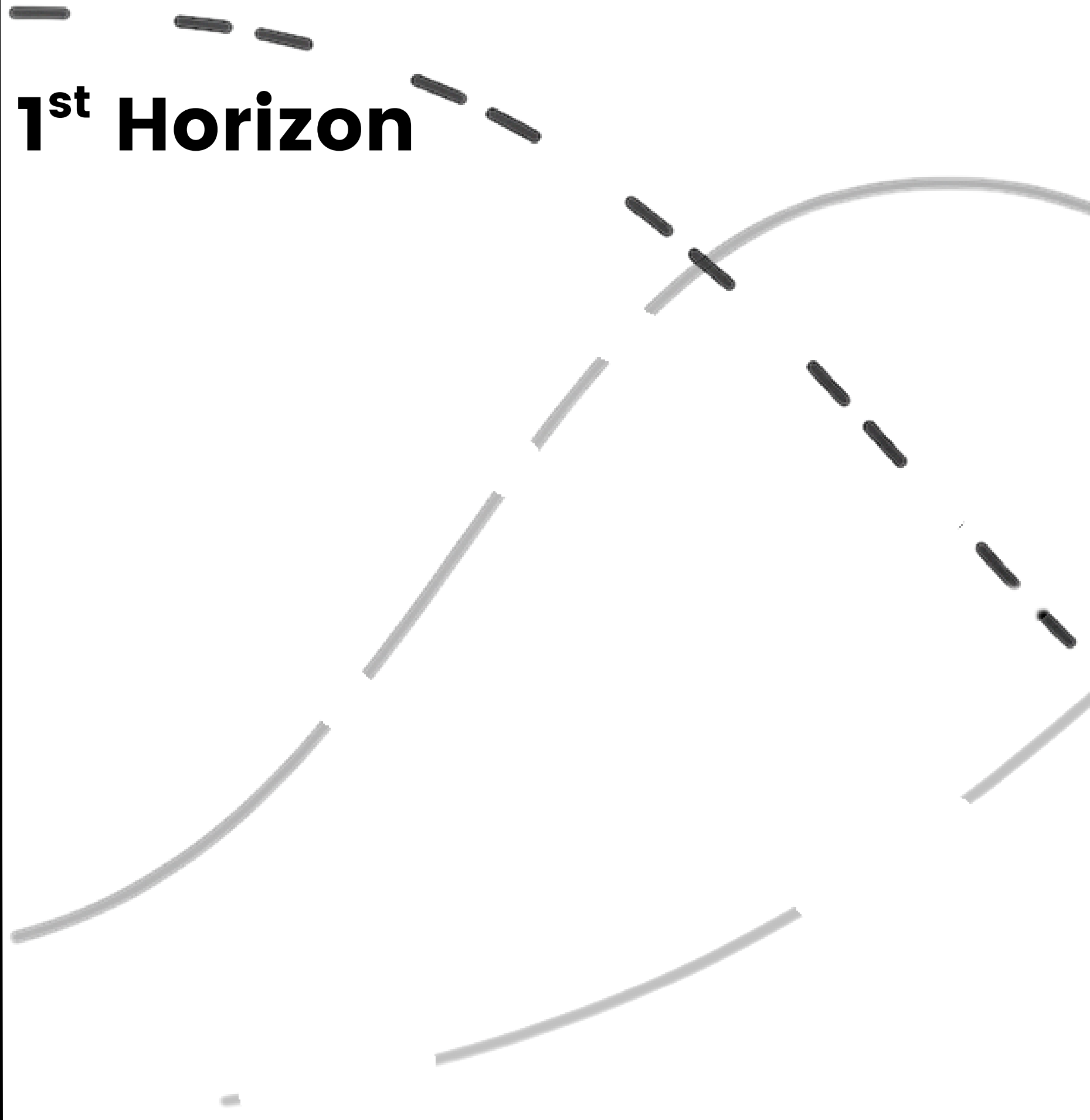
Era 5
2010s-Present

Transactional medicine and the return of out-of-pocket care

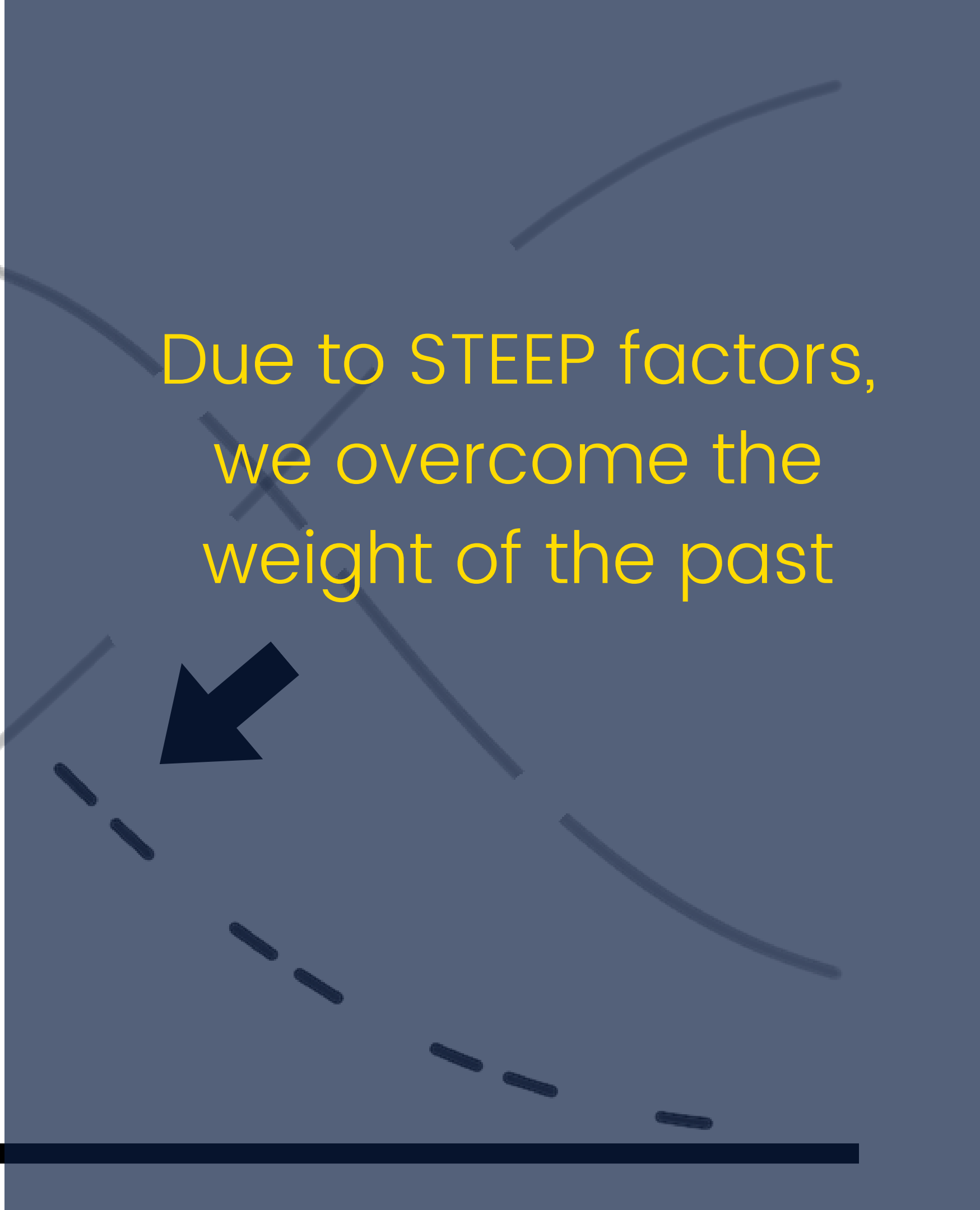
Movement to local, relational care



1st Horizon



Due to STEEP factors,
we overcome the
weight of the past

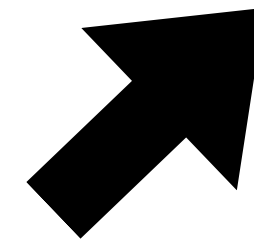


Pushed forward by STEEP factors,
we are forced to find more
adaptive mental models and
reimagining our stories and
social norms

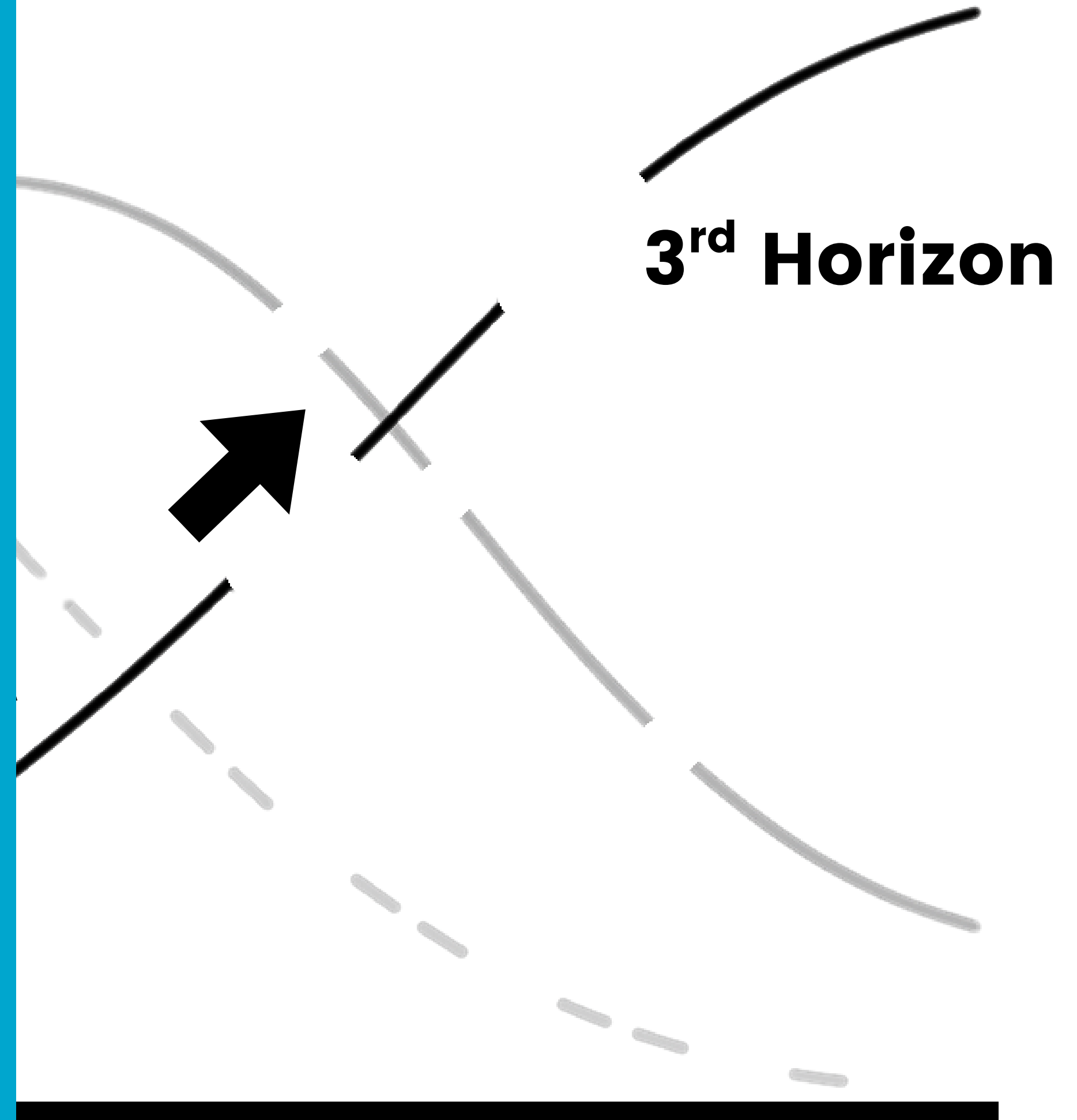
2nd Horizon

Eventually we get
pulled into a new
future

3rd Horizon



The Pull of the Future is determined by the images, stories and ideas we set through our intentions, goals, and plans. They capture our imagination for what lies ahead. Its also determined by what lessons we've learned from the past and what we're willing to exchange for the future.



Lessons from how past Eras shaped both Canadian and Indigenous health systems

- Our current Era is built on how we responded to the crises of the past
- Properly funded relational care is generally more impactful than efficient, transactional care
- How we provide care is more dependent on the systems we work in than our personal intentions
- Canadian healthcare has shifted from relational → transactional, but Indigenous healthcare has shown us a path from transactional → relational

What can I do to change the social contract of healthcare?

Recognize design, not intent, drives behaviour

- Each Era was shaped by STEEP forces, relationships thrived with proximity and trust and declined with scale and control

Redefine what “efficiency” should mean

- Efficiency without empathy created the widget economy of volume over value; Indigenous-led systems consider relational efficiency

We need a movement confronting the managerialism culture of medicine

- Managerialism made care impersonal
- Belonging, continuity and connection should be metrics of success

1st Horizon

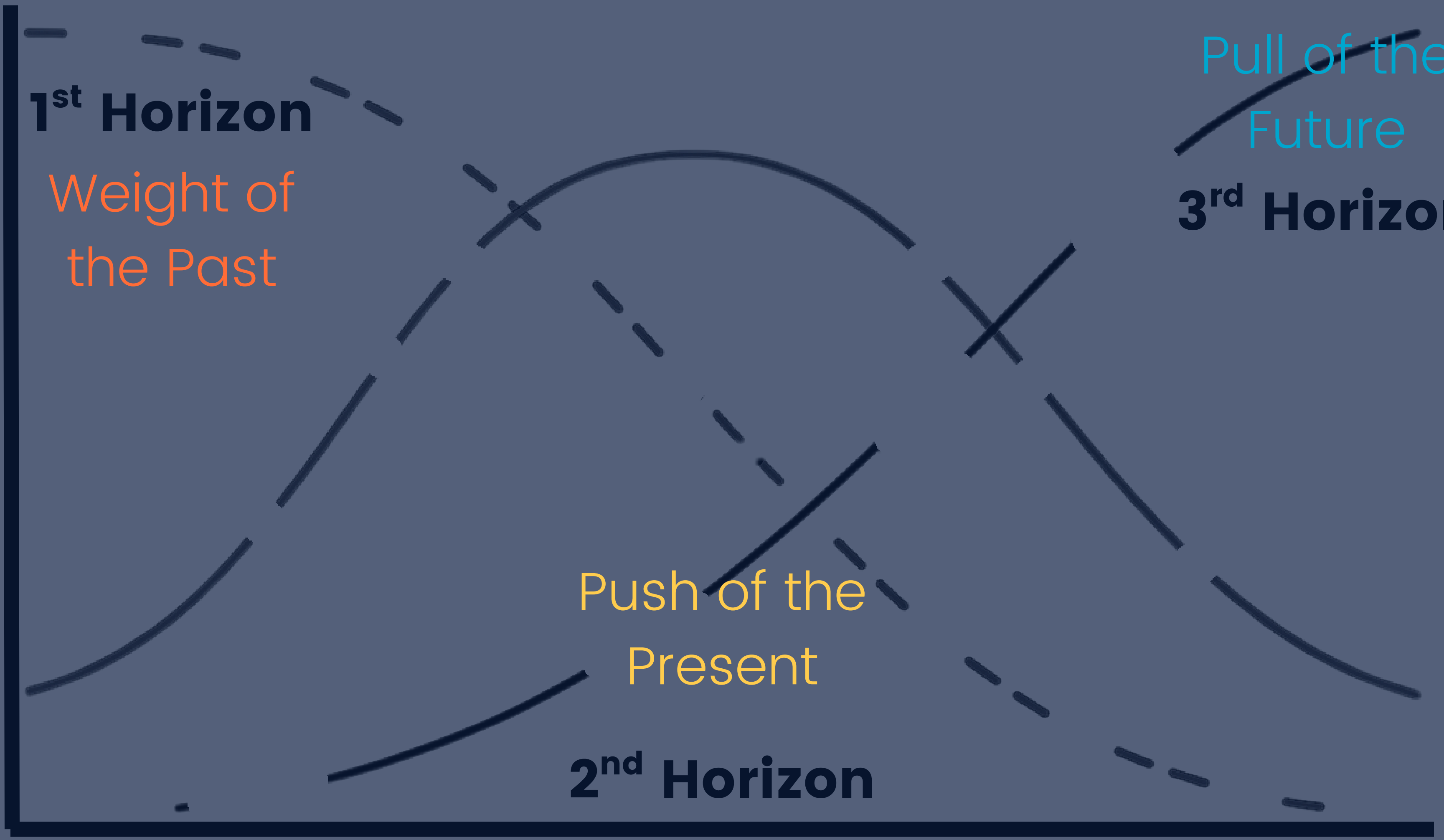
Weight of
the Past

Pull of the
Future

3rd Horizon

Push of the
Present

2nd Horizon



1st Horizon

Weight of
the Past

Pull of the
Future

3rd Horizon

We are here



Push of the
Present

2nd Horizon



We are here

1st Horizon

3rd Horizon

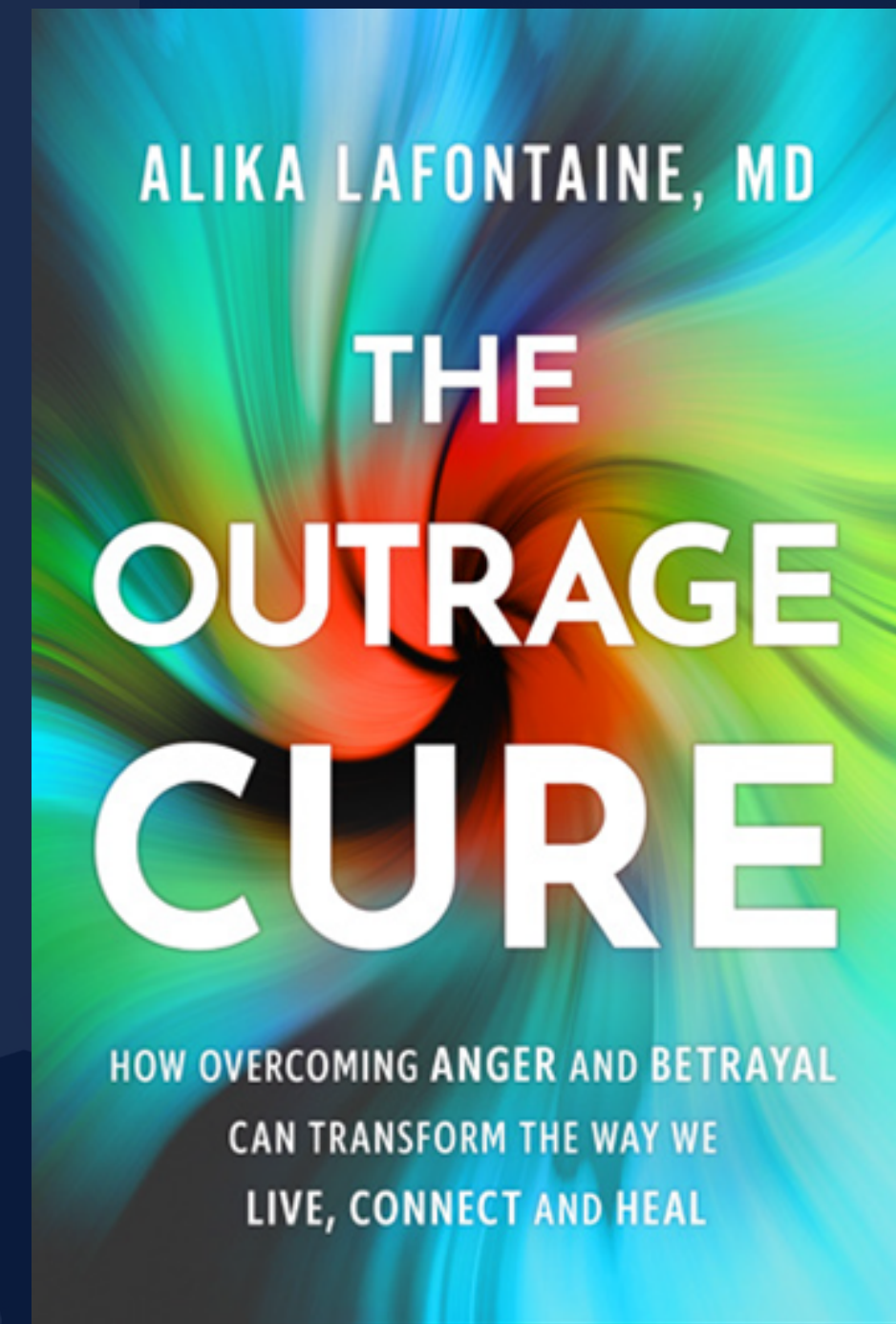
Start where you stand: An emerging social contract is being created right now. There's never been a more important time to show up around the tables of change and its never been more frustrating and difficult. Working together to respond to STEEP drivers is the only way to overcome the weight of the past. Now is not the time for going it alone.

Where the future pulls us will depends on what we're willing to exchange for the future, in the present.

2nd Horizon

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