The development of the First Nations, Inuit and Métis medical workforce

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ABSTRACT

- Indigenous people make up more than 4% of the Canadian population, but less than 0.25% of the physicians.
- National initiatives are being undertaken to increase the representation of First Nations, Inuit, and Métis people in the medical workforce.
- This is a necessary step in developing a health care system that is culturally safe and responsive — one step towards equity in health for First Nations, Inuit, and Métis people.
- Initiatives focus on recruitment and retention of indigenous physicians, and development of a curriculum framework to ensure all physicians can provide culturally safe care.

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There are persistent health disparities between indigenous people in Canada and the Canadian general population. The life expectancy of indigenous people is 5–12 years below the national average, and potential years of life lost due to injuries and suicide are more than five times and three times the national averages, respectively.[1,2] Rates of overweight and obesity, diabetes, arthritis and rheumatism, heart disease, high blood pressure, tuberculosis, and *Chlamydia* infection remain higher than in the non-indigenous population.[2-4] Since the inception of the use of the United Nations Human Development Index, Canada has consistently ranked at or near the top. However, considering only Registered First Nations people living on reserves, in 2001 the calculated Human Development Index would have been 0.765, equivalent to that of Colombia (ranked 62) and below rankings of Mexico, Malaysia, and Romania.[5,6]

Canada has three constitutionally recognised aboriginal peoples: the First Nations, Métis, and Inuit. Of the estimated 1.4 million aboriginal people in Canada, First Nations, Métis and Inuit account for 62%, 30%, and 5%, respectively.[7] The health status of non-registered First Nations, Métis, and Inuit people is largely unknown because of significant gaps in health care datasets; there are also significant limitations to the health status information for Registered First Nations people. For example, in the 2004 Federal Report on Comparable Health Indicators, data for First Nations or Inuit people were only available for five of the 18 health indicators selected.[8] Measures on wait times, timely access, difficulty accessing health services, patient satisfaction, health-adjusted life expectancy, physical activity, and influenza vaccination rates were missing. This hampers the ability of the health system to respond to nationally identified priority areas as they relate to First Nations, Inuit and Métis people.

Physician workforce in Canada

In 2005, there were 61 622 physicians in Canada.[9] The exact number of indigenous physicians is unknown, but estimates range from 100 to 150.[10,11] Hence, aboriginal people make up 4% of the population, but account for less than 0.25% of physicians. In recognition of this under-representation, the 2005 Kelowna Accord — a historic deal signed by the federal government, provincial and territorial governments, and aboriginal leaders — set a target of doubling this number over the next 10 years.[12] This followed the 2004 announcement of C$100 million over 5 years to support an Aboriginal Health Human Resources Initiative, with three areas of focus:

- To increase the number of aboriginal people working in health careers;
- To adapt health care educational curricula to support the development of cultural competencies; and
- To improve the retention of health care workers in aboriginal communities.[13]

Before the recent national endeavours to increase the number of indigenous physicians and the cultural competence of all physicians in Canada, some universities implemented innovative programs to support admission of aboriginal students to, and their successful completion of, medical school. Universities leading the way in this regard include the University of Manitoba,[14] University of Alberta,[15] and University of British Columbia.[16]

National indigenous workforce initiatives

In December 2004, the Association of Faculties of Medicine of Canada (AFMC) formed an Aboriginal Health Task Group (AHTG) to provide recommendations to the deans of medicine that address the health needs of aboriginal peoples.[17] Identified core areas of action were education, research, aboriginal professional training, and community service.

The social accountability of medical schools has been defined by the World Health Organization as "the obligation to direct their education, research and service activities towards addressing priority health concerns of the community, region, and/or nation they have a mandate to serve". The priority health concerns are to be identified jointly by governments, health care organisations, health professionals and the public.[18] The challenge for the AHTG was to relate this to aboriginal communities (in urban, rural, and remote areas) in Canada. In line with government-stated priorities, the AHTG focused on actions that the 17 medical schools could take to increase the number of aboriginal students, and the development of a national aboriginal health curriculum framework.

In recognition of the expertise of First Nations, Inuit and Métis physicians, and the right of indigenous peoples to set priorities and strategies for health programs affecting their communities,[19] in March 2006 the Indigenous Physicians Association of Canada (IPAC) signed an agreement with the AFMC to jointly lead all further aboriginal health initiatives undertaken by the medical schools.[20] Two subcommittees of the AHTG were formed, one to focus on recruitment and retention of First Nations, Métis and Inuit medical students, and the other to focus on developing the curriculum framework.

The Recruitment and Retention Subcommittee is developing strategic plans and priorities to increase the number of self-

identified First Nations, Inuit and Métis physicians in Canada.[21] This involves national collaboration with aboriginal representatives, institutes of higher learning, holders of traditional indigenous knowledge, aboriginal physicians, and medical learners.

The challenges facing many First Nations, Inuit and Métis people require a strategy that focuses on community-level supports for adequate educational preparation for university-level learning, early exposure programs for young students at the elementary, middle and high school levels, and collaboration with aboriginal and non-aboriginal organisations, governments, elders and educators. Evaluation will ensure proper monitoring of retention and recruitment, with a 3-year work plan currently being developed.

Complementary initiatives undertaken by several organisations include scholarship and bursary support (administered by the National Aboriginal Achievement Foundation), and recruiting campaigns, including Health Careers in the Classroom (National Aboriginal Achievement Foundation)[22] and the Role Model Program of the National Aboriginal Health Organization (NAHO). NAHO has also undertaken an environmental scan of health careers education and training opportunities, and the report is available on their website.[23]

On the other front, the AFMC–IPAC AHTG, along with the Aboriginal Health Curriculum Subcommittee, is developing a national aboriginal health curriculum framework for implementation at all 17 medical schools in Canada to ensure that current and future physicians can provide culturally safe health care to aboriginal peoples.

The 1996 Royal Commission on Aboriginal Peoples highlighted that First Nations, Inuit and Métis peoples of Canada wanted culturally relevant and meaningful health care and to enjoy the same health status as other Canadians.[24] Training more self-identified aboriginal physicians and influencing the education of non-aboriginal physicians are two important steps in creating a culturally safe and responsive health care system for aboriginal peoples in Canada.

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Competing interests

None identified.

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