

## **Commentary on training Aboriginal health professionals in Canada**

*Malcolm King, PhD, University of Alberta, Edmonton, AB*

Canada falls far short of any goal of equity when it comes to educating health professionals from the Aboriginal community. The Royal Commission on Aboriginal Peoples in its 1996 report to Parliament recommended that 10,000 Aboriginal health professionals were needed to provide for the health needs of our people. The numbers of Aboriginal health professionals at that time, and even now fall far short of this recommended target. There are well-defined benefits to having Aboriginal health professionals deliver health services to Aboriginal people, such as cultural sensitivity and retention, and probably many more less tangible benefits. The purpose of this paper is not to address the needs issues, but the more practical issues of costs and responsibility.

How to achieve this goal of educating 10,000 Aboriginal health professionals? Which health professionals? How much would it cost? Would it exacerbate the strain on the system for the non-Aboriginal population? Who is responsible? The Government of Canada acknowledged its responsibility on September 12, 2004, by announcing \$700M additional funding for Aboriginal health, including \$100M for human health resources development. Is this funding sufficient to achieve the desired results, i.e. improved health for Aboriginal Canadians. Is the goal actually to eliminate the disparity in health, and not just narrow it?

I would like to mainly address the issue of human health capacity development, a topic I have been dealing with during my 12 years as Chair of the Aboriginal Health Care Careers Committee of the University of Alberta Faculty of Medicine and Dentistry. Let's take an example, and I will use round numbers. Let's say a province has 100,000 First Nations and Inuit people (*this ignores the Métis and non-status, and more will be said about that later*). In the general population, there is about one doctor per 500 people. That means there should be about 200 FNI doctors per 100,000, if equity is to be achieved.

It costs about \$50,000 per annum to educate a medical doctor (\$52,000 - *Univ of Alberta*). Over 4 years of medical school, that means \$200,000. This ignores residency training, where although there are additional costs, the resident doctors also contribute to the medical economy. To educate 200 doctors at \$200,000 each takes \$40,000,000. Across Canada, the cost would be 8 times this, or \$320,000,000, based on a total FNI population of 800,000. This is the expenditure needed to achieve equity over a generation (20-25 years – *here I depart from the urgency of RCAP*). Let's say for the sake of round numbers \$12,000,000 per year, i.e. \$60M over 5 years. Add in similar numbers to include the Métis and non-status population, and the 5-year cost goes up to about \$80 million.

Are we starting from scratch? Not really, but not far from it. There may be 150 or 200 Aboriginal MDs in Canada, most of them recent graduates (*e.g. the University of Alberta has graduated 33 Aboriginal MDs and 8 dentists since 1993*), but most universities in Canada, particularly in the East, have graduated very few over their history. Another way to look at it is based on the percentage of Aboriginal Canadians to the total population – purely an equity basis. If 3% of the population of Canada is Aboriginal, then 3% of the 60,000 physicians (*57,000 in 2003-04: CMA*) in Canada should be Aboriginal. This amounts to some 1,800 Aboriginal MDs. To educate an additional 1,600 over the next 20 years (*400 in 5 years*) would require an additional investment of \$16 million per year, based on the above reasoning. In other words, by these simple estimates, just to educate Aboriginal medical doctors will require an investment of about \$80 million over a 5-year period.

Of course, health service delivery needs much more than just physicians. Nurses and nurse-practitioners are the real front-line workers in the health system: There are more than 120,000

registered nurses in Canada (*CNA website*). How many of these are Aboriginal? This is not known, since it is based on self-identification; maybe 800? Certainly not the 3000-4000 one might expect, just based on population percentage. It costs substantially less to educate a nurse than a doctor – about \$13,500 per year or \$54,000 over a 4-year program (*Univ of Alberta*), so this is good value from a health care economic point of view. Training 3000 additional nurses would require an additional \$160 million over 20 years or about \$40M for 5 years. Educating Aboriginal nurses and doctors then requires an additional investment of \$120 million over 5 years. This already takes up more than the total of \$100 million offered for human health capacity development.

What about the other health professions? Physiotherapists? Pharmacists? Dietitians? Dentists? Midwives?... These will add substantially to the totals, perhaps doubling the combined numbers of physicians and nurses, and it is easy to see how the figure of 10,000 health professionals was achieved. The total cost of the professional education of these Aboriginal people is hard to estimate, but let's say for the sake of argument that it increases the total 5-year investment to \$180 million. These figures do not necessarily make provision for recruitment and retention programs to support Aboriginal students. The University of Alberta has had the benefit of a full time coordinator for its Aboriginal Health Care Careers program for 15 years, carried for several years out of the Faculty's own resources. This has been a crucial factor in our success. Across Canada, support programs for Aboriginal health students would probably add another \$10-15M over 5 years. The other point to make is that these special programs should be supernumerary in nature, so as to not take away from the health professional opportunities of non-Aboriginal Canadians, which is why it's an extra cost at all. Given the current and projected shortage of doctors and nurses in Canada, these extra training opportunities can only help to relieve some of the pressure on the health system.

Is this all that it will take? Unfortunately, no. Even now, the limiting factor in recruiting Aboriginal students into health professional programs is the lack of suitably qualified graduates of science programs. The University of Alberta recruits nationally, and each year we receive applications from 15-20 Aboriginal students, and perhaps 10-12 of these turn out to be qualified to enter medical school. About 5 of these enter the U of A program; some of the rest going to other universities, but usually two or three qualified applicants are turned away for the lack of positions. However, based on our enquiries, we believe that there are not currently 80 qualified Aboriginal applicants per year in Canada. This means that we need to put resources into increasing undergraduate science enrollment from Aboriginal communities. This in turn requires additional resources to be put into promoting science and health education in high schools and junior high schools, particularly in on-reserve schools. What is the cost of this? A big unknown, but probably at least as much as the \$190 million estimated above. The benefit, of course, would be that better science and health education in our schools would also promote health, and work towards achieving our fundamental goal of improving the health of our people.

The other aspect of the September 12 announcement was the provision of more culturally appropriate education to the 97% of health professionals who are not Aboriginal, since most health professionals in Canada will have at least some contact with Aboriginal clients. The division of the \$100 million was not announced, but funding for this part of health professional education cannot be put aside either, since better training for health professionals would improve the appropriate access to health services for Aboriginal people. Even if our equity goals are achieved, we cannot expect that Aboriginal people will always receive health services from Aboriginal professionals.

What is the right mix of Aboriginal health professionals? This needs a study of its own, since it involves the development of new models for health service delivery, another component of the announced new funding. Should we include Community Health Representatives / Workers in the

mix. This group of Aboriginal health professionals – some 1000 currently (*NIICHO report*) – provide community-based health promotion, and serve as an important link with the mainstream health professionals. What about traditional medicine and traditional healing. Should this be part of the health care mix? and should the practitioners be counted among the health professionals? Perhaps these are questions to be included in the discussion of the health promotion portion of the funding.

In the nation as a whole, the government receives its payback in the form of taxes over the working life of a doctor. Should the government expect a payback from FNI doctors? For those working on reserves, where income (part or whole) is tax-free, is it a legitimate goal of government to expect a payback of the cost of education? Could there be programs to reduce this requirement, as there are for doctors relocating to other underserved communities or regions. The bigger payback for governments, of course, is not through recouping the cost of education, but the reduced cost of providing health services to a healthier population. One of the unknown costs of not having Aboriginal doctors and nurses is the cost of ill health among Aboriginal people caused by misunderstanding and miscommunication with non-Aboriginal personnel.

There are a number of questions raised in this brief paper, and many more that could have been raised. As the additional programming is rolled out, it is important that we examine what is needed and what we are doing on the basis of knowledge. It is important to provide for evidence-based research to support this process. Canada has made recent advances in Aboriginal health research through the CIHR Institute of Aboriginal Health Research. We should take advantage of the available capacity in this area, and foster a research culture to go along with the program delivery.

Whose responsibility is all of this? Clearly the Federal government has not provided all the resources required to accomplish the task. As in most aspects, it appears that the Government of Canada is expecting partnerships to provide the rest of what is needed. However, they are to be commended for beginning to address the process in a very substantial way, although it should have begun much earlier. Who are the other partners? The provincial and territorial governments have to be partners. Not all Registered Indians live on reserves, or even near reserves. The academic industry have to be partners. The Association of Canadian Medical Colleges (ACMC) have indicated they have a Social Responsibility (*2003 conference*). Surely with this statement, they cannot expect governments to fully subsidize the cost of educating Aboriginal health professionals and providing culturally appropriate health education to non-Aboriginal trainees. This is not a cost-recovery business. Finally, the Aboriginal communities and their organizations must be partners in this process. No amount of funding will close the gap in health status of Aboriginal peoples without their active participation in their health. Aboriginal people and their organizations must be willing to step up to the plate and work with governments and academia to address the health issues facing our peoples.

What about sustainability? In my view, equity once achieved is self-sustainable. Education, employment and income are the major social determinants of health. Doctors beget doctors; doctors inspire other people around them to become doctors. That's the normal process. This is a one-time investment over a generation to create a new culture. Let's do it right. Let's make the investment.

Malcolm King, PhD, FCCP  
Mississaugas of the New Credit First Nation  
Professor of Medicine, University of Alberta  
Chair, Faculty of Medicine and Dentistry Aboriginal Health Care Careers Committee  
Principal Investigator, Alberta ACADRE Network for Aboriginal Health Research Training