National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
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Aboriginal Health Human Resources
"A Pillar for the Future"

A Discussion Paper for the

International Network for Indigenous

Health Knowledge and Development Forum

Townsville, Australia
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INTRODUCTION

"We need to involve our own people, in our own way with our own human resources." (G. Manyfingers ~ Royal Commission on Aboriginal Peoples, 1996)

As Indigenous Peoples work towards the improvement of their overall health status, health human resource capacity becomes an important issue to consider. The importance of health human resource (HHR) planning is captured in the World Health Organization's (WHO) position that "human resources, the different kinds of clinical and non-clinical staff who make each individual and public health intervention happen as the most important of the health systems inputs."[1] WHO reports that work is underway to increase the evidence base to strengthen human resources capacity.[2]

This paper presents an overview of health human resource issues and initiatives for both the general Canadian population and Aboriginal Peoples. The purpose of this paper is to provide a springboard for discussion at the International Network for Indigenous Health Knowledge and Development Forum which is being held in Townsville, Australia, October 2 to 6, 2003. A brief review of the national HHR picture serves to provide the context of health human resource issues in the general Canadian population. The Aboriginal picture follows with a description of issues and areas where further inquiry is indicated. A focused literature search for national level activities was undertaken within the scope of a limited timeframe. It is acknowledged that the area of HHR literature is extensive. In addition, there are many provincial and territorial initiatives underway however the focus here is on national level projects. It is intended that our respected colleagues at the Forum will contribute to expansion on the identification of issues, solutions and strategies.

BACKGROUND – HEALTH HUMAN RESOURCES PLANNING FOR ABORIGINAL PEOPLES

A recent Canadian Senate Committee report acknowledges that "addressing the supply of professionals in all health care disciplines and finding ways to increase their individual and collective productivity are two of the most pressing yet complex problems facing health care policy makers."[3]

In 2000, Canada's total Aboriginal population was estimated at 1,398,400 and comprised: Status Indians on reserve 28.5 per cent , Status Indians off-reserve

[1] WHO Department of Health Service Provision, World Health Organization www.who.int/health-services-delivery/human/index.htm
[2] Ibid.
[3] Standing Senate Committee on Social Affairs, Science and Technology (SSCSAST) (2002) *The Health of Canadians – The Federal Role: final report on the state of the health care system in Canada*, 185

20.8 per cent; Non-Status Indians 30.6 per cent , Métis 15.6 per cent; and Inuit 4.5 per cent.[4] It is well cited that there is a wide disparity between the health status of Canada's Aboriginal population and the rest of the country. Lower life expectancies, higher infant mortality rates and higher rates of some chronic illnesses evidence this.[5] Two important factors to consider related to addressing the health care issues of Aboriginal peoples are the overall rapid growth rate; that they are younger on average than Canada's general population and that there is a broad diversity of cultures, languages, geographic location and community size.[6]

The 1996 *Report of the Royal Commission on Aboriginal Peoples* (RCAP) identifies the development of Aboriginal HHR as essential to ensure the success of new approaches to health and healing.[7] The report states that "more services, if imposed by outside agencies, will not lead to the desired (health) outcomes."[8] A new approach to improving Aboriginal health was articulated in RCAP that identified the characteristics of equity, holism, Aboriginal control and diversity. This approach was espoused as having the power to do what the present system cannot; to focus on whole health and to breakdown restrictive program boundaries to focus on healing.[9] In addition, recommendations for an Aboriginal health and healing strategy calling for the mobilization and training of Aboriginal personnel is supported by the rationale that "Aboriginal control of human services is necessary because control over one's situation is a major determinant of health."[10]

To that end, RCAP recommended that governments and educational institutions undertake to train 10,000 Aboriginal people in health including professional and managerial roles, over the next decade.[11] An important element in achieving this goal will be to undertake the collection of data, which will support the development of Aboriginal human resources. RCAP acknowledged that the absence of this vital information is an obstacle to planning.[12]

In addition, the National Aboriginal Health Organization (NAHO) recently conducted a poll of 1,209 First Nations across the country and 801 Métis in Ontario, Saskatchewan and British Columbia. Forty-three per cent of First Nations respondents said they prefer to visit an Aboriginal health care provider to

[4] SSCSAST (2002) *The Health of Canadians – The Federal Role: Interim Report Volume Two: Current Trends and Future Challenges,* 57
[5] Ibid. 61
[6] Ibid. 58, 57
[7] Report of the Royal Commission on Aboriginal Peoples, (RCAP) (1996) Volume 3, *Gathering Strength,* 260
[8] Ibid. 293
[9] Ibid. 229
[10] Ibid. 232
[11] Ibid. 265
[12] Ibid. 267

a non-Aboriginal health care provider; only 29 per cent had no preference.[13] The findings in this preliminary report support the supposition that Aboriginal peoples may access services from their own people more readily, may be more compliant with health promotion and prevention interventions and therefore improve their health outcomes.

It is important to examine Aboriginal health human resources within the broader national context as federal and provincial/territorial initiatives usually append Aboriginal specific recommendations or planning to mainstream initiatives. In addition, various Aboriginal health care workers are bound by their provincial/territorial governing bodies and therefore Aboriginal planning strategies will need to work collaboratively with various stakeholders to successfully implement health systems reform.

CANADIAN HEALTH HUMAN RESOURCES – WHAT WE KNOW

THE NATIONAL PICTURE

The current shortage of various health care providers in Canada is well documented. The Commission on the Future of Health Care in Canada chaired by the Honourable Roy Romanow and the Senate Standing Committee on Social Affairs, Science and Technology chaired by the Honourable Michael J.L. Kirby are two recent federal government reports which reiterate RCAP's recommendation to increase the supply of professionals in all health care disciplines.[14][15]

The nursing profession in Canada is considered to be in crisis.[16] Canada currently has three regulated nursing professions: Registered Nurses (RNs), Licensed Practical Nurses and Registered Psychiatric Nurses. These three groups combined account for more than half of all health care workers in Canada.[17]

The Kirby Committee report also supports the Canadian Nurses Association's projections that "there will be a shortage of 78,000 RNs in 2011 and 113,000 RNs by 2016";[18] the number of registered nurses in Canada has dropped by about eight per cent in the last nine years alone, and licensed practical nurses by

[13] First Nations Centre, National Aboriginal Health Organization, (NAHO) (2003) *Public Opinion Poll First Nations Views on Their Health and Health Care,* (Preliminary results)
[14] SSCSAST,185
[15] Commission on the Future of Health Care in Canada, (2002) *Building on Values: The Future on Health Care in Canada,*104
[16] Human Resources Development Canada (HRDC) (2002) *Building The Future – An Integrated Strategy for Nursing Human Resources in Canada*, www.buildingthefuture.ca/e/nursing
[17] Ibid.
[18] SSCSAST, Final Report, 187

as much as 21per cent.[19] Issues reported as common to the three groups include: ageing workforce, retention and recruitment issues, stress and work overload, safe and healthy work environments, and high attrition rates.[20]

The national picture for the supply of physicians indicates that the number of physicians increased from 54,918 in 1996 to 57,803 in 2000.[21] However, despite an overall increase in the number of specialists, some specialties are still experiencing shortages and the number of family doctors increased only by 3.2 per cent, indicating that the availability of family physicians on a per capita basis has declined slightly.[22] In a 2002 Canadian Institute for Health Information report, it is noted that physician supply in Canada peaked in 1993 and has suffered a five per cent decline since then, bringing the ratio of physicians to population down to the level it was 15 years ago.[23] Similarly, physician supply is also affected by factors such as age, specialty, clinical demands, community needs and size, place of graduation, workloads, and gender.[24] Shortages in rural and remote areas are of particular concern and the Kirby Committee reports "the number of physicians serving this population is proportionately under half of that serving those in the cities."[25]

The Kirby Committee report also acknowledges that the human resource shortage is not limited to doctors and nurses. Over 20 disciplines are reported as experiencing shortages. Romanow cites workplace issues, scope of practice and the impact of changing ways of delivering service as issues affecting other health care providers.[26]

ABORIGINAL HEALTH HUMAN RESOURCES – WHAT WE KNOW

The current status of Aboriginal HHR is clearly articulated in RCAP. There is very little information available regarding the number of Aboriginal health care professionals. The RCAP confirmed that there is "significant and widespread under-representation." In 1993, there were about 40 Aboriginal physicians and 22 Aboriginal students enrolled in medical school. The Native Physicians Association of Canada has reported 51 self-identified Aboriginal physicians. Whereas the estimated ratio of Aboriginal physicians to Aboriginal population was approximately 1:33,000, the mainstream ratio was reported as being 1:515. The disciplines of nursing, dietetics and dentistry registered numbers were also consistent with serious under-representation.[27] The Aboriginal Nurses Association of Canada (A.N.A.C.) estimates that there are between 1,000 and

[19] Commission on the Future of Health Care in Canada, 93
[20] HRDC, 104
[21] SSCSAST, Interim Report, 76
[22] Ibid.
[23] Canadian Institute of Health Information,
[24] Commission on the Future of Health Care in Canada, 97
[25] SSCSAST, Interim Report p.
[26] Commission on the Future of Health Care in Canada, 104
[27] RCAP Vol. 3, 260

1,200 Aboriginal nurses out of a Canadian total of 252,000. A Health Canada study found it is necessary to increase the number of Aboriginal health professionals; as an example, more than 800 new Aboriginal nurses are needed.[28] The A.N.A.C. has also identified the critical need for more nurse managers in particular. Another pressing need is Inuit nurses. Inuit groups have identified human resource development is the priority.[29]

A major challenge is the difficulty of recruiting physicians to the Canadian North with the result that the number of doctors per 1,000 people is equivalent to that found in Third World countries.[30] With more than half of Canada's 1.4 million Aboriginal peoples residing in rural, remote and northern areas,[31] HHR recruitment and retention to these areas is a critical issue to address. The Canadian Medical Association (CMA) has identified the breadth of physician's practice, long working hours, geographic isolation, and lack of professional backup and access to specialist services as factors contributing to recruitment and retention.[32] The A.N.A.C. has done extensive work in the area of Aboriginal nursing, and recruitment and retention of nurses for Aboriginal communities is identified as an important HHR focus for strategy development.[33] The NAHO First Nations Centre Public Opinion Poll reports that the ease of access to health care providers varied by the degree of community isolation. Specifically, a higher difficulty in accessing dentists, family doctors/physicians, pediatricians, ophthalmologists, optometrists, and obstetricians/gynaecologists was cited.[34] RCAP also acknowledges the need for Aboriginal administrators and service providers; without them, it will be impossible to improve Aboriginal health and social conditions.[35]

TRADITIONAL HEALING AND MIDWIFERY

Traditional Healing and Aboriginal traditional midwifery also present important Aboriginal HHR issues. There is a trend to accepting the existence and validity of Traditional Healing within the context of providing health services that are culturally appropriate. Returning to ways of traditional healing has been described as being part of a general restoration of respect for Aboriginal ways.[36] The Ministerial Advisory Council on Rural Health recommended the integration "of traditional knowledge, medicine and healing practices into existing Aboriginal health services for First Nations and Inuit people and working with provincial and

[28] NAHO, (2003) Analysis of Aboriginal Health Careers Education and Training Opportunities,37
[29] NAHO, (1999) The Aboriginal Health Institute Community Consultation Phase Report, 7
[30] Ibid, 37
[31] Ministerial Advisory Council Rural Health, (2002) *Rural Health in Rural Hands – Strategic Directions for Rural, Remote, Northern and Aboriginal Communities*, 6
[32] Canadian Medical Association, (2000) *CMA Policy, Rural and Remote Practice Issues*,
[33] Aboriginal Nurses Association of Canada, (A.N.A.C.) (*2000) Survey of Isolated First Nations Communities: Recruitment and Retention Issues*
[34] First Nations Centre NAHO, Public Opinion Poll, Preliminary Data (2002), 3
[35] RCAP, Vol. 3, 32
[36] RCAP, Vol. 3, 212

territorial governments with respect to other Aboriginal peoples, including Métis and non-Status Indians."[37] RCAP has identified the importance of "promoting traditional Aboriginal healing practices as one of the essential components of effective Aboriginal health and healing systems."[38] NAHO positions traditional medicine as central to its mandate.[39]

The issues related to traditional healing and those who practice it are complex. The context of diversity within and between First Nations, Métis and Inuit traditional healing beliefs and approaches, access, protection and promotion of existing skills and knowledge, regulation of traditional healing practices by traditional healers themselves, and cooperation between traditional Aboriginal and western practitioners are cited in RCAP.[40] However, the relevance of traditional healing to Aboriginal people's personal satisfaction with health care provision is evident in the NAHO First Nations Poll in that, "the majority of First Nations respondents reported using traditional healers and medicines, and would be more likely to use traditional care if it were locally available and covered by the health care system.[41] Métis preliminary poll findings indicated that 67 per cent of respondents were in agreement that a return to Aboriginal medicine and healing practices would improve health.[42]

Midwifery is another area of traditional healing that is currently in a revival. Midwives are women with specialized knowledge in prenatal care, birthing assistance and aftercare. The midwife may employ the use of massage, diets, medicines and ritual, prayers and/or counseling. Traditional midwifery exists worldwide and involves a variety of skills, often biophysical, but can also include spiritual and ritual activity as well.[43] There is significant diversity in traditional Aboriginal birthing practices.[44] Legislative variability, access, recruitment and education, and peer support are midwifery HHR issues that need to be further examined and addressed.

The number of Aboriginal traditional healers, midwives and Elder advisers is not known. RCAP notes that their numbers are not likely to rise fast enough to meet the demand for their services, in light of the resurgence of interest for Aboriginal people to access this option of health care. This also implies the need for exploring the demand for training and/or apprenticeship programs.[45]

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[37] Ministerial Advisory Council Rural Health, 26
[38] RCAP, Vol. 3, 290
[39] NAHO,(2003) T*raditional Medicine in Contemporary Contexts*, 3
[40] RCAP, Vol.3, 290
[41] NAHO First Nations Centre Public Opinion Poll, (Preliminary findings), 7
[42] NAHO Métis Centre Public Opinion Poll, (2002) (Preliminary findings),1
[43] NAHO *Traditional Medicine in Contemporary Contexts*, (2003), 9
[44] NAHO *Midwifery and Aboriginal Midwifery in Canada* (Draft) 2003, 5
[45] RCAP, 290

CULTURAL COMPETENCY

As one considers Aboriginal HHR issues, it is important to acknowledge the existing utilization of non-Aboriginal health care providers in the provision of health care services to Aboriginal populations. Today, many Aboriginal people use Indigenous and western medicine concurrently.[46] Both of these factors suggest that there is a need to further the work in addressing cultural competency issues. Cultural competency is described as "a set of behaviours, attitudes and policies that enable a system, agency or group of professionals to work effectively in cross-cultural situations."[47]

The demand for cultural competency arises out of the failure of health care services to be responsive to diverse population segments. Since the 1960s awareness of the need for culturally sensitive health care has been growing.[48] RCAP suggests that the integration of traditional healing practices and bio-medical approaches are an opportunity for "enhanced health among Aboriginal people and, indeed, enhanced health for the human race."[49] In 2000, the Society of Obstetricians and Gynaecologists of Canada (SOGC) approved a policy statement that recognized the need for cultural competency. The policy statement serves as a guide for health professionals working with Aboriginal Peoples.[50] Armstrong and Armstrong, in their background paper for Romanow, state that "health care is about individuals, each with their own specific complex of health issues and each shaped by particular cultural, social and economic contexts."[51]

ABORIGINAL SELF-DETERMINATION AND HEALTH CARE

Aboriginal HHR issues also need to be addressed within the context of evolving Aboriginal community control of their own health services.[52] Janet Smylie states that a return to community-based, community-directed models of health services "will involve a paradigm shift towards systems that are more consistent with community-based value systems."[53] There is a need for health care professionals to work together "in solidarity with Aboriginal communities in order to facilitate the transition towards self-determined health care services for Aboriginal Peoples."[54] The Kirby Committee report also acknowledges the complexity of "federal, provincial and Aboriginal-run programs and services; and that the framework for

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[46] NAHO, Analysis of Aboriginal Health Careers Education and Training Opportunities, 40
[47] Ibid. 26
[48] Public Health Reports, (2000) *Cultural Competent Health Care*, 26
[49] RCAP, Vol 3, 202
[50] NAHO, *Analysis of Aboriginal Health Careers Education and Training Opportunities*, 40
[51] Commission on the Future of Health Care in Discussion Paper No. 28, 3
[52] Society of Obstetricians and Gynecologists of Canada, (SOGC) (2000) *A Guide for Health Care Professionals Working with Aboriginal Peoples,* 48
[53] Ibid.
[54] Ibid.

the delivery of a number of federal programs is changing as Aboriginal communities, governments and organizations take control over the delivery of health-related programs.[55] Scope of practice, peer support and professional development are examples of issues related to variable Aboriginal community HHR policies and supervision. Training and education and the development of culturally appropriate curricula for non-Aboriginal health care providers are also implicated and will require further discussion and planning.

Furthermore, when referring to any issues involving the Crown and Aboriginal people, the protective and fiduciary responsibilities of the federal Crown[56] must be considered: "The Crown has a general fiduciary duty toward Native people to protect them in the enjoyment of their Aboriginal rights…"[57] These existing Aboriginal and treaty rights were affirmed in the *Constitution Act*, 1982.[58] Aboriginal rights are derived from Indigenous knowledge and heritage[59] and include the right to health and community control of their own health services. These constitutional rights create limitations on governments that enact health law, policies and regulations.[60] The Supreme Court of Canada has articulated that the government (and its agents) must justify any laws or regulations that interfere with the existing rights of Aboriginal peoples.[61] This would include discussions regarding health services.

Finally, it is important to acknowledge that HHR reform and planning in Aboriginal communities faces a number of complex multi-jurisdictional issues which in turn impact health care providers. First Nations and Inuit communities have or are undergoing the transfer of certain responsibilities for managing and delivering health services from Health Canada to Aboriginal communities. As of 2001, 82 per cent of eligible First Nations and Inuit communities have or are in the process of transferring responsibility.[62] This translates to variability in who is employing health care workers – Health Canada or community leadership. The Romanow Commission report calls for the establishment of "a clear structure and mandate for Aboriginal health partnership to use funding to address the specific health needs of their populations, improve access to all levels of health care services,

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[55] SSCSAST, Interim Report, 63

[56] "The term Crown is indivisible and applies equally to the Crown in right of Canada and the Crown in right of the Provinces." *Gitanyow First Nation v. Canada,* [1993] 3 C.N.L.R. 890 (B.C.S.C.). Further, as ruled by the Supreme Court of Canada in *R. v. Guerin*, "It is the nature of the relationship, not the specific category of actor involved that rise to the fiduciary duty." *Guerin v. Canada*, [1984] 2.S.C.R. 335.

[57] Brian Slattery, "Understanding Aboriginal Rights" (1987), 66 Can. Bar Rev. 727 at 753.

[58] *Constitution Act*, 1982, Schedule B to the *Canada Act 1982* (U.K.), c. 11.

[59] M. Battiste & J.Y. Henderson, *Protecting Indigenous Knowledge and Heritage: A Global Challenge* (Saskatoon: Purich, 2000) at 205.

[60] Ibid.

[61] *R. v. Vander Peet*, [1996] 2 S.C.R. 507, reversing (1993), 175 C.N.L.R. at para. 25; *R. v. Sutherland*, [1980] 2 S.C.R. 451 at 464, [1980] 3 C.N.L.R. 71 at 80 (S.C.C.). See also NAHO Discussion Paper Series #1 *Aboriginal and Treaty Rights to Health – A Constitutional Rights Analysis* (2003) Ottawa: Native Law Centre of Canada.

[62] Commission on the Future of Health Care, 213

recruit new Aboriginal health care providers and increase training for non-Aboriginal health care providers."[63] The Romanow Commission report states that transferring responsibility from Health Canada to Aboriginal communities has been successful in some ways but does not deal adequately with capacity building within Aboriginal communities.[64]

ABORIGINAL HHR – WHAT WE DON'T KNOW

RCAP acknowledges that there is a paucity of information about the status of Aboriginal human resources in health and social service in Canada.[65] Governments, professional associations and service delivery organizations rarely collect information about the participation of Aboriginal people in the health and healing professions.[66] Mainstream HHR planners acknowledge the need for more quantitative research in HHR planning and management.[67] There are optimal examples of initiatives underway such as the Canadian Institutes of Health Research (CIHR) Institute of Aboriginal Peoples' Health (IAPH) which strives to "eliminate disparities between Aboriginal and non-Aboriginal populations." One of the CIHR four pillars of health research is health systems and services. One of the key objectives of CIHR-IAPH is to build research capacity in First Nations, Inuit and Métis communities.[68]

NAHO, Health Canada, the CMA, and other organizations agree that there is a need for a human resources study aimed at determining the Aboriginal presence among the health professions and are taking steps to pursue this.[69] In addition, there is a need for more constituency specific data on HHR issues and planning specific to First Nations, Métis and Inuit populations.

The federal government's Primary Health Care Transition fund is an initiative reflecting Health Canada's commitment to developing and supporting initiatives to renew and improve primary health care in Canada. Two of the objectives of the national envelope for funding speak to the need to facilitate collaboration among health professionals and change to practice patterns for primary health care providers.[70]

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[63] Ibid, 211
[64] Ibid, 224
[65] RCAP, 293
[66] Ibid.
[67] Diallo, K., Aurn P., Gupta, N. and Dal Poz, M., (2003) *Assessing human resources for health: what can be learned from labour force surveys?,* Human Resources for Health http://www.human-resources-health.com/content/1/1/3
[68] Reading, J. and Nowgesic, E., (2002) *Improving the Health of Future Generations: The Canadian Institutes of Health Research Institute of Aboriginal Peoples' Health*, American Journal of Public Health, Reprint Vol. 92,(9), 1396
[69] NAHO, Analysis of Aboriginal Health Careers Education and Training Opportunities, 37
[70] Health Canada, (2003) *Primary Health Care Transition Fund Request for Proposals*

Health Canada's First Nations and Inuit Health Branch (FNIHB) with the oversight of NAHO have become third-party co-sponsors for the 2004 Canadian Health Services Research Foundation (CHSRF) Open Grants Competition. FNIHB/NAHO will be co-sponsoring certain applications under the health human resources theme, which was seen by CHSRF as the dominant issue for the next two to five years for policy makers and managers. More information is required to inform the development of regulatory frameworks for strategies for coordinating regulations and human resource planning across regulated and unregulated professions in First Nations and Inuit communities. Key interests to be examined include jurisdictional issues, mechanisms for avoiding cycles of surplus/shortage, and the leadership vacuum within management and policy-making organizations.[71]

It is reported that the national research organizations have made health human resources a top priority for new funding as a result of a national consultation process sponsored by CHSRF, CIHR, CIHI, CCOHTA and the Advisory Committee on Health Services.[72] In addition, as part of Human Resources Development Canada's (HRDC) Sectoral Partnership Initiative, two national sector/occupational studies have been commissioned. A nursing study will investigate how changes in nursing practice environments and the increased use of technology will influence future education, skill requirements and training needs. A physician resource study will inform planners regarding "existing and emerging models for health care delivery and assess their implications for education and training."[73] To date there has not been significant involvement of Aboriginal Peoples in these national processes.

RCAP posed the following questions, which although there has been some progress towards advancing the Aboriginal HHR situation are still relevant today:

- What barriers exist that prevent Aboriginal students from participating in professional training programs, and how can these barriers be removed?
- How can Aboriginal people become more fully involved in the development and delivery of professional education programs?
- How can Aboriginal organizations and governments, mainstream educational institutions, professional organizations, and Canadian governments work together more effectively to increase the number of Aboriginal people in the health and social service professions?
- What is the best way to address the awareness building and relationship building required to sensitize non-Aboriginal health care providers to the benefits and credibility of traditional healing practices?

[71] Health Canada – NAHO Call for Proposals for 2004 *CHSRF Open Grants Competition*
[72] Commission on the Future of Health Care - Appendix B summary of Recent Government Initiatives in Health Human Resource Planning, 213
[73] Commission on the Future of Health Care - Appendix B summary of Recent Government Initiatives in Health Human Resource Planning, 213

WHAT'S BEING DONE?

An overview of initiatives relevant to Aboriginal HHR issues are included here. There are a number of national level initiatives in various stages of development implementation and completion. Drivers for various policy reform and development include:

- The 2002 *Speech From the Throne* to Open the First Session of the 38th Parliament of Canada – The Canada We Want - acknowledged that "no one government or organization can build a skilled workforce on its own. It must be a national effort."[74] It was further noted how the "most enduring contribution Canada can make to First Nations is to raise the standard of education on-reserve."[75]

- The Health of Canadians – The Federal Role: final report on the state of the health care system in Canada, Standing Senate Committee on Social Affairs, Science and Technology (SSCSAST)(Kirby Report) (2002) – The Committee emphasizes that "addressing the issues relating to human resources in health Care must be amongst the top health care policy priorities for all levels of government."[76] It proposes that what is needed is a "country-wide, long-term, made-in-Canada, human resources strategy."[77] The Committee recommends "the federal government work with other concerned parties to create a permanent National Coordinating Committee for HHR to be composed of representatives of key stakeholder groups and of the different levels of government."[78]

  The SSCSAST report proposes the federal government undertake, in collaboration with the provinces, territories and Aboriginal representatives of all groups, the development of a national action plan on Aboriginal health, to improve inter-jurisdictional co-ordination of health care delivery. Relevant to HHR, such a plan would:
    - Ensure adequate access to culturally appropriate health services for Aboriginal Peoples;
    - Increase the number of Aboriginal health care providers; and
    - Address training, recruitment and retention issues of emerging health career categories.[79]

[74] Parliament of Canada, (2002) *The Canada We Want, Speech From the Throne to Open the First Session of the 38th Parliament of Canada*
[75] Ibid.
[76] SSCSAST, Interim Report, 91
[77] SSCSAST, Interim Report, 181
[78] Ibid, 189
[79] NAHO Internal Briefing note #016/02, 2002

Relevant to the health needs of Aboriginal People, the report reiterates the need for the federal government to address Aboriginal health as a priority. It identifies research as perhaps the most important element to improve the health status of Aboriginal Canadians. The report endorses that additional funding be provided to the CIHR to increase the numbers and participation of Canadian health researchers, including Aboriginal researchers. Recommendations encouraged that the federal government work with the provinces and medical and nursing faculties to finance places for students from Aboriginal backgrounds over and above those available to the general population.

It also reiterates that strategies be developed to increase the supply of health care professionals from under-represented groups, including Aboriginal Peoples and in under-serviced regions, particularly the rural and remote areas of the country. Further, that the federal government work with medical and nursing faculties to finance places for students from Aboriginal backgrounds, over and above those available to the general population.[80]

- Building on Values – The Future of Health Care in Canada Final Report (2002) The Commission on the Future of Health Care chaired by the Honourable Roy Romanow, was launched as a fully-independent body whose mandate was to recommend policies and measures to ensure the long-term sustainability of a universally accessible, publicly funded health system, while striking a balance between investments in prevention and health maintenance, and investments directed to care and treatment.

  One of the three 'Directions For Change' in the Final Report, Chapter 10 "A New Approach to Aboriginal Health" relevant to Aboriginal health human resources, recommends establishing "a clear structure and mandate for Aboriginal Health Partnerships….recruit new Aboriginal health care providers and increase training for non-Aboriginal health care providers."[81]

- 2003 First Minister's Accord on Health Care Renewal – First ministers directed health ministers to work on health human resources; "appropriate planning and management of health human resources as key to ensuring that Canadians have access to the health providers they need."[82] "Collaborative strategies are to be undertaken to strengthen the evidence base for national planning, to promote inter-disciplinary provider education, to improve recruitment and retention, and to ensure the supply of need health providers (including nurse practitioners, pharmacists and diagnostic technologists)."[83]

[80] NAHO Briefing note #044/02, 2002
[81] Commission on the Future of Health Care, 211
[82] 2003 First Ministers; Accord on Health Care Renewal, Health Canada (web report) 2003
[83] Ibid.

The First Ministers are "committed to enhancing funding and working collaboratively with other governments and Aboriginal Peoples to meet the objectives set out in this Accord ….governments will work together to address the gap in health status between Aboriginal and non-Aboriginal Canadians through better integration of health services."[84]

- Federal Budget 2003 – In accordance with the February 2003 *First Ministers' Accord on Health Renewal*, and building on the recommendations of the Romanow Commission and the Kirby Senate Committee, the budget makes a notable investment to address concerns relating to the Canadian health care system.

  Of the total increase in health care funding, $1.3 billion over the next five years will be allocated to support health programs for First Nations and Inuit. Of relevance to HHR are new investments for nursing; $72 million to improve educational outcomes for Aboriginal Peoples and $12 million to the National Aboriginal Achievement Foundation.

- Health Canada, *National Nursing Strategy* in 2000. The goal of the Nursing Strategy was to achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed throughout Canada, and deployed in order to meet the needs of the Canadian population.[85] Four areas of focus to address nursing workforce issues included; unified action, improved data, research and human resources planning, appropriate education and improved deployment and retention. A September 4, 2003 report on the progress of the Strategy reports that most of the mechanisms to achieve the strategies are in place and considerable progress has been made. Specific challenges to full implementation are identified.[86]

- Canadian Nursing Advisory Committee *2002* - A multi-stakeholder group tasked with reviewing and advising on nursing workforce issues calls for a Pan-Canadian collaboration on the analysis, priority-setting and implementation of recommendations.[87]

  Recommendation 51 of the report calls for federal, provincial and territorial governments to work with multiple stakeholders to work on issues of diversity and that funding should be targeted for the development of a national task

[84] Ibid.
[85] Advisory Committee Health Delivery and Human Resources (2003) *A Report on The Nursing Strategy for Canada* Ottawa: Health Canada
[86] A Report on the Nursing Strategy for Canada, www.hc-sc.gc.ca/english/media/releases/2003_67bkl.htm#2
[87] A Report on the Nursing Strategy for Canada, www.hc-sc.gc.ca/english/media/releases/2003_67bkl.htm#2

force to increase the recruitment and retention of Aboriginal nurses and nursing students.[88]

- Human Resources Development Canada (HRDC) *Building The Future – An Integrated Strategy for Nursing Human Resources in Canada* - A national nursing sector study is underway with the goal to create an informed long-term strategy to ensure that nursing supply needs in Canada are met.[89]

  A national physician resource study is underway, which will examine existing and emerging models for health care delivery and assess their implications for education and training.[90]

- Aboriginal Nurses Association of Canada (A.N.A.C.) *Aboriginal Nursing Educational Needs Analysis* (2002) A.N.A.C. has been the leader in a number of research activities related to the education and HHR planning for nurses working in Aboriginal communities. Research issues including workplace considerations, best practices, nursing professionalism, career development, and retention have been targeted. In addition, A.N.A.C. is working towards the development of a fully accredited Aboriginal nursing specialization; Aboriginal health nursing. Long-term plans include the development of an Aboriginal nursing summer school which could serve as an annual testing ground for the evolution of the specialty and a collaborative forum for improving the Aboriginal nurses' workplace.[91]

- The National Aboriginal Health Organization – NAHO has identified a key objective of fostering the recruitment and retention, training and utilization of Aboriginal Peoples in the delivery of health care. The development of a strategic framework is underway and NAHO has completed a listing of education and training opportunities for Aboriginal health careers. In addition, key networking and collaborative discussions are underway with key stakeholders.

- Ministerial Advisory Council on Rural Health – The mandate of the Council is to provide independent advice to the federal Minister of Health on how the federal government can maintain and improve the health of rural individuals and communities. The Council advocates for the integration of traditional knowledge medicine and healing practices into existing Aboriginal health services.[92]

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[88] Advisory Committee on Health Human Resources, (2002) *Our Health, Our Future- Creating Quality Workplaces for Canadian Nurses – Final Report of the Canadian Nursing Advisory Committee,* 45

[89] HRDC, website www.hrdc.gc.ca

[90] Appendix B ~ Summary of Recent Government Initiatives in Health Human Resource Planning, 2002 www.cprn.com/dcuments/14945_en.pdf

[91] Aboriginal Nurses Association of Canada (2002) *Aboriginal Nursing Educational Needs Analysis: Results of a National Survey – Summer 2002* Ottawa: A.N.A.C.

[92] Ministerial Advisory Council Rural Health

- Indian and Northern Affairs Canada (INAC) – INAC funds and supports the provision of elementary and secondary services to on-reserve First Nation students. The Government of Canada has made education for First Nations a priority and confirmed its commitment in the 2002 speech from the throne and in the 2001 budget. An Educational Advisory Working Group was formed and recently released a report with multiple recommendations on educational reform in First Nations communities.[93]

- Indian and Inuit Health Careers Program This is a federal government initiative established in 1984 to increase the representation of Aboriginal professionals in the health field. The Indian and Inuit Health Careers Program targets Aboriginal students enrolled in health programs, post secondary institutions preparing health professionals and Aboriginal communities. Bursaries and scholarships are offered.[94]

CONCLUSION

As Canadian HHR policy makers and planners undertake to implement reformative HHR initiatives, it is clear that issues related to Aboriginal Peoples urgently need to be addressed. Seven years have passed since the RCAP report was released. If we were to develop a report card on the progress of implementing recommendations, how would Canada score? While there has been some progress made, there is a long way to go to reach the goal of increasing the numbers by 10,000. There is an urgency which is related to the often dismal picture of the health status of Aboriginal Peoples and the need to improve health outcomes.

It is important also to acknowledge the success stories. There are many excellent program models and individual role models of Aboriginal-controlled health care centres, of integrated western and traditional healing services, of Aboriginal nurses, doctors, dentists and other health care models and health care workers. Many academic and health professional organizations have started to address the issue of Aboriginal HHR needs in their strategic plans. There is however a need for a more cohesive national approach to HHR planning in Aboriginal communities (including urban communities). The Canadian Policy Research Network states that HHR planning needs to be a separate policy exercise.[95] This is especially true for Aboriginal communities due to the diversity of issues and the need for culturally-relevant solutions.

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[93] Indian and Northern Affairs Canada, (2002) *Backgrounder on Educational Advisory Working Group,* INAC website, www.inac.gc.ca

[94] Health Canada, Indian and Inuit Health Careers Program, (2001) Environmental Scan, Final Report, 1

[95] Commission on the Future of Health Care in Canada, *Discussion paper Health Human Resource Planning in Canada: Physician and Nursing Work Force Issues, v.*

Potential key areas of focus for such a strategy were identified by participants at a recent health careers meeting hosted by NAHO including:

- Planning should occur within a population health framework; there are many determinants of health which impact on recruitment and education. Cultural, education, age and gender and socio-economic issues need to be addressed.

- HHR planning for Aboriginal communities should reflect self-determination principles.

- Opportunities for dialogue and planning are needed so that information can be shared and strategic solutions and collaborative initiatives can be developed. There are many success stories to learn from.

- Cultural competency needs to be addressed in academic curricula and in professional standards; non-Aboriginal health care providers, policy makers, health professional associations and other Aboriginal health stakeholders need to understand the issues and the a cultural context to provide effective services.

- HHR planning for physicians and nurses is a priority however there is a lack of health care workers in all disciplines.

- More specific information is required about Métis and Inuit HHR context and needs in order to build a more equitable base of health providers from their respective populations.

- Improved information is needed to focus promotion initiatives to youth (e.g. the numbers dropping out of school, the numbers of youth who do not pursue post-secondary education).

- A collaborative Aboriginal HHR research agenda is a fundamental development.

In closing, as Indigenous Peoples across the world strive to improve their health outcomes, HHR issues remain as one of the greatest challenges. There are opportunities to share international success stories, assist one another in creating solutions that are innovative, and collaborate in research. It is worth considering that Aboriginal Peoples are the fastest growing population group in Canada and have a comparatively young population. Therefore, Aboriginal health care providers potentially represent an important labour pool for Canada and could be an alternative to strategies recruiting from other countries.

APPENDIX A

GLOSSARY OF TERMS AND ACRONYMS

A.N.A.C.: Aboriginal Nurses Association of Canada
Aboriginal Peoples: A collective name for all of the original peoples of Canada and their descendants, consisting of three groups – First Nations, Métis and Inuit
Aboriginal people: when referring to more than one Aboriginal person rather than the collective group of Aboriginal Peoples
CIHR: Canadian Institutes of Health Research
CIHI: Canadian Institute of Health Information
CNA: Canadian Nurses Association
CHSRF: Canadian Health Services Research Foundation
CMA: Canadian Medical Association
First Nations: adopted in the 1970s to replace the word Indian; applies to both Status and Non-Status Indians.
FNC: First Nations Centre (Within NAHO)
HHR: health human resources
HRDC: Human Resources and Development Canada
INAC: Indian and Northern Affairs Canada
Indigenous: A noun or adjective for those peoples whose ancestors were the original peoples of the Americas and internationally.
Medicine: The healing systems of the original people of North America and their descendants (Also called traditional medicine)
Inuit: The Aboriginal Peoples of Arctic Canada and the Circumpolar region
Métis: The *Constitution Act* of 1982, recognizes Métis as one of the three Aboriginal Peoples of Canada. The Royal Commission on Aboriginal Peoples defines Métis as follows: Every person who (a) identifies himself or herself as Métis and (b) is accepted as such by the nation of Métis people with which that person wishes to be associated, on the basis of criteria and procedures determined by that nation to be recognized as a member of that nation for the purposes of nation-to-nation negotiations and as Métis for that purpose.
NAHO: National Aboriginal Health Organization
Non- Status Indian: First Nations Peoples who consider themselves to be Indians or members of a First Nation but are not recognized as Indians by the Government of Canada.
Status Indian: People who are entitled to have their names included on the federal government's Indian register.
RCAP: Royal Commission on Aboriginal Peoples
SOGC: Society of Obstetricians and Gynaecologists of Canada
SSCSAST: Senate Standing Committee on Social Affairs, Science and Technology
WHO: World Health Organization
FNIHB: First Nations and Inuit Health Branch