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Chair

Mrs. Joy Smith

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● (0905)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, everybody, and welcome to the health committee.

I'm very pleased to see our wonderful guests today.

Pursuant to Standing Order 108(2), we will do our study on health human resources.

I want to welcome all the witnesses today. We're very involved in our health human resource initiative. Having you come is extremely helpful to us as a committee.

Each of you will have a five-minute presentation, and then we'll go into our Q and A, because I think it is most helpful for the committee to have the opportunity to do that.

We will start with the Aboriginal Nurses Association of Canada, with Rhonda Goodtrack, director of education and secretary-treasurer.

Rhonda, can I have your presentation?

Ms. Rhonda Goodtrack (Director of Education, Secretary-Treasurer, Aboriginal Nurses Association of Canada): Good morning, and thank you very much for this opportunity.

I'll speak to the briefing note circulated last week. I'll talk to the first three points of our issues on page two.

The first point is improving the science, math, and language skills. Many times the students come to us in the nursing program where they're under-prepared in those areas. At the university level, we have transition programs that help those students be successful in the math, sciences, and English classes. The transition programs are structured with smaller classrooms with extra tutorials. English can be taken over the summer in a more relaxed environment, so that students get the reading and writing skills they need before university starts. Also, the students begin to adapt to university life and expectations. We need to maintain the funding for transition programs and the like.

Funding uncertainty and other constraints are the second point. One of our students is a licensed practical nurse. He wants to get his degree in nursing to become a registered nurse, as he knows there are more opportunities as an RN. He has come to school unable to get a student loan because he and his wife work. He went on maternity leave and took out a line of credit. He works as an LPN and takes full-time nursing classes. You can imagine that he wasn't able to dedicate as much time to those nursing classes as he wanted to.

He recently found out that the funding he was going for under the Métis institution in Saskatchewan wasn't able to fund him in his degree of nursing. He's dropped out, and we don't know if he's going to be coming back to obtain his degree in nursing. This is unfortunate, because he is a much-needed positive role model for our young men.

Another part of the constraints around funding is the definition of what a full-time student is, and the discrepancy between the two individuals I am going to talk about. The university defines a full-time student as someone who has three classes, but post-secondary policies on reserves define it as four classes, so there is a discrepancy. In order to get a full-time living allowance as well as tuition and books, they have to take four classes. There's no question that in nursing the classes are very intensive.

The third point is the systemic support in educational institutions. Equity seats are very important, and where they are implemented, you see a difference. We went from three equity seats in Saskatchewan to 104 in Regina, Saskatoon, and Prince Albert. Currently we have over 200 aboriginal students enrolled in a nursing education program in Saskatchewan, in the undergraduate and graduate programs. As of February 2009, the SRNA, our licensing body, recorded 442 self-identified aboriginal RNs. There are more, but we have a minimum of 442. That number will change in 2010.

It is very important to incorporate aboriginal ways into the nursing curricula. We are serving our people more and more. We are having a greater population base. It is very important to include indigenous knowledge into the curricula, so that we can better serve our communities. We need more aboriginal scholars in the mainstream institutions. The mainstream institutions will be the ones carrying the bulk of educating our people. We need scholarships dedicated to aboriginal students. We need physical symbols that are figured prominently across campus, not just put in someone's office. We need space dedicated for aboriginal people to go to. This builds a sense of community for individuals from remote communities. It also allows them time to be themselves, to take a break from the mainstream.

In those spaces, you will find student advisers who are aboriginal. They can help the students navigate their way through university life and find those resources that will help them become successful. Student ambassadors are used to do community outreach. They are our role models who go to the communities, relate to the students, and share their experiences.

We have pre-health-science summer camps at the U of S. We bring in 20 first nations youth from across the province. They spend two weeks on campus and live the life of a university student. What this does is demystify campus life. It introduces them to staff and faculty and gives them mini-lectures and the like.

That was my five minutes. Thank you, Madam Chair.

● (0910)

The Chair: Actually, I gave you a little bit more than that.

Ms. Rhonda Goodtrack: Probably you did. I figured...

The Chair: Your presentation was so good.

Ms. Rhonda Goodtrack: Thank you so much. I appreciate that.

The Chair: We will now go to Dr. Marcia Anderson, past president of the Indigenous Physicians Association of Canada.

Dr. Marcia Anderson (Past President, Indigenous Physicians Association of Canada): Thank you for the opportunity to be here today.

The Indigenous Physicians Association of Canada is a voluntary association of first nations, Inuit, and Métis physicians and medical students who hold the vision of healthy and vibrant indigenous nations, communities, families, and individuals, supported by an abundance of well-educated, well-supported indigenous physicians working in partnership with others who share this vision with us.

Since 2004, IPAC has been a leading organization in the development of Canada's medical workforce, through promotion of the recruitment and retention of first nations, Inuit, and Métis medical students and the development of curriculum that will enhance the ability of all of Canada's physicians to deliver high-quality, culturally safe care to first nations, Inuit, and Métis patients.

Our work to date has been in partnership with other organizations such as the Association of Faculties of Medicine of Canada, the Royal College of Physicians and Surgeons of Canada, and national aboriginal organizations. I'm pleased with the progress we have made in developing strong foundational materials for the 17 faculties of medicine to use as they implement recruitment and retention policies and indigenous health curriculum locally. These can be found on our website and include *First Nations, Inuit, Métis Health Core Competencies: A Curriculum Framework for Undergraduate Medical Education*; *IPAC-AFMC Pre-Admissions Support Toolkit for First Nations, Inuit, Métis Students into Medicine*; and curriculum modules in family medicine, mental health, and obstetrics and gynecology for use at the post-graduate and continuing medical education levels.

We have celebrated these accomplishments, but much remains to be done. We must keep in mind that it takes a minimum of nine years to train a physician and that the development of the indigenous medical workforce requires increasing the number of students who are graduating from high school, successfully completing the required undergraduate university courses, either identifying or being identified as being qualified to enter medicine, completing medical school, applying to residency, and completing a residency program. While I'm thankful that the aboriginal health human resources initiative has been renewed for two years, I'm concerned that the changes that are still necessary at all levels of learning, which I've just mentioned, are not accomplishable in that timeframe, and that a student who began his or her medical training when AHHRI was first established will not have completed it by the end of the current two-year funding term. Aboriginal health human resources require a long-term commitment and sustained investment in order to achieve its important goals.

Further, as a national professional organization we must maintain our ability to provide leadership in the development of Canada's medical workforce. We are uniquely placed because of our combination of medical training, indigenous health expertise, indigenous community connections, and knowledge of appropriate process to continue to guide our partner organizations and the medical schools as we seek to see curriculum implemented in all 17 schools at all levels of learning, and more students supported to apply and succeed through medical education.

IPAC continues to seek ways in which we can encourage and facilitate this implementation. If supported, we will again be able to have substantial representation at the Canadian Conference on Medical Education, the largest national medical education conference and an excellent chance to meet with deans, administrators, and other indigenous health educators. It was a year ago that Dr. Barry Lavallee, Charlene Hellson, and I presented a plenary session at that conference on cultural safety and indigenous health that provoked tears in multiple attendees and earned us a standing ovation, which had never been done at that conference before.

I mention that because never has it been more apparent, the appetite and the readiness for change that exists when it comes to further developing the indigenous medical workforce. We must continue to push this agenda forward through maintaining the indigenous health educators working group, reviewing the evaluation of projects currently under way and building on the lessons we have learned; developing an indigenous physicians and medical student role model book to inspire our kids and youth; developing courses that will help first nations, Inuit, and Métis students prepare for medical school admission interviews; making progress on the development of a textbook on indigenous health in partnership with the Society of Rural Physicians of Canada, and through nurturing our collaborative relationships with our international indigenous brothers and sisters.

IPAC is privileged to host the Pacific Region Indigenous Doctors Congress in Whistler, B.C., in August 2010. PRIDoC includes representatives from Canada, Australia, New Zealand, United States, Hawaii, Taiwan, and the Pacific Islands. I am the current chair.

PRIDoC will bring to Canada internationally recognized indigenous health researchers, clinicians, and medical educators. There are significant benefits to our students and physicians, and thus to our colleagues and patients. PRIDoC is an excellent time to develop and nurture mentoring relationships; international collaborations in areas of mutual priority such as medical workforce development; knowledge translation; and skill development.

● (0915)

I would not underestimate the importance of peer support for indigenous physicians, given our high workloads, high stress, and resulting high levels of burnout. This is a key retention issue that is often under-addressed.

We have previously applied to Health Canada for support for this important conference through the health care policy contribution program, and we're working with the health human resources strategies division and AHHRI to obtain Health Canada's support. Given the direct relationship of PRIDoC to aboriginal health human resource development, I am hopeful that we will soon hear positive news about Health Canada's support for this high-profile conference.

In closing, on behalf of IPAC I would like to thank the staff at AHHRI in first nations and Inuit health and Health Canada nationally, who have worked with us and supported our leading work in the development of Canada's medical workforce.

We remain committed to improving the medical workforce that serves first nations, Inuit and Métis people by increasing the number of indigenous doctors and better training all physicians to provide high-quality, culturally safe care. We hope we can count on sustained commitment and resourcing until our shared goals are achieved.

Thank you.

The Chair: Thank you very much, Doctor, for your very insightful comments. We really appreciate them.

Next we will go to Isabelle Verret, program officer of Aboriginal Health and Human Resources Initiatives. I understand, Isabelle, you have a bit of laryngitis but you're going to persevere and do the best you can.

Thank you.

[*Translation*]

Ms. Isabelle Verret (Program Officer, Aboriginal Health and Human Resources Initiatives, First Nations of Quebec and Labrador Health and Social Services Commission): *Koey*, good morning.

My name is Isabelle Verret, and I am a program officer for Aboriginal Health and Human Resources Initiatives. I am here with my colleague, Michel Deschênes, a policy analyst. We work at the First Nations of Quebec and Labrador Health and Social Services Commission.

We want to thank the Standing Committee on Health for inviting us to give a presentation as part of its discussions on first nations health resources. We hope that your government will take into account first nations realities and that the information we present will serve as a basis for a true partnership, one where Canadian government representatives are on equal footing with first nations political representatives, in an effort to develop policies and implement appropriate measures.

Created in 1994 by the First Nations of Quebec and Labrador Chiefs' Assembly, the commission was intended to help first nations communities and agencies protect, maintain and assert their inherent rights to healthcare and social services, and to help them develop and carry out these programs.

Under the commission's leadership, Quebec's first nations communities established the Quebec First Nations Health and Social Services Blueprint for the period of 2007 to 2017. It represents an important learning process for developing their skills, with a view to asserting their right to manage their programs and services.

In Quebec, 42% of our population is under 25 years of age, and first nations represent nearly 71,000 people. There are 10 nations spread throughout more than 40 communities. It should be noted that almost 70% of our population lives in the communities.

Certain first nations communities live in conditions similar to those in the third world: substandard housing, overcrowding, water problems, outdated schools, underemployment, poverty and so forth. In some communities, the dependency rate on social assistance can reach more than 50%. We can easily see that this difficult environment imposes specific limitations on education in the communities, especially with respect to students dropping out of school.

According to a 2002 study in Quebec communities, more than half of the adults did not have a high school diploma. That proportion is hard to reverse in youth, since half of all young people have already had to repeat a school year.

It is clear that, in order to develop health human resources in Quebec's first nations, they must first receive better access to primary and secondary education, access that it is comparable to that of the rest of the population.

To improve access to basic education, it is first necessary to give schools and communities adequate funding so they can acquire the staff and infrastructure they need to provide appropriate services.

In addition, particular attention should be paid to tailoring teaching methods within and outside the community. To that end, educating aboriginal teachers on first nations culture and society so they can better understand their students would make it easier for students to learn, thereby contributing to a more stimulating academic environment.

Just 3% of first nations students will be able to meet the requirements to access post-secondary education. And those who do manage to overcome the barriers face a number of other factors that make going to school difficult. Some of these factors are as follows: the distance of specialized training institutions in the field of health and social services, which requires students to be away from their families, friends and communities for prolonged periods; the lack of incentives and information regarding health training available in provincial learning institutions; the difficulty related to gaining proficiency in the language of instruction; and the racism endured by aboriginals when they leave their communities.

Furthermore, given the high drop-out rate, a number of students become young adults with families of their own, who must then deal with the obligations of having a family. So not only do they need additional financial assistance, but they also need better access to family housing and daycare. Efforts are needed to tailor extra-curricular activities, so these students can have a well-balanced social life, despite being far away from their families and communities.

There is considerably less money spent on recruiting and retaining health professionals, as compared with health institutions in the Quebec network. As a result, Quebec's network is without question more appealing to first nations graduates. What's more, there is little in the way of measures to support health professionals and help them integrate into the communities. Well-established mechanisms should be put in place to address that shortcoming.

In spite of the structural barriers to the development of health resources for first nations, before we wrap up, we would still like to mention a few examples of initiatives and best practices undertaken in Quebec in terms of the recruitment and retention of first nations health professionals and stakeholders.

● (0920)

The Université du Québec à Chicoutimi, UQAC, offers youth intervention training, as well as a program through its faculty of medicine with an aboriginal component. A number of communities have established their own cooperative initiatives with respect to specialized training for their population, such as the human resources training and development centre in Wendake and the Job Education Training Association of Kanawake.

In short, the development of health human resources for first nations is highly complex and requires the involvement of a large number of government and non-government partners in both the education and health sectors. A one size fits all approach cannot be used for all of Canada, as needs vary by region. Solutions must be tailored to the specific reality of each region. That distinction is especially clear in Quebec.

We recommend the following: that the federal government encourage and provide financial support to first nations so they can develop their own health human resources strategy on a regional scale; that, in Quebec, the federal government agree to bring its programs and policies in line with the framework set out in the First Nations Health and Social Services Blueprint for 2007 to 2017; that the federal government foster the creation of post-secondary institutions tailored to first nations, in partnership with colleges, universities and first nations authorities; that the federal government fund training, support and cultural adaptation initiatives to prevent first nations students from dropping out of school for the duration of their academic careers; that the federal government agree to increase funding so that first nations can receive education services comparable to those available to the rest of the population; and that the Aboriginal Health Human Resources Initiative be extended and that the procedural requirements be made clearer and more consistent with the regional needs of first nations.

[*English*]

The Chair: Thank you very much. I know you were trying to get through that, so I gave you some extra time.

We will now go to Valorie Whetung, director of the First Nations Centre.

Welcome.

Ms. Valorie Whetung (Director, First Nations Centre, National Aboriginal Health Organization): Thank you for inviting the National Aboriginal Health Organization here this morning to speak to you. I am here on behalf of Paulette Tremblay, who was unable to come.

I am Ojibway and am a member of the Curve Lake First Nation. As director of the First Nations Centre, I'm responsible for ensuring that we do high quality research that meets the needs of the communities. In fact, tomorrow I'm going to do a health career fair on reserve to speak to students to try to encourage them to enter health careers. That's an issue for us.

We have a young population. As you know from the statistics, half the Inuit population is 22 years and younger, half the first nations population is 25 years and younger, and half the Métis population is 30 years and younger. This compares to a Canadian population that has a median age of 40.

We have a lot of issues in terms of health human resources that need to be addressed to try to correct the health disparities between aboriginal people in Canada and mainstream Canadians. The lack of first nations people in the health care workforce is an issue. Other issues are the recruitment and retention of first nations health care professionals; the need for self-determination in the management of health human resources; and the recognition of the legitimacy of traditional health human resources in the health care system, such as traditional healers, midwives, and elders.

In 2007, NAHO completed a comprehensive survey of the aboriginal health human resource landscape in Canada. We found that there is a general lack of data to identify first nations people in the health care labour force. Where we do have data, we find that the number of first nations people in health care is not nearly equal to the ratio in the population. For example, in Saskatchewan, only 3.7% of health care workers identify as aboriginal, but that population represents 8.5% of the employed population, according to Statistics Canada. The data is limited, but where we have it, we know that there's a disproportionate number of first nations health care professionals.

A possible solution would be to improve access to training possibilities for first nations people who wish to enter health care professions. This may sound simple, but there are barriers to access for first nations that are unique. First, the entrance requirements can be difficult to meet. This is because the completion rate for high school is much lower than it is for the rest of Canadians. For those who do graduate from high school, participation in hard sciences is low. These subjects are necessary to get into the health care professions. More focus on math and science in elementary schools is needed.

It should be noted that per capita funding for first nations students is less than two-thirds of what it is for other Canadian students. In 2008 Jean Charest stated in *Le Devoir* that spending on the education for first nations children comes to less than half the amount spent on the education of children in non-aboriginal communities.

To encourage first nations people to pursue health careers, it is necessary to invest in early education.

For those who do enter medical training, there is a high dropout rate. Even those who have graduated report that they had to overcome barriers to stay the course. According to the 2006 census, only 240 people who identified as first nations had graduated in medicine, veterinary medicine, or dentistry.

Admission to medical training can be daunting. But paying for it can be even more of a barrier. Because first nations students experience high levels of poverty, funding is an enormous problem, especially when first nations people tend to drop out of high school and then return to higher education as mature students with children. They do not come from wealthy, influential families with a history of medical practitioners and the resources to help them. If they qualify to receive educational assistance from their first nations, the allowance is not enough to live on, so they have to work or get family assistance. Access to student loans is limited for these students if they receive educational assistance from their first nations.

The need for self-determination in the management of health human resources is a critical element in addressing the inequities that exist for first nations people. Clearly, a coordinated effort between first nations governments and health care professional groups will lead to improvements. Research has found that control is a necessary precondition to improvement.

● (0925)

Finally, it's important for first nations that the health care system formally acknowledge the value and legitimacy of traditional health care human resources. The benefits of traditional knowledge and practitioners have been undervalued and maligned by western medicine. It must be remembered that in the not too distant past some of these practices were illegal.

Cultural safety is an ongoing issue, and mainstream health professionals are slowly starting to acknowledge the important contributions of traditional healers, midwives, and elders. It would be advisable to expand the initiatives of the Canadian Institutes of Health Research and the First Nations and Inuit Health Branch to examine the benefits of traditional medicines and cultural practices in health care.

The First Nations Centre supports single parents in health careers with a bursary program. Last year the number of applicants was over 80, but we only had the budget to award five grants. The number of applicants underscores the need to support first nations people wanting to have a career in health.

Now I'd like to speak a bit about the issues that were identified by the Inuit.

Health human resources is a high priority for Inuit. Currently, most health care staff working in Inuit—

● (0930)

The Chair: Excuse me, Valorie, do you have a whole lot more? I've given you quite a bit of extra time.

Ms. Valorie Whetung: Oh, really?

The Chair: Yes, really, but you know, we will have questions.

Ms. Valorie Whetung: Can I just quickly do four points for the Inuit?

The Chair: Please. Yes, of course.

Ms. Valorie Whetung: The four main points for the Inuit were the lack of understanding between providers and parents, high turnover of staff and lack of continuity of care, lack of trust and other issues arising from differences in language and culture, and expensive health care delivery.

Thank you.

The Chair: Thank you so very much. You'll get an opportunity to fill in some of those things during questions.

We're now going into our first round, with seven minutes... I'm sorry, do we have one more? Yes, we do. Sorry about that.

From the National Indian and Inuit Community Health Representatives Organization we have Debbie Dedam-Montour, executive director. We'd be very pleased to hear from you.

Ms. Debbie Dedam-Montour (Executive Director, National Indian & Inuit Community Health Representatives Organization): Okay.

Our organization works on behalf of CHRs, community health representatives. CHRs are the front-line, paraprofessional health care providers who have been serving in first nation and Inuit communities for close to 50 years. Many of these communities are remote or isolated. The CHR's tasks encompass health education, health promotion, and disease prevention based on a concept of wellness where the body, mind, spirit, and soul are interconnected. The view of the aboriginal health continuum is about wellness, not illness.

As an organization, we do our utmost to provide an annual national training session promoting holistic health and to build capacity on various issues ranging from diabetes, to prescription drug abuse, to tobacco cessation, to developing resources on sudden infant death syndrome, to HIV/AIDs, to keeping older aboriginal elders active.

The health needs and human resource requirements are about justice and the right to have basic health needs met and the right to fundamental health protections. It is for this reason that I am here to present the health human resource needs and challenges facing CHRs. I will touch on the related issues, such as community and nursing needs.

As far back as 1943, when the then Department of Health and Welfare assumed the responsibility for the health services of Indians, emphasis was put into providing health institutions and into providing professionals to work in these institutions in the remote areas. In 1958 a different approach was taken that led to a primary health care program being initiated in 1962 with 11 CHR pilot sites. The basic element of the program was the training of Indian and Inuit as primary health care workers to enable them to fulfill a role that expanded the health care system. By the time National Indian and Inuit Community Health Representatives Organization was incorporated in 1992, there were an estimated 717 first nation and Inuit CHRs.

In relation to health needs and human resources, it is unreasonable and unjust that first nations are expected to provide an increased and increasing quality and level of community-based health care with funding that does not recognize population growth and current costs over the past 20 years. In addition, the number of CHR positions or associated funding has remained static since 1990, which was the same time as the introduction of the First Nations and Inuit Health Branch's health transfer policy. There was a nursing transformation strategy implemented around the year 2004 that provided one additional nursing position to remote nursing locations only. Everywhere else the number of nursing positions has remained static since the mid-1990s.

When thinking of health human resources from a first nation and Inuit perspective, our list—and I would have to say considering NIICHRO and many of the communities—is doctors when available, nurses when possible, but more importantly, we think of the stable workforce, workers who come from and live in these communities. We think of the community health representatives, a paraprofessional, and how that role has facilitated community development through the introduction of various health programs, such as the national native alcohol drug addiction program, the Canadian prenatal nutrition program, and the aboriginal diabetes initiative.

The CHR scope of duties is very broad. They work with all community members within all stages of life, from promoting good pre-conception health, right up to providing comfort to those in the last stages of their life. They are key in delivering services from a local context, a lifeline in community health. Yet supports for many CHRs are lacking. CHRs and nurses are absolutely necessary in the delivery of core community-based health services, which at the very bare minimum must provide for immunization, TB, and communicable disease control activities.

In preparation for this presentation, I reviewed the 1983-84 CHR program evaluation study. The recommendations from the study are still issues that need to be addressed: financing of CHR training, taking a systematic approach to training, having CHRs as trainers, a method for allocating CHR resources, having advanced training, and having CHR coordinators.

While this evaluation study is dated over 25 years ago, the situation is still the same. The needs of CHRs remain access to training, competitive wages, and defining their scope of practice, as there is such a diversity in that role across the country.

● (0935)

The Royal Commission on Aboriginal Peoples stated that the CHR program is one of the “most successful programs involving Aboriginal people in promoting the health of Aboriginal people”. It further states that, in particular, CHRs “can help Aboriginal individuals and communities learn to exercise personal and collective responsibility with regard to health matters”. One would believe that such statements would set the stage for greater support and capacity development of CHRs.

Sadly, instead of greater support for the program and these important, stable, and trusted front-line paraprofessionals in first nation and Inuit communities, we have in fact seen the CHR program removed from the compendium of programs at the federal level. Other cuts that support the program were made to the CHR national organization, which had operational funding cut in 2000.

Through our initiative called “Road to Competency”, we have developed a list of seven CHR core competencies and 22 sub-competencies. These competencies are to facilitate development of training programs for CHRs. With support from the Assembly of First Nations, we hope to bring this to the regions for consultation that will lead to development of CHR training programs in each region of Canada.

A well-trained community health provider knows their community and has the trust of the population to work together on the modifiable factors to extend life expectancy, that is, lifestyle, diet, exercise, driving safely, reducing misuse and abuse of tobacco, and facilitating access to care. All of these are within the scope of the CHR duties. Thus, they can generate a positive impact, but they need training, ongoing continuing education opportunities, sufficient culturally appropriate resources, and wage parity.

There are some who have stated that the role of CHRs has diminished or that communities are not hiring CHRs. What NIICHRO has noted is that the CHRs are just being retitled; instead of building capacity and increasing the number of these paraprofessional health providers, a variety of new program positions are being created. These new program workers are doing what CHRs have done for almost 50 years.

Working to increase the number of CHRs and their skills capacity is needed now more than ever as we consider the lack of health professionals in this country. For isolated and remote first nation and Inuit communities, this is especially important, as they suffer from periods when there is no nurse, and they only have access to fly-in doctors. The amount of time these health professionals spend in communities is limited and does not provide continuity and opportunity to build trust relationships, both of which would enable better health outcomes.

The major issue is that there needs to be a policy or formula to address how to correct the base funding of health transfer agreements. That funding was based on populations at the time of the health services transfer in the early 1990s.

Support the first nation and Inuit communities with adequate funding to meet their growing population and needs. Support CHR training so that they can evolve to respond to community needs now and in the future.

● (0940)

The Chair: Excuse me, Debbie. How much more do you have? I've given you a whole bunch more time.

Ms. Debbie Dedam-Montour: I have just another couple of lines, if that's okay.

The Chair: Okay.

Ms. Debbie Dedam-Montour: Support CHRs through a policy that supports program delivery through that position, as they are the stable and trusted health care providers.

Invest in the future by increasing human capital. This will lead to health capital. Thus, increasing the number and skills capacity of CHRs will bring better health outcomes.

Thank you.

The Chair: Thank you very much.

I've let everyone stretch the time because the presentations were so good.

Debbie, yours was very, very good. Thank you.

We're now going to go into the first round of seven minutes of questions and answers.

We will begin with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you very much.

Thank you all for coming. You represent some of the most important organizations in our country at this time. This is a direct responsibility of the federal government, and you look after a population that has the worst outcomes in this country.

In trying to close the embarrassing gap in health status of our aboriginal peoples, we need to know what we have to do. To warn you, my question is going to be, if you got to write the recommendations in our report, what sentence would you want in there in order for you to have what you need to be able to do what you're doing?

We also want you to help us determine what would be the leadership role you would play to help us move the country, for non-aboriginal people, away from the medical model and towards the medicine wheel, because we know that your approach in terms of holistic and wellness is actually the way we have to move the whole of our health and health care systems. We want you to be able to have the resources to lead on that as well.

I was heartened two weeks ago, as I explained to the minister, to have been invited to an NWAC conference where they took 100 bright young 17-year-old women from across the country and tried to persuade them to become interested in health careers. I thought that was excellent, but it seems small if we can only do this little bits at a time. When you have only five positions for 80 applicants on various programs, and if people can't afford to go and do it, we have to have a long-range plan.

After the 2004 health accord, in the 2005 budget there was $100 million put into that. We're not quite sure what happened to it. What we're hearing from all of you is the need for stable, predictable funding is there, and the aboriginal health human resources initiative is a reasonable beginning. I'm quite shocked to hear that the community health representatives aren't part of that strategy, and yet in the remote and rural communities that's sometimes all you have. That doesn't seem quite right.

The Chair: Dr. Bennett, do you want time for them to answer? Half the time has been used up. Do you want them to answer and then you go ahead after? I just wanted you to get your answers.

Hon. Carolyn Bennett: Well, I am happy that they take away the project and send back exactly the language they would want in the report.

The point is, in terms of the homework we need from you, we need to make sure it's as broad as it can be, in terms of also the cultural safety, in terms of the curricula—not only in medical schools but in nursing schools as well.

At CIHR, I wanted to know does the Institute of Health Services and Policy Research deal with the different way of delivering care, or is that relegated to the aboriginal health institute in terms of both the traditional knowledge and cultural safety issues? Is that straddling both institutes, or is it just in the aboriginal institute in terms of health care?

I guess I would like to know how much money you need, how long-term should it be—a ten-year program—and what would we need to actually get on with this so that you're not scrambling, worrying whether your money is coming year by year?

● (0945)

The Chair: Who would like to answer that?

Maybe we'll start with Dr. Anderson.

Dr. Marcia Anderson: I will start.

In terms of how much money, our proposal will be for $850,000 for this year. That would be really helpful. That's not just from AHHRI. We're also working with the Health Human Resource Strategies Division, because this is not solely the responsibility of First Nations and Inuit Health Branch. This affects all of our physicians and all of our workforce, not just the aboriginal health human resources. What would be really helpful is if we could have multi-year funding agreements as well. Part of the big problem with AHHRI is that it is project-based, so it is not core operational funding for our organizations, none of us. And only last year were we able to get a two-year agreement, which means that every year in March, April, May we are trying to cash-manage to keep our programs going until we have secured funding and cashflow, which often doesn't begin until the summertime. It is very hard to run a national organization like that when we have employees too.

The other comment I would make in reference to that is it would be very helpful if there were a mechanism and funding by which our organizations could actually work together more effectively. Of the many common issues, one priority common issue is we need our students to stay in school, graduate high school, with the science and math skills that they need to enter further training. That applies to any health profession or para-profession. If there were a more effective way for us to work together and for the medical schools, the nursing schools, the undergraduate schools we work with to understand that is part of their problem too, it would be really key to advancing this agenda.

Hon. Carolyn Bennett: Does the strategy actually have targets—what, by when, and how, and how many aboriginal physicians, nurses, allied health professionals? Do you have a ten-year plan so that we could close the gap, including public health professionals who could obviously better customize a TB strategy from the bottom up?

Dr. Marcia Anderson: No. As you know, with the Kelowna Accord they set the target of doubling over a period of ten years, I believe. There is no current set target, at least not for the number of indigenous doctors, that's been federally endorsed.

Ms. Audrey-Claire Lawrence (Executive Director, Aboriginal Nurses Association of Canada): Good morning. My name is Audrey Lawrence. I'm the executive director of the Aboriginal Nurses Association of Canada.

Thank you very much for having us here and listening so openly to our comments.

I want to echo and say ditto to everything you have said. I just would like to add some other salient points. One, this is the 35th anniversary of the Aboriginal Nurses Association of Canada, which formed itself to address the issue of improving aboriginal health through improvements to nursing practices and through the support of aboriginal nurses.

As mentioned, with the fact of the uncertain funding structure we went from being operationally funded by Health Canada, which we had been working with in partnership over the 35 years on and off, from 100% funding down to only getting the 10% funding from submitting projects. We have to lay off staff and then possibly be able to re-hire—

The Chair: I'm sorry, I'm going to have to go to the next person. You're way over time.

Monsieur Malo—

Ms. Audrey-Claire Lawrence: Okay.

I have just two short points. One is the support—

The Chair: Perhaps Mr. Malo would like to continue; I don't know.

It's your turn, Mr. Malo.

I've gone over time for all of you.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair.

I heard what Ms. Verret and Ms. Whetung said about the high school completion rate. This reminds me a lot of our hearings on H1N1 prevention measures. We were trying to solve a public health problem while a number of communities did not even have running water. The foundation was lacking.

We are talking about health human resources, but the foundation is not there. Ms. Anderson was clear: we cannot train people to become doctors and nurses, if, at a basic level, they are not able to complete the natural sciences, biology, chemistry and physics courses they need for that health training.

Before you tell us what we need to do for people who are in a position to go to school, I would like to know what we can do, at a basic level, to increase the high school completion rate. I think we need to address that issue before moving on to something else.

● (0950)

[*English*]

The Chair: To whom did you direct that question?

Ms. Verret.

[*Translation*]

Ms. Isabelle Verret: The problem is that young people drop out starting in their second year of high school. Some communities do not even have high schools. Sometimes, only junior high school is offered. That means that 13 and 14 year olds have to leave their communities to go to school in another community or in an urban area. We see the feelings of isolation and stress that this can cause for these students, who are dropped into another reality. In addition, the promotion of health careers is lacking. There is no motivation. First nations see these careers as unattainable. So we need to tell them that is not the case.

Mr. Luc Malo: Why do they see these careers as unattainable?

Ms. Isabelle Verret: Because education in the third, fourth and fifth years of high school is extremely inadequate. Students are not very interested in completing high school. It takes more work, and the education system is not necessarily tailored to how first nations students assimilate the material. That is why students become despondent and drop out very early on. Furthermore, the socio-economic conditions are not conducive to the completion of high school.

Schools are underfunded, but teachers also need to adopt teaching methods tailored to first nations youth. Teachers need to be more motivating and to take an approach that is more hands-on than theoretical. First nations youth learn much better through practice than theory. Teachers need to be made aware of all these factors, which distinguish the communities where they teach, so they better understand them. Unfortunately, the majority of teachers working in our schools are non-native. They need to be educated so they do not end up leaving after two months because of overwork or unsuitable teaching methods.

[*English*]

Dr. Marcia Anderson: The other very important thing I would mention is that the vast majority of our students and physicians were the first people in their families, and often the first people in their communities, to go to university. So we need to consider what makes any child think that a career in nursing or any health profession like medicine is realistic for them.

Our targets cannot be just the students; we also need to look at their learning environment, both at home and in the schools, to ensure that their dreams are being nurtured and they're being inspired. We need to teach our kids to dream big, and then give them the tools they need to take action on those dreams.

Ms. Audrey-Claire Lawrence: Can I add very quickly to that? I used to work in aboriginal education and I am a teacher.

Some of these children come from areas where they've never even seen a three-storey building before. As you said, they transition into a high school that may have 2,000 students. The transition points are really key: better supports for them in high schools with aboriginal advisers, and that transition year Rhonda was talking about.

When they go to university, if there is funding for that transitional year they get used to the campus, get their sciences reinforced, and actually work in proper labs. Then they can start the training. Many universities have found they've really been able to increase the number of aboriginal physicians and nurses when the students are supported. But when they are funded for only four years and they have a transitional year, after year three of a university program their funding runs out and they quit. We just lost another student at the University of Ottawa because of the same thing—funding. You hear these stories time in and time out, and it's so frustrating.

They need access to multi-year funding. As long as they're in the program and doing well, they should still have access to funding. It shouldn't be arbitrary, where they have three years of funding and they're out. The student Rhonda was talking about was offered a grant of $500. How can you go for a full year of nursing training and buy textbooks? The textbooks alone would cost $500.

● (0955)

The Chair: Thank you so much.

We'll now go to Ms. Hughes.

[*Translation*]

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Good morning. Thank you for taking the time to speak with us regarding the issues facing first nations.

[*English*]

I want to touch base on this, because I actually have 17 first nations in my area alone, and I know that northern Ontario is actually quite populated with first nations communities. In particular, the United Chiefs and Councils of Manitoulin have six first nations under their umbrella on Manitoulin Island.

I've heard today that there are funding issues. Education is needed, starting basically at a very young age. There are a lot of inequities as well. I have a briefing note that was prepared in March 2008. I know the concerns have certainly increased.

The Noojmowin Teg Health Centre indicates that they have recruitment and retention issues with staff due to the inability to pay fair market rates for work. Again, not only are they not funded in the same way as non-aboriginal education centres, but there's also an inability to pay those professionals and to maintain them. They also say the staff leave due to the inability to provide a similar standard of funding that's comparable to non-aboriginal hospitals, family health teams, and community health centres.

Ms. Dedam-Montour, I also heard you speak about the fact that funding has been cut. In 2008 Noojmowin Teg was looking for $2 million in funding and appropriate increases. They talked about the 6% increases retroactive to 1997 that were given to non-aboriginal community health centres. We know those were actually under the previous government, the Liberal government, and now it's the Conservative government.

There are inequities. I would almost say it's a discrimination of some type. Could you elaborate a little more on some of the issues that surround this type of funding or the lack of funding?

The Chair: Valorie, do you want to take the first shot at that?

Ms. Valorie Whetung: Yes.

One of the issues for funding is the jurisdictional problem among the province, the federal government, and the regional health authorities. This has a dramatic impact on the ability of first nations, Inuit, and Métis groups to deliver competitive health care.

You don't want me to go into all the examples. They occur everywhere. There are examples of children dying in hospitals because of jurisdictional issues over who's going to look after them when they leave the hospitals, who's responsible for the health care costs, and who delivers it.

There's an example right here in Ottawa. The Wabano Centre operates on a fraction of the amount given by the province to the Sandy Hill Community Health Centre and delivers more services to more people. The inequities are enormous. It's a huge problem.

Mrs. Carol Hughes: Audrey, you had begun to comment earlier, when Dr. Bennett had asked questions. Do you want to finish your thoughts on that? I want to give you the opportunity.

Ms. Audrey-Claire Lawrence: In addition to the comments that were already made about consistent funding and setting up a structure where the work of the non-profit organizations is supported in conjunction with that, rather than on a project-by-project basis all the time, one of the issues we have is that we really don't have a good handle on how many aboriginal nurses are actually in the country, nor do we know what impact the programs and supports have, because there's no consistent data mechanism across the country.

I have contacted every regulatory body across Canada to find out if they're making any move to do more self-identification on the registries. Because many are now online, some of them can do it. They say the regulation comes from the government or CIHR.

It might be a good idea for CIHR to start looking at the feasibility of collecting consistent data across the country on initiatives and things. It's not to assess one province against another. It's for the overall impact or where more support is needed. You can't note improvements if you don't know the numbers.

As is the case in Saskatchewan, because they were able to self-identify and see the numbers, they're at least able to see which programs are really working and have been able to put more funding and support into those areas.

Thank you.

● (1000)

The Chair: Thank you very much.

You do have two more minutes, Ms. Hughes.

Mrs. Carol Hughes: I wanted to give an opportunity as well to Dr. Anderson, because I'm sure that within five minutes—I believe it was five minutes—you didn't have a chance to really put out as much information as you would have liked. So you have the opportunity right now to add something to what we need to do or need to consider.

Dr. Marcia Anderson: Thank you for that opportunity.

Now you're putting me on the spot. Of course, my mind just went totally blank.

I think I would just take the opportunity to really enforce how successful our organizations have been, even in these difficult climates. One concern I would raise again that I haven't dealt with too much is the physician retention and physician support issue. We've mainly focused and often focus on student recruitment and retention. We have not focused as much on physician retention, and I mean physician retention in remote, rural, and underserviced urban indigenous communities.

You mentioned one issue, which is the inability to pay market rates. Our students are graduating with among the highest debt loads because of our higher likelihood of living in poverty. It's an absolute myth that all of us have access to band funding, especially for the duration of medical training. We have new physicians with higher debt loads and generally higher family responsibilities, so asking them to go work in lower-paying jobs under those financial pressures is unrealistic. I think that is a key issue why we may not achieve one of our goals, which is to increase the number of indigenous doctors working in areas where there is a high proportion of indigenous patients.

Further, although we don't have definite studies, I can tell you anecdotally from my personal relationships across the country and in my term as president, we have a very high rate of burnout among our physicians. I think it is because of the very stressful and emotional nature of our type of work. We work in advocacy roles, in addition to providing just straight health care, advocating for not only our communities, but often for our family members, in a system that is extremely unfriendly to us.

We need to do more to support our physicians.

The Chair: Thank you, Dr. Anderson.

We'll now go to Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

I'd like to thank all the witnesses here. We've had very important discussions and presentations this morning.

I'll also reiterate what my colleague started off with, which is on the absolutely unacceptable disparities in terms of health status. I'd also like to acknowledge the work that the CHRs do across this country. I think they are perhaps one of our lesser known paraprofessional groups, not only in the work they provide in rural and remote communities but in the support they give for non-aboriginal physicians and nurses, as they enter into those communities, in terms of supporting them to be successful. Certainly it's important work.

For my clarification, I just want to understand something. Let's say there's a vacancy in a community for a community health representative. To qualify for that position, can anyone be hired and then get the courses as they go? Is there any work towards having those courses perhaps qualify for laddering in terms of credits? Could you maybe just share a little bit more about how that's working these days?

Ms. Debbie Dedam-Montour: The training of CHRs is not a standardized process. If you wanted to be a CHR tomorrow, you could probably get hired. You have no training, you've never done any presentations, you may not have a computer, you just have a telephone and a fax, and you're supposed to provide services to the community. That is some of the reality faced by many new CHRs.

In the past, before the health transfers, CHR training was under the mandate of the medical services branch, or Health Canada, or any of the different names it has had over the years. Once the health transfers came in, much became decentralized, so training in one region might be happening, while in another it isn't. So unfortunately that's what we're seeing.

Last year I was speaking to a CHR. She was a young person, in her mid-twenties, and she'd been a CHR for two years. I asked her, "What was your training?" She said, "Well, I followed her around." She followed the other CHR around, so basically it's on-the-job training. They do take some courses that may give them some skills, and those courses may not have an ability for accreditation, for laddering, etc. That's some of the work we're trying to get done in our road to competency for the CHRs. Our work had originally looked at including all the paraprofessionals in the community, but we weren't able to move it as far forward as we would have liked, so we had to refocus just to do the work for CHRs. That is one of the things we want to see: accredited training in every region. We want to see CHRs giving that proper support so they can do their job better, because they have very important roles in the community, not only for the community members, but, as you mentioned, for the health professionals.

● (1005)

Mrs. Cathy McLeod: Thank you.

I'd like to go over now to Ms. Goodtrack. When the nursing associations or the colleges went from two-year access to four-year, one thing I always wondered about was whether that had a profound impact in terms of aboriginal nurses entering the field or being supported? Did that change make a difference?

Ms. Rhonda Goodtrack: Thank you very much.

The two-year programs are for diploma nurses, you could say, and the four-year programs are degree preparations. When we do health careers in the schools and talk about how many years it takes to be an RN or a physician or whatever, they are just astounded at the number of years. Certainly the funding and the time away from their communities and families all come into play when they decide whether they're going to venture into health careers and take the challenge, so that's definitely a factor. When I talk to them, when I see their eyes in shock, I tell them to figure out what they want to do, because when they put the work in at the front end it pays off when they take on their careers. As for the length of time in the school, invest in that education, because your life and the future of your family and your community will be greatly impacted by it.

However, you have to address the funding and the social supports for these individuals. In terms of recruitment or retention in the remote and rural communities, you'll see greater retention if you educate those individuals from those communities. They're invested in those communities. They have community ties and kinship there. It's important to educate.

My colleague down there was right: secondary is critical. They come to us underprepared in the maths and sciences, and that's where they struggle. That's where they fail. They'll take those classes over and over and over again, and at some point they just give up. Others who want to succeed will stay in there, but the supports have to be in place, and the secondary education is critical.

Mrs. Cathy McLeod: We've heard a great deal about Saskatchewan's success—

Ms. Rhonda Goodtrack: Sorry; I apologize for that.

Mrs. Cathy McLeod: No, no. I think it's very important for us to hear about success, because I think we need to learn throughout the country. Do you know of any other examples of places in this country where they seem to be making really good progress?

● (1010)

Ms. Rhonda Goodtrack: On Monday, when I was at a summit on post-secondary education for aboriginal people in Saskatchewan that was held by the Public Policy Forum, there was a presentation on best practices from Manitoba and Alberta. Manitoba has great success in recruiting aboriginal people into their post-secondary programs, and it's because of the supports that are in place in those institutions. Those supports include student advisers, as I mentioned, who provide a space where students can go and have that sense of community and relate to someone who is facing the same issues. Many themes came out from that summit, but that was a common thread across the country.

Other provinces definitely include Manitoba, and Alberta as well. There aren't any institutions in B.C. I'm sorry about that; I apologize.

The Chair: Thank you so much.

Did you want to make a quick comment?

Ms. Audrey-Claire Lawrence: I wanted to address the issue around the two-year and four-year programs. The level of complexity of care that is required, particularly for nurses in rural and remote areas, really requires that four-year program. Like the physicians' association, we recently established the cultural competencies, and it's much easier to integrate that aspect into the four-year program. They can modify it and have a better understanding and understand the relationships of working with the clients.

As to the whole issue of scope of practice, as Debbie pointed out, the lack of consistency in scope of practice in the CHRs means that the nurses cannot count on the scope of practice in the CHR he or she is working with in a community. It's the same thing; the level of demands placed on nurses in rural and remote communities, and in urban centres, is so high that they really need to be RN-based.

There are also issues of lack of nursing oversight in some communities. We're working with Health Canada to try to address that issue.

Thank you for your question.

The Chair: And thank you for your comments.

We're going to go into the second round. It's a five-minute round, for questions and answers.

I need to make you aware that at about 10:30 Ms. Murray will be taking the chair; I have another event I need to be at.

We will continue with the five-minute rounds, beginning with Ms. Murray now, please.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thanks for your presentations.

I just had the privilege of being in Vancouver and Whistler throughout the 2010 Paralympic and Olympic Games. I went to a number of receptions hosted by the four host first nations. The empowerment of aboriginal peoples that came out of that initiative, as communicated by the aboriginal peoples there, was unbelievable from my perspective as an observer and participant. To me it's inspiring to see how equality, lifting up, and being completely part of the leadership of an initiative must happen with first nations in all other important areas, as it worked so well with the 2010 games.

With that vision of possibility that was expressed in Vancouver and Whistler, I have a question about two things that I have heard today. Essentially, at the risk of oversimplifying it seems to me that everything we're talking about boils down to “attract, train, and retain” in any of the different areas. Dr. Anderson made the comment about teaching our kids to dream big; that's part of the “attract”. I saw that happen with the 2010 games, in the dreams of aboriginal kids to get into sport and to be on the podium and win the gold medals.

One question is, what would be something that would be comparable to attracting, to dreaming big, in health human resources?

The Chair: Who would like to take that? Ms. Goodtrack or Ms. Lawrence?

Ms. Audrey-Claire Lawrence: I think it was mentioned in various comments that if the students get a taste of what is actually involved, that's when they realize that they can do it too. That's when the support for camps, whereby they come in to universities and get to connect, or get the experience of even having access to professors coming in, or of remote tele-health conferences in the north, in which they actually see what science is involved... It's exciting. The provinces are working to support education, but they need to get the sciences earlier; they need to get a taste for it and get better science and math training and possibilities, if they are to see that they can be in those roles.

In particular, we're really trying to emphasize that of the 75% of aboriginal students who drop out of high school, 80% are males. We are really concerned in nursing, because nursing is a community role in which they can have a good-paying job, about trying to recruit more aboriginal males into nursing. We want to get them to feel that they can have the confidence to see themselves in that function, in addition to other health science careers as well. Those efforts pay off in the long run.

Then there's the ability of organizations to stay in touch with them. You see a kid in grade eight and you send them an e-mail every year. You talk to them and ask whether they are still continuing, how they are doing with their math, and whether they need a tutor—that kind of thing. We're looking at doing more cyber-mentoring with our students across the country, just so that they turn to someone, rather than just quit because they think they can't do it.

● (1015)

Ms. Joyce Murray: So it's a question of nurturing the dreams they have. I would like to get my second question in, Rhonda, but I am interested in your comments as well.

Ms. Rhonda Goodtrack: There is also a program called the Pre-Health Professions Club. It links up high school students who have identified that they are curious about a health career with a mentor in either medicine, nursing, or pharmacy at this point, and there are other health groups that we'll be exploring. It gives them an opportunity to job-shadow that individual for eight hours.

It's a great opportunity, because they get to see whether that's the profession for them. And they stay connected with the students.

Ms. Joyce Murray: That question was around “attract”. Another one is around “train”.

The systemic lack of stable funding is very worrisome and unacceptable, especially when comparable organizations I'm hearing about that are non-aboriginal get that kind of funding. There are jurisdictional problems leading to this.

Again, my touchstone for comparison is the 2010 games. Early on —in 1998, 1999, 2000—the leadership for those games set that vision of absolute equality for first nations as hosts and completely part of the leadership and drivers.

Something like that has to happen here for your organizations' and first nations' success and training.

Whose responsibility is this? Is it a federal responsibility to ensure that this kind of interjurisdictional squabble is not leading to a lack of nurturing or support?

Dr. Marcia Anderson: I think we need to recognize that it's the responsibility of all of us. Half of our population is urban, so it is not exclusively a federal responsibility; we all have to step up and play our roles.

When I was in St. Theresa Point about a month ago now, we had a forum on public health and improving the public health system. One of the things we talked about was public health human resources. A community member there asked why health is not working with education to build something like a feeder education system. We have specialized schools in which they say they want to train more engineers, or they have an excellent basketball program and everything in the curriculum is geared to that. Why are we not doing this with our education systems, whether in a first nations school that's directed by a first nation, in Inuit communities, or in urban schools where there are high proportions of aboriginal peoples? Why do we not work with our education colleagues?

I think the four host first nations provide an excellent example. They identified who the relevant stakeholders were—it was the four first nations—and identified their common goal, which is to empower their communities to ensure that they got part of the benefits from hosting and to ensure that there was meaningful education and participation for everyone who came there.

Why can't we work with all of the relevant partners, including those around the table here today—our organizations—and the provincial education, the federal, and the first nations education holders, to make this happen in a systemic and sustained way?

The Chair: Thank you, Dr. Anderson.

I'm sorry, Ms. Murray; we'll now have to go to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair.

Thanks very much to each and every one of you for being here this morning. We certainly heard some very interesting testimony. I applaud you for the roles you have taken with your organizations in moving things forward in the way that you have.

My first question is going to be for Ms. Goodtrack. I'm referring to the testimony you gave us earlier. I'll ask two or three things about it, and you can continue then.

Could you enlarge a little on your transition program, which you were speaking about?

You also talked a bit about the discrepancy involved in the definition of a full-time student. To me that is something that should be simple to fix. How does it get fixed? Maybe the things that should be the simplest are often the most worrisome to get to the bottom of.

You talked a bit about space dedicated to aboriginal students.

Could you elaborate a little more on those three items, please?

● (1020)

Ms. Rhonda Goodtrack: Thank you very much.

On the transitional programs, we have a program called the aboriginal first year experience program as well as the math and science enrichment program at the University of Saskatchewan. Both programs are meant to give students the basic arts and science classes. It is the stuff they would take no matter which discipline, which college, they go to.

The classes are a lot smaller. They build a sense of community among the students, because they're used to a smaller classroom. Whether they're in their community in high school or are from a rural setting, it's a smaller classroom. They're not overwhelmed by taking biology with 120 to 200 other students. Also, it's easier to ask questions. If they don't know anything, then everybody else looks like that. They understand the content.

There are extra tutorials set aside so that the students can better absorb the content. As well, in our programming we provide monies for extra tutoring outside those tutorials, in case they can't make it, for whatever reason.

There is an English class offered over the summer. What they do is apply, and then they take the class. They get the reading and writing skills, which are critical for being able to do any other papers. It's a slower pace, a more relaxed pace, and they're meeting other individuals who will be taking university classes. So they're already building that community before university starts, before the September rush.

You asked about the discrepancy between the definitions of “full-time student”. I think the reason for that difference is that it's now a competition for funding dollars. When I went to school, there was just me. In that nursing class, there was just me. I was the only Indian in that class. Now there are 32 in Saskatoon, 32 in Regina, and 40 in Prince Albert. That's a lot. That's a lot of competition for those dollars, and I think that's part of the reason. A lot of people are falling through the cracks. There's no question there.

In regard to the space, we have dedicated student lounges for our aboriginal nursing students. It gives them an opportunity to just unwind and come together.

It is an intensive group, and they break them up into smaller groups and they're not all together. It's a smaller group, so that's good, but sometimes someone is the only aboriginal in a smaller group. The lounge gives them an opportunity to come together, talk to each other, and debrief. They can articulate the common problems they're having, or better yet, they can help each other out. They'll share notes and share assignments. The second-year students will help the first-year students navigate their way through, as well, when we're not there. It gives them a sense of belonging. They build a nice community, and that carries them through the four years.

I just had a conversation with one of my students. She was confronted by a non-aboriginal nursing student who said that there was a controversy going on about the aboriginal students. She said that they had heard that the aboriginal students have their own space and that none of the non-aboriginal students are allowed to enter. I'm not sure where that information got circulated. They had also heard that the aboriginal students have special luncheons, and the information that's shared they're not allowed to share with the rest of the students. That's completely false. All we're doing at those luncheons is having a third-year student come in to talk to the second-year students to tell them how to ease the transition into third year.

Right now, how it is in Saskatchewan is that you take first and second year at one campus, and you take third and fourth year at another campus. So there's fragmentation. When you transition into third year, that student said, this is the best way to do it. They can tell you that when your teachers say to read the cardiology and neurology notes before September starts, do it, because they expect you to have read them by September; it's common knowledge.

● (1025)

The Chair: Thank you very much for your very insightful comments. They're very useful to this committee.

I now go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you very much, Madam Chair.

I want to thank the witnesses for being here today. I also want to echo what my colleague Mr. Malo said earlier about one of the key problems being the lack of funding for aboriginal communities. Similar to the problem of dealing with H1N1, without basics such as drinking water, the matter of developing students and encouraging them to have dreams and the desire to pursue them is more complex.

What I find fascinating is that, instead of giving up and being negative, you are extremely optimistic and you continue to fight, day after day, for the ability to instill in these young people the desire to pursue meaningful careers in medicine. That is very much to your credit, and I want to commend you.

That being said, I would like to talk about initiatives. A little earlier, we heard about some real initiatives that successfully captured the interest of young people in communities and engaged them.

First, I would like each witness to give us a tangible example of an initiative that was successful at the local level in terms of encouraging and engaging youth. At the same time, I would like to know if you have methods for communities to share information on initiatives that work so as to promote their implementation—I know that there can be cultural differences.

Mr. Michel Deschênes (Policy Analyst, First Nations of Quebec and Labrador Health and Social Services Commission): Perhaps I can speak for the Quebec region. Last year, in terms of doctor training, for example, we set up a program in conjunction with four universities that have a faculty of medicine. The purpose of the program is to give the most successful aboriginals—those who have managed to overcome all the barriers but who are still lacking in a few areas, curriculum or otherwise, in terms of meeting the requirements for university—access to a university program reserved for aboriginal students.

That is one measure that makes it a little easier for these students to access a university education. A mentoring program is then set up to support them throughout their studies, because obviously, in the end, they will have to meet the same licensing and certification requirements as other doctors. That is an initiative that was developed in Quebec and that has been in place for a year and a half.

In association with that, there is an officer, here at the commission, who is responsible for visiting communities and explaining to youth how they can access medical training in Quebec. The officer explains the prerequisites and the procedure, and takes students—starting at the high school level—to visit the campus and meet with people who explain to them what university studies involve and what their future could look like.

I think this is an example of an initiative that can be developed. Again, it is based on initiatives undertaken by aboriginal partners, who themselves decided that this was a way to interest youth, that it was possible, obviously, as a result of financial support from the federal government and the cooperation of the universities. So this is a type of partnership and approach that can be used to give young aboriginals a dream—as someone said earlier.

Imagine the impact that this can have. A young aboriginal who follows this path, who successfully becomes a doctor and who goes back to his community to show that it is possible to have a dream and to make that dream come true in Quebec—or anywhere in Canada, for that matter. That is a very powerful incentive. The same could be done in other fields.

● (1030)

[*English*]

Dr. Marcia Anderson: If I might comment, I appreciate both your and Monsieur Malo's comments about H1N1 and the underlying social determinants of health, and I believe I referenced them when I was here speaking at the H1N1 meeting.

What I think is really important that we all make very clear is that the underlying social determinants of health are also the underlying determinants of educational success. In order for us to make really broad steps here, we need a broader understanding that in society at large, in education, in health, and in government... In order for us to move on that, a lot of the funding decisions and policy decisions that need to happen have to happen at that level.

The Vice-Chair (Ms. Joyce Murray): Thank you.

It's now Dr. Carrie's turn.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I want to thank all the witnesses for being here today.

My biggest problem I'm going to have is where do I start. There's really not a lot of time in a situation like this, but I would like to focus on solutions. If you don't get a chance to speak, could you put it in writing for us, because we are looking to you for leadership.

When you talk about solutions, I thought Madame Dedam-Montour had a great comment talking about wellness versus illness care, and if we were able to implement that across the entire health care system, how would we go about doing that?

Dr. Anderson talked about high-quality, culturally sensitive care. My colleague here said this seems simple to fix, but if it were simple to fix, I think it would be fixed by now. I, myself, as an observer, look at the challenges, and they seem almost insurmountable. You look at the federal government bureaucracy, then you're looking at the provincial government bureaucracies, then you're looking at municipal bureaucracies and first nation political bureaucracies. Then we have professional bodies and their bureaucracies. I don't know any simple solutions to this, but I am looking forward to your input, especially since we're studying human health resources.

The federal government has money out there, and I think, Valorie, you mentioned the problem with the resources to follow through at schools. Is there support for things like, for example, voucher systems, where money goes directly from governments to the students so you bypass a lot of that bureaucratic garbage that the students have to find their way through? You mentioned programs. The kids should be allowed to follow through with the programs. If it's a three-year program and they don't have the funding to follow through, how do you go about doing that? What are the solutions?

I hear there have been some successes with the aboriginal student nursing mentorship program. I was wondering if you were able to comment on that, and even on using the online mentorship forum, the technology that's available today.

With those comments, I'm going to be quiet, and hopefully we can give you at least some time to comment on that, because I'm looking forward to your input. Thank you.

Where do we start?

Ms. Audrey-Claire Lawrence: As everyone has pointed out, there is no simple solution, and going for simple solutions won't help. But there are things that can be done, and we should be moving ahead and supporting all of those initiatives and looking at them—keeping the big picture in mind but supporting the smaller ones.

One of the big things that has happened is the cultural safety work that has been done by the physicians' association and with the Aboriginal Nurses Association. Not only is it a benefit to the recruitment and support of aboriginal nurses, but it also educates the non-aboriginal population on the issues concerning aboriginal health and aboriginal people. When you have that mutual respect and understanding, it fits in there. The work that's being done and bringing that culturally safe curriculum into place is going to be very important in the future.

Work is just starting on that. Pharmacology courses will be addressing issues concerning traditional medicines. That's a benefit not only for aboriginal people but also for people of Chinese and other ethnicities.

All of the work that's being done in the cultural safety aspect primarily benefits aboriginal people because of the constitutional recognition, but it also suits the other diversities of Canada. That work needs to be continued and supported throughout the schools. The work that the schools are doing in education, such as saying "let's start working more in interdisciplinary and partnership teams so that we can look at and identify the things to keep moving forward", I think is going to be paramount.

You had asked earlier about one example. One thing that was done was the University of Manitoba would tell their students in the transition year that if you could get your grades to a certain point, we will take you in, you don't have to reapply. That was very motivating and part of their success. Plus there were supports in there. Those are the kinds of small things to build on, while at the same time other work is happening.

● (1035)

The Vice-Chair (Ms. Joyce Murray): Thank you.

Ms. Whetung.

Ms. Valorie Whetung: I think one of the things we always need to keep in mind is self-determination. As long as the decisions on education, health, and entrance are determined by non-aboriginal people without input from the people who know best how to solve these things, they're not going to be solved.

If I could give any feedback to this committee, it's that we need more ability to influence how these things are rolled out, how funding decisions are made. It's all about self-determination and giving control to us. I was in a meeting this week on food security. There were probably 40 people in the room. It was food security for aboriginal folks, and there were two aboriginal people in the room. I was one of them. How can these decisions be relevant if we're not key people in how it rolls out?

You mentioned jurisdiction. That's a huge problem. We need to find a way we can address jurisdiction by maybe giving some of the authority for decision-making back to the aboriginal people, who have solutions. We have solutions if we're in a position to make decisions.

The Vice-Chair (Ms. Joyce Murray): Thank you. We have to move on to the next question.

Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair.

Thank you, everyone, for coming.

I am struck by the links with education and health. We talked about how in high school students are struggling with math and science and we probably have to go back earlier to figure out why. I'd love to address that, but I'm going to start with the universities and colleges.

Do we have data on what percentage of our university and college population is aboriginal?

Dr. Marcia Anderson: No.

Ms. Kirsty Duncan: None.

Dr. Marcia Anderson: Very little. First, you should understand that most of the universities do not collect any self-identified aboriginal information, and when they do they are very reluctant to release it externally, so we don't have any access to that data.

We have tried to address that by starting to survey indigenous physicians and medical students directly to try to count how many there currently are, but as Audrey mentioned previously, there's no systematic way to do so right now.

Ms. Kirsty Duncan: That's what I wanted to know. Okay.

How many spots are there for aboriginal students in universities and colleges, and what is the level of funding for students?

Dr. Marcia Anderson: Again, the number of spots is going to vary by university and by province and by program. I think what's important to realize is that an aboriginal student can apply to any university through the general programs and get admitted, but I think what you're probably referring to is the number of designated seats that are specific for aboriginal programs. In medicine it ranges from zero in some of the schools to as high as...I believe B.C. would probably be the highest, and they're upwards of ten now per class year.

Ms. Kirsty Duncan: Zero to ten.

Dr. Marcia Anderson: More than ten. I can't remember the exact number.

Ms. Kirsty Duncan: What's the funding structure? I had medical students come to my office and they were talking about how it is so difficult. Medicine costs now, and they were saying that in Toronto, unless you're from Rosedale, it's challenging. What's the funding available?

Dr. Marcia Anderson: It's variable. The registered first nation students may have access to band funding, depending on if their band has rules about the maximum number of years they're eligible for funding, or the maximum number of degrees, since everyone has to have a prior degree. Then there would be the bursary programs that are available that may be federal, such as through the National Aboriginal Achievement Foundation or provincial or local or directly through the university. It's extremely variable across the country.

Then of course there are student loans. We know that aboriginal students are less likely to want to take on student loans than other students, so that's not always seen as the same option.

● (1040)

Ms. Kirsty Duncan: What is the average debt load for a medical student or a nursing student when they leave, and how does that compare to the non-aboriginal population?

Dr. Marcia Anderson: We don't have evidence-based numbers on that; it's anecdotal. For the general population we know it's over $100,000 now for a medical student. Anecdotally, and because I've been in a position to see some scholarship applications and stuff, we often see numbers that are higher than that, but I can't give a firm answer.

Ms. Kirsty Duncan: Thank you.

Ms. Lawrence, you had started to talk about the funding that was available. You said originally it was 100% and it's now down to 10%. Could you talk about that, please?

Ms. Audrey-Claire Lawrence: As with NIICHRO and IPAC, we have been moved to project-based funding. If you don't have any core funding it's very hard to take on projects or have sustainability of staff. While we're not necessarily looking for 100% funding—though that would be ideal—even having a certain base capacity so we retain a certain core staff that is able to continue and then go for additional funding for specific projects and things...

One of the concerns we have is we are not accrediting bodies. Our nurses and our physicians must get their accreditations and licences from other regulatory colleges and nursing associations.

We're an interest group, so asking our members even for an additional $50 or $60—we just raised our rate because we have to get some funding—only drives out the number of nurses who will be members, because that's a third tier. Some of them are already paying over $900 for their regulatory association and nursing membership fees, so that little bit, when they're single parents, is too much more. So we cannot really continue to sustain that.

I think the fact that we work in a very effective and cost-efficient partnership, bringing in that voice that's needed about solutions, as Valorie says, means there is some responsibility to help support the associations that can help work on these: what are the priority areas, how can we have some successes, and how do we work on those long-term issues to bring effective change?

Ms. Kirsty Duncan: Thank you, Ms. Lawrence.

The Vice-Chair (Ms. Joyce Murray): Thank you.

Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you, Madam Chair.

I'm curious about how the recent changes to Ontario recruitment and retention abilities have affected the aboriginal communities in Ontario. I come from the riding of Barrie, where we have huge physician shortages. They came out two weeks ago with changes that said if you no longer meet the rural index they will no longer be able to offer tuition paybacks or incentive grants. In my community that means $55,000 that the community can no longer offer, and 17 doctors in my riding are affected by that.

Is this affecting areas with aboriginal populations, and is it something you were able to use as an incentive previously? Is it something that the province didn't make available?

Dr. Marcia Anderson: This is the first I've heard of it, so I'm not going to pretend this is a well-thought-out and researched answer. I can certainly see the potential for that to affect our communities. I'm from Manitoba, so I'm less familiar with Ontario policies, and I defer to anyone else who is. Everyone else is shaking their heads.

I think it relates back to the previous issue about funding parity and the ability to offer competitive packages. I'm not sure how your rural index is calculated, but based on community size, many small, distributed communities often can't support a full-time physician anyway. Anything that makes it harder or more challenging, and where they may be more likely to pick a place where they are eligible for that bonus, could be a step backwards. I can see how that could potentially be harmful.

Mr. Patrick Brown: I know that was the most effective carrot we were able to offer, so I imagine if that's been taken away from the aboriginal communities in Ontario as well it would be particularly challenging.

What types of recruitment efforts are utilized? What tools are you given and what tools would you like to be given to entice doctors to aboriginal areas?

● (1045)

Dr. Marcia Anderson: Salary certainly is one. One of the real challenges our physicians face is if they are working in small communities and have to maintain fee-for-service practices, it can be very difficult to make competitive salaries. So there's a preference to maintain salaried positions, despite the health care system's attempt to shift away from them. So maintaining salaried positions is going to be one real key.

In Manitoba there are northern recruitment bonuses as well. I think it's important to realize that, at least in Manitoba, all physician services are paid for by the province. It's the province's responsibility to recruit and retain physicians and set the bonuses. So we need to continue to support our provinces in that.

The third thing I will mention is the support that's necessary for any professional when they're in a small community on their own, whether they're a nurse, a physician, or a CHR. We all need to have that kind of professional and personal support, and I think that is really an area that's overlooked. Our organizations need to have the capacity to pay for ongoing cyber-technology, whether it be for "webinars", online mentoring forums, or what not. We need to do a better job of supporting our staff when they are in remote rural locations.

Mr. Patrick Brown: In Ontario and Quebec we've started to see investments in nurse practitioners as a way to help alleviate some of the shortages. In Ontario they have the one-to-four ratio, where every four doctors can have the use of one nurse practitioner if they can find them. In my riding a nurse practitioner can take 800 patients off the wait list, but the challenge is that many of the doctors don't want a nurse practitioner or haven't been able to get one because they're still in the elementary stages of educating and training enough nurse practitioners in Ontario.

Do you find that to be a similar challenge? Is there an adequate number of nurse practitioners in aboriginal communities?

Ms. Audrey-Claire Lawrence: I think the issue Rhonda highlighted is that a lot of funding is at the base level to get people in, and we don't want to erode that funding, because it's inadequate as it stands. But when people try to bridge or build up their programs so practical nurses become RNs, and RNs become nurse practitioners, the funding may not be available or may be incomplete.

There's the issue of being able to hold a position while somebody takes a year off to complete a degree program or obtain the credentials they need to be a nurse practitioner. There's nothing wrong with putting in an employment requirement that they have to stay in a position for two years after an employer has paid for training. That kind of thing would be fine, but people need the funding at the time. As mentioned, many of the people who do make it as nurses and physicians tend to be more mature students. They have families and kids. So there's the issue of day care funding. Other related expenses also need to be taken into account. I think that area needs to be explored.

The Vice-Chair (Ms. Joyce Murray): Thank you.

Ms. Hughes.

Mrs. Carol Hughes: Thank you.

I have a question with respect to the First Nations University of Canada in Saskatchewan. I'm assuming that there are health courses being given there. I'm wondering, based on the fact that the government has pulled the funding from that university, what the impact will be on some of the first nations who are taking the courses there, if any.

Ms. Rhonda Goodtrack: Thank you very much.

Currently we have students enrolled in the nursing program at First Nations University. As I said, it's a partnership between Saskatoon, Regina, and Prince Albert, and they have students in all sites. All the students who are currently enrolled will be able to finish their program. I believe the University of Regina will be managing that piece.

In terms of future or prospective students, they come to aboriginal-run institutions such as First Nations University because of the indigenous piece that's there. They want that piece. If First Nations University isn't allowed to continue, students are going to miss out on it, absolutely.

I can't comment on administration at this point, but the capacity to have the indigenous knowledge piece incorporated is critical for aboriginal health care.

● (1050)

Mrs. Carol Hughes: Just to add to that, how important is it, because there is a lack of the cultural aspect in the general education for health professionals, to ensure that it is put into all the curriculums for health care?

Ms. Rhonda Goodtrack: It is very important that indigenous knowledge be incorporated in all health disciplines. We have been working with the Indigenous Physicians Association of Canada. We have a cultural competency framework that is discussed in the briefing note that was circulated and is also on our website for download. It's very important that this piece be incorporated to help improve the care that the practitioner delivers to the end-user, the patient, the client.

Mrs. Carol Hughes: I want to touch upon the silos that are currently out there; I'll leave this question open.

When we're looking at the life expectancy of registered Indians, it's 6.6 years less than that of the Canadian population—that was in 2001. And I'm looking at the Auditor General report of 2008: the infant mortality rates, the incidence of tuberculosis, the diabetes rates are all higher. So we're not just talking about doctors and about nurses; there are many other health care needs out there. I can tell you that Wikwemikong First Nation has been advocating for a dialysis machine, and in Manitoba people were looking for an X-ray machine.

How imperative is it for us to address the need out there for other health care professionals? Do you have any suggestions for how we can address this issue?

Dr. Marcia Anderson: That is an excellent point, the range of health professions that ought to be looked at. One of the reasons we can be here today as organizations is that we have reached a critical mass in our profession. We're very thankful for it. The reason we don't see physiotherapist organizations or occupational therapist organizations or pharmacist or X-ray techs is that they don't have that critical mass yet. We have to tread the very difficult line of taking care of our own interests as mediciners—nurses or CHRs, etc.—rather than ensuring that our students are aware of the range of options available to them.

If you're talking about a student from a rural remote community, they'll never have seen an occupational therapist or have any clue as to what it even means or what that person does. I know that's probably true for most of the general population, though: occupational therapy is a tough one.

This goes back to one of the points I raised earlier, which is that we have to be working with students, families, and teachers much earlier to ensure that when students are at an age at which they can start to understand what the range of different health professions is, they are prepared to enter one, whether they want to be the CHR and work in heath promotion in their community or want to become an X-ray tech or a PT or whatever. It's the common beginning that we need to focus more on.

The Vice-Chair (Ms. Joyce Murray): Thank you, Dr. Anderson.

It's Ms. Block's turn.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair.

This has been a good conversation to be included in. I'm not a regular member of the health committee. Before I was a member of Parliament, I was the chair of a district health board in Saskatchewan in the third-smallest health district in Saskatchewan and then a member of the largest health region, Saskatoon. It seems to me we were discussing these very issues back in 1993, 1994, and 1995. I believe some progress has been made. I'm hearing that from you. I recall back in 1997, as the chair working through the SIMAS agreement—I don't know, Rhonda, if you're familiar with the Saskatchewan Indian and Métis Affairs Secretariat when we were trying to find ways to encourage first nations young people to get involved in health care professions.

I believe we've made some progress with the first nations graduates coming out of post-secondary education. Simply because we're talking about recruitment and retention and trying to recruit health professionals to remote and rural areas, do you have any data on how many are returning to their home communities and providing services?

● (1055)

Ms. Rhonda Goodtrack: There's nothing in place to be able to capture that data. Anecdotally, some are returning. We were talking about the experience of one of my students in the nursing program. She's from Onion Lake on the Alberta-Saskatchewan border, and I asked her if she was going back when she'd done nursing school. She said ideally she'd love to, but the reality is she's going to stay in an urban centre until her kids are done school, because she doesn't want them to struggle the way she is struggling in the maths and sciences.

Dr. Marcia Anderson: We are trying to collect that data through the survey I mentioned before. We don't have it yet. One thing I often state is to keep in mind what it means to work in indigenous health and serve the indigenous community in Canada. Certainly one way is by working in rural and remote first nations, Inuit, and Métis communities, and also by teaching indigenous health in the faculties of medicine; by working in urban centres, since 50% of our population is urban and all tertiary care is delivered in urban areas; by working in health policy; and by working in indigenous health research. I passively encourage our members to work in any of those areas, not just in the remote and rural communities.

The Vice-Chair (Ms. Joyce Murray): That concludes our meeting. I want to thank you for taking the time from what are obviously very busy schedules and the tough issues you're working to resolve on behalf of Canadians. So thanks for coming to help us understand these issues better.

I would like to let the members know that the Subcommittee on Neurological Disease is meeting right now.

The meeting is adjourned.

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