Indigenous medical workforce development: current status and future directions

Ian P S Anderson, Shaun C Ewen and Debra A Knoche

Both more Indigenous doctors — for the sociocultural capabilities they bring — and better sociocultural education of all medical students will be needed to "close the gap"

When Prime Minister Kevin Rudd and representatives of Australian health leadership signed a statement of intent to close the Indigenous health gap by 2030, they committed to putting in place by 2018 the primary health services and other health infrastructure necessary to achieve this goal.[1] Although health service development has been key to the national policy agenda in Indigenous health since the National Aboriginal Health Strategy in 1989, a high level commitment to workforce development was not in place until the Australian Health Ministers' Advisory Council endorsed the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework in 2002.[2] This priority was subsequently reinforced when the National Indigenous Health Equality Council was established in 2008 — with a significant focus on workforce strategy.[3]

There are two key issues in Indigenous medical workforce development — the relative undersupply of Indigenous Australian doctors, and the need to equip all Australian medical graduates with the skills, knowledge and attributes to provide quality health care to Indigenous Australians regardless of where they present in the health system.

Indigenous Australians represent 1.9% of the total population aged 15 years and older, but only 1% of the total health workforce.[4] In 2006, there were 100 Indigenous Australian medical practitioners (0.2% of the total), including 40 medical specialists.[4] In 2008, the Australian Indigenous Doctors' Association (AIDA) estimated that there were 125 graduates, with another 125 in training (an estimate consistent with figures previously published in the Journal).[5,6] According to 2006 census figures, the proportion of doctors in the Australian population was 0.27%, while the proportion of Indigenous doctors in the Indigenous population was 0.019%.[5]

Increasing the participation of Indigenous people in the health workforce is an important workforce development strategy, as well as an important goal to pursue for equity reasons. Indigenous Australians can contribute to improved quality of care by aligning their technical and sociocultural capabilities to maximise patient or population health outcomes. The presence of Indigenous practitioners in the health workforce adds a collegiate dimension to relationships between non-Indigenous practitioners and Indigenous Australians, and this has the potential to facilitate reform in health care practice. To that end, the leadership provided by Indigenous practitioners in health research and education is also important. However, the responsibility for quality health care for Indigenous people is one that must be shared. Non-Indigenous colleagues play a critical role, which is why all graduates need to be equipped to work across the entire range of Australian sociocultural contexts, including in Indigenous health.

The Indigenous health medical workforce agenda has been implemented through a broad partnership that includes AIDA, Medical Deans Australia and New Zealand and the Australian Medical Council. This has resulted in a suite of tools for supporting medical school reform and revised standards and procedures for medical school accreditation.[7-10]

There have been two recent developments that we anticipate will provide further impetus in curricula development.

The first is the development of the Critical Reflection Tool (CRT).[11] The CRT was developed to support medical schools in their efforts to implement the national Indigenous health curriculum framework and their initiatives to support Indigenous students. It was designed to cover the broad context of medical schools in implementing an Indigenous health reform agenda. The CRT provides an opportunity for medical schools to critically analyse factors such as their structural relationship with existing Indigenous health units, and the aspirations of the medical school as articulated through mission statements, through to the detail of the curriculum itself (including teaching and learning, assessment, implementation and review and evaluation) and Indigenous student recruitment and retention initiatives and strategies.

All medical schools in Australia and New Zealand were invited to trial the CRT in October 2007 through to June 2008, and 12 of 21 schools were able to provide feedback within the timeframe required. Trial findings endorsed the content of the CRT.

The second development supporting curricula development is the creation of the Leaders in Indigenous Medical Education (LIME) Network for medical educators, specialists in Indigenous health, policymakers and community members with an interest in quality Indigenous health content in medical education.[12] Medical Deans Australia and New Zealand established the LIME Network to provide a forum for medical educators in Indigenous health, promote the exchange of best practice and facilitate professional development. The Network hosts a biennial conference to facilitate dialogue on Indigenous health between medical educators, colleagues across the other health disciplines and community partners.[12]

There is still much work to be done to increase Indigenous participation in the health workforce, and to develop medical schools into places that produce a workforce fit to meet the needs of Indigenous Australians. Clearly, there is a significant undersupply of Indigenous doctors, but as yet there are no nationally agreed targets. This is an important policy agenda and a brokered agreement on targets by key stakeholders would enable a more robust framework for monitoring change. Targets should be achievable and take into account high school retention rates, tertiary readiness, potential pathways and population demographics.

Nationally, the track record for medical schools in recruiting and retaining Indigenous students is very mixed. Institutions such as the University of Newcastle, the University of Western Australia, James Cook University and the University of New South Wales

clearly lead the field.[6] There is a debate about whether strategy should focus on building the programs within schools with a proven record of success, or whether all medical schools should be encouraged to do better. Our view is that the system should enable Indigenous students to select the university that will maximise their opportunities for personal success. However, this would require more universities to develop the comprehensive integrated programs that develop pathways through secondary education, promote health sciences as a career choice for Indigenous Australians and provide robust support for the academic and social development of enrolled students. Graduate attributes are arguably the best marker of efficacy in curriculum reform. The CRT provides a framework for internal reflection by medical schools on their structures, curricula, and recruitment and retention strategies, to maximise their potential to graduate Indigenous and other students who can contribute to "closing the gap".

Acknowledgements

Funding for Medical Deans Australia and New Zealand Indigenous Health Project (2004–2007) was provided by the Australian Government Department of Health and Ageing (DoHA). Core funding for the Onemda VicHealth Koori Health Unit is provided by the Victorian Health Promotion Foundation and the DoHA. Onemda receives funding support from the Cooperative Research Centre for Aboriginal Health.

Competing interests

Ian Anderson is the chair of the National Indigenous Health Equality Council (NIHEC). The Onemda VicHealth Koori Health Unit hosts the Leaders in Indigenous Medical Education Network for Medical Deans Australia and New Zealand. The views expressed in this article are those of the authors and do not necessarily reflect the position of the NIHEC or Medical Deans Australia and New Zealand.

Author details

Ian P S Anderson, MB BS, FAFPHM, Director
Shaun C Ewen, BAppSc(Physio), MMIL, Senior Lecturer and Deputy Director of Academic Programs
Debra A Knoche, BA(Hons), Research Assistant

Centre for Health and Society and Onemda VicHealth Koori Health Unit, Melbourne School of Population Health, University of Melbourne, Melbourne, VIC.

Correspondence: i.anderson@unimelb.edu.au

References

1 Australian Human Rights Commission. Close the Gap: Indigenous health equality summit. Statement of intent. Canberra, 20 Mar 2008 http://www.hreoc.gov.au/Social_Justice/health/statement_intent.html (accessed Jan 2009).
2 Standing Committee on Aboriginal and Torres Strait Islander Health. Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. Canberra: Australian Health Ministers' Advisory Council, 2002. http://www.ahmrc.org.au/Downloads/Workforce%20Development/wrkstrgy1.pdf (accessed Apr 2009).
3 Rudd K, Prime Minister of Australia. Joint media release with the Minister for Health and Ageing and the Minister for Indigenous Affairs. Rudd government tackles Indigenous smoking rates and health workforce in next down payments on closing the gap. 20 Mar 2008. http://www.pm.gov.au/media/Release/2008/media_release_0143.cfm (accessed Apr 2009).
4 Australian Bureau of Statistics and Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. Canberra: ABS and AIHW, 2008. (ABS Cat. No. 4704.0; AIHW Cat. No. IHW14.) http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/51B575E133A75C6DCA2574390014EDFE/$File/47040_2008.pdf (accessed Apr 2009) .
5 Anderson IPS. The knowledge economy and Aboriginal health development. Dean's Lecture, Faculty of Medicine, Dentistry and Health Sciences, 13 May 2008. Melbourne: Onemda VicHealth Koori Health Unit, University of Melbourne, 2008. http://www.onemda.unimelb.edu.au/docs/deanslecturefinal.pdf (accessed Apr 2009).
6 Lawson KA, Armstrong RM, Van der Weyden MB. Training Indigenous doctors for Australia: shooting for goal. *Med J Aust* 2007; 186: 547-550.
7 Phillips G, on behalf of the Project Steering Committee, Committee of Deans of Australian Medical Schools. CDAMS Indigenous health curriculum framework. Melbourne: VicHealth Koori Health Research and Community Development Unit on behalf of CDAMS, Aug 2004. http://www.limenetwork.net.au/system/files/cdamsframeworkreport.pdf (accessed Apr 2009).
8 Minniecon D, Kong K. Healthy futures: defining best practice in the recruitment and retention of Indigenous medical students. Canberra: Australian Indigenous Doctors' Association, 2005. http://aida.encode.net.au/res/File/pdf/AIDA_Healthy_Futures_Report.pdf (accessed Apr 2009).
9 Australian Medical Council. Assessment and accreditation of medical schools: standards and procedures. Canberra: AMC, 2006.
10 Mackean T, Mokak R, Carmichael A, et al. Reform in Australian medical schools: a collaborative approach to realising Indigenous health potential. *Med J Aust* 2007; 186: 544-546.
11 Medical Deans Australia and New Zealand. The LIME Network. Leaders in Indigenous medical education. Critical Reflection Tool (CRT). http://www.limenetwork.net.au/CRT (accessed Apr 2009).
12 Medical Deans Australia and New Zealand. The LIME Network. Leaders in Indigenous medical education. LIME Network Project. http://www.limenetwork.net.au/welcome (accessed Apr 2009). ❑