Canada Student Loan Forgiveness

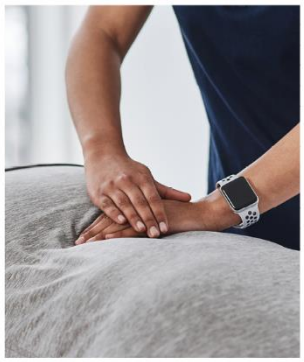
Public Consultation

Submitted by

The National Indigenous Chiropractic Caucus







Submitted by the National Indigenous Chiropractic Caucus (NICC)

For questions, please do not hesitate to contact NICC Co-Chairs:

Dr. Jennifer Ward, DC, M.Sc
drjward@mymts.net

Dr. David Peeace, DC
ldp.rhcc@sasktel.net

Questions about Canada Student Loan Forgiveness

1. **To what extent does the current Canada Student Loan Forgiveness benefit assist the recruitment of health professionals in rural and remote communities?**

   The Canada Student Loan Forgiveness Program (CSLF) currently provides monetary incentives for doctors and nurses to work in rural and remote communities, improving access for residents and improving health benefits for the community. This program would be strengthened if it better reflected the interdisciplinary healthcare that Canadians have come to rely on. The National Indigenous Chiropractic Caucus (NICC) requests that Doctors of Chiropractic (DC) be included as an eligible medical professional in this important program.

   Currently, 20% of Canadians live in rural and remote areas, while only eight percent of physicians work within these regions, compromising the health of those living within these communities. Many of the traditional territories of Indigenous people are located within these rural and remote areas. Very few chiropractic clinics are located on reserves across Canada, resulting in a lack of access to non-invasive, non-pharmaceutical management options for musculoskeletal conditions and chronic pain. As a result, residents of these communities must travel far distances to be able to access these services. Expanding the eligibility of the CSLF, and thereby providing an incentive to recruit and retain chiropractors in rural and remote communities, creates the possibility of expanding the level of service and healthcare to these underserved communities.

   After graduation, most new DC graduates have a debt load of between $150,000 and $200,000, including significant student debt. Working in a rural or remote community may also likely mean they would likely need to start their own practice, which would require additional commercial loans. Having an incentive would help alleviate that financial burden and make moving to a remote or rural community a more viable option.

   The possibility of accessing the CSLF program will also serve to enhance early recruitment of professionals into the training program. Healthcare professions such as chiropractic, will be more successful in recruiting students who are originally from rural and remote communities by demonstrating this opportunity to return home and address student debt load.

2. **Would a different amount of loan forgiveness from what is currently available provide a stronger incentive? If so, over what period of time?**

   The opportunity to increase the amount of loan forgiveness will only serve to strengthen the program as an incentive for recent graduates. Given the severity of Canada's Healthcare human resources crisis, every opportunity to incentivize new healthcare graduates should be pursued. Most new DC graduates carry a debt load of $150,000 and $200,000. If the amount of loan forgiveness were to be adjusted, based on the cost

of the post-graduate training program, this could increase participation rates. This way, the amount of loan forgiveness is automatically reviewed on an annual basis and stays consistent with possible program increases and inflation. This would also further incentivize new DC's to open a practice or work in a rural or remote clinic by lowering the financial burden post graduation.

3. **What other factors, other than financial incentives, would help motivate recent graduates in health professions to work in rural or remote areas (e.g., post-graduate training in a rural or remote community, personal connections to the community, etc.)?**

   For new DCs, geographical distance to family, friends, or community is often a strong factor in where they decide to live and practice. The best-case scenario for these programs involves recruiting students from within the community, supporting them through their training, and then offering further means to facilitate their desired return home afterwards to practice. If there is an incentive to chiropractors whose home community is in a rural or remote community or reserve, they are more likely to return home to that community to start their practice and stay long-term. This is an advantage not only to the new graduate but also to the community at large because they are more likely to receive continuity of care. Cultural sensitivity training courses and knowledge of creating safe environments for Indigenous people would benefit both the practitioners and the patients they are serving. Courses that address appropriate care and recognizes the distinct cultures, traditions, and practices of the community would position new professionals for success. Additionally, while there is a strong sense of community in many rural and remote communities, this can sometimes be experienced as alienating for newcomers to the community. Facilitating connections with other local healthcare professionals or within the business community, may help address concerns of isolation or loneliness and facilitate smoother integration into the community.

4. **To what extent do financial benefits, such as Canada Student Loan Forgiveness, provide an incentive for health professionals to provide health services in rural or remote communities over the medium-term (e.g., beyond the 5-year loan forgiveness period)?**

   Extending the eligibility of the CSLF to regulated allied healthcare professionals, like chiropractors, has the potential to increase access to health services for Canadians living in underserved rural and remote communities in the short-term, medium-term, and long-term. The CSFL can provide an incentive to open a clinic by decreasing student debt, one of the largest burdens most new healthcare professionals face.

   After spending five years to establish a professional practice, including developing a patient base, reputation, and working relationships with other healthcare professionals, most practitioners would be inclined to stay in the community. Competition between chiropractors in larger urban centres is more prevalent, which makes many chiropractic professionals hesitant to start over and rebuild their client base by moving elsewhere. Additionally, chiropractors have a deep commitment to their patients and view their

responsibility to offer continued support very seriously. When chiropractors do decide to move their clinic, they frequently develop a transition plan with another chiropractor to ensure continuity of care so patients do not feel abandoned.

In a few cases, there have been youth and students within these small rural and remote areas who have been inspired by their chiropractor to go to school to become a chiropractor and to return home after graduation. If there was not a professional within that community, then the students or youth may have never known anything about that profession. This can apply to many other health professions where the practitioner acts as a role model for the youth in that community.

5. What are the factors that might cause them to leave these rural or remote communities to work in more urban areas?

While living and working in rural communities has a number of benefits that are attractive to early-career healthcare professionals, there are a number of factors that may be a consideration for leaving. These include:

- An existing pay gap for chiropractors in small and rural communities compared to those in large urban cities,
- The absence of cultural/spiritual roots and practices within that community,
- Feelings of isolation, and lack of amenities (stores, restaurants, airports, schools),
- Opportunities for family members, and
- Professional development opportunities

The viability of an extended healthcare clinic like chiropractor, physiotherapist, or massage therapist also requires an adequate patient base that has some level of private insurance or ability to pay for services out of pocket. Chiropractors may relocate to larger urban centers where rates tend to be higher and a larger client base resides.

Another issue that could face new chiropractic graduates considering practicing in rural or remote communities is that chiropractic services are not covered by the Non-Insurable Health Benefits (NIHB) for those who hold status. This is a consideration for new chiropractors trying to build a client base near or on reserves. Because of the demographic and economic size of the communities targeted by the program, rural and remote populations may not have the same level of private insurance coverage compared to large urban centres. Chiropractors, like other allied healthcare professionals, typically do not charge the same for their services as in larger urban areas when the patient base may not have health insurance and must pay out of pocket. Although the operating costs in a rural area are slightly lower, the patient load and restrictions in fees may limit the incentive to establish a practice or work in a rural or remote location.

6. **As outlined in Budget 2022, the Government is reviewing the definition of "rural community" which determines eligibility for Canada Student Loan Forgiveness. The review is focused on ensuring that the definition of rural communities under the program does not leave out certain communities in need.**

    a. **Are you aware of areas that are considered underserved/rural/remote (e.g., are eligible for similar incentives), but are not currently eligible for Canada Student Loan Forgiveness?**

    The NICC is not aware of ineligible communities at this time.

    b. **Statistics Canada defines rural areas as all territory lying outside of population centres, where population centres consist of areas with a population of at least 1,000 and no fewer than 400 persons per square kilometre. Statistics Canada then further defines population centres by their sizes, such as:**
        - **rural areas, which consists of all territory lying outside of population centres**
        - **small population centres, with a population between 1,000 and 29,999**
        - **medium population centres, with a population between 30,000 and 99,999**
        - **large urban population centres, with a population of 100,000 or more**

    Would this concept be appropriate for determining community eligibility for this benefit?

The government of Ontario analyzed the definition of rural and remote community and healthcare access. In the Ontario report, it flagged concerns about utilizing the Statistics Canada population definition and felt that a ceiling population of 10,000 residents was too restrictive, and did not reflect many of Ontario's larger rural communities, which have dispersed populations that experience many of the same challenges in health care access. The Ontario panel agreed that a broader definition of rurality is needed for the Framework/Plan, which considers a continuum of several characteristics including proximity to urban centres, scope of services (e.g. community, primary, secondary, tertiary services), and population size.[1]

More than 1.67 million people in Canada (4.9% of the population) self-identified as an Indigenous which comprise of First Nations (60%), Métis (33%) and Inuit peoples (4%). More than half of Indigenous people live in Canadian cities, with the remaining 40% living largely in Canada's 630 rural or remote small communities spread throughout the nation.[2] More than half of Indigenous people live in Canadian cities, with the remaining

[1] Government of Ontario, Rural and Northern Health Care Framework/Plan – Final Report, https://www.health.gov.on.ca/en/public/programs/ruralnorthern/docs/report_rural_northern_EN.pdf.
[2] Statistics Canada - https://www.statcan.gc.ca/en/subjects-start/indigenous_peoples

40% living largely in Canada's 630 rural or remote Indigenous communities throughout the nation.[3] The largest land mass for a First Nation in Canada has a population of 4,177 people, however spans 1,413 kilometers. Then you have the largest population of any reserve in Canada with 12, 848 people, but they have a smaller land mass and fewer resources. Therefore, merely basing eligibility on population risks leaving out the communities with a larger population but less resources available. The concept outlined by the Ontario government should be reviewed, and an assessment based on the healthcare services that are available in the communities be considered.

c. If appropriate, what would be an acceptable maximum population size for community eligibility? Please include the rationale for your suggestion.

The criteria should be based on the services available in the community rather than strictly be based on the population size. Consideration should be taken for population centers that have populations over 10,000 or larger but are dispersed and may lack adequate access to care, services, or healthcare professions.[4]

7. Please identify up to five health professionals in order of priority, beyond family doctors and residents in family medicine, registered practical nurses, licensed practical nurses, registered nurses, registered psychiatric nurses, and nurse practitioners that are most urgently needed in rural/remote communities. Please provide a rationale for your suggestions and prioritization. Your suggestions could include, for example, health professionals in:

- **Specialized physician care**
- **Oral health care**
- **Primary and extended health care**
- **Mental health services**

Please include any available supporting evidence (e.g., data, research, survey results, examples, etc.) to demonstrate the need for the priority health professionals you identify.

Rural communities, including First Nations reserves would benefit from improved access to primary healthcare professionals that have the expertise to assess, diagnose, manage, and treat conditions. The First Nations Regional Health Survey identified the most common health conditions reported among First Nations adults, which has informed this list.

1. Chiropractors
2. Physiotherapists
3. Mental Health providers
4. Oral Health providers

[3] Statistics Canada - https://www.statcan.gc.ca/en/subjects-start/indigenous_peoples

[4] Government of Ontario, Rural and Northern Health Care Framework/Plan – Final Report, https://www.health.gov.on.ca/en/public/programs/ruralnorthern/docs/report_rural_northern_EN.pdf.

Doctors of Chiropractic

Each year, more than 11 million Canadians suffer from musculoskeletal conditions and by 2031 Health Canada projects this number to grow to an alarming 15 million.[5] Musculoskeletal conditions such as back pain, headaches, arm or neck strain and diseases of the muscle and joints are having a devastating impact on the health, quality of life, and workforce participation of Canadians, as well as on Canada's economy. According to Health Canada, the total direct (healthcare) and indirect (lost production) cost of chronic pain in 2019 was $38.2 - $40.3 billion. Over the next decade the total cost is expected to increase by 36.2 per cent and reach $55 billion.[6] As licensed primary healthcare contact providers, who are muscle and nervous system experts, Canada's chiropractors can play a role in managing musculoskeletal conditions and pain through conservative non-pharmacological treatments.

The burdens surrounding MSK conditions and disease are uniquely experienced and prevalent in Indigenous populations. According to the 2018 First Nations Regional Health Survey (RHS), chronic health conditions such as diabetes, arthritis, and chronic back pain remain the most reported conditions among First Nations adults and remain some of the most prevalent chronic conditions overall[7]. In fact, among First Nations adults reporting a chronic health condition, arthritis (18.3 per cent), diabetes (15.9 per cent) and chronic back pain (12.4 per cent) were the most commonly reported conditions.

In addition, chiropractors can assist in easing the pressure in rural and remote communities' public healthcare system by treating and managing MSK conditions. According to the Canadian Institute for Health Information, the third-highest cause for emergency room visits was back pain, and MSK conditions account for 27% of physician visits.[8] Moving these cases away from the public healthcare system will decrease pressure on rural and remote communities' healthcare system.

Improving access to non-pharmacological pain management treatments will also help reduce the heavy reliance on opioids in treating pain. The COVID-19 pandemic has worsened Canada's opioid overdose crisis with a record number of opioid-related deaths registered across the country. The effects of the opioid crisis are more intense in rural communities where employment opportunities are often limited, and isolation is pervasive. According to a recent report by the Ontario COVID-19 Science Advisory

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[5] Canadian Orthopaedic Care Strategy Group. (2010). Backgrounder Report: Building a Collective Policy, Agenda for Musculoskeletal Health and Mobility.

[6] Canadian Pain Task Force, An Action Plan for Canada, Health Canada, May 2021. https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report-2021.html

[7] National Report of the First Nations Regional Health Survey, 2018: https://fnigc.ca/wp-content/uploads/2020/09/713c8fd606a8eeb021debc927332938d_FNIGC-RHS-Phase-III-Report1-FINAL-VERSION-Dec.2018.pdf

[8] CIHI. NACRS emergency department visits and lengths of stay. https://www.cihi.ca/en/nacrs-emergency-department-visits-and-lengths-of-stay

Table, people living in rural and Northern communities have experienced disproportionate increase in opioid-related harm during the pandemic.[9] Low back pain is one of the primary causes for over-use of prescribed opioids.[10] As licensed primary healthcare providers, who are muscle and nervous system experts, Canada's chiropractors can play a bigger role in reducing over-reliance of opioids by managing musculoskeletal conditions through conservative non-pharmacological treatments instead of pharmacotherapy. A recent study showed that patients with non-cancer spinal pain who saw a chiropractor were 50% less likely to require an opioid prescription, and those patients who saw a chiropractor within 30 days of diagnosis were 70% less likely.[11]

Physiotherapists

There is a need for physiotherapists as rural and remote regions lack access to their services. According to the Conference Board of Canada, urban areas comprise just 3.6 per cent of Canada's geography and about 82 per cent of the population but contain 90 per cent of Canada's physiotherapists.[12] Patients in rural and remote locations have reduced access to the resources necessary to meet their physical therapy needs.

Early treatment by both chiropractors and physiotherapists results in better outcomes for patients, and results in cost effective care and efficient use of health human resources. Having both professions working hand in hand together in rural and remote communities and reserves can give patients the access to care they need while also helping any backlog doctors and hospitals may face.

Mental Health Providers

MSK and mental health disorders are often intertwined. Functional limitations and chronic pain associated with MSK conditions predispose people to a variety of mental health problems. Reversely, mental health disorders can also have a damaging effect on MSK health. The 2021 Benefits Canada Healthcare Survey found that 61 per cent of people with mental health conditions also experience chronic pain[13]. The economic

[9] Friesen EL, Kurdyak PA, Gomes T, et al. The impact of the COVID-19 pandemic on opioid-related harm in Ontario. Science Briefs of the Ontario COVID-19 Science Advisory Table. 2021;2(42). https://doi.org/10.47326/ocsat.2021.02.42.1.0

[10] Bhamb B, Brown D, et. al., Survey of select practice behaviors by primary care physicians on the use of opioids for chronic pain. Current medical research and opinion. 2006;22(9):1859-1865

[11] Emary, P. et al, (2022) Association of Chiropractic Care with Receiving an Opioid Prescription. https://doi.org/10.1016/j.jmpt.2022.06.009

[12] Conference Board of Canada, Shortage of physiotherapists limits access for some Canadians, Mach 2017, https://www.newswire.ca/news-releases/shortage-of-physiotherapists-limits-access-for-some-canadians-617287343.html

[13] Benefits Canada, 2021 Healthcare Survey: https://www.benefitscanada.com/wp-content/uploads/sites/7/2021/10/BCHS-Report-2021-ENG-7-Final-WEB1.pdf

impacts of this comorbidity are also substantial - mental health and MSK conditions represent the two leading causes for short- and long-term disability claims in Canada[14].

MSK and mental health disorder comorbidities are also present in Indigenous populations. A cross-sectional study examining the connection between musculoskeletal pain and psychosocial factors in Arctic Indigenous and non-Indigenous adolescents found a strong association between MSK pain and psychosocial problems[15]. According to the study, anxiety, depression, negative life events, and school-related stress were the most important factors associated with MSK pain. This is highly problematic given that First Nations experience mental health challenges such as depression and anxiety at a greater rate than the general Canadian population[16].

Within Indigenous communities, our concept of health is based upon the medicine wheel, integrating the whole person and incorporating the mind body, spirit and emotion. Historical determinants, such as the legacy of residential schools, continues to shape the mental health trauma of Indigenous peoples. A research project commissioned by the Aboriginal Healing Foundation found that the most common mental health diagnoses were post-traumatic stress disorder, substance abuse disorder and major depression.[17] There is a need for mental health services on reserve in culturally responsive ways and working respectfully within Indigenous frameworks of mental wellness. Given the history of trauma and high level of adversity experienced by some Indigenous people, there is a need for a trauma-informed approach to mental health care based on compassion, placing priority on a trauma survivor's safety, choice, and control.

Dental Care

Dentists, as well as dental hygienists, are needed in rural and remote locations. Statistics from the Canadian Institute for Health Information show that 21% of Canadians live in rural areas, while only 11% of dentists practise in these areas.[18] The majority of oral health conditions are preventable and Canadians living in rural and remote areas need access to dental care to have good oral health. Nearly one-third of Canadians do not have dental insurance, and that number climbs to 50 per cent for lower-income Canadians.[19] Without dental care, minor issues like cavities can result in serious infections. People visit emergency rooms for care that could be better delivered

[14] Louise Chénier, Crystal Hoganson, and Karla Thorpe, "Making the Business Case for Investments in Workplace Health and Wellness," Conference Board of Canada, 2011.
[15] Eckhoff, C., Kvernmo, S. Musculoskeletal pain in Arctic indigenous and non-indigenous adolescents, prevalence and associations with psychosocial factors: a population-based study. BMC Public Health 14, 617 (2014). https://doi.org/10.1186/1471-2458-14-617
[16] Assembly of First Nations, The First Nations Health Transformation Agenda, February 2017. https://www.afn.ca/uploads/files/fnhta_final.pdf
[17] Government of Canada - https://www.sac-isc.gc.ca/eng/1576089278958/1576089333975
[18] Canadian Dental Association, CDA Provides Input to Federal Committee on Labour Issues, https://www.cda-adc.ca/en/about/media_room/archive/articles/2012/062712-2.asp.
[19] Dr. Catherine Carstairs, Filling the Gaps: Why Canada still Need a Public Dental Health Plan, University of Guelph, https://news.uoguelph.ca/2022/04/filling-the-gaps-why-canada-still-needs-a-public-dental-health-plan/.

in a dental office. Canadians lose teeth that could have been saved, which makes it hard to eat nutritiously and can make it more difficult to find work.[20] Dental care is needed to ensure good oral health and divert patients to the appropriate care instead of utilizing emergency rooms.

The Ontario Dental Associations' Remote Areas Program (RAP) delivers care to about 30 communities spread throughout northwestern Ontario, from the Kenora area all the way up to the Hudson Bay coast, however it does not cover every rural and remote Indigenous community in Canada. Dental care is covered under NIHB, however most Indigenous peoples living on rural and remote reserves cannot easily access a dentist, with travel becoming another barrier. Including dentists and dental hygienists in the program would serve to address this need.

8. Are there shortages in professions outside of health care (e.g., social services, education) that are urgently needed in rural or remote communities? If so, please identify up to five, in order of priority.

There are many professional shortages in the rural and remote communities. Many rural and remote communities, as well as Indigenous communities, face numerous issues that impact all aspect of their lives. There is a well-documented lack of clean drinking water in First Nation communities that has resulted in 32 long-term drinking water advisories in 28 Indigenous communities across Canada.[21] This affects the health of all individuals living in these communities in every possible way and can be rectified with a strong commitment by the government to fulfill their fiduciary responsibilities in providing adequate infrastructure.

Statistical achievement data confirms there is a gap between the educational outcomes of rural and urban students, and even larger for rural Indigenous students.[22] Educational programs that are historically accurate and take into account the perspectives of Indigenous peoples in a decolonized fashion will build stronger nations. There is a need to adapt current health-care education curricula by improving educators' cultural relevance. These students do not have the same level of access of educational programs and extra-curricular activities as their urban counterparts. They face barriers with transportation, distances, environmental conditions, lack of physical infrastructure, costs and have fewer opportunities to engage in physical activity through specialised programming.[23] There needs to have equitable access to educational programs,

[20] Dr. Catherine Carstairs, Filling the Gaps: Why Canada still Need a Public Dental Health Plan, University of Guelph, https://news.uoguelph.ca/2022/04/filling-the-gaps-why-canada-still-needs-a-public-dental-health-plan/.
[21] https://www.sac-isc.gc.ca/eng/1506514143353/1533317130660
[22] British Columbia Rural Education Report - https://www2.gov.bc.ca/assets/gov/education/administration/resource-management/k12funding/funding-model-review/stakeholder-perspectives-and-reports/bc_k12_draft_rural_education_report.pdf
[23] Ward K, Pousette A, Pelletier CA. Not Everybody's an Athlete, But They Certainly Can Move": Facilitators of Physical Activity Maintenance in Older Adults in a Northern and Rural Setting. J Aging Phys Act2020;6:854–63

services, and extra-curricular activities for students, as these play an important role in the long-term health of the students and the community.

In terms of other professions, there is a lack of trade professionals in all areas including electricians, plumbers and carpenters. The lack of adequate housing and the horrible over-crowding conditions on reserves further contribute to challenges in health and well-being of Indigenous people.

9. **Is the current requirement that family doctors and residents in family medicine, registered practical nurses, licensed practical nurses, registered nurses, registered psychiatric nurses, and nurse practitioners provide a minimum of 400 hours of service appropriate?**

   The current minimum number of hours of service within the community is appropriate. Increasing the period of time would run the risk of adding additional pressure on early-career practitioners, who are just establishing their practices, to meet the required hours especially when the potential patient base is lower or may not support the increase needs. Increasing the minimum hours further could increase the risk of burnout within the healthcare profession.

10. **Would the same service minimum be appropriate for the priority professions you identified above?**

    Yes. While rural and remote communities have smaller populations that may impact patient load, we feel this minimum service level is appropriate and achievable.

11. **Would a multi-year service commitment (e.g., a commitment to remain in the community for two or three years) to access the benefit help with health professional recruitment or retention?**

    Requiring a multi-year service commitment should receive further study, as it may negatively impact program participation. Many young people are hesitant around long-term contractual obligations as they enter a phase of life with many new dynamics post graduation. By nature of the required hours of service, coupled with the investment into establishing a clinic and practice, the program effectively achieves these same outcomes of encouraging multi-year program participation.

    The addition of a multi-year commitment would necessitate an additional increase in the financial incentive for the CSLF to ensure that the program is seen as an incentive. Increasing the service commitment and amount may increase the time for the healthcare practitioner to settle down in the community, and provide more stability for both the professional and that community.

12. **Would it be appropriate to extend eligibility of the benefit to virtual services provided by the priority professions you identified above?**

Virtual healthcare has become an important tool for healthcare professionals to provide care during the pandemic. This tool can also be utilized to provide adjunct access to Canadians living in rural and remote areas. However, this tool requires that patients have access to reliable, affordable internet access and devices. In Canada, only 45.6% of Rural and remote householders have access to reliable, high-speed internet. That number drops to 34.8% when looking at rural Indigenous reserves.[24] According to the Canadian Internet Registration Authority, 28% of Canadians visited their doctor virtually, compared to 17% the previous year.[25] This shows that virtual healthcare is quickly becoming a common use for Canadians, and it is more important then ever to have accessible, universal broadband services available regardless of geographical location.

Virtual care has been utilized by the chiropractic profession since the start of the pandemic. It has been incorporated into the standards of practice by all provincial regulatory colleges, and has been deemed eligible by private insurance practices. While virtual care cannot replace hands-on therapies and treatments, it can be an important tool between visits for taking patient history, assessing range of motion, consultation, guiding and supervising stretches and exercises, provide nutritional advice, or provide ergonomic advice. Especially in situations where travel is time consuming and costly, virtual care would be an appropriate way to augment care.

13. Please share any additional input on Canada Student Loan Forgiveness that is not covered in your answers to the previous questions.

There is a need for stronger Indigenous representation in every aspect of the healthcare field. Indigenous peoples experience lower health outcomes than non-Indigenous peoples in Canada, which is exacerbated by the lack of access to quality health care and lower socio-economic situation (as confirmed by the social determinates of health).[26] Indigenous peoples also lack access to adequate health services, especially in rural and remote communities. Health disparities between Indigenous and non-Indigenous people are rooted in Canada's history of colonization, cultural oppression, socioeconomic disparities, discrimination, racism, and Western organizational culture. Traumatic injury rates are four times higher for Indigenous peoples, and they are 10 times more likely to have difficulty accessing family physicians than the general population.[27] There is a need for the recruitment and retention of health-care workers in First Nations, Inuit, Métis and other Aboriginal communities, and in the accessibility of care for these communities. Considerable systemic change is needed to improve Indigenous health given the persistent inequity and inaction across the health system that the Truth and Reconciliation Commission of Canada identified.

[24] Canadian Medical Association – Virtual Care in Canada: Progress and Potential - https://www.cma.ca/sites/default/files/2022-02/Virtual-Care-in-Canada-Progress-and-Potential-EN.pdf
[25] Canadian Medical Association – Virtual Care in Canada: Progress and Potential - https://www.cma.ca/sites/default/files/2022-02/Virtual-Care-in-Canada-Progress-and-Potential-EN.pdf

[26] Gunn, Brenda - "Ignored to Death: Systemic Racism in the Canadian Healthcare System" https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/UniversityManitoba.pdf
[27] Merritt, Larry – First Nations Health Care - https://www.cndoctor.ca/first-nations-health-care-918/

The inclusion of Doctors of Chiropractic within rural and remote communities also serves to address access to the public healthcare resources. Chronic pain conditions, like musculoskeletal (MSK), are one of the leading causes for emergency room visits. Chiropractors are experts in evidence-based, non-invasive, drug-free manual therapies. Most physicians are not MSK experts and see these cases infrequently, so they tend to over prescribe diagnostic imaging and drug treatments. In many rural and remote communities, as well as First Nations reserves there is a drug and opioid crisis present. Improving access to chiropractors increases the opportunity to provide drug-free chronic pain management, improve the quality of life for patents in these communities, while also reducing the potential for over-use of opioids.

Information about your organization

14. Please provide a short summary of what your profession does (e.g., what services you deliver to Canadians, who are key clients/beneficiaries of your services, does practice take place in privately set up clinics, hospitals, other community sites, etc.).

The National Indigenous Chiropractic Caucus (NICC) brings the Canadian Indigenous chiropractic community together to help address the health inequity faced by Indigenous peoples across Canada, promote chiropractic as a viable option for MSK health, and as a career of choice among young Indigenous peoples. While we recognize the diversity of priorities that exist among Indigenous communities across Canada, there is a common need to increase access to high-quality, wholistic and culturally relevant health services, particularly in the area of MSK health. Our vision is to realize the UN Declaration on the Rights of Indigenous Peoples by ensuring the minimal standards of healthcare, and have chiropractors as a part of Indigenous healthcare across the country.

15. Can you describe the post-secondary education and other professional requirements (e.g. passing an exam, clinical/work experience, joining a professional and/or regulatory body, etc.) required to practice your profession?

For a comprehensive outline of regulatory bodies, protection of the public, scope of practice, education and accreditation of Doctors of Chiropractic in Canada, please see the submission by the Canadian Chiropractic Association.