

SPEAKING NOTES

Director, Health

First Nation Healthcare Workforce Development Roundtable

February 13, 2026 | Anishinabek Employment and Training Services & Indigenous Primary Health Care Council

Opening

- Good morning. My name is Cheyenne Joseph, Director of Health at the Assembly of First Nations.
- I am a member of L'sitkuk First Nation (Bear River First Nation) located in Mi'kma'ki, the ancestral, unsundered and unceded homeland of the Mi'kmaq people, whose presence stretches back since time immemorial. Mi'kma'ki is land shaped by the Peace and Friendship Treaties, agreements that were not about surrender or submission, but about living alongside one another with mutual respect, shared responsibility, and peace.
- I want to acknowledge the land in which we are gathered today, the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples. This land is covered by Treaty 13 with the Mississaugas of the Credit.
- Thank you to Marie and Jimmy for opening this gathering in a good way. I offer you my sincerest condolences, Jimmy, for the loss of you good friend.
- I want to acknowledge the Elders, Knowledge Keepers, ISETA holders, health organizations, and training partners and everyone who works in these sectors. And want to acknowledge the AETS and IPHCC who came together and worked very hard to organize and host this gathering, thank you!
- Thank you for this invitation to share a national First Nation perspective on health human resources and to speak to the reality behind the healthcare workforce crisis.

The Workforce Crisis: What the National Data Shows

- Let me start by grounding this conversation in the national evidence, because the numbers make the urgency undeniable.
- In December 2025, the Canadian Institute for Health Information (CIHI) reported that 5.7 million Canadian adults did not have a regular health care provider (Canadian Institute for Health Information, 2025). That's 13% of the adult Canadian population.
- Canada now ranks last, among ten high-income countries for adults with access to primary care (Schoen, Osborn & Davis, 2023).
- The supply of family physicians has actually decreased over the past five years even as demand grows (Canadian Institute for Health Information, 2025).
- CIHI estimates that a 49% increase in family physicians would be required just to meet existing demand. Not future demand. Current demand (Canadian Institute for Health Information, 2025).
- The nursing crisis is equally alarming. "A 2019 analysis projected a shortage of 117,600 nurses in Canada by 2030. Seven years later, that projection is now our current reality" (Scheffler & Arnold, 2019).
- Nursing job vacancies have tripled in the last five years (Faubert, 2025).
- A 2025 national survey of nurses found that: 1 in 5 is considering leaving their current job; 1 in 10 wants to leave the profession altogether; 1 in 4 shows clinical signs of anxiety, depression, or burnout (Canadian Federation of Nurses Unions, 2025).
- In rural and remote hospitals, the reliance on private agency staffing has increased by more than 250% since 2019 (Canadian Institute for Health Information, 2025).
- This is a costly and unsustainable model that provides no continuity of care and no relationship with the communities they serve.
- These are not isolated problems. They are a pattern repeated across geographies.

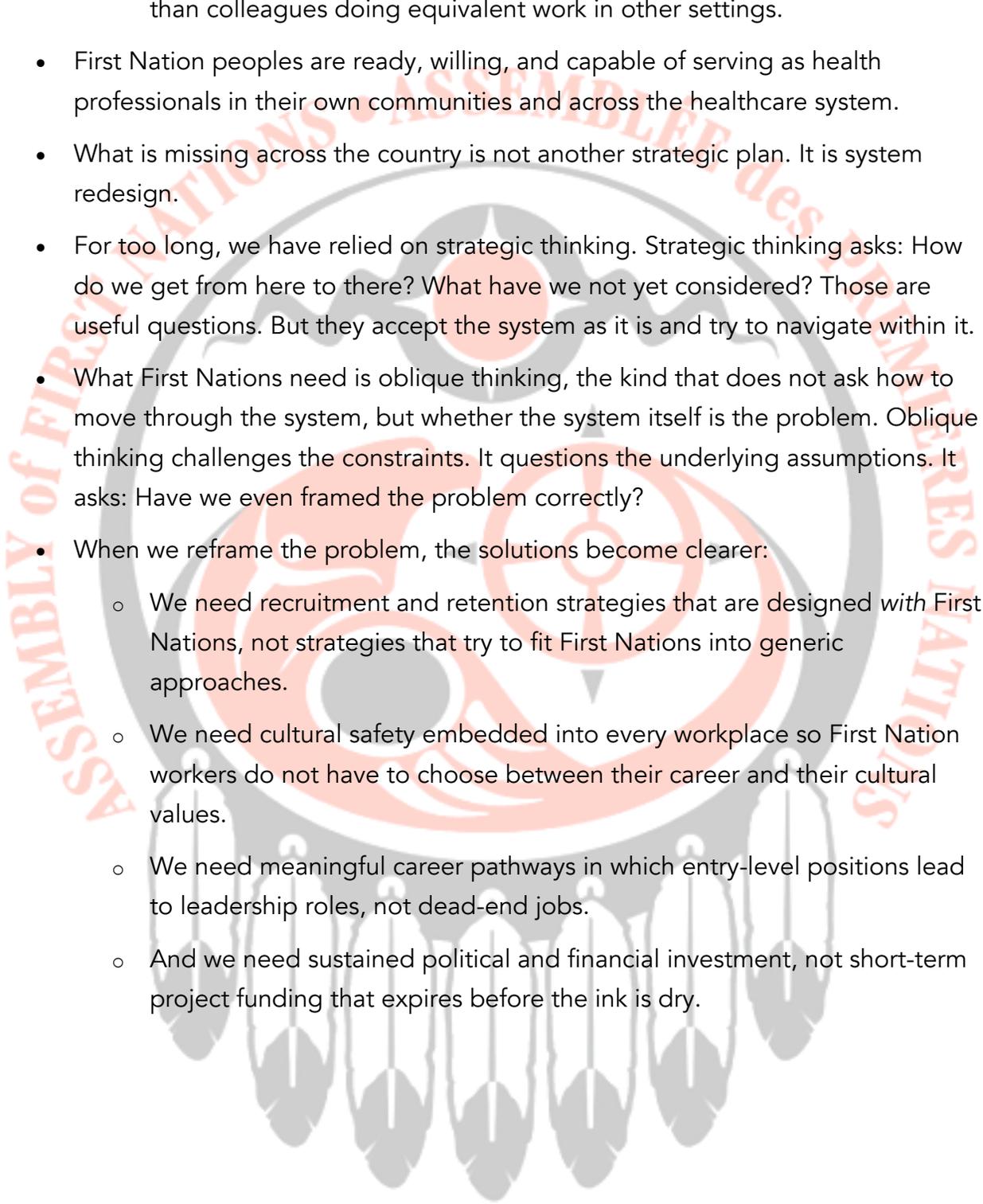
What This Means on the Ground in First Nation Communities

- The 2025 Office of the Auditor General's report confirmed what First Nations have advocated for decades: there are dangerous shortages in the health workforce serving First Nation communities, and First Nation people (Office of the Auditor General of Canada, 2025).
- What makes this finding particularly damning is that the federal government increased spending on these HHR programs by 84% since 2019 and still failed to meet over half of the Auditor General's previous recommendations (Office of the Auditor General of Canada, 2025).
- More money went in, yet the same gaps remained.
- The report shows that First Nations are being asked to rely on under-resourced primary care models to handle situations that, elsewhere in Canada, would be managed in fully resourced health care centres (Office of the Auditor General of Canada, 2025).
- The critical shortage in the health workforce for First Nations in Canada means:
 - there are gaps in access to basic health care ... access to essential services that other Canadians take for granted.
 - it means delays in care, become preventable emergencies.
 - when there are not enough staff, urgent issues escalate from something treatable in community to a life-threatening emergency requiring transport by land or air, often hours away ... if transport is even available at the time.
 - it means burnout and moral distress for health workers who are working beyond what is sustainable, often carrying clinical, administrative, and cultural expectations all at once.
- Many health care staff and workers leave communities, not because they do not care, but because they cannot continue under those conditions.
- For First Nation health professionals and staff, the pressures are even greater. They are caring for their own families and communities while working in systems that were not designed with First Nation realities in mind.

- They are bridging Western and First Nation knowledge systems, translating language and culture, and dealing with racism in the workplace, and doing it with fewer resources and less support than their counterparts.

The Core Issue: A System Design Problem, Not a People Problem

- From a national First Nation perspective, it is critical to say clearly: this is not a problem of First Nation people lacking interest, talent, or commitment to health careers.
- This is a problem of system design and policy choices that were not built for us, and in many cases, were built to exclude us.
- The federal government's own 2025 Canadian Health Workforce Education, Training Study acknowledged that First Nations experience "significant disparities and challenges in accessing health professions education and training opportunities in Canada," rooted in "historical injustices and ongoing systemic barriers" (Health Canada, 2025).
- The AFN's *Coming Out of Hibernation* (Kelly, 2023). strategy mapped the specific barriers that block First Nation people at every stage of the health career pathway. The evidence is overwhelming: this is not a pipeline problem, it is a system design problem. Barriers include:
 - Inadequate math and science preparation in elementary and secondary school, not because First Nation students lack ability, but because their schools are chronically underfunded;
 - Admissions processes with expensive exams, arduous interviews, and a lack of First Nation representation on admissions committees;
 - A lack of First Nation-focused programs, community-based training options, and flexible learning pathways for mature and parenting students;
 - Isolation, tokenism, and racism within health education programs;
 - Tension between biomedical and First Nation worldviews that forces students and professionals into an impossible choice between their clinical role and their cultural teachings; and

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- Pay inequities, where First Nation health workers are compensated less than colleagues doing equivalent work in other settings.
 - First Nation peoples are ready, willing, and capable of serving as health professionals in their own communities and across the healthcare system.
 - What is missing across the country is not another strategic plan. It is system redesign.
 - For too long, we have relied on strategic thinking. Strategic thinking asks: How do we get from here to there? What have we not yet considered? Those are useful questions. But they accept the system as it is and try to navigate within it.
 - What First Nations need is oblique thinking, the kind that does not ask how to move through the system, but whether the system itself is the problem. Oblique thinking challenges the constraints. It questions the underlying assumptions. It asks: Have we even framed the problem correctly?
 - When we reframe the problem, the solutions become clearer:
 - We need recruitment and retention strategies that are designed *with* First Nations, not strategies that try to fit First Nations into generic approaches.
 - We need cultural safety embedded into every workplace so First Nation workers do not have to choose between their career and their cultural values.
 - We need meaningful career pathways in which entry-level positions lead to leadership roles, not dead-end jobs.
 - And we need sustained political and financial investment, not short-term project funding that expires before the ink is dry.

AFN's National Strategy on Health Human Resources

- At the national level, AFN's Health Sector is working to shift from reactive responses to a First Nations-led HHR strategy.
- We are driving systemic change through cultural safety standards
- This work aims to enshrine cultural safety as a non-negotiable requirement for health system accreditation, to move cultural safety away from "training" or "best practice" language and towards concrete standards backed by accountability mechanisms.
- The Health Standards Organization has drafted the National Cultural Safety and Humility Standard in response to AFN Resolution 30/2023.
- It is currently in public review until February 27, 2026, with finalization targeted for Summer 2026. This Standard is a structural lever to enforce cultural safety as a non-negotiable requirement across federal, provincial, and private health services.
- Once cultural safety becomes a standard tied to accreditation, it directly affects how systems are funded and held accountable.
- In addition, we are advocating to securing First Nation ownership of data and forecasting.
- Right now, many of the numbers used to describe the HHR crisis come from federal or provincial systems that do not fully capture First Nation realities.
- Health Workforce Canada acknowledged in its 2024 report that health workforce modelling has "inadequate attention to equity-deserving populations, like First Nations, Inuit, and Métis communities" and "persistent issues in the distribution of the workforce in rural and remote areas" (Health Workforce Canada, 2024)
- When we are not counted, we do not count.

What We Know Works

- Across First Nations and in international research, several themes consistently emerge about what actually works to strengthen health human resources. These are not theoretical. They are proven.
 - Successful First Nation health workforce initiatives are built on long-term, trust-based relationships between communities, training institutions, and employers.
 - This begins with establishing partnerships with First Nations before jobs are posted or programs are designed, and continues by ensuring First Nation voices shape the recruitment process, interview committees, and educational + workplace culture.
 - When organizations make genuine, sustained investments rather than relying on one-time hiring campaigns, they build the loyalty and retention that are essential for a stable First Nation health workforce.
 - Partnerships between educational institutions, professional associations, regulatory bodies, and employers can facilitate remove admissions barriers, improve student experiences and outcomes, and promote First Nation leadership in governance structures.
 - Advocate to expand the Canada Student Loan Forgiveness benefit beyond doctors and nurses to include midwives, psychologists, social workers, dental hygienists, and other health professionals who serve First Nation communities.
 - Expand community-based and remote learning options so First Nation students can train for health careers without being forced to leave their families, their communities, and the cultural connections that sustain them.

- Every retention study for First Nation health workers points to the same core factors.
 - Workers stay when: their workplaces value First Nation knowledge systems instead of asking them to leave parts of themselves at the door;
 - culturally relevant, trauma-informed practices are embedded into service delivery;
 - supervisory relationships are respectful and grounded in an understanding of First Nation worldviews and community responsibilities;
 - ceremonial obligations, language learning, land-based practices, and cultural roles are recognized as legitimate, not treated as "time off" from real work; and
 - mental health and wellness supports are designed specifically for First Nation health workers who face vicarious trauma, racism, and community pressure.
- The most promising and sustainable solutions emerge in First Nation-led health systems where First Nations control their own health services and governance structures allow communities to set priorities, design roles, and define "success" on their own terms.

Closing

- You are gathering at a pivotal moment.
- The shortages are immediate and severe, the evidence is stronger than it has ever been, and the solutions are already known in broad strokes.
- First Nation youth are ready to serve.
- First Nation communities are ready to lead.
- First Nation organizations are ready to partner in ways that are grounded in respect, rights, and real accountability.
- What is needed now is a health system that believes in First Nation peoples' futures and invests in them, not only in moments of crisis, and not only for their labour.
- I leave you with this: The work each of you does, whether in employment and training, health services, or education, is a vital part of the bigger story.
- Together, we can build a First Nation health workforce that serves our people with both clinical excellence and cultural integrity.
- This work is urgent because our people's health depends on it, but it is also filled with possibility, for our youth, for our communities, and for health systems to finally live up to their promises.
- The fact that you are here today is proof that this future is not only necessary ... it is achievable.
- Miigwetch. Wela'liq. Merci. Thank you.

Contact Information:

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