



Socioeconomic Status as a Determinant of Medical School Admissions

Ontario Medical Students' Association Position Paper

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Executive Summary

Socioeconomic status is a measure of an individual's economic and social position in relation to others. The comparison is typically based on a combination of income, education and occupation. A lack of socioeconomic diversity among medical students produces physicians who are not representative of their patients and serves to exacerbate inequities in access to care. In striving to train doctors who meet the varied needs of Ontarians, medical schools must improve admissions policies to increasingly admit students with low socioeconomic status. The Ontario Medical Students' Association (OMSA) asserts that lack of socioeconomic diversity in medical schools is an important issue which impacts applicants, students, and patients, and requires changes to the status quo.

Principles

In an effort to address socioeconomic disparity in medical school admissions OMSA proposes the following principles: Ontario Medical Schools (OMSs) have a responsibility to show commitment to social accountability in their admission processes; there are considerable financial barriers, both tangible and perceived, to entering medicine; data collection regarding applicants' and matriculants' socioeconomic status is critical to addressing this issue; and mentorship programs targeting underrepresented populations are important in improving diversity in admissions.

Recommendations

In adherence with these principles we make the following recommendations for Ontario Medical Schools:

1. Make demonstration of efforts to increase socioeconomic diversity through admissions policies part of Committee on Accreditation of Canadian Medical Schools criteria.
2. Implement a Fee Assistance Program to reduce costs associated with writing the MCAT and application fees to Ontario Medical Schools and make clear statements on the availability of financial aid.
3. Utilize the Association of American Medical College's Socioeconomic Status Education Occupation indicator to collect data from applicants to Ontario Medical Schools through the Ontario Medical School Application Service.
4. Support research of mentorship programs that target underrepresented populations and evaluate their efficacy in increasing socioeconomic diversity among students at Ontario Medical Schools.



Background

Medical schools must produce physicians who are responsive to the healthcare needs of society or risk compromising standards of care. Though Ontario Medical Schools (OMSs) recruit certain underrepresented minorities through modified admissions criteria and pipeline programs, there remains a large disparity between the socioeconomic status (SES) of medical trainees and that of society at large¹. This position paper summarizes the socioeconomic distribution of Canadian and Ontario medical students, describes the importance of achieving greater diversity for the physician workforce, and makes tangible recommendations for OMSs to evaluate and improve their efforts.

Socioeconomic Distribution of Students in Canadian and Ontario Medical Schools: *What is the Problem?*

SES is a complex construct, typically thought of as the social standing or class of an individual or group². It is often measured by aggregating data on income, education, and occupation³. Importantly, SES is positively correlated with formal educational achievements such as acceptance to universities and colleges, and high scores on standardized tests⁴.

In medical education, a diverse student population is crucial in creating a physician workforce that will meet the needs of a diverse patient population. However, Canadian medical students' demographics do not reflect those of the general population: they have a higher average family income, are disproportionately from urban areas, and have parents who are more likely to have completed post-secondary education⁵. Indeed, data from the 2015 Association of Faculties of Medicine of Canada (AFMC) Graduate Questionnaire (GC) showed that over 80% of medical graduate respondents had at least one parent with a post-secondary degree⁶. This is in contrast to data from the 2011 Canadian National Household Survey, which revealed that 64.1% of adults aged 25-64 in Canada had postsecondary qualifications⁷. Similar findings have been reported in the United States. Data collected from 1987-2005 showed that over 50% of American medical students were from the highest family income quintile, and less than 6% were from the lowest family income quintile⁸.

Many factors contribute to this socioeconomic disparity. Prospective students with low SES are chronically disadvantaged during the admissions process. This student population faces considerable monetary, experiential, and attitudinal barriers⁹. Viewing medicine as privileged and unattainable, potential applicants with low SES may not consider it as a viable career path¹⁰. These students lack the social support and role modelling from healthcare professionals that their peers with higher SES can access¹¹. In addition, students who currently apply to all six OMSs pay more than \$850 CAD in application fees¹². Four of six OMSs also require applicants to write the Medical College Admissions Test (MCAT), for which registration and preparation can cost \$305 USD and over \$1000 CAD respectively^{13,14}. While such preparatory courses are optional, they do provide an advantage in resources to students who are able to afford them. Students with low SES may be further disadvantaged after gaining admission by high tuition fees. From 2001 to 2007, tuition fees rose at OMSs from an average of \$11600 CAD/year to over \$15675 CAD/year^{15,16}. In Quebec, where tuition



fees did not increase substantially, medical students were more likely to report a lower debt load and have grown up in low-income neighborhoods¹⁷. High cost of tuition, now an average of \$23600 CAD/year at OMSs, is a significant financial and psychological barrier to applicants that promotes inequity in medical school admissions^{9, 10, 18}.

The Impact of Physician Workforce Demographics on Patient Care: *Why is this a problem?*

The effects of inequity in medical school admissions ripple into hospitals and clinics. Medicine as a profession has been viewed as elitist¹⁹; such a view impacts how patients with low SES interact with physicians and the healthcare system. These patients are often those in the greatest need yet are not well represented in the physician population^{20, 21}.

Access to healthcare in Canada is becoming more limited beyond dense urban centers. Within these urban centers, services are concentrated away from low income areas²². Historically, physicians have been more likely to serve patient populations that reflect their own socioeconomic background. A large proportion of medical students having high SES may partially explain current levels of underservice to lower income areas²³. Addressing socioeconomic factors in medical school admissions can create a more equitable distribution of physicians and facilitate better access to care for individuals with low SES²⁴.

Efforts by Ontario Medical Schools to Target Underrepresented Populations: *What is being done?*

The Future of Medical Education in Canada (FMEC) Project recommends that schools recruit and select students who are representative of the Canadian population and address barriers to medical education, such as high debt loads²⁵. With the creation of the FMEC Project and FMEC final project report in 2010, Canadian Medical Schools have renewed their focus on enhancing the admissions process for applicants with low SES. Policy changes to address these barriers are developing, but significant improvement is required. A comprehensive summary of current admissions policies at OMSs to increase socioeconomic diversity can be found in Appendix 1. This section highlights several key findings.

Addressing the complex etiology of such a lack of diversity requires a coordinated effort from Ontario's medical schools. OMSs have made notable progress in recent years in attracting more Aboriginal applicants, a group that has been associated with low SES and decreased access to healthcare²⁶. OMSs also recruit students from rural and remote communities. UOttawa, NOSM, and UWO seek applicants from Francophone minority communities, Northern Ontario and rural parts of Canada, and South Western Ontario respectively. In addition, mentorship programs are utilized in OMSs to increase awareness of academic and career choices and provide guidance to applicants. Despite these advances, OMSs must continue to try and improve their admissions process.

Principles



OMSA maintains the following principles with regard to socioeconomic status in admissions at Ontario Medical Schools.

1. Considering socioeconomic status in medical admissions demonstrates the ongoing commitment of Ontario Medical Schools to social accountability.
2. Current application and other mandatory fees create financial and perceived barriers to entering the field of medicine and contribute to a lack of socioeconomic diversity among medical students and physicians.
3. Collecting data around the socioeconomic status of applicants is imperative to improving the recruitment of students with low socioeconomic status to medicine.
4. Mentorship programs can encourage underrepresented populations to pursue healthcare professions, and by extension improve diversity in medical school admissions.

Recommendations

Recommendation 1: Make demonstration of efforts to increase socioeconomic diversity through admissions policies part of Committee on Accreditation of Canadian Medical Schools criteria.

There is substantial evidence of disparities between the socioeconomic background of physicians and Canadian society at large⁵. Creating accreditation criteria to consider SES in admissions will make OMSs more accountable for producing a diverse physician workforce. This increased accountability would promote transparency and longevity of proposed changes to admissions policies as well as encourage evaluation of progress.

OMSs currently do not have any clear guidelines for addressing socioeconomic diversity in admissions. All medical schools in Ontario have focused streams for applicants of rural, Francophone minority, and/or indigenous backgrounds, and such applicants are more likely to have lower SES^{26, 27, 28, 29}. However, there is no specific consideration given to applicants based purely on SES, potentially creating barriers for students who have low SES but are not targeted by the above-mentioned application streams^{30, 31}. Most schools provide the option to submit claims of extenuating circumstance to explain parts of an application, but the lack of clarity around the use of this submission in the admissions process threatens its utility³¹.

The Liaison Committee on Medical Education (LCME), a Canadian-American partnership, works with the Committee on Accreditation of Canadian Medical Schools (CACMS) to accredit and monitor medical education. One component of the CACMS standards is “Medical Student Selection, Assignment, and Progress”. A subcomponent under this heading, “Characteristics of Accepted Applicants”, states: “A medical school selects applicants for admission who possess the intelligence, integrity, and personal and emotional characteristics necessary for them to become competent physicians”³². *OMSA recommends this statement be revised such that it clearly outlines a requirement to demonstrate equitable access and consideration for all students during admissions.* While this statement broadly addresses various underrepresented groups in medicine, a guideline tailored specifically to SES may be more effective. Admissions policies at Canadian and American Medical



Schools tend to target applicants based on race, ethnicity, and/or the size of the communities they grew up in^{11, 31}, despite such factors not correlating perfectly with SES³³. These admissions criteria only partially address the problem. It is important that accreditation criteria supplement current admissions policies by promoting strategies to consider SES for applicants.

Recommendation 2: Implement a Fee Assistance Program to reduce costs associated with writing the MCAT and application fees to Ontario Medical Schools and make clear statements on the availability of financial aid.

Students who apply to all six OMSs can pay more than \$850 CAD, \$305 USD, and more than \$1000 CAD in application, MCAT registration, and MCAT preparation fees^{13, 14, 30}. These high fees have exacerbated the already severe financial barriers faced by applicants with low SES⁹. Costs rise higher as interviewees travel around the province to attend interviews⁹. In comparison to the US, OMSs lag behind in reducing these costs. The Association of American Medical College's (AAMC) Fee Assistance Program (FAP) gives eligible applicants access to reduced MCAT registration fees, complimentary preparatory material, and a waiver for the American Medical College Application Service (AMCAS) fees for one application submission with up to 15 medical school designations³⁴. Together, these benefits may save the student over \$1100 USD during one application cycle. Though Canadian students often take the MCAT, they do not qualify for the FAP and there is no similar program in Canada. *OMSA recommends that OMSs collaborate with the AAMC to create a FAP that reduces MCAT-related costs and provides vouchers for application fees.* Though the research on the impact of FAPs in the US and elsewhere is underdeveloped, reducing these costs may help remove barriers for applicants with low SES.

In addition to tangible financial barriers, high application fees also create perceived barriers. Indeed, individuals from low socioeconomic backgrounds are less likely to consider medical school, as they may see medicine as elite, privileged, and unattainable^{9, 10}. Moreover, these individuals underestimate potential financial aid, have concerns about their eligibility for financial aid, and are apprehensive about facing financial hardship after graduation¹⁰. In Ontario, there is significant financial support for students who gain admission, but this information is often unclear and difficult to find. *OMSA recommends that OMSs create and distribute clear statements on their financial aid policies through admissions websites, outreach and pipeline programs, and financial aid offices at all Ontario Universities.* In addition to creating affordable methods to apply to medical school, it is imperative to show potential applicants that financial support is available should they be accepted.

Recommendation 3: Utilize the Association of American Medical College's Socioeconomic Status Education-Occupation indicator to collect data from applicants to Ontario Medical Schools through the Ontario Medical School Application Service.

Currently, support is growing for the collection and use of SES information in admission to medical schools^{30, 35}. Though there is improved targeting and recruitment of certain populations, collecting socioeconomic data during the application process will allow OMSs to identify a broader population



of students based on SES³⁶. Furthermore, collecting information each year will allow schools to evaluate their progress towards achieving a desired socioeconomic diversity.

In Canada, the AFMC began administering its Graduation Questionnaire (GQ) in 2015⁶. Prior to this, the AAMC collected similar information through their Canadian Graduate Questionnaire. This survey elicits feedback about educational experiences of graduating students from Canadian Medical Schools and collects information on ethnicity, culture, parental education level, and the size of the communities students have lived in before university. The AFMC uses this data, among other purposes, to provide evidence for progress of FMEC recommendations. However, there is little collected on the socioeconomic background of medical students and applicants³⁷. Though the National Physician Survey (NPS) previously collected data from medical students on parental income, ethnicity, and the size of the communities they grew up in, it came to a close in 2014. The most recent NPS in 2012 had only a 24% response rate³⁸. Regarding applicants, the AFMC has collected extensive data on legal status, gender, and age since 1977, but none on SES¹⁸. South of the border, the AAMC collects information from applicants regarding legal status, gender, age, legal residence, race, and ethnicity. Applicants also self-report parental education and occupation to the AMCAS when they apply. Recently, the AAMC created a SES indicator based on parental education and occupation (EO), which has been rationalized and validated as being intuitive, accurate and stable over time for assessing SES, and easy to collect^{35, 36}.

OMSA recommends that OMSs utilize the AAMC EO indicator to identify potential applicants with low SES using information collected through the Ontario Medical School Application Service (OMSAS). OMSAS allows applicants to submit a single application to OMSs with supplemental pieces for some schools, similar to AMCAS in the US. This parallel creates a unique opportunity for OMSs, OMSAS, and the AAMC to collaborate and offer the EO indicator to candidates. Schools will be able to identify applicants with limited access to resources who, if accepted, could contribute to the diversity of the medical student population³⁵.

Recommendation 4: Support research of mentorship programs that target underrepresented populations and evaluate their efficacy in increasing socioeconomic diversity among students at Ontario Medical Schools.

Mentorship can effectively enable underrepresented students to enter medical school²¹. Successful mentorship can improve both academic outcomes and the impacts of psychological determinants, such as self-image³⁹. Mentorship programs have shown promise in enabling underrepresented students in a number of academic settings. For example, the Pathways to Education program uses mentorship as one of its core pillars. Pioneered in the Regent Park community of Toronto, this program has been able to drastically reduce high-school dropout rates and increase university/college acceptance rates amongst low SES populations⁴⁰. Since its inception, Pathways to Education has been expanded and modelled to serve other at-risk populations.

Mentorship can increase an individual's self-efficacy, a key determinant in student success³⁹. In medical education, this finding has garnered interest and led to the creation of mentorship programs



aimed at students from disadvantaged backgrounds. The Altitude Mentorship Program is one such initiative that was founded by OMSA and the OMA. The program aims to empower students from underrepresented populations to pursue a career in healthcare through mentor-mentee relationships with medical students. Applicants to the program report parental education level, ethnicity, and parental income if it is below \$70,000 CAD per year⁴¹. There are also mentorship opportunities available at individual medical schools. University of Toronto's Summer Mentorship Program (SMP), available for Black and Indigenous high school students, is a free four-week course that introduces grade 10 and 11 students to medicine¹. At McMaster, MacMEDucation is a weekend long program that places grade 10 and 11 students in a medical school-like environment, modeled after McMaster's undergraduate medical curriculum. Though this program has a registration fee, subsidies are available for individuals identifying as having low SES.

A common criticism of pre-medicine mentorship and enrichment programs is that there is insufficient evaluation to ensure that goals are being achieved⁴². Specifically, a data drought regarding participants' post-program attitudes towards higher education and academic achievement limit our understanding of their efficacy⁴². The value of these programs is difficult to determine if we are unable to link their usage to future benefits. Major barriers to program evaluation include lack of funding and evaluation expertise⁴³.

School specific programs may help to expose high school students to the field of medicine. But they do not create long-term mentorship relationships as Altitude attempts to do, nor is there substantial data regarding their effectiveness of improving diversity in medical school admissions. *OMSA recommends that OMSs support research into and evaluation of mentorship and enrichment programs.* This may entail encouraging greater transparency regarding the data collected on mentorship programs, evaluating existing mentorship programs, and creating new ones. Evaluation efforts would include identifying evaluation needs and gaps, identifying quantifiable outcomes of the programs to evaluate and the creation of common data definitions that can be consistent across mentorship programs and evaluation⁴³.

Conclusion

Access to healthcare in low income areas is often tenuous. Lack of socioeconomic diversity in Ontario's medical schools plays a role in creating this deficit as physicians tend to practice in settings that reflect their own socioeconomic background. As such, persistent inequity in medical school admissions translates to a physician population that under-serves areas of lower income. To address this issue, social accountability needs to be brought to the forefront of admission policies, financial barriers to admission addressed, data collected surrounding the SES of students, and mentorship programs improved. The principles and recommendations in this position paper can help to reduce tangible and perceived barriers for applicants with low SES in service of creating a more equitable admissions process in Ontario's medical schools.



References

1. FMEC MD 2015: 5 Years of Innovations at Canadian Medical Schools. *Assoc Fac Med Can.* 2015.
2. American Psychological Association. Socioeconomic Status. <http://www.apa.org/topics/socioeconomic-status/>. APA. Accessed February 15 2016.
3. Duncan GJ, Daly MC, McDonough P, Williams DR . Optimal indicators of socioeconomic status for health research. *Am J Public Health.* 2002;92(7):1151-1157.
4. Sirin SR. Socioeconomic status and academic achievement: A meta-analytic review of research. *Rev Educ Res.* 2005;75(3):417-453.
5. Dhalla IA, Kwong JC, Streiner DL, Baddour RE, Waddell AE, Johnson IL . Characteristics of first-year students in Canadian medical schools. *CMAJ.* 2002;166(8):1029-1035.
6. Association of Faculties of Medicine of Canada. AFMC Graduate Questionnaire. *Assoc Fac Med Can.* 2015.
7. Statistics Canada. Education in Canada: Attainment, Field of Study and Location of Study. *National Household Survey.* 2011.
8. Jolly P. Diversity of U.S. medical students by parental income. *Assoc Am Med Coll.* 2008.
9. Richardson M., Sheppard, M. Representation in Medicine: Examining Socioeconomic and Rural Backgrounds. *Canadian Federation of Medical Students.* 2009.
10. Greenhalgh T, Seyan K, Boynton P. "Not a university type": focus group study of social class, ethnic, and sex differences in school pupils' perceptions about medical school. *BMJ.* 2004;328(7455):1541.
11. Meilleur, Paris. Early Outreach Programs: Reaching Out Early to Reach Higher. *Ontario Undergraduate Student Alliance.* 2006.
12. Ontario Medical School Application Service. OMSAS Instruction Booklet. *OMSAS.* 2016.
13. Association of American Medical Colleges. The Cost of Applying to Medical School. <https://students-residents.aamc.org/financial-aid/article/the-cost-of-applying-to-medical-school/>. *Assoc Am Med Coll.* Accessed February 15 2016.
14. Kaplan Test Prep. MCAT Courses. <http://www.kaptest.com/mcat>. Accessed February 15th 2016.
15. Association of American Medical Colleges. Canadian Medical Education Statistics Volume 23. *Assoc Am Med Coll.* 2001.
16. Association of American Medical Colleges. Canadian Medical Education Statistics Volume 29. *Assoc Am Med Coll.* 2007.
17. Merani S, Abdulla S, Kwong JC, Rosella L, Streiner DL, Johnson IL, Dhalla IA. Increasing tuition fees in a country with two different models of medical education. *Med Educ.* 2010;44(6):577-586.
18. Association of Faculties of Medicine of Canada. Canadian Medical Education Statistics Volume 37. *Assoc Fac Med Can.* 2015.
19. Baxter C, Baxter D, Baxter M. Widening participation in medicine: moving beyond the numbers. *Med Educ.* 2015;49(1):15-17.



20. Chen E, Miller GE. Socioeconomic status and health: mediating and moderating factors. *Annu Rev Clin Psychol.* 2013;9:723-749.
21. Dalley B, Podawiltz A, Castro R, Fallon K, Kott M, Rabek J, Richardson J, Thomson W, Ferry P, Mabry B, Hermesmeier P, Smith Q. The Joint Admission Medical Program: a statewide approach to expanding medical education and career opportunities for disadvantaged students. *Acad Med.* 2009;84(10):1373-1382.
22. Grobler L, Marais BJ, Mabunda SA, Marindi PN, Reuter H, Volmink J. Interventions for increasing the proportion of health professionals practising in rural and other underserved areas. *Cochrane database Syst Rev.* 2009;(1):CD005314.
23. Kirby JB, Kaneda T. Neighborhood socioeconomic disadvantage and access to health care. *J Health Soc Behav.* 2005;46(1):15-31.
24. Heng D, Pong RW, Chan BTB, et al. Graduates of northern Ontario family medicine residency programs practise where they train. *Can J Rural Med.* 2007;12(3):146-153.
25. Future of Medical Education in Canada: A Collective Vision for MD Education. *Assoc Fac Med Can.* 2010.
26. Adelson N. The embodiment of inequity: Health disparities in Aboriginal Canada. *Can J Public Heal Can Sante'e Publique.* 2005:S45-S61.
27. Bouchard L, Gilbert A, Landry R, Deveau K. Social capital, health, and Francophone minorities. *Can J Public Heal Can Sante'e Publique.* 2006:S16-S20.
28. Pampalon R, Hamel D, Gamache P. Health inequalities in urban and rural Canada: comparing inequalities in survival according to an individual and area-based deprivation index. *Health Place.* 2010;16(2):416-420.
29. Young TK. Review of research on aboriginal populations in Canada: relevance to their health needs. *Bmj.* 2003;327(7412):419-422.
30. Magnus SA, Mick SS. Medical school's, affirmative action, and the neglected role of social class. *Am J Public Health.* 2000;90(8):1197.
31. Ontario Medical School Application Service. OMSAS Instruction Booklet. OMSAS. 2016.
32. Committee on Accreditation of Canadian Medical Schools. CACMS Standards and Elements: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. *Assoc Fac Med Can.* 2015.
33. Takagi DY. We should not make class a proxy for race. *Chron High Educ.* 1995;41(34):A52.
34. Association of American Medical Colleges. Fee Assistance Program. <https://students-residents.aamc.org/applying-medical-school/applying-medical-school-process/fee-assistance-program/>. *Assoc Am Med Coll.* Accessed February 19 2016.
35. Grbic D, Jones DJ, Case ST. The Role of Socioeconomic Status in Medical School Admissions: Validation of a Socioeconomic Indicator for Use in Medical School Admissions. *Acad Med.* 2015;90(7):953-960.
36. Grbic D, Jones DJ, Case ST. Effective practices for using the AAMC socioeconomic status indicators in medical school admissions. *Assoc Am Med Coll.* 2013.
37. Walji M. Diversity in medical education: data drought and socioeconomic barriers. *CMAJ.* 2015;187(1):11.



38. National Physician Survey. 2012 National Physician Survey: 2012 Medical Students by Year of Study. <http://nationalphysiciansurvey.ca/surveys/2012-survey/>. Accessed February 15 2016.
39. Eby LT, Allen TD, Evans SC, Ng T, DuBois D. Does Mentoring Matter? A Multidisciplinary Meta-Analysis Comparing Mentored and Non-Mentored Individuals. *J Vocat Behav.* 2008;72(2):254-267.
40. Glogowski K, Ferreira M. Parental Engagement: Research Evidence, Practitioner Knowledge, Effective Implementation. *Toronto: Pathways to Education Canada.* 2015.
41. Altitude Healthcare Mentorship. Project Overview. <http://altitudementoring.ca/about/project-overview>. Accessed February 29 2016.
42. Carline JD, Patterson DG, Davis LA, Irby DM, Oakes-Borremo P. Precollege enrichment programs intended to increase the representation of minorities in medicine. *Acad Med.* 1998;73(3):288-298.
43. Foster L. Effectiveness of Mentor Programs; Review of the Literature from 1995 to 2000. *California Research Bureau.* 2001.
44. Association of Faculties of Medicine of Canada. Admission Requirements of Canadian Faculties of Medicine. *Assoc Fac Med Can.* 2016.



Appendix 1^{1, 44}

Procedures in Admissions to Increase Socioeconomic Diversity at Ontario Medical Schools					
	Quotas for Aboriginal Students	Special Considerations	Pre-interview Measures	Information Sessions	Mentorship Programs
McMaster University	N/A	Aboriginal applicants are reviewed by a separate committee	Scenarios related to the health of Indigenous Peoples in the CASPer test	Information sessions that target students from underrepresented minorities	Altitude Healthcare Mentorship, MacMEDucation
Northern Ontario School of Medicine	2/64 positions for Aboriginal students	Aboriginal Admissions Stream for Aboriginal applicants. Selection favours applicants from Northern Ontario, other rural and remote areas in Canada, and Francophone minority communities	Community members from underrepresented communities are part of the interview panel	N/A	Altitude Healthcare Mentorship
Ottawa University	7/164 positions for Aboriginal students, 8/164 positions for students from Francophone minority communities	Lower grade point average for Aboriginal applicants	N/A	Mini Medical School sessions for Aboriginal and Francophone applicants to connect them to the medical education pipeline	Altitude Healthcare Mentorship
Queen's University	4/100 positions for Aboriginal students	Special consideration for Aboriginal applicants	N/A	N/A	Altitude Healthcare Mentorship
University of Toronto	N/A	Indigenous Student Application Program for First Nations, Metis, and Inuit applicants	N/A	N/A	Altitude Healthcare Mentorship, Summer Mentorship Program
Western University	3/171 positions for Aboriginal students	Special consideration for Aboriginal applicants and applicants from communities in Southwestern Ontario	N/A	N/A	Altitude Healthcare Mentorship