"Promoting Wellness in American Indian Communities: Addressing Health Disparities and Health Literacy"
A Conference

Sponsored by:
the Minnesota Board on Aging, the North Central Chapter of the Arthritis Foundation, and Pfizer, Inc.

Mystic Lake, Minnesota

"Literacy and Wellness"
Statement of

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director, Indian Health Service

October 29, 2003

I am Dr. Charles Grim, Director of the Indian Health Service (IHS). I am a member of the Cherokee Nation of Oklahoma and I applaud your focus today on the health of American Indian and Alaska Native communities.

The connection of health to every facet of our lives – for example, education, culture and traditions, family relationships, employment, and individual success and achievement – is undeniable. Study after study confirms those connections. The higher someone's education level, the higher their health status. The higher someone's health status, the greater their potential for educational achievement and success. Higher education level results in increased earning power. Greater income results in higher health status. It is a complicated and never-ending cycle; there cannot be an improvement in health status without an equal improvement in other factors that influence health status. Eliminating health disparities also means that we must make a commitment to eliminate all disparities.

The Indian Health Service will celebrate its 50th anniversary in 2 years. Over that time span, there have been significant health challenges that have been overcome. Mortality rates have decreased in almost all categories, including maternal deaths, gastrointestinal disease, tuberculosis, infant deaths, unintentional injuries, pneumonia, influenza, homicide, alcoholism, and suicide. And the lifespan of Alaska Natives and American Indians has increased from 51 years in 1940 to 71 years today, but that is still 6 years below the average life span of other Americans. And over this timeframe our illness and disease challenges have transitioned away from infectious disease control to challenges of chronic disease and the consequences of behavioral and lifestyle choices. These lifestyle and behavioral issues contribute to almost 70% of the diseases that occur at a higher rate in Indian country. Because our health challenges today, as a nation as well as in Indian Country, are largely the result of behavioral choices – we need to help people make healthier choices.

The definition of health literacy, provided by the conference sponsors, is one that the IHS also endorses. Health literacy is the ability of individuals to obtain, interpret, and understand basic health information and services and to use such information and services in ways that enhance health.

Health literacy is an integral part of the factors influencing health status – literacy impacts health knowledge, health status, and access to health services – it even has an influence on compliance with health treatment. Health literacy can even affect occupation, education, and housing choice. Studies show that people of all ages, races, incomes, and education levels are challenged by low health literacy. Research also indicates a link between poverty and health literacy. Poverty is a characteristic of most rural communities, and approximately 43 percent of

The text is the basis of Dr. Grim's remarks at the Addressing Health Disparities and Health Literacy conference in Mystic Lake, Minnesota, on Wednesday, October 29, 2003. It should be used with the understanding that some material may have been added or omitted during presentation.

all Indian people live in non-metropolitan areas, making the Indian population the most rural population in the U.S. Eliminating the negative factors that result in poverty should, it appears, increase the quality of life for rural communities.

The definition of health disparities provided by the conference planners is another definition that clearly states the issue. Health disparities are differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States.

Even with significant improvements in health status, Indian people continue to experience health disparities and death rates that are higher than the rest of the nation:

- Alcoholism - 770% higher
- Diabetes - 420% higher
- Accidents - 280% higher
- Suicide - 190% higher
- Homicide - 210% higher

These statistics identify some of the scope of the lifestyle and behavioral health challenges facing our communities. Making significant reductions in health disparity rates, and even eliminating them, can be achieved through the implementation of best practices by our health system partners, through partnerships to ensure that our programs and practices are using traditional community values, through partnerships to invest in and build the local capacity to address these health issues, and, perhaps most importantly, through partnerships with our people to promote healthy choices.

The issue of health disparities is one that President Bush and Secretary Thompson are committed to eliminating and they have established various initiatives focused on improving the health of the nation and also eliminating health disparities. The Secretary has also revitalized the Intradepartmental Council on Native American Affairs. This has been a huge effort within the Department to elevate the health and social service issues of Indian country with the leadership in the Department. It has eliminated many of the barriers that might have previously existed within the Department of Health and Human Services programs and funding.

For example, the Council undertook a Grants Access Study to inventory HHS programs and determine how many of those programs were being accessed by Tribes. The study indicated that HHS has 315 programs that offer grant funding. Of the 315 programs, Tribes are eligible for 125, or about 40% of grants offered by the Department. Of the 125 programs, Tribes are only accessing 85 of them. In 2004, the Council will begin to look at why Tribes are not accessing the other 40 grant programs. If the challenges to accessing these grant programs are internal to HHS, we are going to eliminate that barrier.

We must reduce or remove the factors that influence health status and perpetuate health disparities among people of our nation and between American Indians and Alaska Natives and the rest of the nation – and one of those factors is low health literacy. A renewed emphasis on health promotion and disease prevention will be our strongest front in the ongoing battle to eliminate the health disparities affecting our people, and health literacy plays an influential role in our efforts to educate the public about health issues and their consequences.

As I stated in my testimony during my confirmation hearing, health promotion and disease prevention is one of my priority initiatives during my tenure as the Director to meet the challenge of eliminating the disparity between the health status of American Indians and Alaska Natives and the rest of the nation. The rates of some health disparities are decreasing, but the rates of most leading causes of death for Indian people remain more than double the rates for the rest of America's population.

In the early history of the IHS, the greatest achievements in reducing health disparities were through increased medical care and public health efforts that included massive vaccination programs and bringing safe water and sanitation facilities to reservation homes and communities. I believe future reductions in disparities of any significance will be made through health promotion and disease prevention efforts and programs rather than through treatment. To continue on a treatment track alone would bankrupt the nation's health system, including the IHS. For the Indian health system as well as all the United States health programs, there is no practical way the health resources of this great nation can begin to meet the health demands of an aging population whose chronic health conditions are largely the result of a western diet and sedentary lifestyle. I believe the more we invest in promoting good health the less will be needed for treating the consequences of poor health.

For example, obesity-related health problems cost United States businesses an estimated $13 billion annually. And of the $13 billion, $8 billion, or 60 percent, was for health insurance costs. The total direct and indirect costs attributed to overweight and obesity amounted to $117 billion in the year 2000—that's $400 per person in America. Doing a simple projection for the population we serve, which probably underestimates the actual need, that comes to $640 million, or 27% of the entire IHS budget for 2000.

And since obesity is a symptom or risk factor associated with so many diseases and health issues affecting our people – like diabetes, cardiovascular disease, arthritis high blood pressure, stroke, lipid disorders, and certain cancers – then it is easy to see the benefits to Indian people to remain healthy, as well as the economic benefits to the Indian health system.

Another example is diabetes. The health care expenditures for people with diabetes are approximately $13,243 per person, compared with $2,650 per person for people without diabetes. Again, you can see the impact diabetes has on Indian Country when the IHS' per capita appropriation and collection for Indian Health Service expenditures for our population is roughly $1900 per person.

A final quick example of the cost and benefits of health promotion and disease prevention efforts through increasing health literacy is smoking. The HHS report, "Prevention Makes Common Cents," determined that the annual cost for covering smoking cessation treatment and programs annually costs from 89 cents to $4.92 per smoker. Whereas the annual costs to treat smoking related illness ranged from $6 to $33 per smoker.

To maximize the effectiveness of health literacy, health promotion, and disease prevention efforts for American Indians and Alaska Natives, I cannot overemphasize the importance of community input, ownership, and control of health efforts - not just because it is the right thing to do, but because scientifically the programs work better. Study after study of primary prevention shows that the most important predictor of effectiveness of a prevention intervention is the degree of community ownership and control. This is true for studies on a wide variety of conditions and issues - from tobacco, to fitness, to nutrition, to school health. To this end, we have to develop more partnership programs for training community leaders and community members in wellness planning and motivation skills - so they can develop their own plans based on local priorities, needs, and resources.

Because we are the Indian Health Service, and for many of us our patients are members of our families or tribes, I believe we are more sensitive to cultural, traditional, language, and literacy issues. Of the approximately 15,000 IHS employees, 69 percent are American Indian or Alaska Native. Excluding medical and engineering professionals, where the pool of Indian applicants is low, 88 percent of the IHS employees are Indian.

Some of the programs of the agency also contribute toward increasing health literacy of the population we serve. For example, our one-to-one Community Health Representative program, and, in Alaska, the Community Health Aide program. These representatives and aides are members of the communities they serve. They provide home visits and basic health information and some services. Home visits have been shown to be effective in health education efforts to change behavior, as indicated by increased treatment compliance and promotion of healthy choices and practices.

The IHS has other programs that also have a long history with the agency that emphasize the importance of health literacy and communication for improving health outcomes. This focus gained renewed emphasis in 1995 when the IHS developed the Patient Education Project. The Project continues to provide education and training to service units of the IHS on the importance of literacy, communication, and education to our health providers at all levels. And the results? The number of documented educational encounters increased from 452,000 in 2001 to over 1.6 million by August of 2003.

The Patient Education Project also initiated two trial projects, one at Tuba City and one at the Phoenix Indian Medical Center, using kiosks in the waiting rooms with literacy tested and appropriate educational information for Indian clients to use. The goal is to increase the number pilot projects and test and evaluate the effectiveness of kiosks to increase health literacy and change behavior.

Through our collaborations with other medical programs of the federal government, the Department of Defense assisted the IHS in the development of factors to measure the various aspects of health literacy and health education – and in the process discovered that the IHS is far ahead of any other federal health program. The IHS is a model program for health education and health literacy that can benefit health programs everywhere.

By developing health factors on the Patient Care Component of the agencies' Resource and Patient Management System to track language barriers (as well as identifying clients who are deaf, blind, and those that need translators), we are now able to track behavior changes that result from education, and we are able to demonstrate learning preferences, barriers to learning, and readiness to learn at each and every patient visit.

The IHS level of health literacy and health education is due in large measure to the training of health care providers by our health education team. In fiscal year 2003, 400 health care providers received this training.

I believe that health literacy needs to improve throughout America – particularly as the health focus

of the nation has shifted from infectious diseases to chronic diseases. More and more of the population is going to deal with chronic diseases because of behavioral choices made decades ago. To successfully treat complex and long-term conditions will require a level of health literacy above that currently demonstrated by the majority of Americans. And this includes patients as well as their family and personal caregivers – our emphasis on ambulatory care and outpatient services is relying more and more on family members as an extended part of the health care team; and we seem to expect them to mostly educate themselves on the disease, side effects of medications, and administering health care services.

The Administration and the Department of Health and Human Services have long been committed to improving the health of all Americans with emphasis on disadvantaged populations. In recent years, HHS has advanced several significant initiatives in this area, including the President's initiative to eliminate racial and ethnic disparities in health care. HHS was also the first federal Department to publish guidance for culturally and linguistically appropriate services in health care and on equal access to services for individuals with limited English proficiency who are served by federally funded programs. Improving health literacy is also a goal outlined in the Healthy People 2010 document. And grants have been issued by the National Institutes of Health to research the issues and complexities of literacy so that everyone living in the United States can take full advantage of the health information and services available to them.

I assert that we need to view increasing the health literacy of our nation as a challenge, not a barrier. The most significant improvements in the health status of the nation will come from educating the public to make healthy choices. Studies have demonstrated that 10 percent of the current health status of the country is influenced by access to care issues, 20 percent is the result of environmental causes, 20 percent is related to genetic predisposition, and 50 percent is behavior related. Increasing the health literacy of our nation will go a long way to changing those percentages. Except for certain population groups of the country, which includes Indian and rural communities, access to care is not the greatest challenge to increasing health status, it is educating the public to consider the health consequences of their behavioral choices.

While health communication alone cannot change systemic problems related to health – such as poverty, environmental degradation, or lack of access to health care – it can help improve the access to health services, support health education efforts, and increase the level of health literacy and therefore the health of our families and our communities. It can help people better understand and ultimately make better choices about the influences behavioral and lifestyle choices have on their overall health status.

Closing the gap in health literacy is an issue of fundamental fairness and equity and is essential to reducing health disparities. And together we can remove the factors that adversely influence health status and perpetuate health disparities, and improve the health literacy and the health status of every American.

Thank you.

The text is the basis of Dr. Grim's remarks at the Addressing Health Disparities and Health Literacy conference in Mystic Lake, Minnesota, on Wednesday, October 29, 2003. It should be used with the understanding that some material may have been added or omitted during presentation.