

STATEMENT
OF
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OFFICE OF PUBLIC HEALTH
INDIAN HEALTH SERVICE
BEFORE THE
SENATE INDIAN AFFAIRS COMMITTEE

FEBRUARY 12, 1998

**STATEMENT OF THE INDIAN HEALTH SERVICE ON THE TRIBAL PROVISIONS
CONTAINED IN PROPOSED TOBACCO LEGISLATION
BEFORE
THE SENATE INDIAN AFFAIRS COMMITTEE**

Good Morning: Mr. Chairman and Members of the Committee:

I am Dr. W. Craig Vanderwagen, Director, Division of Clinical and Preventive Services, Indian Health Service (IHS). The IHS is an agency of the Public Health Service (PHS) within the Department of Health and Human Services. The IHS is responsible for providing health services to members of Federally recognized American Indian and Alaska Native (AI/AN) tribes and also has limited authority and funding to provide services to urban populations of American Indians and Alaska Natives. The provision of these services is based on a special relationship between Indian Tribes and the U.S. Government and is defined by Constitutional provisions, executive orders, treaties, and a broad range of laws and judicial decisions.

IHS MISSION

The IHS goal is to raise the health status of AI/ANS to the highest possible level. The mission is to provide a comprehensive health services delivery system for AI/ANs with opportunity for maximum Tribal involvement in developing and managing programs to meet their health needs. I am pleased to be here today to further discuss the issue of tobacco related health concerns since there are significant impacts of tobacco use among the people we serve. We commend the Committee leadership's commitment to address the many issues related to tobacco usage among American Indians and Alaska Natives. As the primary agency responsible for the provision of health care to Indian people, we are particularly appreciative of your interest in making certain that Indian tribes are considered in any benefits that result from legislation related to the regulation of the tobacco industry.

PREVALENCE OF TOBACCO USE

Studies conducted by the IHS reveal that tobacco use is a common health risk factor. A study by the staff of the IHS Cancer Prevention and Treatment Program revealed that 10 percent of all deaths in AI/ANs are related to cigarette smoking or use of other tobacco products. This translates to well over \$200 million in health expenditures by IHS to provide care for tobacco related illness. But the frequency of tobacco related disease has great geographic variability.

Using the Behavioral Risk Factor Surveillance System Surveys (BRFSS), Sugarman, et al compared tobacco use among American Indians (AI) in the 36 states participating during the

years 1985 through 1988 (Alaska did not participate in the BRFSS during this time period). These states were divided into four geographic regions: the Southwest, the Plains, the West Coast and Other States. The populations served by IHS were studied to assess regional differences in use of tobacco products.

The prevalence of current cigarette smoking varied by geographic region more than two fold for AI Men and more than fourfold for AI women. For example, in Southwest States, 18.1 percent of Indian males and 14.7 percent of Indian females reported current smoking compared to the Plains States where 48.4 percent of Indian males and 57.3 percent of Indian females reported current smoking. Cigarette smoking is one factor in which regional differences among Indians were markedly different from those among whites, as the prevalence of current smoking reported by white respondents varied relatively little by geographic region.

Variability of tobacco use by different regions was also documented in the IRS Oral Health Monitoring System in 1991. In this survey, each AI/AN patient who was provided care in the IHS dental clinic (above age 5) was asked if he or she used any form of tobacco products routinely (other than for culturally/religiously determined events). The findings revealed a great deal of age and geographic variability. For example, 9 percent of 5-19 year olds reported tobacco use, but 39 percent of 20-34 year olds admitted routine use. Geographic variability was also extreme with Albuquerque, Phoenix, and Navajo reporting tobacco use in less than 30 percent of the adult population. By contrast, Aberdeen, Alaska, Billings, and

Bemidji reported in excess of 50 percent of adults routinely using tobacco,

The IHS has also analyzed the use of smokeless tobacco. These studies revealed that use of smokeless tobacco products has regional variability that mirrors the smoking trends. More distressing is the finding that young people from age 15-24 are using these products in significant numbers. There appears to be an especially high frequency of use among American Indians who participate in rodeos. This association with rodeo activities is currently being studied by an American Indian medical student who has received a grant to analyze the marketing of smokeless tobacco products to rodeo participants and American Indian participants in particular.

The significance of these findings is reflected in the diseases associated with tobacco use. Lung cancer was the leading cause of cancer mortality for all IHS areas combined (1984-1988). The trend has continued and in the next publication of "Cancer Mortality among Native Americans in the United States," lung cancer is still the leading cause of cancer mortality for the years 1989-1993. In Alaska, lung cancer is the leading cause of cancer related deaths among women in contrast with the rest of the IHS service population where reproductive cancers are the challenge in cancer prevention and treatment. Chronic obstructive pulmonary disease (COPD) also is a significant health problem in those regions where smoking is prevalent.

Current Activities to Treat and Prevent Tobacco Abuse

The IHS has undertaken a number of activities to treat patients with an addiction to tobacco products. This has included modifying materials from the American Cancer Society and the American Lung Association to make them more culturally relevant. These materials are being used by primary providers and also by Community Health Representatives to provide smoking cessation training and support. The success rate of cessation programs in AI/AN communities does not appear to differ from the rate in the general U.S. population.

Primary prevention efforts have been the major emphasis of the EHS and tribal organizations.

The Northwest Portland Indian Health Board for example has developed a model Clean Indoor Air Policy which it is disseminating to tribal governments. The IHS has developed model policies for reducing youth access to tobacco products. Our agency is distributing this information for use by tribal governments in developing approaches to limiting youth access. Other materials have been developed by tribes and IHS to promote and support drug free rodeos, powwows, and other cultural events.

Lastly, state governments and state based organizations have increasingly included American

Indian and Alaska Native tribes and organizations in the tobacco related activities. The Alaska Native Health Board working with others in Alaska were able to promote a tax increase on tobacco products which has provided additional funds for educational efforts in the state. California and Arizona have also been states where program initiatives have been developed to include American Indian concerns and populations specifically.

In summary, tobacco use is a significant health issue in American Indian and Alaska Native communities. American Indians and Alaska Natives have the highest smoking rate of any racial sub-population. The IHS and its tribal and urban partners have committed themselves to treatment and prevention aimed at reducing the health impact. The principles articulated by Secretary Shalala in her recent testimony on the tobacco settlement are applicable to the needs of the population we serve. We will work under her direction and in consultation with our partners to continue to address these health needs.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you may have.