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Ethical and Practical Considerations Relating to Governmental Coverage of Traditional Indigenous Medicine

There are approximately 2.4 million American Indians in over 500 federally recognized tribes in the United States. Since the 1975 passage of the Indian Self Determination and Education Assistance Act[1], the tribes are assuming increasing control of the federal programs that serve them, including those for health care delivery. However, many Native American communities are not content to simply rearrange the elements of a health care system that lacks cultural relevance at the deepest level. They are re-thinking the components including finding a place for their own traditional beliefs about health and healing. In the past Native American traditional healers were dismissed and outlawed by federal government as part of a program of forced assimilation of indigenous communities. But traditional Indian medicine (TIM) survived in many tribes. Currently, TIM is often used by Native Americans in conjunction with biologically based medicine[2] ("biomedicine")[3], sometimes referred to as "western medicine"[4]. Yet, only relatively recently has there been significant movement in coordinating and legitimizing traditional indigenous care with the biomedical health care system or even any serious effort to evaluate its efficacy. This lack of information about indigenous health care beliefs and practices confounds policy development for government-funded health care delivery to Native Americans.[5] The issues engendered from the emerging indigenous medicine claims on government-sponsored systems are intriguing and need to be addressed if the government is going to provide culturally sensitive, effective health care to its citizens. This paper will examine some of the ethical and practical implications of governmental coverage of traditional healing services that the Dine' (Navajo) Medicine Men have been considering in their Association meetings for the past few years.

Background

In general, there is little evidence of severe disease among Native Americans until European contact[6] exposed them (in some cases unwittingly, but also at times deliberately) to new infectious agents for which they had no immunity. This exposure combined with a federal government policy of privation, forced migration, homeland confiscation, and proscription of the traditional healing practices which had served them well resulted in poor health marked by high infant death rate, malnutrition, and frequent debilitating infectious diseases[7]. Finding that these policies had seriously undermined this country's first citizens' well being, the federal government assumed a special fiduciary responsibility for their welfare, including health care. Initially, in the late 1700s and early 1800s, health care had been promised by the federal government in only a minority of the over 400 treaties signed with the many widely diverse and independent tribes. This care was erratically delivered through the military posts and their medical staffs. In 1849, responsibility for health care was transferred to civil control via the new Department of the Interior but still remained piecemeal in its delivery. Through the late 1800s and early 1900s, health care to Native Americans was delivered either through crisis-oriented public health drives (eg against early infant death and against epidemic trachoma) or through the boarding schools used to assimilate and educate Native American children[8] [9]. In 1955, responsibility for Indian health care was turned over to the Indian Health Service (IHS) which successfully brought under control the infectious diseases so prevalent then.

The 1970's saw a dramatic change in governmental policy towards American Indians. The passage of the Indian Self Determination Act of 1975 was an attempt to facilitate the nation's indigenous people's return to an autonomous state after centuries of paternalism. The Indian Health Care Improvement Act in 1976 specifically facilitated self determination in health care[10], through tribes assuming control over the health care system that has been administered by the IHS.

Coincident with this resurgence of tribal authority has come a change in the disease profile of Native Americans. The high infant mortality and infectious diseases prevalent when the IHS was created are areas against which biomedicine has been highly effective[11]. These have been replaced in the last one to two generations by degenerative and life-style-related diseases as the predominant causes of morbidity and mortality. Biomedicine can often only treat, not cure these new epidemics resulting from dominant

culture diet and sedentary lifestyle.[12] As tribes reorganize programs in assuming administrative responsibility and to deal with the mounting burden of this changing disease profile[13], they often envision culturally relevant health care systems that merge the best of the imported biomedical system with the traditional Indian medicine[14] (TIM) that has served them for hundreds of years and which is beginning to be covered by some third party payers, including governmentally funded health programs; for example:

1. Some Veterans' Administration medical centers provide coverage of traditional healing ceremonies for Native Americans who have failed standard psychiatric care for post traumatic stress disorder[15].
2. Indian Health Service has a policy permitting traditional healers to treat inpatients at IHS facilities. At the local level, centers may even decide to provide limited coverage for traditional diagnosticians, for traditional healers as mental health counselors[16] and for sweat lodge ceremonies in alcoholism treatment[17].
3. Within Medicaid, states may choose to cover traditional healers' services as an option similar to Christian Science practitioners' coverage. In Arizona, AHCCCS (the state's Medicaid program) has covered TIM through behavioral health programs.

But this limited coverage for TIM is not consistent with the role that traditional care fills for many American Indians[18]. One recent study of traditional practitioner use done among Navajo Indian Health Service patients showed that 62% of those interviewed had seen a traditional healer at some point, and 39% had consulted a healer within the last year[19]. According to the study, the varied reasons for these visits ranged from arthritis (the most common) to depression. People in the study reported that they would avail themselves of these traditional healing services more except for cost. A similar study was done in a Milwaukee, Wisconsin (urban) Indian Health Service clinic serving thirty tribal affiliations, including Ojibwa, Oneida , Chippewa, and Menominee. The researchers found that 38.0% of the patients see a healer, and of those who did not, 86.0% would consider seeing one in the future. More than a third of the patients seeing healers received different advice from the biomedical and traditional practitioners. The patients rated the traditional healer's advice higher than the physician's advice 61.4% of the time[20]. This contrasts with the Navajo study whose participants reported equal confidence in the two types of

practitioners. However, the latter study may reflect some element of bias as all subjects were recruited while visiting an IHS facility.

Defining Traditional Indian Medicine

There is no one Indian traditional medicine; instead there is a system of health and healing for each tribe[21]. While the many systems share commonalities, they differ from biomedicine in that traditional Indian medicine seeks to restore the patient to his rightful place in the environment while physicians focus on controlling the disease. That a particular disease episode is resolved by allopathic medicine is not sufficient for many Native Americans, as that alone does not restore the patient to health. There still remains the need to identify the predisposing condition which, they believe can cause recurrent illness, if left untreated. This is analogous to the smoker who sees a physician not only for treatment for bronchitis causing a cough but also reassurance that the disease episode is not a symptom of lung cancer. In the case of traditional Native Americans, however, the patient has a completely different framework of the origins of disease, so that the allopath who can relieve a disease episode's symptoms with medications cannot assess or treat an underlying condition that may be suspected based on the patient's beliefs. For this form of relief, a traditional healer is employed[22].

This failure of biomedicine to provide what many Native Americans view as necessary to good health has assumed urgency as the numbers of traditional practitioners are rapidly decreasing through aging[23]. There are too few younger persons undergoing the demanding training, which takes years. Unlike M.D.s, the financial austerity that comes with training is not relieved once traditional healers establish a practice. Also, changing occupational profiles of tribal members has had an effect on traditional medicine training and practice. For example among the Navajo, subsistence occupations such as shepherding previously provided both a steady supplemental income and the time flexibility necessary for both trainees and established chanters to participate in ceremonies that last from one to nine days. Wage employment, however, is replacing the subsistence occupations and is done by a fixed schedule and may be off-reservation[24] interfering with apprentices' and practitioners' availability for traditional healing ceremonies. Low reimbursement rates and failure to use traditional healers due to cost are problems that could be relieved by third party payment. However, there is a conflict between the need for a reliable

livelihood that third party payers may provide and the resistance of traditional healers to the codification, scrutiny and conformity that payer regulation could require.

Governmental Health Care Programs Serving Native People

IHS and Medicaid are the governmental entities for whom concerns about traditional Indian medicine (TIM) coverage are most relevant. IHS is available to and responsible for approximately 1.5 million of the over 2.0 million registered tribal members in the United States[25]. It serves people in 34 states, mostly in rural areas and in the Western States and according to its own managed care constraints. Unique among American health service delivery programs, it has an obligation and commitment to full access of a community to health care. In order to accomplish universal access within its lean budget, the IHS usually engages in some degree of service prioritization[26] [27]. Adding TIM coverage in a frankly rationed system could result in increased rationing of other services unless TIM use results in less use or need for the existing medical services or unless there is additional funding.

But the IHS is not alone in covering Indian health care. Since nearly a third of Native Americans have incomes below the federal poverty line, many American Indians qualify for Medicaid. But not all tribal members who qualify are willing to go through the bureaucratic work of obtaining coverage since they can already receive IHS care and the Medicaid provider is often the same as under IHS. Medicaid, however has the advantages of providing a fixed benefit package year round and making out-of-area tertiary care more available. In order to maximize IHS resources, tribal health programs encourage their eligible members to obtain Medicaid.

Depending on the individual, some tribal members may also qualify for Veterans Benefits and/or Medicare. Medicare is the federally-provided insurance available to the disabled, elderly and those with end stage renal disease, a condition which occurs in some tribes at a rate of twenty times the national average due to epidemic type II diabetes. However, many elderly Native Americans who have had subsistence occupations do not have the salaried work history necessary to qualify for Medicare, but as Native Americans increasingly have wage occupations, this is changing. In 1996, approximately 1.5% of the nation's dialysis population were Native American. But this can be expected to change. American

Indians have diabetic renal disease out of proportion to the general population and the diabetes epidemic has not yet reached a steady state and with the onset of the disease's complications usually following diagnosis of diabetes by 10-20 years[28].

While the federal government including HCFA (the federal agency overseeing Medicaid and Medicare) have increasingly prioritized issues relevant to Native Americans' health, TIM coverage has not been one of them[29]. Given the number of issues that are critical to strengthening both Medicaid for Native Americans[30] and IHS, it is understandable. But this issue is going to make itself heard.[31] The number of requests to HCFA for coverage of TIM is increasing.

Basis for coverage

In light of these multiple sources of governmental care, if there is a right on the part of American Indians to traditional care, on what is that right grounded and which entity is obliged to satisfy it? One may have a hard time making a legal case for traditional healing coverage based on treaties or as evidenced by legal interpretations of the Indian Health Improvement Act[32]. But it would be a thin social fabric we have if obligations were solely determined by legalities, especially when the affected citizens have, until relatively recently, experienced a government policy based on gross disregard for their rights collectively and as individuals[33]. What arguments tribes consider as most relevant is beyond the scope of this paper. But since the rationale for coverage may have practical implications for the health care program, both tribes and the federal government should consider well which justification(s) to use in staking or considering a claim for TIM coverage. We will suggest four possible reasons for governmental coverage of TIM in order to examine the variability in program that can result from different grounds for coverage:

1) Because of tribal autonomy and self determination,

2) As part of a general obligation to provide culturally sensitive care;

3) On the basis of corrective justice[34]; and/or

4) As a benefit extension in keeping with current insurance coverage procedures for exceptions made for investigational treatments.

The last argument refers to case by case consideration of coverage of TIM as an investigational

therapy ("investigational" in the sense that it is unproven by published scientific trials) in instances where standard therapy of a serious disease is inadequate and there is sufficient reason to believe that an unproven treatment would be effective. This exceptional benefit is in spite of contractual language excluding unproven therapies from coverage.[35] [36] Commercial insurance policies and procedures are relevant to governmental programs since Medicare and many states Medicaid programs subcontract to commercial insurers and within healthplans, it is difficult to maintain distinctions between product lines. Further, HCFA often mirrors commercial insurers' standard administrative practices.

In those tribes experiencing epidemic incidence of diabetes, diabetes clearly qualifies as a serious illness, being directly responsible for 9% of all Native American deaths, and through complications contributes to the death of many more. In addition, diabetes is responsible for an incidence of renal dialysis as high as twenty times the national average[37], as well as amputations, blindness, and cardiovascular disease`. Allopathic medicine (that practiced by M.D.s), even when all recommended interventions are implemented in a comprehensive disease prevention program has had insufficient impact on this disease among Native Americans as evidenced by the increasing incidence of diabetes and its complications and by studies showing only modest response at best to numerous interventions in various Native American subgroups[38].

But is it a realistic expectation that shamanistic ritual can actually succeed where biomedicine has failed?[39] [40] Certainly, there is no evidence at this time to suggest that TIM could directly substitute for the dialysis, laser retinal surgery, and revascularization procedures needed by Native American diabetics with end stage complications of diabetes. But given the success of TIM in behaviorally mediated disease[41][42][43][44][45][46], it is reasonable to speculate that it could prevent or ameliorate the diabetes and secondarily its complications, through a number of mechanisms: traditional healing might decrease stress which through beta adrenergic stimulation contributes to poor diabetic control; may prevent or decrease obesity; directly control hyperglycemia through herbal remedies, and/or increase compliance with allopathic diabetic therapeutic regimens due to traditional healers' recommendations to cooperate with biomedical treatment.[47] This has tremendous consequences both for those diabetic Native Americans who anticipate developing high rates of complications and for the federal government which is often the payor

of the laser eye surgery, cardiac bypass, and especially the $57,000 annual per patient cost for those on dialysis.

While the studies that will resolve those kinds of questions are up to clinical researchers and epidemiologists, how the current health care system evaluates the acceptance of TIM is an ethical concern. What is the legitimate role of cost efficacy in that decision? And by whose values should efficacy be judged when there is disagreement about fundamental beliefs? In studying the use of TIM in diseases such as diabetes, there may be good reasons to use allopathic measures of outcome, such as HgbA1c: 1)Allopathic measures of efficacy have the advantage of being developed to assess a specific physiologic disorder not specifically recognized in traditional practice such as diabetes or HIV which are new diseases to traditional healers. 2) Diagnostic measures such as HgbA1c are not dependent on observer interpretation. 3) The results are more likely to be interpretable to governmental health policy personnel who are for the most part grounded in the allopathic paradigm. And 4) by using the same standards, cross system comparisons can more easily be done between TIM and allopathic care.

If cost efficacy is established for TIM in diabetes, it would justify coverage. But there are arguments against relying on cost efficacy as a sole consideration in determining whether to cover traditional medicine. First, aging and experienced traditional healers in their seventies are running out of time to pass on their knowledge before studies can be completed which would determine efficacy[48]. The decision to support this modality must be made now on the basis of whatever information is currently available. Later, as more information is developed through research, policies can be modified. More importantly, other justifications exist for covering TIM which conflict with considerations of efficacy. Those others rest on principles of self determination and corrective justice. According to one proponent of corrective justice: "Modified trust responsibility (MTR) incorporates corrective justice through the following elements:

1. The federal government should make payments to indigenous people that are related to the harm it has inflicted on indigenous people.
2. The federal government should construct a system of laws that attempts to restore the liberty and autonomy of Native political entities, and that allows Indian Tribes to exercise regulatory and

adjudicative jurisdiction over their lands.

3. The federal government should help Indian Tribes solve problems created by the legacy of genocide, mass land expropriation, and forced assimilation."[49]

Providing coverage of TIM directly reverses assimilation and doing so at government expense, would be a form of reparations payments. Under these principles, what matters is whether TIM is efficacious by standards acceptable to indigenous community decision makers. How that would actually play out requires finding out how American Indian communities view TIM and for the dominant culture to anticipate and accept departure from dominant culture policies and procedures relating to coverage. In the mainstream health care environment, negative outcome studies usually are grounds for not paying. For federal funds to be used for an indigenous clinical practice if it were shown to be less effective than allopathic practices would require institutionalizing true tribal autonomy.

On the other hand, if there are negative study results would indigenous healers or patients reconsider that particular indigenous approach? In order to avoid studies resulting in conflicting actions from dominant and indigenous policy makers, guidelines that clarify the interaction of indigenous and dominant culture health care policies are needed. To further complicate, the multiplicity of indigenous traditional healing systems makes the impact of a single policy or procedure in a single indigenous community is difficult to interpret for the entire Native American population. Mechanisms are needed by which policies are developed that have applicability to and acceptance by more than a single tribe. One issue in particular that would require general applicability is the justification for funding health programs based on political considerations such as reparations. One might wonder which governmental entity should be responsible for this decision. While health care agencies such as IHS and HCFA would have to deliver on the decision, the actual decision itself seems outside the scope of their appropriate considerations. Obviously, such a rationale would require at least coordination on this issue among all governmental entities providing health care to identifiable Native Americans.

The increasing interest of the general population in alternative or complementary medicine has been responded to by the formal health care system with demands for outcome studies substantiating its efficacy. Since outcomes studies have become the standard by which physicians judge their own

discipline[50], this is not an unreasonable expectation. This expectation would at first glance seem to apply to TIM practices also. But while TIM is alternative and complementary to allopathic care, the similarity to dominant culture alternative medicine use ends there and could in part be explained through a careful analysis of cultural sensitivity as a basis for coverage. TIM is culturally established primary care for many American Indians. More importantly, non-indigenous users of alternative medicine cannot base claims for coverage on the expectation of restitution for the legacy of previous harms inflicted or based on tribal self-determination. While cultural sensitivity as justification for a difference in coverage between main stream alternative medicine and Native American traditional indigenous health care is less immediately apparent, it is intuitive and however, would require grounding in an appropriate definition of culture.

Intellectual Property Rights

Separate from considerations of whether or not TIM should be covered, there are concerns relating to intellectual property rights and ethnomedicine. What protections are appropriate for tribes to avoid exploitation of their intellectual properties such as ethnobotanical discoveries being used by drug companies? The growing field of alternative or complementary medicine enhances large pharmaceutical companies' interest in ethnobotanical discoveries. Indigenous communities have informally been research participants for decades for botanical experimentation by medicine men[51]. Some drug companies are "mining" the resultant discoveries, having found that research which begins with a recognized traditional botanical therapy is more likely to result in a useful discovery than if the research has a cold start in the lab[52]. However, there are no financial rules or precedents in this market. Intellectual property rights of tribes may be unfairly bargained for. Companies may claim that identifying the active ingredient and now making it available in pure form should be sufficient return to the tribe for the ethnobotanical information that was obtained. However, the commercial product is probably of no real value to indigenous patients since the practitioner's preparation is considered integral to the plant's efficacy.[53] Is the belief in ritual preparation a sufficient justification for requiring third party payers to pay additional costs for medicine man provision of the plant form once a botanical is available as a pharmaceutical preparation?

Change resulting from codification of TIM

Within Medicaid, coverage for traditional practitioners is limited in part because coverage is only for "professional providers", a designation which many ethnopractitioners do not satisfy because they lack a credentialing procedure to certify them and/or evidence of group self-regulation[54 55]. But will traditional practice work as well when codified and regulated? Can a federally-acceptable credentialing process result in the same provider network as a process where legitimacy has resulted from community recognition? Indeed there will be reason for less patient confidence if practitioner impersonation results because third party coverage increases the number of people seeking services beyond the service capacity of legitimate diagnosticians, herbalists and ceremonialists. Already fraudulent providers are a problem[56]. The worsening of this problem would justify credentialing as more than just a bureaucratic hoop that healers must jump through.

The absence of organizations and certification of traditional healers makes estimates of their numbers uncertain. Coupled with the paucity of data about the demand for their services, whether a tribe has the traditional healer capacity adequate to meet all its traditional healing needs is uncertain. But the Navajo experience suggests that there is considerable unmet demand already. A physician doing an informal study of his medicine man father's practice for one month found that the healer (in his seventies), working full time, could only accept 40% of those who came to engage his services[57]. Consistent with anecdotal reports, he found that people traveled long distances to see a traditional healer because they could not find one near their home. The current estimates of the number of healers ranges from 150 very traditional medicine men to 1500 registered roadmen with the Native American Church (two different types of healers with the roadmen serving NAC members who make up 40% of the population). A ratio of about 1 to 900 for very traditional healers compared with 1 to 30 people in their most active period. In the event that coverage increases use of traditional providers beyond existing network capacity, should services be rationed and if so, how? The problem with access to care in the American health system in general because of a refusal to ration health care resources should be a cautionary tale for TIM. The general US health care distribution problems is itself an argument for developing a rational and deliberate allocation scheme for TIM in anticipation of shortage. Such a

scheme could take into account the community's priorities, including how increased medical use of traditional providers will affect any social-maintenance functions they performed. If there is not enough practitioner time for all the demands made, in addition to possible fraudulent providers, it is conceivable that individual treatments could be abbreviated, and that social-fabric-maintenance functions could not compete with medical needs. The social ceremonies, which will not be reimbursed by third party medical payers, may not be able to compete with medical demand for traditional practitioners' time. This could result in medicalization of social issues or increases in fees for the social functions to compete or to match new financial expectations that result from third party payment of other services. On the other hand, if medically-related traditional healing services were abbreviated, patient satisfaction or outcome could be adversely affected. Erroneous negative results early in the program could confound assessments of it, especially if there were demonstration projects. To avoid this, anticipated demand and network capacity should be gauged and initial and backup rationing policies and methods should be worked out before initiating coverage.

A different financial concern relating to possible change resulting from third party payment is that the service or perception of the service's value may be diminished by different funding. It is possible that if providers substantially increase their income through third party payment, they may be less credible and TIM practice may attract a different type of individual than the current ascetic lifestyle attracts. Second, practitioners are concerned that a third party payer may even compromise therapeutic efficacy. Now a fee is established by negotiation with the patient's family and typically involves sacrifice and collective family effort to pay it, demonstrating to the patient that he is supported by a strong social network. This evidence of social support will be removed unless a substantial copay is instituted and required. But a required copay would necessitate a waiver for the Medicaid program which allows it, since Medicaid services may not be denied for lack of patient payment.

The current methodology for determining payment results in there being no usual and customary fee on which to base a standard fee schedule. One way of dealing with this uncertainty used by the VA and IHS is to employ a healer on salary. But often healers are specialists, and thus, one can no more be a full service provider than any physician specialist can be. Some means of paying a range of healers must

be developed for comprehensive TIM care. A valuation based on length of ceremony plus training of healer is possible as often the practitioners' time needed to perform certain healing functions is established. What particular services are needed for what types of complaints is the more difficult determination to make at this time and are essentially based on provider discretion. This is particularly of concern regarding efficacy and cost efficiency with diseases for which there is no historical practice (such as diabetes which is new for Native Americans.) With more experience in coverage, patterns of utilization (and efficacy) should eventually emerge. Alternatively, a healers' consortium or professional association could contract to provide services for a given population for a capitated rate and decide individual case payment among themselves.

Group contracting for all services with responsibility for quality assurance could, to some extent, obviate the dilemma of state or federal regulators determining quality and utilization standards for a system based on oral tradition and usually not open to outsiders' review. Indigenous beliefs and practices traditionally have not been analysed. They are often firmly established conventions which practitioners learn without questioning. Out of respect, lay tribal members also do not examine the discipline. And there is reluctance to expose traditional practices to potential criticism and misunderstanding by outsiders. Cultures controlling their own story by doing their own reporting and research would probably decrease these concerns. This should include developing standards and controlling studies that are of value and interest to their community. This can be done by community/healer input and oversight of outside projects and through indigenous researchers actually initiating and doing the projects. But it may be difficult for non-practitioner indigenous researchers to objectively study their healers while treading the thin line between disrespect and investigational bias. From a cultural perspective, indigenous healers can probably more safely do their own research without transgressing sacred boundaries. How funding agencies could encourage and evaluate a specific type of researchers based on their professional culture is not a totally new problem. Physicians have pointed out that Ph.D.s doing the bulk of clinical research investigations is a concern[58] and as a result, a fixed amount of NIH research dollars are dedicated to MD clinical research projects. Similarly, a researcher's cultural paradigm should be relevant as a funding consideration in traditional medicine investigations.

That some healers do not read text is a disadvantage in an academic research system, but should not be confused with illiteracy due to lack of education. Practitioners have an oral tradition, retaining vast memorized informational stores, and often are knowledgeable about a complex symbolism that is well illustrated by Navajo sand paintings. To make this point, a Navajo medicine man-apprentice, Philmer Bluehouse asked an audience at an international bioethics conference if they could interpret the intricate symbolism of a sand painting commonly created for Navajo healing ceremonies. No one could, since the audience–all with advanced degrees, were "illiterate" [for that culture's symbols.] In RFAs and publishing, communication options would have to be considered for non-reading researchers: they could use audiovisual media, dictation with transcription, or link with academicians who would co-author written work. Communications between co-authors can be done by cassette recordings or voice e-mail.

Cost neutrality

In the event that a community decides to pursue governmental coverage for traditional healing, how should payers expect addition of TIM coverage to impact the total health care budget for American Indians? If TIM is successful in significantly ameliorating costly conditions such as the diabetic epidemic, then a savings can be expected in the long run. But since the largest savings would be due to decreased cost of treating long term complications, it will likely be at best five years, and more likely, ten to twenty years before a significant return is seen on this investment for diabetes. But the potential savings are great and tangible. The ideal results would see the disappearance of at least some of the renal dialysis and retinal laser treatment centers that have become necessary on the reservations. Success would also mean a decrease in air transport for cardiac emergencies from rural area reservations to facilities with invasive cardiac care capabilities, not to mention the many Indian Health Service and Medicaid inpatient days saved that are currently spent on heart disease, vascular disease, and lower extremity ulceration and infection. Can any figure be projected for this hoped-for turn around? One yard stick by which to calculate projected impact is comparison with the results of aggressive allopathic management in Type I diabetes which results in a 70% decrease in diabetic complications. In the absence of evidence to suggest that a different outcome should be expected, that is also the expectation commonly held for control of Type II diabetes[59], the type most common among Native Americans.

Programmatic details such as payment, in large part can be determined by the justification for the coverage but by any method will probably result in higher than average per capita costs compared to the general population. If justification for coverage is based on corrective justice as previously alluded to, then an enriched benefit package is ethically consistent. If self-determination alone without reparation is the motivation, then only budget dollars for health care are negotiable with the tribe deciding whether to allocate some of those funds to traditional healing. But how should the per capita allocation for health care be determined when the average health status of the Native Americans is worse[60] than the average profile of most members of the general population? Norman Daniels work about justice within health care[61] [62] is relevant to this question. Daniels' definition of a fair health care system focuses on the need to eliminate health conditions that act as limitations to equal opportunity. The "equal opportunity" concept in light of Native Americans' worse health status would also obligate higher than average per capita spending for Native American health in order to eliminate health status disparities. If traditional medicine is the vehicle by which a tribe attempts to correct health status disparities, should there be a time limit to increased funding if improvement does not result?

That tribes could consider cultural maintenance alone in the absence of medical savings to be adequate payback for the coverage of traditional medicine is a possibility. Cultural competence as a stand-alone indication for services to Native Americans would be consistent with a justification for coverage based on corrective justice, but should there be a budget limit if cost of TIM coverage is ultimately found to be additive to allopathic care without any improvement in outcome or subsequent savings due to increased efficacy or substitution for allopathic care currently used?

In Closing

As tribes reconsider the changing medical needs of their members and Native Americans' legal right to control their health programs, formally integrating traditional healing into the formal health delivery system becomes a goal. Traditional Indian medicine is often used with allopathic medicine and treats conditions either in a more culturally acceptable fashion (with herbs, sweat lodge ceremonies, or sings) or treats an underlying disorder that predisposes the patient to the physiologic disease. Even

though the physiologic disease is treated by physicians, the predisposing condition requires intervention or will have recurring consequences.

There are many obstacles and concerns to TIM coverage for the federal and state government programs (IHS, Medicaid, Medicare, Veterans Administration) which are being asked to fund the care and for the tribes and traditional practitioners who are considering this step. On the government/payers' side, there are considerations of provider credentialing, therapeutic efficacy, oversight, and fee schedules. Many traditional healers do not meet the requirement of being professional. Since this deficiency is mainly due to lack of credentialing and group self-regulation, no exceptions to expectations about professional status should be made for them. Rather than legitimize them at the margins, traditional practitioners' full professional standing can be established by instituting processes for credentialing and peer review.

Whether TIM will be efficacious against medical disorders, as judged by allopathic standards, has not been studied. The standards by which to judge its efficacy should be a separate matter of study. Since there are over 500 federally recognized tribes each with its own traditional healing practices, generalizability of any one study in a single tribe is difficult to estimate.

Just what price tag covering TIM will entail and whether it will be offset by savings due to increased efficacy or from substitution for biomedical services use is unknown at this time, but possibly enough patient-supported use has occurred to allow retrospective review to sketch the range of services that have been used and some aspects of the outcome. Such basic descriptive work may be necessary to identify common treatment patterns that can then be studied with randomly controlled trials.

From the tribes' perspective, it is hoped that third party payment will assure a reasonable livelihood to healers. Assuring a certain level of income through third party payers would offset the adverse effects that wage employment has had for traditional healers and their calling. Denied the flexibility that they had with subsistence occupations such as herding, the traditional healers who take wage jobs to supplement their income from traditional healing, do not have the time for performing ceremonies or teaching apprentices. But traditional practitioners are concerned that the codification and scrutiny that come with third party payment may entail unacceptable risks and therefore, do not uniformly

endorse third party payment.

Comparing the many possible adverse consequences of allowing third party payment to intrude on their culture's most esteemed institution versus the benefits of reimbursement may have no obviously best answer and thus, an indigenous community or its practitioners may be paralyzed with indecision about this issue. But if a major reason to seek third party payment is to stabilize the traditional healing network and maintain the knowledge, then to delay the decision is to decide. Without prompt action, aging practitioners may die without having passed on all of their learning.

Citations

1.Public Law No. 93-638, codified as 25 U.S.C. Secs. 450f et seq.

2.Coulehan JL. Navajo Indian Medicine: Implications for Healing. The Journal of Family Practice, 1980; 10:55-61.

3.Kim C and Kwok YS. Navajo Use of Native Healers. *Archives of Internal Medicine*, 1998;158:2245-9.

4. How to refer to the medicine practiced by physicians and surgeons is problematic in this context. To refer to "Western medicine" for a medical system of European origins when compared to traditional indigenous medicine that has been practiced for centuries in the US is confusing. Therefore, the terms that will be used to refer to medicine practiced by M.D.s (allopaths) and osteopaths in this proposal are "physicians' medicine", "scientific medicine", "allopathic medicine" (which for reasons of brevity will be meant to include osteopathic medicine), or "biomedicine".

5.Approximately 40% of American Indians qualify for Medicaid though only 25% are on Medicaid. If they meet criteria, some tribal members may also qualify for Medicare and/or Veteran's Administration benefits. Approximately 60% of all American Indians and Alaskan Natives in the United States are eligible for Indian Health Service coverage. IHS is the payor of last resort, paying only after all other private and governmental payors.

6.Pfefferbaum B, Strickland RJ, Rhoades ER, and Pfefferbaum RL. Learning How to Heal: An Analysis of the History, Policy, and Framework of Indian Health Care. American Indian Law Review, 1997;20:365-97.

7.Kunitz SJ. *Disease, Change and the Role of Medicine*. University of California Press, Los Angeles, 1989, 64-117.

8. Rhoades ER (chairman). Report on Indian Health Task Force Six: Final Report to the American Indian Policy Review Commission. US Government Printing Office, Washington, DC, 1976, especially part 2, chapter 4.

9.Pfefferbaum RL, Pfefferbaum B, Rhoades E, and Strickland RJ. Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices. American Indian Law Review, 21:211-

58, esp. 214-20.

10.Ibid, especially pp131-6.

11.Henderson, J. Native American Health Policy: From Us Territorial Expansion to Legal Obligation. *JAMA*, 1991; 265:2272-3.

12.Kunitz SJ. *Disease Change and the Role of Medicine,* cited above, p. 3.

13.This is year 4 of a 5 year $125 million per year federal grant specifically for Native American diabetes programs.

14.Kuschell-Haworth HT. Jumping through Hoops: Traditional Healers and the Indian Health Care Improvement Act. *DePaul Journal of Health Care Law*, 1999; 2: 843-60.

15.Scurfield RM. Healing the Warrior: Admission of two American Indian war-veteran cohort groups to a specialized inpatient PTSD unit. *American Indian and Alaska Native Mental Health Research*, 1995;6:1-22.

16.Ross H. IHS Policy Ensures American Indian Beliefs are Respected. *Closing the Gap*, January, 2000, p. 13.

17.Hall RL. Alcohol Treatment in American Indian Populations: An Indigenous Treatment Modality Compared with Traditional Approaches in Babor TF, Alcohol and Culture: Comparative Perspectives from Europe and America. *Annals of the New York Academy of Sciences, New York*, 1986, pp168-78.

18.Morse JM, Young DE and Swartz L. Cree Indian Healing Practices and Western Health Care: A Comparative Analysis. *Social Science and Medicine*, 1991;32:1361-6.

19.Kim and Kwok as cited above.

20.Marbella AM. Harris MC. Diehr S. Ignace G. Ignace G. Use of Native American healers among Native American patients in an urban Native American health center. Archives of Family Medicine, 1998; 7(2):182-5.

21.Hollow W. "Traditional Indian Medicine" in Galloway J, Alpert J, and Goldberg. *Primary Care of Native Americans*, 1999.

22.Kunitz, *Disease Change and the Role of Medicine* cited above, pp 118-45.

23.Kunitz SJ and Levy JE. *Drinking Careers: A twenty five year study of three Navajo Populations*. Yale University Press: New Haven, 1994, p. 201.

24.Levy JE. " Traditional Navajo Health Beliefs and Practices" in Kunitz SJ, *Disease Change and the Role of Medicine* cited above in 8, p 118-20.

25. Information unless otherwise cited is from the Indian Health Service's web site: www.ihs.gov.

26.Cunningham PJ. Access to Care in the Indian Health Service. *Health Affairs*, Fall,1993; 12: .

27.US Department of Health and Human Services, Public Health Service, Indian Health Service Office of Planning, Evaluation, and Legislation. *Allocation of Resources: a Handbook on the Resource Allocation Methodology*, April 1988.

28.Nelson RG et al. Incidence and determinants of elevated urinary albumin excretion in Pima Indians with NIDDM. *Diabetes Care*, 1995; 18:182-7.

29."Medicaid and HCFA's Commitment to American Indian Tribes." in *National Indian Health Board Health Reporter*, late summer, 1999; 8;6-9.(Quoting a speech by Mr. Michael Hash, HCFA Deputy Director at a Sept 2, 1998 meeting: *Indian Health, Medicaid and Managed Care: A Call to Action.*)

30.Schneider A and Martinez J. Native Americans and Medicaid: Coverage and Financial Issues. Policy Brief of the Kaiser Commission on Medicaid and the Uninsured, 1997. Available on-line through WWW.KFF.ORG.

31.DePaul article

32.Ibid.

33.Pevar SL. *The Right of Indians and Tribes; the basic ACLU guide to Indian and Tribal Rights* (2nd ed.) . Southern Illinois University Press, Carbondale, 1992.

34. See works S. "Governmental Coverage of Traditional Indigenous Medicine, an Ethical Justification", presented at the Fifth Annual Congress of the International Association of Bioethics, London, September 23, 2000.

35.United States General Accounting Office. NIH Clinical Trials: Various Factors Affect Patient Participation. 1999. GAO/HEHS-99-182 NIH Clinical Trials.

36.Maryland House Bill 45 passed in 1998 and a similar bill passed in the Arizona legislature in 1999 mandating insurance coverage of clinical research using similar criteria.

37.Nelson et al. Clinical and Pathological Course of Renal Disease in Non-Insulin Dependent Diabetes Mellitus: The Pima Indian Experience. *Seminars in Nephropology*, 1997; 17:124-31.

38.Narayan KM et al. Randomized Clinical trial of lifestyle interventions in Pima Indians: a pilot study. *Diabetic Medicine*, 1998; 15:66-72.

39.McElroy A and Townsend P. *Medical Anthropology in Ecological Perspective*. Duxbury Press, North Scituate, MA, 1979, \p. 107.

40.Coulehan JL cited in 3.

41.Brady M. Culture in Treatment, Culture as Treatment: A critical Appraisal of Developments in Addictions Programs for Indigenous North Americans and Australians. *Social Science and Medicine*, 1995;41:1487-98.

42.May PA. 1995. Evaluation Plan for the Dine' Center for Substance Abuse Treatment. Unpublished document. Albuquerque: The University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions.

43.McCloskey JE. 1998. Traditional Components of Treatment for Navajo Alcohol Abusers: Ethnographic Case Studies June 1997-April 1998. Unpublished report. Albuquerque: The University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions.

44.Gossage JP and May PA. 2000. Traditional Healing for Navajo Men and Women in Intensive Outpatient Treatment. Unpublished report. Albuquerque: The University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions.

45.Monaghan PG, Gossage JP, and May PA. 2000. Peacemaker Ceremonies as Modalities of Alcohol and Substance Abuse Treatment for Navajo Men and Women in Intensive Outpatient Treatment. Unpublished report. Albuquerque: The University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions.

46.Gossage JP and May PA. 2000. Traditional Healing Ceremonies as Modalities of Alcohol and Substance Abuse Treatment for Navajo Men in the Window Rock Jail. Unpublished report. Albuquerque: The University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions.

47.The diabetes epidemic among Native Americans follows by twenty years the obesity epidemic which is occurring in most tribes. In the Zuni, the average weight gain for young and middle aged adults over twenty years (1968-1988) has been an average of eighty (80) pounds per person. Obesity has long been known to be a precipitating cause of type II (adult onset) diabetes.

48.Donovan B. Fake healers plague Navajo Nation. *High Country News*, October 13, 1997.

49.Works S. "Governmental Coverage of Traditional Indigenous Medicine, An Ethical Justification" a paper presented at The Fifth World Congress of the International Association of Bioethics", London, September 23, 2000.

50.Millenson R. *Demanding Medical Excellence*. 1997. University of Chicago Press. Chicago.

51.Yano LI. Protection of ethnobiological Knowledge of Indigenous Peoples. *UCLA Law Review*, 1993; 41:443-86.

52.Ibid.

53.Ibid

54.For a discussion of the essential characteristics of professionalism, see Buchanan A "Is there a medical profession in the house?'" in Spece RG Jr, Shimm DS and Buchanan AE (eds.) *Conflicts of Interest in Clinical Practice and Research.* Oxford University Press, New York, 1996.

55.A letter shared at a January 10, 2000, meeting with AHCCCS Administration Director, Phyllis Biedess.

56.Donovan B. cited above.

57. Reported by Dr. Leonard Speck of Kayenta, Arizona.

58. Nathan DG. Clinical Research: Perceptions, Reality, and Proposed Solutions. JAMA, 1999; 280:1427.

59.Clark CM and Vinicor F. Introduction: Risks and benefits of intensive management in NIDDM. The fifth Regenstrief conference. *Annals of Internal Medicine*, 1996;124:81-5.

60.Lee ET et al. All-Cause Mortality and Cardiovascular Disease Mortality in three American poplations, aged 45-74 years. *American Journal of Epidemiology*, 1998;147:995-1008.

61.Daniels N. *Just Health Care*. Cambridge, Cambridge University Press, 1985.

62.Daniels N. Rationing Fairly: Programmatic Considerations. Bioethics, 1993; 7:2-3 and 224-33.