32nd Annual Meeting
Association of American Indian Physicians

"Eliminating Health Disparities in Indian Country"
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Keynote Address

"Eliminating Disparities is More Than an Access Issue"

by

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Good morning. It is a pleasure to be invited to speak at the 32nd annual meeting of the Association of American Indian Physicians. For more than 32 years, almost from the arrival of the Europeans to the Americas, there have been health disparities between American Indian and Alaska Native people and the rest of America. At no time during the history of the United States has the overall health status of Indian people ever equaled that of the rest of the population for most diseases and conditions. Public health programs were slow to reach rural America and slower still to reach Americans who lived on reservations. Once they did in earnest, around the time that the Indian Health Service was transferred to what is now the Department of Health and Human Services, then there were dramatic changes in the health status of our people. But it has never reached parity with the rest of America. In fact, there is a crisis in health disparity, as evidenced by an alarming increase in mortality rates; with rates from all causes increasing 4.5 percent from 1996 to 1999 for American Indians and Alaska Natives, while decreasing by 6 percent for the rest of the nation.

The partnership of IHS, tribal health departments, and urban Indian health programs has made a significant difference in the health of our people and our communities – but our combined efforts have not eliminated health disparities. The socioeconomic problems and lifestyle factors underlying the decreased health status of Indian people are entrenched, long-standing, and pervasive, and therefore difficult to eradicate.

I believe the greatest hope of eliminating these health disparities lies in successfully coordinating the mission, goals, and resources of all Departments of the federal government that operate programs specifically and indirectly that benefit Indian people. As the educational and employment levels improve throughout Indian Country, so will health status. As the safety, security, and environmental status of Indian Country improves, so will health status. As the business and health infrastructure of communities and nations improves, so will health status.

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The health disparities in Indian country are recognized by the Administration, the Secretary, and the Congress.

- Secretary Thompson stated after his visit to Alaska Native villages: *"I am appalled that Native Americans continue to live in conditions that I believed no U.S. citizen endured in this day and time. I was shocked. We came away from that trip knowing there was an expectation left behind that we would do more."*
- As the Assistant Secretary of Minority Health mentioned in the National Forum on Health Disparity Issues for American Indians and Alaska Natives in September of last year: *"Some of the barriers to adequate health care include: underfunding or complete lack of funding, difficulty in recruiting and retaining health care professionals, bias on the part of caregivers and policymakers, and inadequate and aging facilities. Individuals in rural areas face geographic barriers, and urban individuals face heightened cultural barriers."*

Since the Indian Health Service transferred to the Department of Health and Human Services, the health of Indian country has changed from one of disease and illness to one of primarily chronic conditions influenced strongly by behavioral and lifestyle issues. These lifestyle and behavioral issues contribute to almost 70% of the diseases that occur at a higher rate in Indian country. Making a difference in raising the health status of Indian Country will take a business, education, political, and health partnership. We need to look at what we can do outside of the clinic and hospital doors to improve health status. Eliminating health disparities means that we must eliminate all disparities.

And health disparities in Indian country are also recognized by American Indians and Alaska Natives themselves. The leading priorities of tribal governments always include health. Tribal governments are directing some of their resources to augment the services provided by the Indian Health Service, building health facilities in partnership with the Indian Health Service, and providing incentives that promote health in their communities. Indian people are aware of the connection between lifestyle choices and health status, and they are making individual choices to promote healthier lifestyles. This is evidenced by the fact that when fitness centers are built in Indian communities, they are filled to overflowing. I believe that when we are building or upgrading our health facilities, we should explore ways to include a community fitness center as part of the project. That would strengthen the health promotion and disease prevention efforts of our health team without compromising the treatment mission of the facility.

Over the past few days, the areas of our greatest health disparities have been shared with you. And there are numerous opportunities available to intervene to promote healthy people and healthy communities. By working together, I believe new strategies and partnerships will emerge that will strengthen best practices, enhance effective research, and coordinate approaches to address all the factors that may play a role in health status and quality of life. By being here today, you are showing that you are willing to take up the challenge of doing more than just talk about the problem, but are willing to work towards integrating our approaches toward the same goal – eliminating health disparities.

Some say that health disparities are a problem of geography – that it is a rural problem. It is estimated that 43% of all American Indians and Alaska Natives live in non-metropolitan (rural) areas of the United States. This makes the Indian population the most rural population in the United States. I believe health problems are more serious in rural America and particularly for American Indian and Alaska Native communities because the infrastructure to respond to the needs of individuals and communities is not as comprehensive as it is in urban areas. And it is often more difficult to recruit and retain health professionals in rural areas.

Some say that health disparities are a problem of poverty and unemployment – well, that is true and studies have shown that correlation. For example, when poverty and lack of opportunity are a daily constant, many people feel they have little to lose if they get involved in drugs. The stress of economic hardship can also affect the relationship of parents and their children, who may perceive they are part of the problem or are not wanted. The children can then be at risk for depression, behavioral, physical health, and substance abuse problems.

Some say that health disparities are a result of many Indian people having to live in two worlds, that of their Tribe and that of mainstream society – leading to dealing with feelings of inadequacy and stress by making behavioral choices that may have long-term or fatal consequences. And inter-generational conflicts between extended family members and children adopting western values increase risk-taking choices.

These assimilation problems among Indian people are much the same as that seen among new immigrants to the United States. Studies have shown that among those who are attempting assimilation, that that is even more of a factor than poverty in the health of the individual and family.

For the Indian health system of IHS, tribal, and urban Indian health programs, we need to at least tailor best practices to also consider the bicultural challenges faced by many of our patients. And we need to increase understanding whenever possible on both sides – our traditional and tribal cultures and the non-native world in which many of us live. Unfortunately, the 21st century offers some destructive coping mechanisms, such as illegal chemical substances, that our children can select as a way to cope with their conflict and stress generated by bicultural issues. And there is also the tragic coping mechanism of suicide. The suicide rate of our children is a health disparity that I believe we must do something about now, without delay. But we cannot do it alone, and it must be more than a medical or mental health intervention – it must be a community intervention, along with an investment in our communities by all our partners in eliminating disparities, not just those of us in the health disparity segment.

How can we identify and address the factors that are perpetuating the health disparity rates between Indian Country and the rest of the nation? One way is through research to determine possible causative factors and their relative importance in predicting and preventing unhealthy behavioral health choices, and to determine at what stage early treatment can reverse the negative health outcomes of a behavioral choice.

The IHS and the National Institutes of Health (NIH) are in the third year of a multi-million dollar NIH-funded partnership to address some of the research needs in Indian communities, through the Native American Research Centers for Health (NARCH). It is important that we continue to direct research efforts toward the causative factors unique to specific Indian communities, since variations among Native American Tribes and communities are as great sometimes as the variations between Indian and non-Indian communities. Research can also help us identify what works so that we can strengthen those programs and identify what investment in a community's infrastructure is required to implement and sustain an effective health program or service.

In addition to the NARCH grants, the Department of Health and Human Services established an initiative to develop a coordinated research agenda for the entire Department. The Research Coordinating Council sent four recommendations to the Secretary – and one was that all HHS agencies would collaborate and partner with the Indian Health Service on any research activities undertaken by the Department that involve or benefit American Indians or Alaska Natives. Another step is the collaboration with the Agency for Healthcare Research and Quality to conduct surveys of the Indian population, in order to gather the data that we all need to make better decisions regarding programs that will benefit Indian people.

Future research efforts will undoubtedly provide some valuable insights into causation, and therefore, treatment factors. What we do know at this point is that community-based, culturally sensitive, and family-focused prevention programs, carried out by culturally competent staff offer the greatest hope for health promotion and disease prevention, and for recovery.

In addition to research, over the past year there are other programs and activities throughout the Department's Operating Divisions that are contributing to eliminating health disparities in Indian country. One example is the Substance Abuse and Mental Health Services $1.5 million in grants for American Indian and Alaska Native Community Substance Abuse Treatment Plans. Also, Secretary Thompson announced the awarding of $11 million to 19 communities to extend health care services to low-income and uninsured Americans. These awards, administered by the Health Resources and Services Administration, are part of President Bush's 5-year health centers initiative to expand health centers in underserved rural and urban communities. Also through HRSA there was a special HRSA program to increase access to primary care for Indian communities with HIV/AIDS or those at risk for infection.

And we are all familiar with the success of the federal investment into the special diabetes program funding – since it began in 1997 with the Balanced Budget Act, the tribal and IHS participation has resulted in more than 300 new programs in Indian communities focusing on prevent and health promotion, especially among Indian youth.

The Department has also implemented decisions to help the Indian Health Service and Tribes to enhance program quality and conserve resources. For example, working with the Centers for Medicare and Medicaid Services, the IHS has status as a national accreditation organization for American Indian and Alaska Native diabetes outpatient entities – which will increase the number of accredited programs in Indian country that are eligible to receive CMS reimbursement. And the

Department made a decision to save $30 million in one year and $17 million in subsequent years by exempting the Indian Health Service and Tribes from implementing the CMS Outpatient Prospective Payment System.

And the Administration has requested increased funding for the Contract Health Services and the Sanitation Facilities Construction programs of the IHS. They also recognized that 30 percent of Indian elderly live alone and nearly half of them consider their health to be fair or poor. Last year the Administration on Aging awarded nearly $28 million to support community services and programs in Indian country for the elderly and their caregivers.

Other examples:

- The Department is supporting additional funding in support of Tribal Colleges and Universities.
- The Department's support, via CDC, of more than $1 million in 2003 to target the needs of tribal governments and American Indian and Alaska Native communities. In addition, the CDC Agency for Toxic Substances and Disease Registry is supporting tribal governments and Indian communities to improve their environmental health services efforts.
- And the Department is supporting funding to improve the electronic medical record capabilities of the Indian health system to improve patient care quality and safety. During the next few weeks, the Agency for Healthcare Research and Quality will be transferring $250,000 to the IHS for evaluation of our electronic medical record project, and we are looking forward to working with AHRQ in the future as they implement an "IT in small and rural hospital initiative" in FY 04.

The Department is also strengthening and expanding tribal consultation within the HHS, not just the IHS. Last November, Secretary Thompson reemphasized the importance of the Intradepartmental Council on Native American Affairs and brought it within the Office of the Secretary organization. The first Council was convened by the Deputy Secretary Claude Allen. The Council Chair is the Commissioner for the Administration for Native Americans and I serve – as the *Interim* Director of the Indian Health Service, as the Vice-chair of the Council. The members of the Council are the Directors of the other Operating and Staff Divisions and programs of the Department. The Intradepartmental Council will help coordinate the resources and programs of the Department to ensure that American Indians and Alaska Natives benefit from the more than 315 programs of the Department.

Secretary Thompson said to the Council: *"We must do more with our existing programs to make them work better for Native Americans and consult with our partners to improve our policies and services to their communities."*

Some of the Secretary's strategies to eliminate health disparity are reflected in his vision for Indian health:

- The responsibility for raising the health status of American Indian and Alaska Native people is a responsibility shared throughout the One Department. It is not the exclusive responsibility of the Indian Health Service.
- Bringing more Native health scholars into HHS hospitals, clinics, and into the workforce in Indian country.
- Involving Native leaders in the planning and emergency response process so that public health emergency preparedness can be fully implemented.
- Promoting Employment Assistance Program TANF grants to ensure Native American parents are employable.
- Establishing Social and Economic Development Strategies grants to revitalize Native government local economies.
- Establishing Language and Cultural Preservation grants in addition to pre-Head Start and Head Start programs on Indian reservations.

Another important issue that cannot be ignored is the role that discrimination plays in health disparities. Outside of Indian country and the IHS, tribal, and urban Indian health system, there is evidence of discrimination toward American Indian and Alaska Native patients – and to be fair, within our own systems there are those individuals whose technical qualifications do not reveal their bias or cultural insensitivity until a egregious situation occurs. Fortunately, that is rare.

As President Bush stated last week, "We must challenge the soft bigotry of low expectations." Typical discrimination is reflected in assumptions that all health problems of Indians are alcohol related; that they are less educated and less capable of understanding their health issues; that they are poor and unmotivated to change their living conditions; that they are being provided "free" health insurance by the government and constantly seeking out and relying on assistance from federal programs.

We should not be hesitant to identify that discrimination is a factor in health disparities and a barrier to health services, and discuss it with our partners. As our partners meet and understand the

communities they serve, we can eliminate stereotypical thinking and increase their appreciation of Indian culture and traditions rather than allow them to retain their view that our culture is a barrier to eliminating disparities. The President also said last week "our journey toward justice has not been easy and it is not over." And he spoke of his dedication to "bringing economic hope to every neighborhood, a good education to every child, and comfort and compassion to the afflicted." Achieving those goals will go a long way towards eliminating health disparities.

As I stated before, many interrelated factors must be researched and appropriately addressed in order to eliminate health disparities. In this brief presentation I have highlighted some, but by no means all, of the activities and initiatives and paradigm shifts taking place to reach the goal of eliminating health disparities. There is *A LOT* that is being done. Yet, health disparities remain – some barriers, such as geography, may never be overcome, but many others can be.

We need to increase our efforts to share those programs that are effective, both across the country as well as within Indian country. The mortality and morbidity data provide us one side of the picture for the treatment programs that we need – but we also need wellness data so that we can identify where increases in health status are occurring and reinforce our health promotion and disease prevention efforts there as well.

Health disparities will still be with us tomorrow if all we do is talk about what someone else should be doing. Talking about them won't make them go away. We can and must take action today to address the crisis of health disparities in Indian country.

Thank you for attending this important meeting.

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