

Health Disparities Challenge Public Health Among Native Americans

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In the Northwest, as in the US as a whole, American Indians and Alaska Natives (AI/ANs) have some of the highest rates of disease and poorest health status of any ethnic group. In the 2000 US census, 4.1 million Americans identified themselves as partly or fully American Indian or Alaska Native (AI/AN). This number represents 1.5 percent of the entire US population, but in the Northwest states AI/ANs make up 3.7 percent of the population. In the first half of the twentieth century, AI/ANs had a much shorter life expectancy than the general population and routinely suffered from markedly higher rates of such diseases as tuberculosis and rheumatic fever.

With advances in medical care and public health measures over the past 50 years, the AI/AN population has transitioned along with the US general population from the era of infectious disease pandemics to the era of degenerative and lifestyle disease. This transition has brought with it an increasing recognition of the health disparities faced by AI/AN communities from noninfectious conditions such as diabetes and cardiovascular disease, cancer, and alcohol/drug abuse.

Although epidemiologic data for the AI/AN population is often incomplete and subject to inaccuracies (due to racial mis-classification on official documentation), some of the comparisons with the non-Native population are dramatic. For example, among AI/AN adults using Indian Health Service (IHS) facilities nationally in 2002, the age-adjusted prevalence of diabetes was estimated at 15.3 percent, significantly higher than the 7.3 percent prevalence rate among all US adults (rates among Alaska Natives are closer to the non-Native population). Heart disease rates have historically been lower in most Native populations than among whites, but this trend appears to be reversing; heart disease is now the leading cause of death among AI/ANs. Deaths from unintentional injuries and violence are a particular problem in Native communities. For the years 1996-98, the age-adjusted death rates from both suicide and homicide among AI/ANs nationally were almost twice that of the US population of all races, and the death rate for all unintentional injuries was more than three times that of US all races. Cancer incidence and

mortality is still lower for AI/ANs nationally than for the general US population. However, in Alaska and the Northern Plains (which include Montana and Wyoming), AI/ANs have a higher mortality rate from all cancers than the US all race rate, and AI/ANs nationally have higher death rates from stomach, renal, and liver cancers.

Lifestyle factors tied to low socioeconomic status clearly play a role in many of these higher disease burdens among AI/ANs. Native communities have some of the highest levels of cardiovascular risk factors of any ethnic group. The REACH 2010 Risk Factor Survey, for example, found that rates of obesity, current smoking, hypertension, hyperlipidemia, and diabetes were each markedly higher among AI/ANs than among blacks, Latinos, and Asians. AI/AN are also more likely than non-AI/ANs to engage in regular binge drinking and heavy alcohol use, which may account, in part, for a national age-adjusted alcohol-related death rate among AI/ANs that in 1998 was over seven times higher than that of the US all races population.

Despite a federal obligation to provide for the health care of AI/ANs, inadequacies in the available health care and social services contribute to the poor health status of AI/AN communities. The federal responsibility to provide health care to AI/AN people grew out of the unique relationship between sovereign Indian tribes and the United States government. Many tribes entered into treaties that guaranteed that health care, including the building of hospitals and clinics, would be provided to the tribe, and that the US government would take responsibility for the health status of tribal members. For many AI/AN people, this federal trust responsibility is the basis of a deeply held conviction that health care is not provided to them for free, but in exchange for the vast lands ceded to the US government.

Health care delivery system

The Indian Health Service (an operating division of the US Department of Health and Human Services) is the federal agency charged with the responsibility to provide health care to all enrolled members of the more than 550 federally recognized Indian tribes, bands, and Alaska Native villages in the US.

The AI/AN population in Northwest states

Alaska	119,241	19.0%
Idaho	27,237	2.1%
Montana	66,320	7.4%
Oregon	85,667	2.5%
Washington	158,940	2.7%
Wyoming	15,012	3.0%

Source: US Census 2000. Includes AI/AN in combination with other races.

The AI/AN health care delivery system consists of approximately 594 health care facilities across the country, including 49 hospitals, 545 ambulatory facilities (231 health centers, five school-based health centers, 133 health stations, and 176 Alaska Native village clinics). These health care facilities can be grouped into three categories: those operated directly by IHS, those operated by the tribes through a Tribal Health Authority (THA) by contract or compact with IHS, and those providing services to urban AI/ANs (individuals not residing on or near an Indian reservation).

Along with ambulatory primary care services, facilities may offer inpatient care, medical specialties, traditional healing practices, dental care, mental health care, eye care, and substance abuse treatment programs. Many tribes are also served by community health (e.g., childhood immunizations, home visits) and environmental health (e.g., sanitation, injury prevention) programs, which may be administered by IHS or the THA. Specialty services and types of medical care that are not available at a given facility are often purchased from providers in the private sector through a contract health service (CHS) program. The IHS and THAs apply stringent eligibility criteria to determine which patients qualify for CHS funding. The severely limited pool of CHS dollars also means that most CHS programs limit reimbursement to those diagnostic or therapeutic services that are needed to prevent the immediate death or serious impairment of the health of the patient. Among other problems, this results in reduced access to screening services and contributes to increased cancer mortality; for example, access to breast cancer screening is a particular problem for Native women, with only 52 percent in 2000 reporting a mammogram in the past two years.

Core funding of most of the health services (including CHS) derives from IHS; however, many programs are also dependent on grant funding, tribal revenue, and collections from third-party payers (including state Medicaid programs) to remain financially viable. More than 36 percent of AI/AN families making less than 200 percent of the federal poverty level had no health insurance, a percentage second only to Latinos.

Along with the community health programs associated with the health care facilities in each community, an increasing number of tribes are taking an active role in public health practice and research in their community. These activities include grant-funded collaborations with academic researchers and federal agencies (such as a population-based BRFSS specific to tribal communities) and active collaborations with state

and county health departments in such areas as increasing access to childhood immunizations. In addition, the last decade has seen a move toward increasing epidemiologic capacity within tribally run organizations. In the Northwest, three tribally operated epidemiology centers have been founded with funding from IHS and sustained by grant-funded activities: the Northwest Tribal Epidemiology Center at the Northwest Portland Area Indian Health Board, serving the 43 federally-recognized tribes in Idaho, Oregon, and Washington (www.npaihb.org); the Alaska Native Epidemiology Center at the Alaska Native Health Board (www.anhb.org); and the Urban Indian Health Institute at the Seattle Indian Health Board, which focuses on urban Indians nationally (www.uihi.org). The work of these tribal organizations has made progress in documenting the dramatic health problems that face Native communities in the Northwest.

Although the health care system serving the AI/AN population may seem comprehensive, the provision of adequate health care to AI/ANs is hampered by chronic underfunding of IHS by the US Congress. The lack of adequate funding to both CHS programs and the direct services provided by IHS and tribal facilities means that universal access to care for AI/ANs is far from a reality. It is estimated that the IHS is funded at only 50 percent of its level of need; some programs, such as mental health, are funded at as low as 30 percent. The relationship between chronic underfunding and increasing health disparities has been outlined in two recent reports from the U.S. Commission on Civil Rights. The reports conclude that the state of health care delivery to the AI/AN population is in a state of crisis. It seems likely that as access to care becomes even more limited due to inadequate funding, health status disparities between Native people and the general US population will continue to widen, and AI/ANs will continue to be denied opportunities for building healthier communities. 🐾

Authors

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Resources

Indian Health Service. *Regional Differences in Indian Health 2000-2001*. http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/Region2001.asp.

U.S. Commission on Civil Rights. *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*. www.usccr.gov/pubs/na0703/na0731.pdf.

U.S. Commission on Civil Rights. *Broken Promises: Evaluating the Native American Health Care System*. www.usccr.gov/pubs/nahealth/nabroken.pdf.

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