

Moderator: Hello, and welcome to Public Health Live, the third Thursday breakfast broadcast. I am Rachel Breidster and I will be your moderator today. Before we get started, I would like to ask that you please fill out your online evaluations at the close of today's program. Continuing Education Credits are available after you complete our short post-test and your feedback is helpful to us in planning future programs. We encourage you to let us know what topics are of interest to you and how we can best meet your needs. As for today's program, we will be taking your questions throughout the hour. You can call us at any time at 1-800-462-0552. You can also send written questions by fax and that number is 518-426-0696. Or you can email us at anytime at phlive.ny@gmail.com. Today's program is *American Indian Public Health Disparities: Regional Differences in Health*. Our speaker is Dr. Donald Warne, the Director of the Master of Public Health Program at the North Dakota State University. Dr. Warne, thank you so much for being here.

Dr. Donald Warne: Thank you very much, happy to be here.

Moderator: Great. We are very glad to have you here and we have so much information to cover today in such a short amount of time, so, why don't we start by just having you introduce the nature of the topic we're going to be looking at.

Dr. Donald Warne: Sure, let me begin, again, my name is Dr. Donald Warne. I'm the Director of the Master of Public Health Program at North Dakota State and one of the things that we focus on in our region is American Indian public health disparities. So, we'll be looking at and today we'll be talking about issues related to health policy, American Indian health disparities and regional differences in health, et cetera.

So, one of the first things that we talk about in my course work is looking at health policy issues and one of the first questions I ask my students is the following, 'Do people have a legal right to healthcare in the United States?' and unfortunately, the answer to that question is, 'No, people are not born with the legal right to healthcare.' And, that's true for everyone in this country except for American Indians. We are actually the only population born with a legal right to healthcare. And, that's based on treaties and other laws and Supreme Court decisions which, in which the tribes exchanged land and natural resources for various social services, including housing, education and healthcare. So, that is why we have an Indian Health Service. That's the agency responsible for carrying out the federal government's trust responsibility to us as American Indians. And that's why we have a Bureau of Indian Affairs. So, we do have a legal right to certain services, including housing, education and healthcare but, as we will see, unfortunately, Indian Health Services is terribly underfunded.

One of the other things that's unique about the healthcare system in the U.S. is that we spend a lot of money on healthcare and we don't get a very good return, in terms of health status. And, unfortunately we spend about \$2.5 trillion dollars a year on healthcare and that's an unbelievable amount of money. That's \$2,500 billion spent every year on healthcare. Yet we still have over 45 million uninsured people and an estimated 40 million or so who are under-insured. So, we have a lot of challenges that we face when we're looking at health policy generally.

Moderator: Some of that information that you just shared is very interesting. I mean, I was unaware that Native Americans or American Indians had a legal right to healthcare. And I would imagine many of our viewers were unaware as well. So, can you talk to us a little bit about the history of some of that information?

Dr. Donald Warne: Absolutely. And actually, American Indians are the only population mentioned in the United States Constitution. The Commerce Clause Article I Section VIII, states that Congress shall regulate commerce among the foreign nations and the Indian tribes. So, we were kind of put on par with foreign nations, when you look at the history of federal Indian law. On this particular slide here, the graphic on the left is from the Indian Health Service website and talks about the legal basis for federal services to American Indians and Alaskan Natives. On the right, I know it's in very fine print, but it is one example of the many hundreds of treaties that were signed between the tribal nations and the federal government. This one happens to be with the Potawatomi Nation in 1846 and at the bottom, again I know it's in very fine print, but it states that 'the United States will give it the same time promise of all proper care and protection.' And that was the typical language in the treaties—'promise of all care and protection.' Unfortunately, as we will see Indian Health Services is terribly underfunded and we have not received all proper care.

Moderator: So, talk to us a little bit about Indian Health Services. I mean, you referenced that a few times and I think that's something that many people might not even be aware that that exists.

Dr. Donald Warne: Yeah, unfortunately, I think that is true. I think that one of the things that we suffer from in Indian country is anonymity. We are kind of the unknown population. We are the minority of the minority populations. But, the Indian Health Service is responsible for carrying out the federal government's responsibility to American Indians in terms of healthcare and this statement here is right from the Indian Health Service website that 'the IHS is the principle federal health care provider and health advocate for Indian people.' And, I would agree that they are the principal provider in terms of either providing direct services or funding to tribally operated programs. But, in truth, the principal advocates have to be American Indian tribal leaders and other partner entities.

When you work for the Indian Health Service directly, you're a federal employee so there are limitations on what you can do in terms of advocacy. You have to be consistent with the president's agenda which is good right now but hasn't always been good depending on who the president is. But also, you really can't lobby and in terms of advocacy for Indian health, it has to be the tribal leaders and that's what I've been working on over the last several years is with tribal organizations and trying to improve advocacy.

Moderator: Interesting. Now in terms of the structure of the Indian Health Service – I mean federal area, that's a lot of area to cover—so are there different service sections broken down? How do they operate in an effective way?

Dr. Donald Warne: Indian Health Service is broken into 12 areas and each area is named either typically after a city or a state and where I work is the Aberdeen area of the Indian Health Service and that's North Dakota, South Dakota, Nebraska and Iowa. Where we are now in New York is ironically called the Nashville area and the Nashville area of the Indian Health Services is the most geographically diverse

and you can see it includes tribes from Maine to Florida to Louisiana and many more states in between. Now one thing you notice on this particular map is that there are several states that are missing. And we have federally recognized tribes in 35 states, which means that there are 15 states with no federally recognized tribes. And, what that also means is that we have 30% of senators who don't have tribes in their constituencies. So, we do have a challenge politically just because of our geographic distribution and most of us are in the west.

Moderator: Now, looking at the way that map is broken up into different areas – I know that there is also some relation with the Centers for Medicare and Medicaid Services. How do the areas that they cover line up with or not line up with the areas of CMS?

Dr. Donald Warne: That's one of the challenges through the Indian Health Service areas. It's not the same regions as the CMS or Department of Health and Human Services regions. So, for example, here in the Nashville area, there is actually four separate CMS regions: Regions I, II, III and IV. So there are separate entities to work with in terms of coordinating Medicare and Medicaid policy as well as each state of course having their own Medicaid program and administering things slightly differently. So, one of the challenges that we face is that our Indian Health Service regions do not correspond directly with CMS regions. It increases the complexity in terms of access to third party revenue.

Moderator: Yeah, I think even just looking at the different areas you can tell it's a very complex situation – complex ways that they have to interact. So, what can you tell us about the role that CMS actually plays in Indian healthcare?

Dr. Donald Warne: I think it's important to remember that the tribes have treaties with the federal government. We don't have a treaty with the Indian Health Service and CMS is a component of the federal government. So in truth, CMS is an important part of the federal government's trust responsibility to American Indians and Alaskan Natives. And, the revenue that we generate from Medicare and Medicaid is now in many cases more than half of the budget for Indian Health Service and tribal sites. So, it's important that we do good billing at the level of the clinics –the service units—but also, it's important for us to remember that CMS is an important component of the federal government's trust responsibility to American Indians and Alaskan Natives.

Also, when we look at the budget within Indian Health Service, we have what's called Contract Health Services or CHS and through Contract Health Services, that's when we purchase services in the private sector. So, in many ways, that's when IHS behaves more like an insurance company purchasing services from the private sector. But, as we will see, under-funding of Indian Health Service means that we don't have adequate resources. So, we don't have all of the providers within IHS that we need. So, we have to purchase services from the private sector and unfortunately those budgets are very tight as well. So, frequently, we have people who need services who just simply do not have access to them because of a lack of resources.

Moderator: So there is clearly a lot of different factors here – a lot of the American Indian health factors to consider. Can we spend some time talking about American Indian health policy issues?

Dr. Donald Warne: Certainly. And, that's one of the courses that I teach. We have a brand new track in American Indian Public Health at NDSU and one of the courses is American Indian Health Policy. And, I think it's important to remember that what we deal with in Indian health, we also have to deal with in the private sector and the health policy circumstances in the U.S. are very complex and we're not immune to any of that in the Indian Health Service or with tribal programs. So, in addition to looking at the complexity of health policy in the U.S. generally, we do have a unique political relationship with the federal and state governments. So, for example when we are doing third party billing – if an IHS facility is billing Medicare—that's actually the only time that the federal government or one agency is directly billing another agency for services that can be, as you can imagine, very complex.

In addition to that, we have unique relationships with state governments and New York, as we'll talk about, historically has had a better relationship with the tribal nations than most states. Where I am from originally in South Dakota, some of our challenges include that the states get block grants for example from the federal government for maternal and child health, substance abuse treatment, or other preventive services and if the relationships between the tribes and the states are not good, frequently those resources do not get to the tribes. So, we face those challenges as well.

In addition to that, there is the whole concept of federal trust responsibility and we do have a legal right to health care but Indian Health Services is not funded as an entitlement program and there is basically two ways things are funded –entitlements like Social Security, Medicare, and Medicaid and then there is also discretionary programs, meaning at Congress's discretion. And unfortunately, by being at the discretion of Congress, we have not yet seen adequate resources to the Indian Health Services to meet the needs of our people.

Moderator: So let's look at, throughout history, the roles of the federal government's role in American Indian health issues and how that has changed over time.

Dr. Donald Warne: Absolutely. And when we look at the Indian Health System, the Indian Health Program was actually originally started within the Department of Interior. It was a VIA program and it was moved to, at the time, the Department of Health, Education and Welfare, which is now the Department of Health and Human Services and that was in 1954 when it was moved over. So Indian Health Services in its current form was started in 1955 and between 1955 and 1975, the IHS was the Indian Health System. And, when we think of the world of medicine back in 1955, it was very different. We didn't have Medicare. We didn't have Medicaid. We did not have HIPPA compliance. We did not have medical sub-specialization. So, it was a very different world of medicine in the 50s. And the system was basically a self-contained unit from 1955 to 1975.

Then in 1975, there was a new player. Through Public Health Law 93-638, which is the Indian Self-Determination and Education Assistance Act, the tribes could then take over funding and management of their own health programs from the Indian Health Service. Historically, that was a contentious relationship with, understandably, an agency not wanting to give up financing and control to the tribes but that relationship has improved significantly over the years and now more than half of the Indian Health Service budget is managed by tribes and we'll see here in the Nashville area it's a significant

percentage. So, Medicaid is also a key player. Unfortunately, we do have very high rates of poverty, particularly in the regions where I'm from in the Aberdeen area. The majority of our people are living in poverty. And Medicaid, therefore, is a very important player within the Indian health System.

So you can see it's a very complex system. We have IHS at the federal level, the 638 programs at the tribal level and Medicaid at the state level and you can see how with that complex web of health policy and systems of governance within the Indian Health System that we can see things fall through the cracks. So, for example, when I worked in Arizona as a primary care doctor—I worked at a 638 facility—and if we had a patient who we suspected might have cancer, for example, we would enroll them in Medicaid if they're eligible and then refer them to Phoenix Indian Medical Center which has an oncology program. So suddenly one patient has engaged three separate systems of care with three separate sets of case managers and they don't coordinate activities nearly as well as they should.

Moderator: Wow, there is so much complexity to the different ways I mean, to get to one end, to get someone healthy. Now you referenced earlier the Nashville area and talked about it being a very geographically diverse area, I mean going from Maine all the way down to the coast of Florida. Can you talk to us for a few minutes about that area and all of the diversity that it encompasses?

Dr. Donald Warne: Yeah, as you can imagine there is a lot of diversity in terms of the geographic diversity but also the cultures. It's important to remember that there is not one single American Indian culture. There are actually hundreds of American Indian cultures and languages and this particular map shows the whole region of the Nashville area. IHS is right from the Indian Health Service website, so people can look at these pictures but within the Nashville area, again there is a great degree of diversity in terms of geographic locations but also in terms of cultural components of the tribes. Each tribe is very different.

One of the things that does exist here, as with other areas, is that there are tribal consortia, so there are nonprofit entities that work as advocacy and regional public health programming entities. So, for example, in the Aberdeen area where the Great Plains Tribal Chairmen's Health Board, I'm the former Executive Director of that organization, and here in the Nashville area there is USET, the United South and Eastern Tribes. And when we look at tribal advocacy and policy development, USET really has been a national leader in terms of being at the table with the key policy decision-making committees and working directly with CMS through the Tribal Technical Advisory Group. So I would say that of multiple regions in the Indian Health System, United South and Eastern Tribes has done a great job in terms of advocacy and really taking a national lead in a number of ways in improving how health policy and health services are delivered.

Moderator: Excellent. So when we look at the Nashville area and you talked a little bit about the diversity both geographic and cultural. Let's focus in a bit on the numbers and what do the budgets look like because you referenced earlier you know that despite this promise of health care, I mean we're really falling short in some ways. So, can we start to talk about the numbers a little bit?

Dr. Donald Warne: Absolutely and when we look at the budget for the entire Indian Health Service, we see that we're funded about \$2,500-\$2,600 per person per year. And relative to other health systems,

that's terribly under-funded and for the Nashville area Indian Health Service budget, you can see that we have about \$312 million annually and that serves over 52,000 people, so that again works out to about \$2,500 per person per year.

The majority of the budget does go into what we call H&C which are hospitals and clinics but you can also see notes in fine print. Another big expenditure is through contract health services. So what happens when you have an under-funded system is that you cannot provide all of the services directly needed and certainly when you have to do referrals, frequently we run out of money before the end of the fiscal year. In the Aberdeen area there is a saying, 'Don't get sick after June,' and it's because we literally run out of contract health services money by that time. These numbers and there are very good documents, the Nashville area has done a great job in terms of documenting these things and their publications are available on the IHS website.

Moderator: It's a scary thought and you joke about, 'Don't get sick after June,' but that's a really scary thought that folks are having to live with that in the back of their minds. What about funds for tribal self-determination?

Dr. Donald Warne: Well, one of the things that's again relatively unique about the Nashville area is that vast majority is managed by tribes now. We have three areas in Indian Health Service in which the tribes really do directly manage the majority of the Health System. That's Alaska area, California area and here in the Nashville area and if you look at the self-determination budget you can see that through self-governance compacts, which are called Title V, and 638 contracts that are Title I, the vast majority of the budget for the Nashville area is now managed by tribes. And I think that is one reason why we've seen better direct connectivity between the provision of services and advocacy at the national level.

Moderator: Now another aspect to consider is third party collections and you've mentioned the funding is insufficient. How do the third party collections fit in with that situation?

Dr. Donald Warne: Well, we absolutely have to depend on third party revenue and in many of our clinics, the majority of the budget is now from Medicare and Medicaid. Predominantly due to poverty, Medicaid is the largest payer and if we look here in the Nashville area, they've done a very good job in terms of increasing revenue and again this is right from the IHS website and looking at their annual reports that they've seen significant improvements, increases in third party revenue from one year to the next, and I think what we're seeing is a stronger recognition of the role of CMS as part of the federal trust responsibility, and if we just wait for the IHS budget to be adequately funded, I think we will be waiting for a long time. So, we have to look at creative ways to increase access to resources and I think that they've done a very good job relative to other regions here in the Nashville area.

Moderator: And what about looking at the number of cases? Has that changed over time as well?

Dr. Donald Warne: Yeah, we have seen an increased utilization of Contract Health Services. I don't think that's a reflection of the population getting sicker as much as it is a reflection of access to more resources. So, even though we are seeing this significant increase in utilization of Contract Health Services, as far as the number of cases I still don't think we're adequately meeting the numbers of

Contract Health Service cases that we should be providing care to. What we've seen is increases in third party collections and some increases in the CHS budget. Therefore, we are able to make more referrals but in truth we still need even more resources to adequately meet the needs of our people. So, even though we have gone up to, here in the Nashville area, over 2500 cases with Contract Health Services, it's still not the complete picture in terms of the services that are needed.

Moderator: I understand. Now, we have been talking about the Nashville area which encompasses New York State, but let's break this down a little bit further now and take a look at New York State – where we are today. Can you talk to us about how many tribes are represented and what does that information look like?

Dr. Donald Warne: Yeah, there are 11 tribes here in New York State and again a lot of cultural diversity even within the state of New York. So, there is not a single American Indian culture nationally and there is certainly not a single American Indian culture here in New York. Though there is 11 tribes, there are no IHS direct facilities but there are some unique partnerships between the tribes and the state of New York.

Moderator: And what are some of the health regulations or information? How does the New York State Department of Health fit in with the New York State tribes that we have here?

Dr. Donald Warne: It is unique because there actually was a law passed in 1962 which is Public Health Law 201, which states that the Department of Health is required to 'administer to the medical and health needs of the ambulant sick and needy Indians on reservations,' and what's unique about that is most states do not have an equivalent law where they're actually providing state-funded services on reservations. In truth, where I am from, we've seen some significant improvements in recent years but historically the states have had very minimal involvement in working with tribes to provide health services and here in New York, I think it's of course no relationship is ever perfect, but I think at least there is an effort to coordinate with the state programs along with the tribes and federal IHS funding. So, in many ways it's a good case study of how states, tribes and federal government can work in partnership.

Moderator: That's great to hear. Now with what we have been discussing, with the diversity of the tribes, the insufficiency of funds, one of the things that's obviously going to come up and become an issue and what we're here to talk about today is health disparities. And, I think in order to have a meaningful dialogue about health disparities, there are some key terms that people need to have a better understanding of, so can you talk to us about some of the terms that we use and incorporate when we're really discussing health disparities?

Dr. Donald Warne: Absolutely. I think 'health disparities' has become the common term that we're all using and there is even a National Institute of Minority Health and Health Disparities. But, it's an interesting term because when we're talking about 'decreasing disparity,' we're really speaking in a double negative. You know, 'decrease disparity' and in truth what we're trying to do is 'promote parity.' One population's health should be on par with another. So when we're looking at 'health parity,' we're

trying to look at producing outcomes in which there is health in one population is on par with another, so 'promoting parity.'

There is also the concept of 'health equality' which is looking at things in terms of having the same health status and access to the same health services for everyone in a population. For example, one of the outcomes of focusing on equality is that within state Medicaid programs typically there is a single Medicaid plan that is to address the health needs of the entire state. Well, one can envision where perhaps with substance abuse treatment programs that for American Indians maybe it would be of great value to incorporate traditional American Indian medicine and traditional methods into the treatment system. But because of the concept of equality, we can't provide those services to American Indians unless we are also providing those exact same services to everyone else. So, we have kind of taken a one size fits all approach to health care when looking at equality and I prefer the term 'health equity.'

We're trying to promote 'health equity.' And, that understands that there is a concept of social justice in health status and we need to meet individual community needs and the best example I have ever heard of the difference between equality and equity, is that equality is like giving everyone a pair of shoes, whereas equity is giving everyone shoes that fit. So, we do take the equality approach in many ways but, in truth, we need to recognize that there are cultural differences, there are community differences and we can approach this in a much more intelligent way focusing on equity.

Moderator: I think that analogy makes perfect sense and really helps to illustrate the great difference between equality and equity. So where we are now in absence of that health equity or health parity, we do see quite a few health disparities among the American Indian population and other populations. Tell us about some of those disparities that the population is facing?

Dr. Donald Warne: Well, nationally we see that American Indians live about 10 years less than the rest of the population and that is looking at things in terms of life expectancy. So, if we look at particular regions of the IHS, it's worse than others. Now, life expectancy is a projection; it's how long you would expect someone to live who is born this year. So it is based on scientific principals but in truth our best educated guess in terms of how long people will live. Where as when you measure the age of death in a given year it's a measurement, not a projection and in a state like South Dakota, we see that the median age of death was 81 for the general population and 58 for American Indians. On the reservation where I am from –Pine Ridge, South Dakota—the average age of death for men in that community is 49 years old and I am 46 and I'm certainly hoping I have many more than just three years left.

So, what's remarkable about that is our average age of death is on par or worse than most third world nations. So, one of the challenges I think we face in public health education is that we have a strong focus in many sectors on international health. We have a strong focus on global health and we have a very, very weak focus on American Indian health and that needs to change because one does not have to cross oceans to find third world health conditions. It's right here on our reservations.

Moderator: Absolutely, I mean those numbers, when you and I first talked, it's just really startling to hear the differences between what anyone else would be expecting to live versus being on the reservation where you grew up or any of the other populations and even beyond that –beyond the life

expectancy— there are also some pretty staggering numbers when you look at preventable deaths, causes of diseases as well. Am I right?

Dr. Donald Warne: Absolutely. When we look at some of the leading causes of disparities, we can see that American Indians nationally die at a much higher rate from preventable causes, so for example, diabetes is a 208% greater rate of death, alcoholism 526% greater death rate, accidents and unintentional injuries 150% greater and suicide 60% greater and when we think about the different regions or areas of the Indian Health Service.

It's important to remember that the national numbers don't necessarily reflect what is happening in specific communities and we see disparities even within Indian country. So, where I am from in the Aberdeen area, we know that the death rate from diabetes is much higher in the Indian Health Services compared to the rest of the U.S. But as you can see in the Aberdeen area, it's even worse due to diabetes and type II diabetes is preventable. This is not something that we have to endure but it's become part of the norm that we expect to see high rates of type II diabetes.

When working now in the state of North Dakota we can see that American Indians have about double the prevalence of type II diabetes, so twice as much diabetes as the white population. So, one would expect to see about double the death rate, the mortality rate. Well, if we look at the mortality rate from diabetes, it's nearly six-fold greater, so we are not managing type II diabetes very well. We get diabetes at double the rate but we die at six-fold the rate of the non-Indian population, and from a public health perspective whether you're American Indian or not this should not be acceptable. We should all recognize that these numbers are not acceptable and we need to do something to address diabetes prevention and management.

Moderator: Absolutely. Again, the numbers are nothing short of shocking when you look at the disparities that exist. Another one of the diseases you referenced was alcoholism and can you talk to us a little bit and share some more information on alcoholism rates?

Dr. Donald Warne: Yeah, I think one of the things that we've seen in many of our communities is unresolved grieving and a lot of self-medication with alcohol and we have issues related to historical trauma. We also have issues related to adverse childhood experiences, growing up in poverty where there is a lot of substance abuse and other types of abuse. Unfortunately, people grow up in very difficult social circumstances and it is really a social determinant of health. And, when we look at death rates from alcohol specifically nationally for Americans Indians, it's much worse than the rest of the nation. Again where I am from in the Aberdeen area, it's even worse than the rest of the Indian Health Service.

And what we see, unfortunately, are very high rates of death due to diabetes and very high rates of death due to alcohol, and one of the things that I have seen as a primary care doctor in literally hundreds of patients is a triad of diabetes, depression and alcoholism and the rates of depression among diabetes patients is tremendously high. I really think we should consider depression as a complication of diabetes and in this country the most common medicine is alcohol intake. Alcohol intake worsens your blood sugar and worsens your depression which worsens your alcoholism intake

which worsens your blood sugar and worsens your depression and, unfortunately, people are on this vicious cycle of diabetes, depression, and alcoholism and as a health care system we don't address this holistically. We haven't even identified this as a syndrome.

Actually, what we do in modern medicine, we cut the patient in half and we say that diabetes and out-patient depression management is a medical issue, but if a patient has major depression and needs alcohol treatment it's a behavioral health issue. So, we have separate systems of care, quite frequently separate Medicaid systems that address medical and behavioral issues and separate sets of case managers, separate sets of enrollment criteria, separate sets of providers and then we wonder why it doesn't work. So, if one wanted to create a system to fail, this is how you would do it. You would divide medical and behavioral and you wouldn't coordinate services. I think one of the potential benefits of the Affordable Care Act is we're starting to see more integration of medical and behavioral services.

Moderator: Now, all of this information that you shared is pretty hard to look at but what is even more disturbing is when we look at causes of death among the younger population. You have got some information for children, even ages one to four, which is really hard and startling to take in.

Dr. Donald Warne: Absolutely and even prior to that if we look at infant mortality and unfortunately we have very high rates of infant deaths, but if we look at specifically ages one to four, we see very high rates of death among American Indians and Alaskan Natives due to injuries. Because of poverty typically on your reservations, we have less access to car seats and if we do have a car seat, we don't necessarily have access to good training on how to use it appropriately. Frequently we have older vehicles that don't operate as well. We have, in many cases, roads that are not in good condition in very rural and frontier settings where we don't have good first responders when there is an automobile accident, for example.

So, the result is, we have significantly higher rates of death due to injuries and even with all of the terrible disparities we see in diabetes, alcohol and cancer the number one cause of years of potential life lost is unintentional injuries and that's public health 101. I mean, these are things that don't require medical interventions whatsoever. These require resources and good public health practices.

One of the other things that is disturbing, when you look at older youth populations from ages five to 14, we still see that trend in higher rates of death due to injuries but look at suicide. Even ages five to 14 we are seeing more than double the suicide rate for American Indians and Alaska natives. And, talk about social determinants of health that is completely rooted in the social circumstances and extremely challenging environments that many of our children are brought up in. So, when we think about how we can make the biggest impact for improving health status for American Indians, we need investment of resources in an intelligent way to address childhood health.

Moderator: And now, in addition to all of the diseases that you've talked about so far, another disease that I think everyone thinks about at some point is cancer. It's one of the big scary ones. What can you tell us about the rates of cancer among the American Indian population?

Dr. Donald Warne: Historically, there was a belief that American Indians didn't get cancer at a significantly high rate and one of the potential reasons behind that is because we had such low life expectancy. Maybe we were dying before we got cancer but when we look at the data more carefully, we can see there are significant regional differences in the cancer death rates and when we look at IHS, generally speaking, we don't see a significant difference between the IHS rate of cancer death and the rest of the nation. However, if we look at specific regions, particularly in the northern plains—the Billing, Bomidji, and where I am from in the Aberdeen area— we have significantly higher rates of cancer deaths and in truth among the highest cancer death rates in the world are among American Indians living in the northern plains.

Moderator: Now we've spent a fair amount of time talking about the different health concerns and the way that the health system works among American Indians. Let's take a few moments to really focus in on the American Indian population itself and talk a little bit about the demographics.

Dr. Donald Warne: Absolutely. When we look at the 2010 Census we can see that there is actually over three million people that identify themselves as American Indian only. If you include people who self-identify as American Indian as well as other races, then there is over five million of us. And one of the things is not very well known is that a majority of us don't live on reservations. Actually, 60% of American Indians are living in urban areas. Another thing to consider is there is over 560 federally recognized tribes, so again there is no single American Indian culture. There are hundreds of American Indian cultures. Within those numbers it's a little bit misleading because over 200 of those 560 are in Alaska and in many other small villages. Over 100 are located in California and where I am from we have less number of tribes but we have much larger land bases and much larger populations within the individual tribes so there is not one homogeneous version of American Indians and Alaskan Natives. We have a lot of diversity within our population. So we went from South Dakota, we have nine tribes, there is 11 here in New York and significant poverty and, as we've talked about, significant social determinants of health.

Moderator: And I would imagine that the diversity of the tribes becomes a factor in some of the health disparities that exist. You know, people want to understand American Indian culture and you're explaining to us that there is not one culture to address. We need to look at each of these individual situations. How have the demographics changes over time in the United States?

Dr. Donald Warne: When there is first contact—it's interesting when we look at the history of what is now the United States. At first contact, a lot of people think of Columbus but Columbus actually never set foot in what is now the United States. He was in the islands and on one trips went to Mexico. But, the reason it's called the West Indies is that he thought he was India. That's actually why we are American Indians is because Columbus was lost. So, it is an interesting history.

But when we look at our population historically, the estimated population of indigenous people in North America is anywhere from two million to 20 million depending on the estimations that you look at. Even if you take a conservative estimate of two million, there is nearly a complete genocide of the American Indian population. By 1900, there were only a few hundred thousand left. So the – so there

was a genocide, an attempted genocide— and many of our tribes were wiped out historically. But, we have seen our population bounce back and, like I had mentioned, in 2000 we had gone over two million of us and now there are over three million and if you include other races, it's over five million of us now. So, our population has made a come-back.

Moderator: And, going back to going beyond just looking at the numbers, it's great to hear that there is a come-back but let's talk about where American Indians are actually located and how has that changed over the years as well?

Dr. Donald Warne: When you look at Indian country, of course the entire U.S. was Indian country and when we look at the 'discovery' of America, the discovered, inhabited land. But as American Indians, we did not draw the lines for U.S. and Canada and the U.S. and Mexico. Those were drawn for us. But when we look at just the 48 states, we know that the 13 colonies, of course, were not good for the Northeastern tribes and one of the outcomes of that is that we have a much lower population of American Indians in the Northeast. And, that's not because historically we did not like the East coast, it was really because of the 13 colonies.

I'm sure people have heard of Amherst College and Amherst, Massachusetts and that is named after Lord Jeffrey Amherst, who was a colonial governor in the late 1600s. And, what he is famous for, at least from the American Indian perspective, is that he ordered the distribution of blankets from the smallpox hospitals to the regional tribes with the purpose of wiping them out. So, the first documented case of bio-terrorism is from our own colonial government and I think that is something that is not well understood or not well-respected in terms of our history as a nation. That is part of our history.

Also if you look at the Southeastern tribes, many of those tribes were relocated to what is now Oklahoma and in that process some of the tribes were divided—their populations were divided— and some of the people wanted to stay in their homelands and some moved to Oklahoma. So, that's why now we have, for example, Seminoles in Florida and Seminoles in Oklahoma, Cherokees in North Carolina and Cherokees in Oklahoma.

So, Oklahoma was opened up as Indian country and there was a specific date when the land was opened up for tribes to relocate in Oklahoma. Unfortunately one of the things that happened is that the state of Oklahoma – there was the land rush and the Sooners were the people who got there sooner and took the land so unfortunately what we're left with now is much more sparse population and less territory that we manage, and this particular map is from the U.S. Census website and shows the concentration of American Indian population by county and you can see most of us are in the west.

Moderator: And, I think it's really interesting to hear that history so people have an understanding of not just the population shifted, shifted and then got dispersed but how tribes were actually broken up and the impact that that's had on American Indians. And, one of the things that you mentioned earlier that I think correlates with that whole history is looking at the American Indian population that's living at or below the poverty level.

Dr. Donald Warne: Yeah and unfortunately nationally, we have very high rates of poverty but particularly in the region where I work in the Aberdeen area, we have even worse rates of poverty. We now estimate that about 45% of all American Indians in the Aberdeen area are living at or below the federal poverty level. But, if you look at some of our reservations, it's about 80% of people living on reservations living at or below the federal poverty level. And I think that dispossession of land, loss of control of traditional economies has led to –not surprisingly— very high rates of poverty and also, poverty correlates with worse health status and is one of the many social determinants.

Moderator: And when we look at the spending, we can see that the population of American Indians is living at a higher poverty level. We would expect then that maybe the amount that is spent on health care for that population would somehow account for that, but is that what we see?

Dr. Donald Warne: One would expect that but unfortunately logic has not entered the picture in terms of how we fund the Indian Health Service. So if we look at various federally funded health systems, we can see for example, Medicare is funded at over \$11,000 per person per year. The Veteran's Administration is over \$6,000 per person per year, Medicaid over \$5,000 per person per year. For American Indians, nationally it's about \$2,600 per person per year so one of the results is we've had to be as good as we can at third party revenue to increase that.

But, when we look at all of these various populations that have a legal right to health care – that's what binds these particular populations together that are represented on this graph and when we think about a legal right to health services whether you're a veteran, whether you are eligible for Medicare or Medicaid or your American Indian—if you look at those numbers, you can see that American Indians are not getting equal protection under the law. We have just as much legal right to health services as any Medicare beneficiary, any veteran, any federal employee, but we are not getting services on par with those populations, so this is a social justice issue. It's a civil right issue. It's a legal issue. We are not getting equal protection under law.

And, if we look at how much money it would take to fix the budget, it's really a drop in the bucket. We estimate that we're about 60% of need with the IHS appropriation. We get a little over \$4 billion per year for Indian Health Service. So to get us up to 100% of need would be about \$7 billion. So, that increase of \$3 billion for us as American Indians would be huge and significant. But, when you look at that amount of money relative to the entire Department of Health and Human Services, it's a drop in the bucket. HHS budget is over \$800 billion per year, so if we just reprogrammed \$3 billion to IHS, we would solve those funding deficit problems. They would be solved. So, when people say that we don't have the money to fix it, that's a lie. We have the money. We just don't have the priority. So, in truth, the few tenths of one percent of the HHS budget, if it was reprogrammed into IHS –the Indian Health Parity Act – if we could move something like that forward, we would solve all of those problems and it's a few tenths of one percent of the budget, that's budget dust, within margins of error for budgeting for the entire department.

Moderator: How about the Patient Protection and Affordable Care Act? Do you expect that's going to have any meaningful impact on American Indian health?

Dr. Donald Warne: In a couple of ways, absolutely. With one component of it, what was included in the Patient Protection and Affordable Care Act was the Indian Health Care Improvement Act and that was due for reauthorization for a long time. So, that was a part of it. In addition to that, we have heard all kinds of rhetoric surrounding the Affordable Care Act and it's been called the 'government take-over of health care' and it's nothing close to that. There is no single payer. It's been called 'Obamacare' and I guess Obama is calling it 'Obamacare' now so we can all use that term but as it stands now there is still no public option for health insurance. This was called health care reform and in truth, it's health insurance reform.

So it will have a good impact in terms of paying for preventive services and not discriminating against people of pre-existing conditions but the Indian Health Service is not health insurance. So, the provisions like forcing insurance companies to pay for preventive services or cancer screening for example, that wouldn't apply to Indian Health Service if you're dependent on IHS but where we will see the greatest impact is with Medicaid expansion. And with Medicaid expansion, we have a lot of impoverished people and we also have a lot of working poor. We should see the number of people, the numbers of American Indians eligible for Medicaid increase dramatically. Unfortunately, in many of the states that have significant Indian populations, those are the very conservative states who are talking about not doing Medicaid expansion. So implementation will have a big impact.

Moderator: So, you mentioned that it's not health care reform but health insurance reform. So, let's talk about insurance and who is insured and what does that mean?

Dr. Donald Warne: If you look at the population that is insured in the United States, it's typically the working families, people who have jobs and their families. So, if you look at employed adults and their families what we see is the healthiest population really in the country. And if we look at health insurance company profits, the five largest insurers have over a \$12 billion profit in 2009 and that is not revenue, that's profit. So, if you look at one year of profit for a health insurance industry, it is equivalent to three years of funding for the entire Indian Health Service. So when we are looking at just the insured populations, typically it's a healthier population. People who get public insurance – elderly, impoverished, veterans or American Indians – again it's not really health insurance. But, Indian Health Service clearly needs more resources to meet the needs of our people.

Moderator: So what role do you expect that the Patient Protection and Affordable Care Act will have on American Indian health?

Dr. Donald Warne: One of the things that is going to be key is implementation and I think the answer to how well the Affordable Care Act will have on American Indians. The answer is 'it depends.' It depends on whether or not our people enroll in Medicaid if they're eligible. If we have a state that does participate in Medicaid expansion, we will have significant improvements and access to services. If someone is dependent on IHS only and they have no alternative resources and they depend on IHS directly for care, there will be little to no impact in truth. So, it really depends on the delivery system. We call our healthcare delivery system the I/T/U system. I is IHS, T is Tribal for 638 programs and U is Urban Indian Health Centers. Another potential provision that will be of benefit is expanding the

federally qualified health centers so there are grants from HRSA, as many people are aware of, for community health centers and tribal programs and urban Indian health programs are eligible for those grants. IHS as a federal entity is not eligible, so if you're dependent on IHS and you have no other alternative resources, the impact on you will be negligible unfortunately.

Moderator: So this is not an easy picture to look at. I mean, when we look at the health disparities and look at the funding issues, certainly it's not something that sits probably very well with a lot of our viewers. So, what can you offer in terms how do we move forward? What really is needed to correct the health disparities that exist?

Dr. Donald Warne: Well, one of the things is looking at advocacy and that's one of the things I have been working on. I am on the National Board of Directors for the American Cancer Society for example and I've been working with their Cancer Action Network, looking at how we can add full funding of Indian Health Service to the American Cancer Society legislative agenda. That should be the same for the American Heart Association, the American Diabetes Association, American Medical Association. We need to look at partnerships and advocacy because unfortunately we just don't have the numbers of American Indians to do adequate advocacy on our own. We need partnerships on that effort.

But, also even at the local level we can do a lot more to coordinate policy and in my own experience working with tribal programs of Indian Health Service and local programs, I have seen a lack of coordination of policy and we have health policy, social policy, education policy, and economic development programs and quite often those have competing agendas. For example, in health policy we might be saying we want to promote breastfeeding because it helps to reduce diabetes, but then we have a tribal work place that doesn't allow breastfeeding in the workplace, so we're not coordinating those messages, or maybe in health policy we're saying we need to have healthier food for our children but the schools on the reservation might be impoverished themselves and have multiple competing agendas so they can't afford to pay for healthy food.

So, we can't think of health policy in its own silo. We have to recognize that public health is influenced by a number of sectors and at the tribal level, the state level, the national level, we need a more intelligent approach to improving community health and we need to recognize that we need to have consistent messages across those disciplines.

Moderator: In addition to what you talked about, looking at the way that medicine is practiced today in this country versus the historical way that American Indians practiced medicine and you had a very interesting picture and I would love it if you would just speak about what that image represents.

Dr. Donald Warne: Absolutely. This is actually a picture of one of my ancestors, a medicine man from Pine Ridge and what we can see here is very different from what we see in the modern medical clinics. You can see he is touching the patient. He is praying with the patient. He is meditating with the patient. And the family and the community are directly involved in that healing process. So, I always like to acknowledge this might not be HIPPA compliant but it is a valuable approach to medicine because it's including the family and the community in the healing process and historically that's what we did and for those of us who participate in healing ceremonies, quite frequently people from all over the reservation

will come to participate in your healing ceremony and the power that you feel when you know that your whole community wants you to be better is indescribable and I think that's a type of healing energy we haven't tapped into in the U.S. and I think that would be a valuable approach to health and healing, not just for American Indians but for all of us.

Moderator: Thank you so much. We have time for just a few questions that we got from the audience. The first one that I guess came in from a few of our viewers is that much of the epi data that is published by the Indian Health Service is outdated. The question is are there efforts at the federal, state or tribal level to collect and publish new data to better direct public health efforts to improve outcomes in the American Indian health population?

Dr. Donald Warne: That's been one of our big challenges is having accurate data and up-to-date, recent data. One of the things that I'm also working on is with a work group through IHS and CDC and we're compiling new data sets that are cleaned and much more accurate. And, we are looking at a special issue in the American Journal of Public Health to describe the health data in much better terms and specifically at North Dakota State University, we have a new American Indian data coordinator because we have multiple data sets –tribal data sets, state data sets, federal data sets, Indian Health Service has it's own data set— so we do have a struggle in terms of coordinating the data and making sure that we are getting the most accurate picture of health.

Moderator: All right. So, the next question is how can we better address the access to care issues that you discussed earlier in the webcast?

Dr. Donald Warne: Well, that does come down to resources and I have heard arguments from political leaders saying, "Well, we can't just throw money at it". Well, appropriate expenditure is not just throwing money at something. You can't provide services without resources. It's a simple equation. And we don't have adequate resources to provide the services that we need. For example, we would have many sites in the Indian Health Service that we don't have enough physicians; we don't have enough nurses; we don't have enough health care providers across the whole spectrum because we can't afford them. We can't afford to pay people adequate salaries to bring them out to very remote and impoverished populations to provide services so we do need more resources.

The other challenges that we face is that – I have heard people say well the IHS is broken. I don't think the IHS is broken. I think it's starved. We just haven't had adequate resources put into the Indian Health Service. We don't know how well it will work if it was adequately resourced. The analogy I like to use is that if you have a vehicle that needs a full tank of gas to get from point A to point B, but every day you only put in half a tank of gas and you're wondering why you're not getting to where you need to be, maybe instead of complaining about the car, the driver or the road, maybe we need to look at the individuals who are responsible for putting only a half tank of gas and in that case it's Congress. And Congress has consistently and for generations have under-funded Indian Health Service and quite frequently, they are the first ones to point at the IHS for failing. But, in truth, the failure lies with Congress for underfunding IHS in the first place.

Moderator: We have another question about are there also other documented disparities related to infectious and communicable diseases in American Indian populations?

Dr. Donald Warne: Yes, there are and the population, for example still the highest rate of tuberculosis is the American Indian population. Unfortunately, where I am from in North Dakota, we just had an outbreak of tuberculosis among homeless American Indians in the cities of North Dakota. I think it's now over ten cases of tuberculosis. We see other serious issues, for example we do have very high rates of STIs – sexually transmitted infections— and that is very concerning because we could easily see an explosion of HIV within our young population and with some of our smaller communities, if HIV were to explode at the rate of some of our other STI issues, we could see entire generations of our people wiped out. So, we have significant infectious disease issues that we need to address in addition to the chronic disease issues.

Moderator: Now what about – have you found that– I mean, you talk about traditional aspects of American Indian healthcare and some of the ways that tribes have used healing in the past. Do you find that it's a barrier when you look at what health insurance will cover or won't cover, does that become an issue –you know—that the types of things used for healing, the insurance says, “No, that is not a legitimate way to treat this and we're not going to cover it.”

Dr. Donald Warne: Yeah, that has been a challenge and I think that we're probably not going to find private sector insurance entities that are going to cover traditional medicine. And, I think that one of the big challenges that we face is that historically we didn't have a system of currency. It wasn't money in exchange for services. That's the world we live in now but historically we didn't have that. So, we just provided services as they were needed. So, I think that is one of the challenges – in terms of looking at how we can best utilize traditional perspectives of holistic health within the current environment that is not holistic. It's a big challenge.

Moderator: All of these seem like big challenges and one of the next questions that segues really well is what can the greater public health community do to assist in advocacy efforts? And I would even expand that from my own perspective given there are obviously issues of trust within the tribe and outside the tribe, so what is the best way that those of us who are not American Indians but are involved and concerned about public health –how do we help? What is our role in these efforts?

Dr. Donald Warne: Well, I think that as any entity like the American Public Health Association, we really should have full funding of IHS on the legislative agenda and for APHA for that as well. And, I think that is a movement that needs to move forward and we've gotten to a point where even many of our advocates have felt like, 'well, we have been asking for this for generations and it's just not going to happen.' I don't think we've adequately developed our partnerships within advocacy. We need American Public Health Association, we need American Medical Association, American Cancer Society and all of these other organizations to recognize that what is happening here is an injustice and if we want to focus on global public health, we need to start here at home and we need advocacy to ensure that Indian Health Service is adequately funded. We have some strong national agencies that focus on advocacy like the National Indian Health Board, National Congress of American Indians and what we

need is our large national agencies and programs to work in partnership with multiple sectors to ensure that IHS is adequately funded.

Now, that will be incredibly difficult in the current environment of budget cuts and sequestration and all of these other issues but, in truth, if we invested adequate resources into Indian Health Service, not only would we save lives and reduce suffering, in the long-run, we would save on cost because when we're not funding Contract Health Services for issues that are not yet emergent, basically what we're saying is that once that is an emergency then we'll pay for it. As an example, if I have a patient who is dependent on Indian Health Service and Contract Health Services and they need a colonoscopy – screened for cancer –and in many areas of the Indian Health Service, that's not considered a level one priority for Contract Health Services. So, what we are telling that patient is that we will not screen for colon cancer today but when you're in symptomatic, late-stage and you're about to die from colon cancer, then we'll send you to the hospital. That is absolute social injustice. It's a civil rights issue and it's solvable relatively easily if we all work together and recognize that we need to advocate for American Indian health programs generally.

Moderator: Thank you Don. Well, that's all the time we have today for questions. But, I believe that you're available – you're willing to provide your contact information if people do have questions after the broadcast.

Dr. Donald Warne: Absolutely. That's not a problem.

Moderator: So, your information is up on the screen and also available on the handouts if folks downloaded them from the website. So, thank you so much for being here with us today. I really think you've done a tremendous job at showing the big picture and really providing a face to this issue that it is so huge and as we've discussed earlier, it's relatively unknown considering the scope of the problem. So, thank you so much for being here.

Dr. Donald Warne: Thank you for the opportunity.

Moderator: And, thank you for joining us today. Please remember to fill out your evaluations online. Your feedback is always important and helpful to the development of our programs. And, Continuing Education Credits are available. To obtain Nurse Continuing Education Hours, CME and CHES credits must visit www.phlive.org and complete an evaluation and a posttest for today's offering. Additional information on upcoming broadcasts and relevant public health topics can also be found future topics can be found on our Facebook page. Don't forget to like us on Facebook to stay up-to-date. As a reminder, you can also download the companion guide to this broadcast on our website phlive.org. And that companion guide will provide you with learning activities to help further your knowledge and understanding of the topics covered in today's program. An archive of this webcast will be available on our website within two weeks. Please join us for our next broadcast on March 21st, *Sodium Savvy: Salient Issues in Public Health*. I am Rachel Breidster and thank you so much for joining us on Public Health Live!