PROGRESS REPORT FOR:

American Indians and Alaska Natives

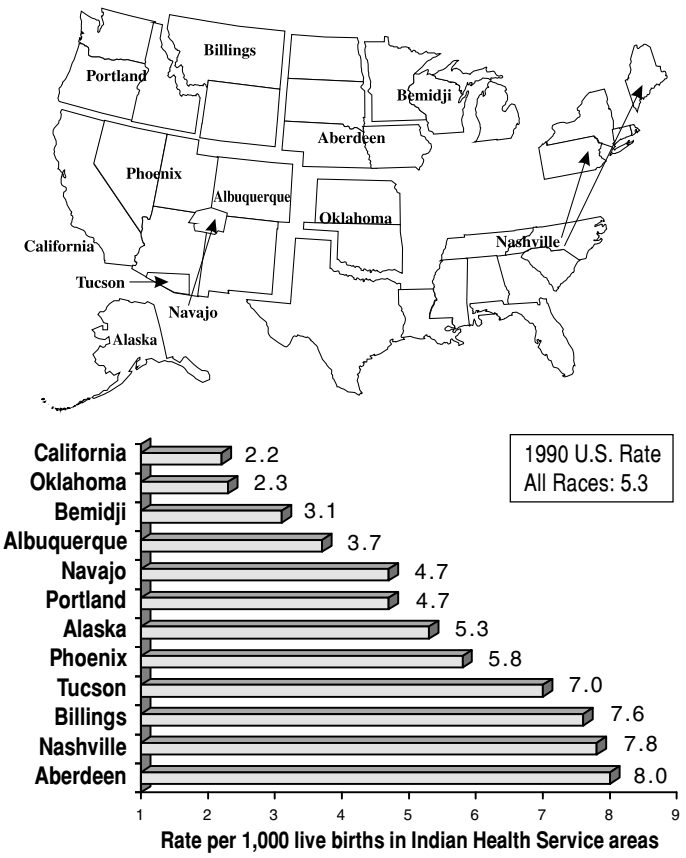
ON FEBRUARY 15, 1995, the Public Health Service (PHS) conducted its second HEALTHY PEOPLE 2000 progress review focusing on the health needs of American Indians and Alaska Natives (AIs/ANs). This progress review cuts across all of the priority areas with specific objectives or subobjectives that address disparities between this specific group and the general population. For AIs/ANs, there are 31 subobjectives in 14 priority areas.

The Indian Health Service (IHS) led the progress review. Representatives from the Cherokee Nation of Oklahoma, the Indian Health Board of Minneapolis, and the National Indian Council on Aging joined in the discussion. Federal representatives included the Bureau of Indian Affairs (BIA), the Administration on Aging (AOA), and the Head Start Bureau of the Administration for Children and Families (ACF). PHS participants included representatives from the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), and Office of Minority Health.

IHS is responsible for providing health services to AIs/ANs in about 500 federally recognized tribes as authorized by treaty obligations entered into by the U.S. Government and tribal governments as well as numerous pieces of legislation. Approximately 60 percent (1.3–1.4 million people) of AIs/ANs receive services from IHS in 12 service areas. Of these AIs/ANs served by IHS, three-fifths live off reservations.

The IHS Director described increased diversity in how services are delivered by IHS and tribal and urban Indian communities. The discussion focused on the role of the Federal Government with various AI/AN populations, the role of self-governance in building public health capacity, and the role of AI/AN tribes in the consolidated partnership grant proposals. The IHS Director presented a vision for improving the health status of all AIs/ANs that maximizes tribal involvement at the community level, is customer-oriented, and enhances the role of IHS as a consultant to the tribes and as a facilitator in the building of coalitions and partnerships with other government and non-Federal agencies to assist all AI/AN populations, including non-federally recognized tribes and AIs/ANs in urban areas.

Neonatal Mortality Rates (<28 Days) in Indian Health Service Areas (1989–1991)



Source: Indian Health Service

Attention was focused on the need for disease prevention and health promotion initiatives and strategies to reduce health disparities between AIs/ANs and the total population. Seven health problem areas were highlighted—alcoholism and substance abuse, child abuse and family violence, diabetes, women's health, the health of the elderly, maternal and child health, and injuries.

The neonatal mortality rates in IHS service areas are indicators of the health of a community. There are considerable differences in neonatal mortality rates among the 12 IHS

Service Areas. The California IHS Service Area had the lowest rate with 2.2 per 1,000 live births in 1990, which is only about half the U.S. rate, while the Aberdeen IHS Service Area had the highest rate of 8.0 per 1,000 live births.

Age-adjusted death rates from homicides, suicides, and unintentional injuries for AIs/ANs in IHS Service Areas are higher than the total population, although between 1980 and 1990 the death rates for AIs/ANs began to decline. When examined by age and gender, homicide, suicide, and unintentional injury death rates peak among adolescents and young adults and among the elderly. Males have considerably higher rates than females. These patterns lead to strategies tailored to those at highest risk.

The Cherokee Nation shared materials about their efforts utilizing ***Healthy People 2000*** objectives tailored to the needs of their community. Concerns were raised by the Indian Health Board of Minneapolis about the impact of State health reform efforts and grants consolidations on AIs/ANs in urban areas. The National Indian Council on Aging emphasized the need to ensure that achievement of ***Healthy People 2000*** objectives translates into quality of life for the elderly. An IHS geriatric initiative to address the health care needs of Indian elders was acknowledged, but needs for functional assessments to determine levels of ability/disability, improved access to services (such as oral health care, nutrition services, and mammograms), and greater cultural sensitivity were raised.

Data on the 31 ***Healthy People 2000*** subobjectives for the AI/AN population indicate that 17 are progressing towards the year 2000 targets. In 1992, the prevalence of smokeless tobacco use among AIs/ANs dropped to 7.3 percent, surpassing the year 2000 target of 10 percent. Motor vehicle crash deaths dropped from the 1987 baseline of 37.7 per 100,000 to 32 per 100,000 in 1992 and met the year 2000 target. Unintentional injury deaths and suicide also declined, but remain at levels higher than the total population. Nine objectives showed movement away from the targets; overweight prevalence (48 percent for AIs/ANs, 29 percent for total population in 1993), diabetes prevalence (70 per 1,000 for AIs/ANs, 30 per 1,000 for total population) and cirrhosis deaths (21.6 per 100,000 for AIs/ANs, 8 per 100,000 for total population) exemplify the serious health problems of this population. Tracking data are not available for three objectives.

Movement toward or away from the targets provides a general indicator of the changes in the health status of the national AI/AN population, but there are considerable regional and tribal variations in death rates, risk factors, and health service utilization. The size of this population (2.2 million in 1994) and the small sample size in national surveys also complicate monitoring of the objectives. Supplemental data from local surveys and sources are helpful in monitoring the health of AIs/ANs.

Based on the progress review, action items related to ***Healthy People 2000*** were suggested. First, the need was emphasized for working with the Association of State and Territorial Health Officials to identify ways to ensure health care for AIs/ANs in the States as changes are made in health care financing and public health granting mechanisms.

Second was the importance of bringing all available Federal resources together through more and stronger interagency partnerships and collaborations. Thus, the progress review identified the need for PHS to enhance its collaboration with BIA, AOA, and ACF on the health needs of AIs/ANs and to explore with BIA options to effect stronger links between health facilities and schools on reservations to meet the health care needs of children and youth. Also mentioned were the need for IHS to work with HRSA and SAMHSA to coordinate strategies to serve the needs of urban Indians (including involvement of community health centers serving AIs/ANs in their service areas); to identify, with CDC and NIH, measures for providing accurate, relevant, and timely information to AI/AN communities about effective, successful community interventions and research results; and to explore ways to increase collaboration with CDC, SAMHSA, and HRSA to provide culturally appropriate information to AI/AN communities on their priority health issues.

The progress review noted that ***Healthy People 2000*** data will no longer be reported using reservation States as a unit of analysis. IHS will work with the National Center for Health Statistics and appropriate PHS agencies to improve representation of AIs/ANs in national surveys and ensure that data are representative of all AIs/ANs rather than only those in IHS Service Areas.

Public Health Service Agencies

Agency for Health Care Policy and Research
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Substance Abuse and Mental Health Services Administration
Office of the Surgeon General

Healthy People 2000 Coordinator

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