Indian Health Service Tobacco Taskforce Meeting

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Tobacco Use in Indian Country – Issues and Opportunities

by

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Good Morning!
Thank you for inviting me to speak at the Tobacco Task Force meeting. When Dr. Cobb asked me to charter this group a couple of years ago, I saw that he had recruited some of the brightest stars in Indian health, and I am excited to meet more of you and to see how your work is evolving. I am also happy to meet some of your collaborators from the non-profit world. We often turn to outside resources for inspiration and expertise, and our work in tobacco control is a good example of that.

Today I will share with you some tobacco use statistics for American Indians and Alaska Natives, then try to tie that into the big picture of how we are redesigning our health care system to meet current needs.

It is important to remember that tobacco is not considered a "bad" thing by most Native Americans. Traditional tobacco has a spiritual role in Indian culture and varies from Tribe to Tribe. It is estimated that the tobacco plant has been used by American Indians for over 18,000 years. Traditional tobacco is still used by many Tribes – often for prayer, ceremony, offerings, gift-giving, or as a medicine for healing.

We find it is helpful to distinguish between the occasional use of tobacco for traditional or ceremonial purposes, which is not harmful to health, and the habitual or addictive use of Commercial tobacco products, which have definitely been shown to be very harmful, even lethal, to human beings.

The text is the basis of Dr. Grim's oral remarks at the IHS Tobacco Workforce Meeting on April 23, 2007. It should be used with the understanding that some material may have been added or omitted during presentation.

Our problem with commercial tobacco abuse is significant: nearly 41% of American Indians and Alaska Natives are smokers. This is the highest rate of tobacco use among every age, ethnic, and gender category in the U.S. Between 1983 and 2002, adult smoking rates fell in all racial and ethnic groups, except for American Indians and Alaska Natives.

The recent Master Settlement Agreement between States and the tobacco industry provided large sums to State tobacco control efforts. Unfortunately, Tribal Nations were not included in that settlement, and the Indian Health Service (IHS) does not have an allocation budget for tobacco control. The fact that so few resources have been available for tobacco control in Indian country goes a long way to explaining why we are lagging behind the rest of the nation in this area.

There are significant regional differences in smoking rates. Tribes in the Northern Plains and Alaska are much more likely to be habitual smokers than in the Southwest. Unfortunately, recent studies have shown that youth in the Southwest are smoking more than their parents did. American Indians and Alaska Natives in middle school and high school were more likely than those from other racial/ethnic groups to have smoked cigarettes during the last month. American Indians and Alaska Natives also begin smoking earlier than any other group. And, American Indian and Alaska Native women smoke more during pregnancy than other groups. This unhealthy practice can have profound impacts not only on the mother but on her unborn child as well.

Also, the highest rates of current smokeless tobacco use are found in the American Indian and Alaska Native population. Among men and women combined, the rate for use of chewing tobacco or snuff was 4.5%.

The consequences of such high smoking rates are easy to see. In Alaska, lung cancer incidence is quite a lot higher than U.S. White rates, while in the Southwest, where smoking rates are low, it is relatively rare. Smoking has also been shown to contribute to many chronic illnesses and conditions, including heart disease and diabetes − two very serious health problems in Indian Country.

The habitual use of commercial tobacco by American Indian and Alaska Native people is causing devastating health problems. We are well aware that there is no single clinical intervention today that can reduce illness, prevent death, and increase the quality of life more than effective prevention and treatment of nicotine addiction.

Now let me fit tobacco into a broader context. In order to better address our most pressing issues in Indian health care, I have established three main health initiatives for the IHS. These are: Chronic Care Management, Behavioral Health, and Health Promotion/Disease Prevention.

These initiatives are linked together, and seek to address the underlying causes of poor physical and mental health, rather than just treating the symptoms. And they stress the empowerment and full engagement of individuals, families, and communities in health care.

We have found that chronic disease has replaced acute illness as our dominant health problem; and that chronic disease is now the principal cause of disability and of clinic visits and the use of health services in general. As I noted earlier, tobacco use can cause or worsen many chronic conditions. Chronic disease issues are currently the focus of many health care efforts, both in Indian Country and across the nation.

Addressing all the diverse elements that contribute to overall good health requires, among many other things, a strong Chronic Care Management Model to help guide our health care efforts. The IHS is adapting the MacColl Institute Chronic Care Model for use in the Indian health care system. This model addresses the underlying causes of poor physical and mental health, rather than just treating the symptoms. This means addressing all the elements that contribute to good health, including the cultural, medical, behavioral, social, and sanitation needs of the population we serve.

This model of chronic care highlights the importance of an informed, interactive patient in the health care process. The chronic care model is based on the premise that improved outcomes result from productive interactions between a proactive health care team and an informed patient.

As we implement these changes in our clinical systems, Dr. Cobb and the Tobacco Task Force are providing us with models for tobacco cessation that will fit into the larger context of chronic care management.

Prevention is also a key issue in the behavioral health field. And one of the main areas that the Behavioral Health Initiative is seeking to address is the severe problem of Alcohol and Substance Abuse in Indian Country. A recent study by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that American Indians and Alaska Natives were about 1.5 times more likely than other ethnic groups to have a past year alcohol use disorder (10.7% vs. 7.6%) and to use illicit drugs (5.0% vs. 2.9%).

And as we have already stated, American Indians and Alaska Natives have the highest rate of commercial tobacco abuse of any racial/ ethnic group in the United States. It is important that we pursue all available recourses and partnerships to deal with this troubling statistic. For instance, tobacco use is often linked to other substance abuse, so we have opportunities to incorporate nicotine addiction treatment into our other substance abuse programs.

The problem of substance abuse is simply not a problem we can solve by ourselves. Collaboration with other federal agencies is the key. IHS is actively collaborating with the Bureau of Indian Affairs, SAMHSA, Housing and Urban Development, Department of Justice, and others in order to coordinate resources to address this problem.

The Health Promotion and Disease Prevention Initiative is closely related to both our Chronic Care Management and our Behavioral Health Initiative. This main purpose of this initiative is to:

- Reduce health disparities among Indian people through a coordinated and systematic approach to preventive health; and

- Create healthier Indian communities by developing and implementing effective health promotion and chronic disease prevention programs.

The underlying principle of prevention in the IHS is that the best health promotion programs are those that are developed in consultation with our key stakeholders, the American Indian and Alaska Native people. We know that listening to those who are most affected by the outcomes helps us to best target the specific needs of each community. And we know that building on the existing strengths and assets of Indian people, families, and communities ensures the most effective use of resources and yields the best possible results, whether we are dealing with ongoing chronic conditions or emerging infectious diseases.

The Health Promotion/Disease Prevention initiative provides many opportunities for tobacco prevention through community pilot projects and partnerships with state and local tobacco control efforts.

As I mentioned before, in order to effectively combat chronic conditions, we must address a host of factors. This requires active partnerships with tribal, federal, state, and private organizations. This is why the IHS has established many partnerships with private and public entities. And we are open to creative relationships with any organization that genuinely wants to help in Indian Country, and I am excited to hear that some of the powerful non-profit organizations in tobacco control are interested in working with the IHS and with tribal communities.

In summary, there are many difficult health problems facing American Indian and Alaska people, including tobacco abuse, and we are making a vigorous effort to redesign our system to meet those challenges. We realize that we can only make progress with the help of many partners − most importantly the Tribes themselves, but also the other federal agencies and private foundations, universities, and organizations that bring a great diversity of resources to bear on Indian health issues.

I sincerely thank you for being here today, and for all the support that you have given and all the work you have done to help address Indian health issues.