

Montana State Legislature

2011 Session

Exhibit 4

This exhibit is a booklet which can not be scanned, therefore only the front cover/table of content and 10 pages have been scanned to aid in your research.

The original exhibits are on file at the Montana Historical Society and may be viewed there.

**Montana Historical
Society Archives
225 N. Roberts
Helena MT 59620-1201
2011 Legislative Scanner Susie Hamilton**

EXHIBIT

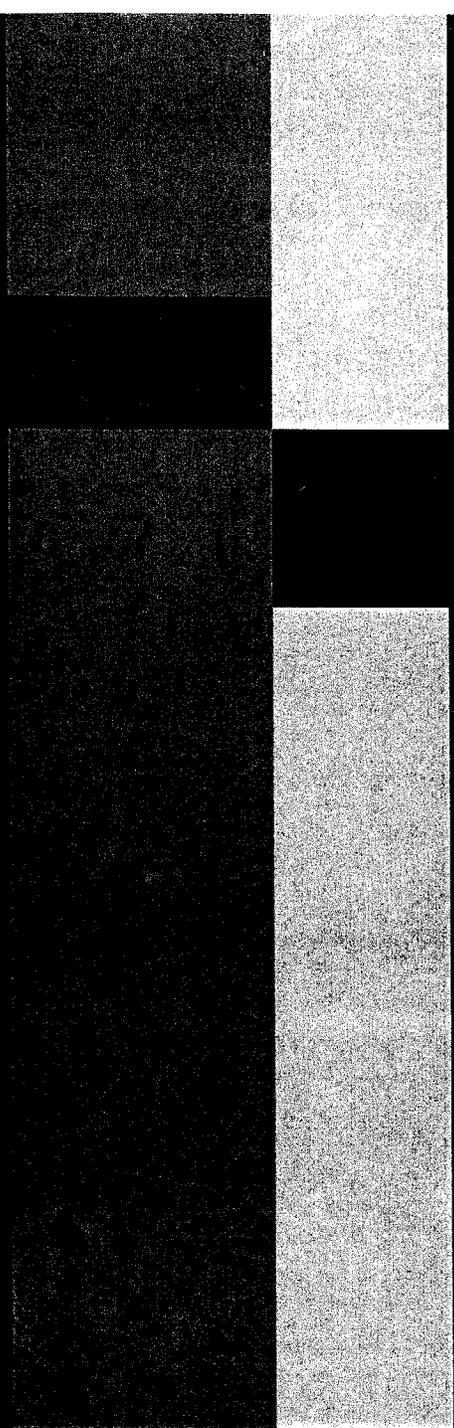
4

DATE

2/1/2011

HB

124



AN AMERICAN DEBT UNPAID

Stories of native health

HEALTH RIGHTS ORGANIZING PROJECT

Edited by Julie Chinitz & Danisha Christian

Northwest Federations of Community Organizations

HEALTH RIGHTS
ORGANIZING PROJECT

Edited by Julie Chinitz & Danisha Christian

NORTHWEST FEDERATION OF COMMUNITY ORGANIZATIONS
2009

ACKNOWLEDGEMENTS

This publication would not have been possible without the immense contributions of Ben Chin, Francoise Mbabazi, Jill Reese, Terri Sterling, and Joe Splinter who collected many of the stories shared here. Bineshi Albert, Drew Astolfi, Angela Evans, Ralph Forquera, Beverly Harbin, and Tristan Reader also made story collection possible.

Jill Reese from the Northwest Federation of Community Organizations and Michaelynn Hawk of Indian People's Action helped coordinate the organizing, planning, design, and story collection for this publication. Maile Tauali'i contributed incomparable expertise, and Eric Holte, Dennis Osorio, and Patrick Tippy also assisted with research.

For invaluable feedback and advice, we are also greatly indebted to Kristy Alberty, Danielle Delaney (National Council of Urban Indian Health), Maile Tauali'i (Papa Ola Lokahi), and Hardy Spoehr (Papa Ola Lokahi).

We especially would like to thank all the people who have shared their stories in the pages that follow.

TABLE OF CONTENTS

9 Executive Summary

10 Introduction

THE STATE OF NATIVE HEALTH

12 Health care & the relationship between Native people and the United States government

13 Native people suffer from poorer health

14 Native people, structural racism, and the social determinants of health

15 Native people go without needed health care

16 Chronic underfunding of the Indian Health Service

17 Hawaiians and the health care system

18 Native people receive lower-quality care

19 Bias and discrimination in the doctor's office

19 Health care often is disconnected from Native cultural practices, traditions, and languages

STORIES

22 Past & Present

25 Life & Land

28 Struggling for Health Care Resources

33 Do No Harm?

37 Being Turned Away

39 Respecting Culture & Community

43 Oral Health

45 Healing the Mind

47 Battling Stereotypes and Disrespectful Treatment

50 Researching Native Health

51 CONCLUSION & RECOMMENDATIONS

56 Sources

59 About the organizations releasing this report

EXECUTIVE SUMMARY

When Native people arrive at the doctor's office, they come bearing the effects of discrimination and dispossession, which take a physical and mental toll. As a result, Native people in the United States bear an excess burden of disease, dying younger and often living sicker than members of other groups.

Yet Native people* often cannot get quality health care when they need it, despite the responsibility of the United States government to provide for Native people's health care. The infrastructure serving Native health needs is chronically underfunded, out-of-date, and understaffed. Native people have extremely high rates of uninsurance, and when they do make it into the clinic or hospital they often receive substandard care and biased treatment.

This storybook shares the experiences of Native people struggling to get health care they need. The contributors provide personal accounts of their efforts to be treated with respect by practitioners, as well as their fight to improve the health and wellbeing of their communities.

The stories touch on the following experiences:

- Battling stereotypes and disrespectful, dismissive treatment
- Being turned away for care
- Struggling to find affordable care in one's community
- Receiving substandard care
- Searching for care that respects one's traditions and practices
- Protecting and reviving practices that promote cultural renewal and health

It will take changes in U.S. federal policy to remove the many obstacles to good care and allow Native people to reclaim a tradition of health. To move toward its obligation for Native health, the federal government should take steps that recognize the full range of barriers to health and health care that Native people experience. In taking such measures, the federal government must respect the sovereignty, self-determination, and consultation rights of Native people. Among these measures are the following:

- Ensure full funding for the Indian Health Service
- Support improvements in the availability and quality of comprehensive health care for Hawaiians
- Increase enrollment of Native people in public health programs
- Support improvements in the quality of care for Native people
- Develop a larger, more diverse, and culturally competent health care workforce
- Support culturally appropriate research and data collection that advances the health of Native people
- Safeguard the rights of Native people—and their relationships with the federal government—in and through health care reform
- Reinforce health care infrastructures
- Support efforts to develop healthy food systems and economies in Native nations and communities

***In this storybook, we use the term "Native people" to refer to American Indians, Alaska Natives, and Native Hawaiians. Unless otherwise noted, the terms "white" and "African American" refer to non-Hispanic whites and non-Hispanic African Americans, respectively.**

INTRODUCTION

THE OFFICIAL INVISIBILITY OF NATIVE HAWAIIANS

A note on data and terminology

This publication uses the term “Native people” to refer to indigenous people from the continental United States, Alaska, and Hawaii. Wherever possible, the information cited applies to all Native people.

However, data for Hawaiians often are not available. Historically, Native Hawaiians and Pacific Islanders were included in the category of “Asian and Pacific Islanders” (API) by the U.S. government. As a result, data and reporting on Native Hawaiians and other Pacific Islanders have been hidden within “API” data.¹ Though the federal government has issued a directive to disaggregate Native Hawaiians and Pacific Islanders, this directive is not enforced. For more on this issue, see Maile Tauali'i's comments on page 40.

When data apply to American Indians and Alaska Natives but not to Hawaiians, we note this in the endnotes or in the text. We use the term “Hawaiian” to refer to the indigenous people of Hawaii.

When Native people arrive at the doctor's office, they come bearing the effects of discrimination and dispossession, which take a physical and mental toll. As a result, Native people in the United States bear an excess burden of disease, often dying younger and living sicker than members of other groups.

Yet, despite these tremendous health challenges, Native people often cannot get quality health care when they need it. They face barriers that range from lack of adequate health care facilities and funding to outright bias and deep mistrust of the medical system. It will take changes in U.S. federal policy to remove these obstacles to care and allow Native people to reclaim a tradition of health.

This storybook shares the experiences of Native people from Maine to Hawaii. It is divided into three parts. The first discusses the health status of Native people and the difficulties they have getting good, timely, and respectful care. The second part shares the stories and commentaries of Native people and other experts in Native health. The third part offers recommendations for the federal government, so it may support improvement of the health of Native people and move toward fulfilling its commitments, debts, and obligations to them.

THE STATE OF NATIVE HEALTH

"They made us many promises, more than I can remember,
but they kept only one; they promised to take our land, and they did."

RED CLOUD | 1822 - 1909

HEALTH CARE & THE RELATIONSHIP BETWEEN NATIVE PEOPLE AND THE UNITED STATES GOVERNMENT

Native people have unique relationships to the U.S. government, and these relationships are relevant to any discussion of the health of Native people.

DATA SHORTFALLS FOR AMERICAN INDIANS AND ALASKA NATIVES

Data also remains a problem for understanding the full extent of poor health and difficulties getting health care for American Indians and Alaska Natives.

Indian people and Alaska Natives frequently have been subject to incorrect racial classification in public health surveillance data. This can result in an undercount of the number affected by a particular health condition, leading to inadequate resources.²

THE FEDERAL RECOGNITION PROCESS AND "TERMINATION" OF NATIVE NATIONS

Through federal recognition, the United States and Indian nations establish government-to-government relations. Federal recognition includes acknowledgment of both the sovereignty of Native nations and the U.S. trust responsibility for matters such as health care.⁴

However, the federal recognition process is fraught with difficulties. It involves extremely strict standards that are often impossible to meet, and it can take decades to complete.⁵

Furthermore, in 1953 the federal government adopted a policy of unilaterally "terminating" its relationship with Native nations, motivated by a desire to end the trust relationship and force assimilation upon Native people.⁶

"Essentially, this was an abrogation of the Federal government's numerous commitments, in treaties, laws, and executive orders...to protect [the] interests [of indigenous people]," writes the National Council of Urban Indian Health. "The results of termination were devastating."⁷ Among the outcomes was the loss of health services, other support, and land, leading to the collapse of many nations.

INDIAN PEOPLE

In exchange for Indian nations' land, the United States government entered into treaties, issued court decisions, and passed legislation acknowledging a set of obligations to Indian nations. Among those obligations is the protection of the nations' sovereignty, remaining territory, and wellbeing. A responsibility for health care arises from this obligation. The Indian Health Service (IHS), a federal agency, was created as part of this trust relationship.³

INDIGENOUS PEOPLE OF ALASKA

The U.S. did not enter into treaties with Alaska Natives after acquiring Alaska from Russia in the 1860's, instead proposing to settle Alaska Natives' land claims through legislation a century later. However, the U.S. government acknowledges the sovereignty of Alaska Natives (though, like Indian nations, Alaska Natives must resist encroachment upon that sovereignty).⁸ Additionally, the U.S. government has recognized that it retains obligations toward Alaska Natives and includes them in the Indian Health Service system.⁹

HAWAIIANS

Hawaiians, too, have a unique relationship to the United States. In 1893, following decades of western colonization, the U.S. government facilitated the overthrow of the Hawaiian government, annexing Hawaii through legislation, rather than by treaty, five years later.¹⁰

In 1993, the U.S. government acknowledged the illegality of the overthrow, as well as Hawaiians' continued claim of sovereignty and land rights, and issued an apology.¹¹ The U.S. government also created a mechanism to fund Hawaiian health care systems.¹²

NATIVE PEOPLE SUFFER FROM POORER HEALTH

Native people bear more than their share of disease. Compared to most other groups, they suffer elevated rates of infant mortality¹⁴ and premature death from a major disease.¹⁵ They have the highest rates of diabetes in the country—almost twice the national average.¹⁶ They suffer from adult asthma attacks most frequently of all groups.¹⁷ And they are the most likely to report themselves in fair or poor health.¹⁸

It's not only physical illness that burdens Native people disproportionately. They also face alarmingly high rates of substance abuse¹⁹ and mental illness, such as psychological distress and hopelessness.²⁰ Depression is a major killer of Native people.²¹ And depression and physical illnesses like cardiovascular disease interact with one another, creating a cycle of worsening mental and physical health.²²



SUICIDE AMONG NATIVE YOUTH

In February 2009, the U.S. Senate Committee on Indian Affairs held a hearing on the alarming youth suicide rate in Indian country.

At the hearing, sixteen-year-old Dana Jetty described the death of her sister, Jami.¹³ “On November 3, 2008 I lost my sister and my best friend,” Ms. Jetty testified. “Suicide has left me feeling lost, lonely, and angry.”

“My mom did all the right things. She took [Jami] to the doctor, she talked to counselors, and she even had her evaluated by mental health professionals from Indian Health Service,” Ms. Jetty explained. “Those mental health providers dismissed my mom’s concerns and diagnosed my sister as being a ‘typical teenager.’”

Ms. Jetty urged Congress to support suicide prevention programs for Native youth. “It is not enough to put a counselor in a community,” she said. “We need trained professionals who really know how to help our communities.”

NATIVE PEOPLE, STRUCTURAL RACISM, AND THE SOCIAL DETERMINANTS OF HEALTH

"I can't tell you the number of highway accidents I've seen from overturned cars, because people didn't have the money to change their tires. It's just tragic. So many health problems arise from these kinds of socioeconomic conditions, from the lack of a safe place to live, from the lack of jobs that pay well, from living next to contaminated waste sites."

Dr. John Fogarty
Santa Fe, New Mexico

MIXED AFFILIATION AND HEALTH CARE

Many Native people have a background of mixed tribal affiliations that may not provide them with the amount of blood quantum from one tribe necessary for enrollment. Lack of enrollment can render that person ineligible for the Indian Health Service. Others may be members of tribe recognized in Canada or a terminated nation, also rendering them ineligible IHS services. Given the alarmingly high uninsured rates among Native people, these men and women often wind up completely shut out of the health care system.

The health disparities affecting Native people can not be explained as the result of individual choices or factors. Rather, they reflect the structural racism that often results in "conditions that are inadequate for living a healthy, dignified life."²³

Structural racism shapes the lives of Native people in a number of ways. Colonization radically altered Native communities, and federal policies into the modern era have been "aimed either at dismantling tribal governments and assimilating Native people or at paternalistically isolating tribes to misappropriate their assets."²⁴ As a result, Native people contend with a lack of economic opportunity, scarcity of nutritious food, environmental degradation, stress resulting from racial stratification, historical trauma, and cultural loss, and other inequities.²⁵

Such factors compromise the physical and mental wellbeing of Native people throughout their lives. These "social determinants" explain why Native people often have poorer health even before they see the doctor.

Diabetes illustrates this dynamic. The disease is especially prevalent among Native people. Not only do Native people suffer more frequently from diabetes; they also develop the disease younger and are more likely to die from it.²⁶ However, this has not always been the case. Native people have become more susceptible to the disease due to historic and current inequities they face.

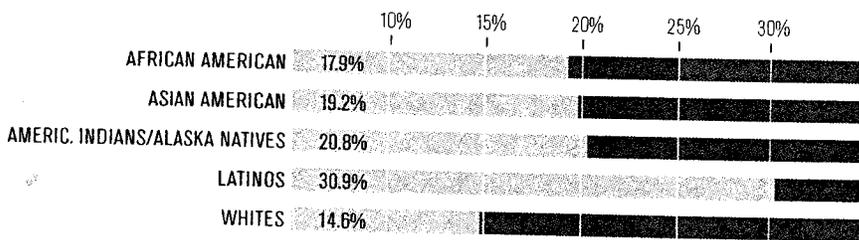
"There is a direct biochemical connection between living in poverty and the stress that people are under and blood sugar control,"²⁷ explains Dr. Donald Warne, Director of the Aberdeen Area Tribal Chairman's Health Board. (Researchers also have linked poverty to other biological processes, such as inflammation, associated with higher risk of cardiovascular disease and other chronic conditions.²⁸) Therefore, loss of land, traditional economies, and indigenous food systems, which kept Native people healthy for generations, also leaves Native people vulnerable to conditions like diabetes.²⁹

These outcomes are not accidental. They resulted from federal policies such as relocation, urbanization, and forced boarding schooling policies that dispossessed Native people and intentionally disrupted Native practices.^{30,31} Yet, though Native people carry an excess burden of disease as a result of such policies, they often must seek treatment from a health care system similarly characterized by racial inequity.

NATIVE PEOPLE GO WITHOUT NEEDED HEALTH CARE

Indian people and Alaska Natives do not receive all the health care they need. One fifth had no usual source of care in 2003-2004.³² They are the most likely of all reported groups to go without timely prenatal services.³³ And, from 1999 to 2003, they went without needed health care due to cost almost twice as frequently as did white people.³⁴

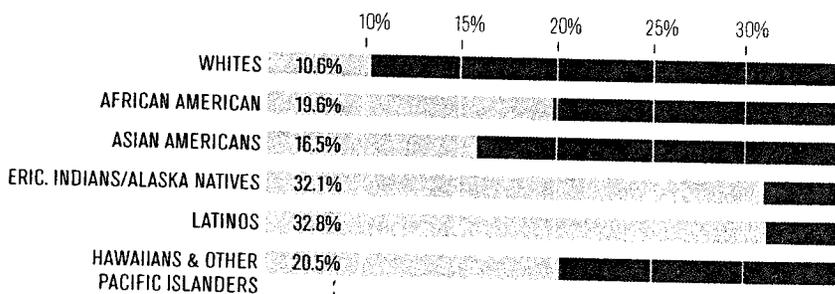
NO USUAL SOURCE OF HEALTH CARE: Adults 18-64 by Race, 2003-2004



Source: Kaiser Family Foundation, "Key Facts: Race, Ethnicity & Medical Care," January 2007. Figure 26, p. 22.

Little research or data is available on Hawaiians' access to the health care system, either in Hawaii or the continental U.S. Yet some data is available: Hawaiian women on O'ahu are less likely than others to see a doctor and more likely to have an emergency room visit.³⁵ They are less likely than white women to receive needed mental health or substance abuse treatment.³⁶ And Hawaiian women in Hawaii are more likely than others to go without early prenatal care.³⁷

UNINSURED RATES 2005-2007



Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," August 2008, Table 7, p. 23.

Though Native people have very high uninsured rates, this is not the only—or, in some cases, the primary—barrier to care for them.³⁸ A number of other obstacles exist, ranging from a poor or stressed health care infrastructure, to mistrust of the health care system, to lack of culturally competent care. The following sections address these obstacles.

"The doctors, nurses, and staff I've worked with in the Indian Health Service are some of the best and most dedicated anywhere, but they are working with so little. If the IHS were fully funded, I think it would be one of the best health care systems in the world. But after years of underfunding, the infrastructure is crumbling. We see the entire health care system collapsing beneath us.

Recently, the Santa Fe Indian Hospital, where I work, didn't have enough money to pay some of its contractors. As a result, we ran out of milk. We had sick children admitted to the hospital, and their parents had to go out and buy food for them. The hospital also has had trouble with the heating system, and we had elders with pneumonia bundling up under four or five blankets to stay warm. Our patients have been very kind and understanding — they know we're doing the best we can. But I think you have to ask, 'Is this supposed to be what health care in the United States of America looks like?'

Our patients often wait a minimum of three hours, but more typically five or six hours, to be seen. Many people just wind up leaving, even though there are few other options. One man — who was quite ill with undiagnosed hyperthyroidism — left the Santa Fe hospital to try the emergency room at the University of New Mexico in Albuquerque, where he waited thirteen hours and was never seen. He came back to Santa Fe the next day and waited four hours."

Dr. John Fogarty
Santa Fe, New Mexico