

## **MCH EPI Conference**

### **Plenary II: MCH in Indian Country - Partnerships to Identify and Address Health Disparities**

December 8 – 11, 2008

STACY A. BOHLEN: Okay, well, good afternoon. Oh, I wonder if that's loud enough. Good afternoon. Very happy to be here today. My name is Stacy Bohlen, I'm the Executive Director of the National Indian Health Board in Washington, D.C., and I'm a member of The Sault Ste. Marie Tribe of Chippewa Indians in the beautiful Upper Peninsula of Michigan where, as I was just talking to my father seconds ago, they just got two feet of snow, so it must be spring. I'm delighted to talk to you about some issues that are not really easy to talk about, but we're going to talk about them in a positive way and share our knowledge with each other today, and I look forward to the session later today to hear from you as well.

I wanted to start off just telling you about what -- who we are, what the National Indian Health Board is. It's a name that does not necessarily cross the boundaries of two worlds and make a lot of sense outside of Indian country, makes a lot of sense inside Indian country. But we are basically the national advocacy organization representing every American Indian and Alaska Native tribe in the country, villages and tribes. We were established in 1972, and as Dr. Thierry showed you earlier, the map of the United States and how it's

geographically divided with the tribes located by the IHS Map, that's how our governance structure works as well.

The tribes from each of those areas nominate a representative to our Board of Directors, and our board has 12 members, one from each one of those areas, and the areas each have an area Indian Health Board. That's the counterpart of the Indian Health Service or the Federal presence. And the Indian Health Boards represent the tribes. They're usually the consortium of the tribes in each of those areas. They find the consolidated voice, the unified voice of the tribes in those areas, and our board members bring that information to the national level. We have a symbiotic relationship to do advocacy and all of the things that we do from the grassroots up and back down. We advocate on behalf of all tribal governments and support all tribal governments in their efforts to provide quality healthcare for all Indian people.

And as Dr. Theirry alluded to, there's a lot more to the care, the healthcare of American Indians and Alaska Natives than just Indian health service. Some of the services that we provide are tribal consultation coordination and facility on health-related issues. How many of you here have heard the term tribal consultation before? Impressive. Well, for the six of you who haven't, tribal consultation is a requirement under Federal law. When the Federal government makes policy that will have an impact on the tribes, the government is supposed to consult with the tribes before making those policies. That doesn't always

happen. I could give you lots of examples of some of the frustrating experiences we have in that arena, but that's a whole other presentation that I'll restrain myself from going into.

We also provide advocacy services at the congressional administration levels. We do policy analysis research. We do a lot of communications. As you can imagine, it's very difficult to communicate with all the tribes in an effective way. It is very difficult for tribal information to reach the tribes. If we relied on the mainstream media, we would be invisible because we are invisible in the mainstream media. I often say that one of the greatest diseases Indian country suffers from is anonymity, because in this marketplace in this country, if you are not seen, you do not exist. And if you don't exist, that's not a problem, right? Well, our job is to make sure that the problems, loud, clear, out front and seen. And the tribes really rely on us to provide accurate, timely information to them about what's going on with their healthcare services and systems because they are usually not going to get that information anywhere else, especially on the national level. We do program managements. We do trainings, public health infrastructure and profession advancement.

This is very important as Dr. Thierry talked about and some of the slides that you saw in the slideshow that was running earlier. There are 35 percent of American Indian and Alaska Natives homes that don't have running water. That's an infrastructure issue. That's a public health issue. We work on those kinds of

issues on behalf of the tribes nationally and regionally. We provide technical assistance on just about every healthcare issue that you can think of. We also -- we put on national conferences, and the reason that I put this in here, we are a national 501(c)(3) not-for-profit tribal organization, and of course, we put on national conferences.

But in keeping with the goals of this meeting and the wonderful opportunities that exist because of the people who are here, we wanted to make sure you knew about our public health summit. We had our first public health summit last year, in Green Bay, Wisconsin. It was a huge success. And what that first maiden voyage was about was breaking down silos. We were meeting with some of the panelists, we were talking to each other before we came up here, and I don't remember what the topic was, something that had been -- oh, it was school-based healthcare. And one of the panelist said, "I just went to a meeting on that last week, I didn't know this other meeting existed."

A lot of times, in Indian country, what will happen is you'll have a tribe like the Tohono O'odham Nation in Arizona doing a phenomenal job on diabetes education and prevention. They are on the Mexican border. They have 50 to 60 miles of border with Mexico. This is a remote place. Where I'm from in the Upper Peninsula of Michigan, we're not hearing about what's happening at Tohono O'odham everyday of our lives, but if we have a diabetes problem and we need

help, we need to know who's doing it right. We don't have 15 years to reinvent the wheel. Lives are lost in that amount of time.

So this public health summit was devoted to breaking those silos down so that people like my tribe would know where the excellent programs are and who's doing what, smoking cessation -- cessation -- sensation, that's a (inaudible) slip, I quit smoking 49 days ago. Oh man, I did say sensation, well, I think we all know what that was about. Okay, so that's what the last public health summit was about. The public health summit this year is tribal state relations. There are phenomenal opportunities for the tribes and the states to work together on public health issues, their necessary opportunities. And I'm anxious to talk about this this afternoon when we have our session later on today, but I want to invite you to be in communication with us and help us with this conference, help us build those bridges, help us show the tribes where this is working or show us what could be that we are not seeing, show us what doesn't work for the states, show us where you have an idea of something that could be really great, whether it's maternal and child health or crisis intervention, emergency preparedness, jurisdictional issues.

There are so many opportunities in public health for us to work together, and this public health summit is the first time that we're looking at this in a national way. And all of our advisory committees, the tribal leaders who advised the Federal government on a variety of issues, talk about this as one of their number one

issues because we're just not where we want to be. It can be so much better than it is. In some places, it's going great. In other places, there are just opportunities that need to be taken to the next level and we can do that together.

So, Audrey Solimon is here with me today. She is one of our program directors at the National Indian Health Board. I've put her contact information down against her will, so please be free to contact Audrey. She's one of our public health professionals, and she'll be one of the point people in putting this conference together.

I'm gonna start going a little bit faster. This just gives you more idea of what the National Indian Health Board is. This is a list of our staff, and this is available. We'll be happy to provide this slideshow to you. We're all listed on our Web site. And these are current openings that we have at the National Indian Health Board. Three years ago, almost to the day, I was the only employee of the National Indian Health Board. So, this is how many employees we have today and the areas that they're working on. Our organization came from Denver, moved to Washington, D.C.. And we just moved into a building that we are calling our permanent home. We don't own it. We have wonderful landlords, though, and it's affordable, so we hope we'll be there a while. It's right on Capitol Hill. And this is part of our growth. We have five very good positions open and we'll try to get these up on your job board out there -- great idea, we're totally stealing that. And if anybody is interested, please do apply, [jobs@nihb.org](mailto:jobs@nihb.org).

Basically, we try to make it easy enough for me to remember, so please think about that.

The most basic human right must be the right to enjoy decent health. Certainly, any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians. This was part of the House report when the Indian Healthcare Improvement Act was passed in 1976. The Indian Healthcare Improvement Act is a piece of law that is the structure and the operating authority for the entire Indian health services and for the entire Indian healthcare delivery system from the Federal level.

And I'm gonna move now very quickly into the legal foundations of American Indian healthcare. Okay, we talk -- these are our current programs. All right, we talk about Federal trust responsibility. One of the things that is very complicated for people to sort of get a hold of is that in America we have many ethnic groups. We have African American, Jamaican American, non-white Hispanics, the whole gamut of races in this country. But American Indians are not a racial classification; American Indians are political. We're the only political classification of people in the United States, and we're the only class of people in the United States for whom healthcare is guaranteed in the Constitution of the United States. That's where the trust responsibility comes from.

We have a lot of case law, treaties, and as I said, the constitution that formed the legal basis and foundation of American Indian healthcare and the relationship between the United States government and Indians in terms of healthcare, yet you will find it interesting to know that despite all of this, healthcare for American Indians is not an entitlement. We have to go every year and fight for the appropriations to have Indian healthcare funded even though we're in the constitution. It's kind of interesting. We've already -- oh, this is from President Nixon -- there exist a special relationship between the Federal government and American Indians resulting from the solemn obligations which have been entered into by the U.S. government written in the form of treaties and informal agreements.

One of the seminal cases that created, affirmed the relationship between the U.S. government and Indians was in 1832 when Supreme Court Justice John Marshall described Indian nations as domestically dependent nations. Justice Marshall described the relationship between tribes and the U.S. government as a trust, much as you would have a relationship of a ward to their guardian. It's a special relationship based in the constitution and, as I have stated, reconfirmed by treaties and Federal statutes. This trust requires the government to protect tribal lands, assets, resources, treaty rights, healthcare, and there are other obligations, but healthcare is what we're interested in today.

And of course, when we talk about healthcare in this country for Indian people, we believe we have the first prepaid health plan in the world, because our people paid for this health plan with 400 million acres of land, blood, lives, culture, and a future. They traded everything that they had under -- with a knife to their throat and a gun to their head. And despite these circumstances and despite the circumstances of being removed from your village, your culture, put into a reservation or a fort against your will, freezing to death, starving to death, despite these circumstances, our people recognized even when there was nothing they could hope to retain that we would need healthcare. Of all the things they could have said and foreseen and envisioned for our future, they knew we were gonna need healthcare. And it's demonstrated in the treaties.

There's almost 400 treaties that have been written between the United States government and Indian tribes. Many of them -- most of them expressly mention healthcare. I'm going to give you few examples. Winnebago Tribe treaty that was signed in 1832, this one deals specifically with a physician to be provided at Prairie du Chien and one at Fort Winnebago, you can see \$200 a year, and you thought capitation was bad. The treaty with the Ottawa, this talks about physicians who can help the Indians while their on the reservation, which, of course, is forever. The treaty with the Oto and Missouri and this talks about, again, medical purposes among other purposes. This one, we included because we wanted to show you that it talks about vaccination services of a physician. This was one of my tribes, part of my nation. This is a Rouge River Treaty. Again

-- and this goes into the buildings where the medicine will have to be provided, hospitals, medicines, and a physician.

You can see the sophistication level increasing as time moves forward because the people, native people from the east were able to share the information as encroachment moved west and the treaties were -- became stronger and the language became more inclusive. This one, of course, is from the Pacific Northwest area that talks about a physician advice, taking care of the sick, vaccination, medical attendance that it's all to be defrayed by the United States government and not deducted from annuities. That's critical because that demonstrates that healthcare is a separate, sacred need that, sure, we know that we have you in a place where you can't hunt fish, you can't do any of the things you used to do to take care of yourself, so we're gonna give you some commodities, but we're not gonna make you pay for your healthcare out of those commodities because, clearly, healthcare is a separate matter.

Each one of these example just gives a little bit of a different picture to make the whole. This one talks about hospitals and buildings, that they would also take care of upkeep and repair, the services of one physician. The Supreme Court rules on treaty construction interpretation -- treaties are to be construed in the manner most just and favorable to Indian tribes. That's a Supreme Court ruling. If there is to be an interpretation, it's to be in favor of Indian people because we're the weak party who already paid for the agreement. Treaty language is to be

understood in the sense in which the Indians would have understood it. So, you can imagine, as I set this portion of this discussion forward where our people's minds were and what they were experiencing, that's the mindset one would have to enter to look at that treaty and read it as we would have read it then, under duress and under those circumstances.

Then the transfers of responsibility for Indian healthcare happened. There was an office of Indian affairs that was located within the War Department. Yeah, I'm not gonna say anything. Then, we move to the Department of Interior, and that office eventually became known as the Bureau of Indian Affairs, which BIA, we all have heard of that, of course. And 1955, the Indian Health Service was born and moved our healthcare within Health and Human Services, which is a very good thing. This is a piece of law that is the very, very foundation of Indian healthcare. I would say that it is even more a powerful a law than the Indian Healthcare Improvement Act. The Snyder Act of 1921, this is the first time that Congress formulated broad Indian health policy. And they were -- Congress was very clear. This is when we were still on the Bureau of Indian Affairs, when our healthcare was still in the bureau. Congress said that they direct, supervise, and expend such moneys as Congress may, from time to time, appropriate for the benefit, care, and assistance of the Indians for relief of distress and conservation of health. So, even though the Indian Healthcare Improvement Act has not been reauthorized for 16 years, shame, the Snyder Act, we can still stand on and the

authorities of the very outdated Indian Healthcare Improvement Act remained because the Snyder Act allows appropriations to still move forward.

I know that I'm beyond my time, you talked about the slide. I'm gonna talk about a couple more things quick. There are lots of people here who have very important things to tell you, so I'm gonna cut mine a little bit. One of the areas that the National Indian Health Board works on, Indian Health Service obviously works on and which, for me personally, is a foundational reason of why I left the mainstream professional world and did what I invite all of you to do, do twice the work at half the pay, is because of this issue. I went into my husband's office, he's at the American Academy of Orthopedic Surgeons. I tried to recruit every one of his staff. They did not fall for it, half the pay and twice the work, but I was being honest. Anyway, this young woman is a victim of what we call shortfalls in contract support costs.

In mainstream America, if you have to see a specialist for any reason, an oncologist, orthopedic surgeon, whatever the case may be, that's something you don't think twice about, you just go see a specialist. You'll probably pay a higher co-pay or, if you go out-of-service, you do a fee-for-service and that's a choice that we all make. But this young woman didn't have a choice like that. She was deemed to have a non-life-threatening illness and she had a diagnosis. They were diagnosing her with depression because she was tired and they kept saying, "Well, it's depression, it's depression." Well, it wasn't depression; it was

cancer. And this little girl died because she did not get the proper healthcare that she needed. And this is not the most unusual event that happens in Indian country. We have a very high rate of amputations for diabetes patients, although that's improving, because when we want to get specialty care, we have to have that service contracted by our tribe. Our tribe has to go out and find somebody who will take care of us, make a contract with them with IHS, and say, "Well, we're going to send -- we can only afford to send three orthopedic cases to you this year." There are 33,000 people in my tribe. You think there's gonna be more than three orthopedic cases in a year, and the rest have to wait until it's a matter of life and limb?

In the State of Montana, the time that an average American Indian waits between having an orthopedic injury \*entails 12 years. That's contract support cost. That's, to me, where the rubber meets the road. That tells a lot of the story and a lot of the problem, and all of the other things I was gonna talk about, the presidential election, the new Congress, the new administration. You know, in the end, what it comes down to is, is it okay to live in a country where that happens? Is that okay? People talk about Canada and, "Oh, my gosh, it's rationing of healthcare." Look in our backyard right here. We have rationing of healthcare that is costing people their lives, and it's not okay, and we're not invisible. I wonder if Dr. Seuss, when he wrote Horton Hears a Who!, wasn't thinking of us. We are here. Thank you very much.