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Beyond Red Lake — The Persistent Crisis in American Indian Health Care

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On March 21, 2005, at the high school on the Red Lake Indian reservation in Minnesota, a troubled American Indian teenager went on a shooting rampage, killing nine people before turning the gun on himself. Most of the news reports highlighted his past, including a history of depression and suicide attempts, and the daunting socioeconomic conditions in his reservation community. Reporters mentioned high rates of poverty, alcoholism, unemployment, and violence among young people as possible factors in the tragedy. Although similar events have occurred in wealthier communities — the shootings at Columbine High School in Littleton, Colorado, leap to mind — this calamity seems to have reminded our country that many American Indian and Alaska Native communities face deep-rooted challenges every day and continue to be affected by significant socioeconomic and health disparities.

An American Indian physician, I spent three years in the 1990s working in an Indian Health Service hospital in rural Arizona and witnessed the harsh realities of life on an Indian reservation. Having spent 11 years in Boston

for my education and training, I felt I was embarking on a great adventure as I drove the desolate stretch of highway that led to the reservation. As I entered it, however, I noticed a change in scenery. Scattered along the road were small houses in various states of disrepair, often with litter and beer cans scattered about the high desert landscape around them. Even some of the newer homes had wooden outhouses close by, and small children played in a yard full of trash and abandoned cars. Some of these houses, no larger than 500 square feet at best, had at least six cars parked in front of them, and as I later discovered, many housed more than one family.

As I drove into the center of town, I found that the main street was only about three blocks long. The town center was framed by the elementary school, the hospital, a small café, a grocery store, tribal offices, and an abandoned gas station. I breathed a sigh of relief when I arrived at the hospital and spotted the government-owned houses for hospital staff across the street — in much better

condition than the homes I had passed on my way into town. Driving into this community, I was reminded of my family's visits to my grandmother on an Indian reservation in South Dakota, but the poor living conditions had not been as striking to a child as they were to a physician.

During a brief orientation, my supervisor described the community of approximately 10,000 people and the challenges it faced. The unemployment rate hovered around 80 percent, and alcoholism, substance abuse, injuries, accidents, and violence were common. National statistics show persistent disparities in socioeconomic conditions between the people who live on most Indian

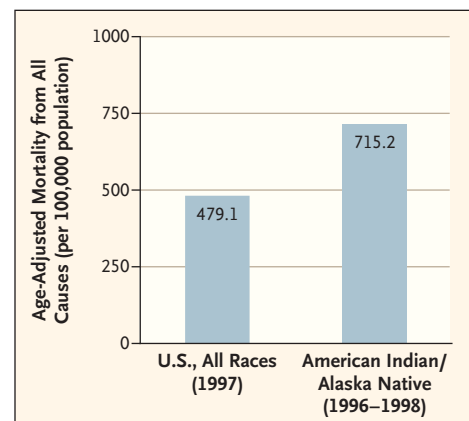


Figure 1. Disparities in Mortality Rates.

Data are from *Trends in Indian Health, 2000-2001*.¹

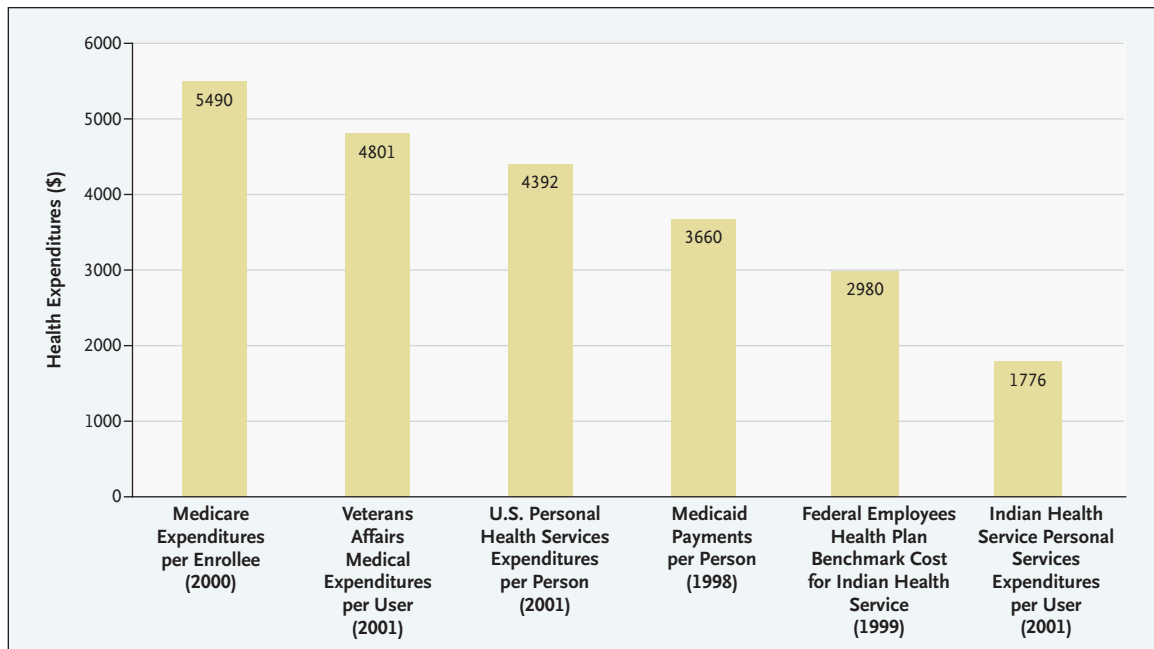


Figure 2. Health Care Expenditures.

Data are from the Indian Health Service.⁵

reservations and the U.S. population at large, with higher rates of unemployment, lower median incomes, lower educational levels, and higher rates of poverty.¹ For most American Indians, relocation to rural reservations in the 1800s resulted in a loss of culture, traditions, and familiar ways of life and left them isolated in places that were far removed from the resources available in urban areas. Years of poor educational systems and lack of opportunity have resulted in seriously depressed socioeconomic conditions on most reservations.

The outdated, understaffed hospital in this community had only four beds, a busy outpatient clinic with five working exam rooms, and a small emergency room with four stations. A few run-down trailers held addition-

al clinics and services. A sign on the door of the emergency room cautioned patients not to bring firearms into the facility — a constant reminder of perennial violence and trauma. After the vast, shiny university teaching hospital in which I had most recently worked, this facility came as quite a shock.

Part of my job was to help cover the emergency room. Although the hospital was built to be staffed by 12 physicians, only 3 others worked there when I arrived. During every emergency room shift, I cared for adults and children with broken bones from unintentional injuries and car accidents, attended to patients in various stages of alcohol or drug intoxication, and treated the unfortunate and often preventable complications of chronic disease.

In particular, American Indians and Alaska Natives are experiencing an epidemic of diabetes, with a prevalence two to three times that among non-Hispanic whites in the United States.² In some Indian communities, more than half of all adults have diabetes,³ and without access to high-quality medical care, the ability to obtain or prepare healthful food, and the money to buy shoes that fit, many patients end up in the clinic or emergency room with infections, strokes, and heart attacks. The lack of fresh vegetables and healthy choices at the local grocery store means that most families live on high-fat foods such as fried bread, Indian tacos, and junk food. Physicians were often frustrated by patients' noncompliance with medication, but I found that the reason for it was usually a

misunderstanding or a lack of information, alcohol or substance abuse, or the need to work or care for others, rather than a lack of caring. Talking with patients about their living situation often helped more than handing them a bottle of pills.

Some people came to the emergency room for the sole purpose of requesting an over-the-counter medication such as Tylenol because they could not afford to buy it. But many came with more serious — and theoretically preventable — problems. I hated to hear the voices of the emergency medical technicians blast over the radio system, because they were usually warning us of their imminent arrival with yet another victim of an alcohol-related accident. Alcohol-related death rates are 7.4 times as high among American Indians and Alaska Natives as in the overall U.S. population,¹ and alcoholism continues to be a substantial health and social problem on reservations.

Not all my experiences in this small Indian community were so gloomy. I made friends among the hospital employees, and some gracious community members invited me to their homes for family events. Many tribal members, despite their difficult circumstances, worked hard at their jobs or planned to further their education. As in any community, many parents did everything they could to create a better life for their children. Still, I worried about the children I saw in the clinic: they had to grow up so quickly in order to help their families survive daily hardship and were always at risk of succumbing to peer pressure to use alcohol or drugs or to join gangs.

Young Indians are more likely to die as the result of homicide, suicide, or accidents than are other young people in the United States, and they have higher death rates from alcoholism and substance abuse.⁴ I hoped that the children would see me in the clinic wearing my starched white coat and realize that it is possible for an American Indian to become a physician.

Some Americans purport to believe that the problems of American Indians have been solved by economic enterprises such as casinos. But the enormous successes of a few tribal casinos in the Northeast are far from the norm. The bright lights and ringing bells in most casinos do no more than divert attention from the continued challenges and hardships faced by Indian communities each day. And far too little has changed since I worked in that community 10 years ago.

Although the federal government has a trust responsibility to provide health care for American Indians and Alaska Natives, the Indian Health Service is substantially underfunded and understaffed. This service was established in 1955 to provide primary care and public health services on or near Indian reservations. Although it can take credit for great improvements in health status, significant disparities in health and the quality of care persist 50 years later (see Figure 1). Many factors contribute to these disparities, but the failure of the federal government to adequately fund the Indian Health Service for the provision of care to the 1.8 million patients it is supposed to serve means that

the promises of treaties signed in the 1800s have never been fulfilled. Indian Health Service per capita health care expenditures are much lower than those of other health care systems in the United States (see Figure 2).

I left that community after three years, the last two of them as the medical director. During my stay, I tried to improve the quality of health care by implementing changes in the clinic structure and hiring well-qualified physicians. My efforts, however, were constantly thwarted by obstacles to good health that extended far beyond the hospital — problems whose roots lie in the high rates of poverty, unemployment, alcoholism, and other ongoing public health crises. I hope, at least, that the tragedy in Red Lake serves as a wake-up call to the federal government and health professionals about the pressing need for more resources to address the persistent crisis in health care for American Indians and Alaska Natives.

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