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## **The State of Indigenous America Series**

### **Ten Indian Health Policy Challenges for the New Administration in 2009**

*Donald Warne*

**T**he new administration that took office in January 2009 faces numerous challenges in the area of American Indian health. Media reports have recently shined a spotlight on disparate life expectancy rates in the United States based on race, ethnicity, culture, and income. Unfortunately, American Indians suffer among the worst health disparities in the nation with alarming gaps in life expectancy. Death rates from preventable causes such as diabetes and alcoholism are dramatically higher in American Indians than in the rest of the population. Nearly a third of our people live in poverty as compared to approximately 12 percent of the rest of the country. In Arizona, the average age at death is 72.2 years for the general population, but it is 54.7 years for American Indians.

Despite this gross inequality, American Indians are the only population born with a legal right to health care in this country. The treaties between the tribal nations and the federal government in which the tribes exchanged vast amounts of land and natural resources resulted in guarantees for social services including housing, education, and health care. The Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS) were established to administer the federal government's trust responsibility to provide health care and other vital services to American Indians.

At the same time we have an underfunded health system, other policies such as the damming of rivers and the loss of land and resources have led to significant lifestyle changes. Less physical activity, less

access to healthy food, and less freedom combine with discrimination to worsen health disparities.

The solutions to American Indian health disparities are in the policy-making arena. Social policies, such as the federal trust responsibility to provide health care to American Indians, have a much greater impact on health outcomes than genetics or other physical causes of disease. The new administration is in a position to change the direction of Indian health policy, and it has the opportunity to focus on policy decisions that can have a significant impact on improving Indian health status and outcomes. There are multiple areas of Indian health in need of improvement. This article is organized into ten policy areas on which the new administration must focus to improve Indian health.

### 1. HEALTH DISPARITIES

Considerable health disparities exist between the American Indian (AI) and the general U.S. populations. The roots of health disparities for AI people are multifaceted: low incomes, inadequate housing, substandard educational systems, underfunded reservation schools without physical education programs or healthy food programs, poor nutrition, and cultural factors. These factors coupled with a severely underfunded health care system have led to decreased access to health care services and to the highest incidence of preventable diseases in the country. As mentioned, in the state of Arizona, the average age at death is 72.2 years for the general population, but only 54.7 years for AIs.<sup>1</sup>

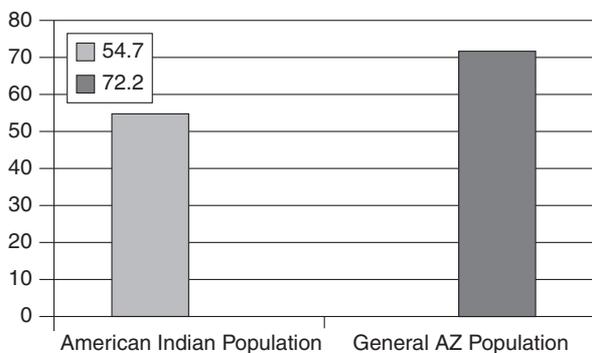


Figure 1. Average age at death in Arizona.

Preventable diseases impact AI populations at a far greater rate than the rest of Americans. Death rates from preventable diseases among AIs are significantly greater than among non-Indians, including diabetes (249 percent greater), alcoholism (627 percent greater), accidents (204 percent greater), and suicide (72 percent greater).<sup>2</sup> In the

Phoenix-area IHS, encompassing most of Arizona as well as Utah and Nevada, the rates of death due to diabetes and alcoholism are even worse than in the rest of the IHS.

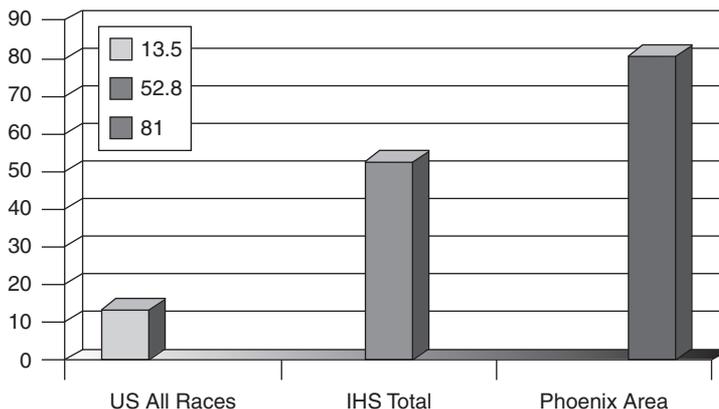


Figure 2. Diabetes death rates (deaths per 100,000 population).

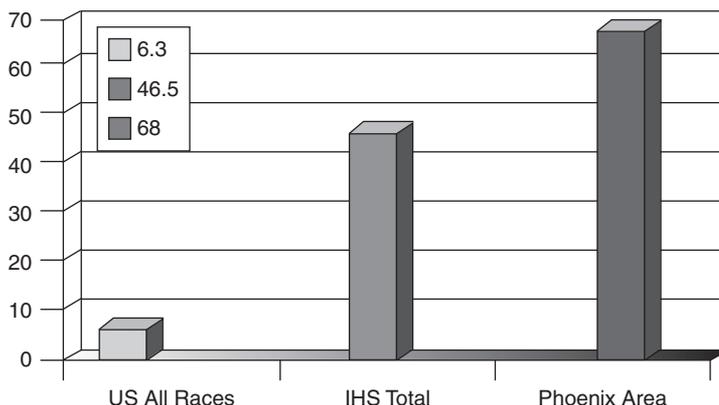


Figure 3. Alcohol-related death rates (deaths per 100,000 population).

High rates of diabetes, subsequent depression, and alcoholism create a significant need for effective behavioral health programs and interventions. At the same time, the policy framework for attacking this inequity is quite complex, and the level of care provided to AI communities is lower, in terms of per capita funding and provision of services, compared to other groups in the United States.

The new administration faces the challenge of continuing to address these health disparities. Funding for programs such as the Special Diabetes Program for Indians (SDPI) must be continued and expanded. Such programs allow for increased local control, management, and priority setting and are best designed to meet the unique cultural and medical needs of tribal communities. The new administration should consider expansion

of special health disparities programs under this model. For example, the IHS could consider developing a Special Cancer Program for Indians (SCPI) to address the significant disparities in cancer prevention, screening, and treatment faced by many AI communities. In addition, special research programs need to be developed and expanded to adequately address health disparities in AI populations.

## 2. FUNDING DISPARITIES

In the 2005 federal budget, per capita expenditures for IHS were \$2,130, a fraction of the federal funding for other health care programs such as Medicare (\$7,631), Veterans Administration (\$5,234), and Medicaid (\$5,010). Even the Bureau of Prisons allocation is higher than IHS (\$3,985).

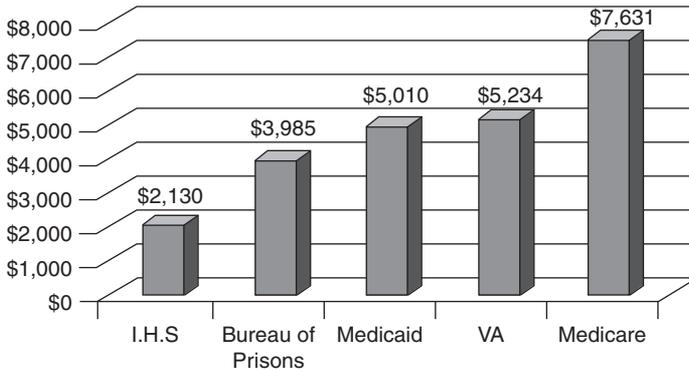


Figure 4. American Indian health care resource disparities.

So what would it take to fix the funding shortfalls in the IHS budget? The number of American Indians actively using IHS services is about 1.5 million, and clinical services for the IHS are funded at approximately \$3 billion per year. Several studies have shown that the IHS is funded at approximately 60 percent of need. Therefore, to bring the IHS up to level of need funding would require an additional \$2 billion. The budget for the Department of Health and Human Services, in which IHS is an agency, is approximately \$700 billion.

Relative to the rest of the budget, \$2 billion is a small investment for the federal government to fulfill its trust responsibility in Indian health. It is remarkable that we can spend \$150 billion relatively quickly to send people \$600 checks to stimulate the economy, or that we spend about \$2 billion per week on the war in Iraq, but we cannot fulfill our trust responsibility as a nation and honor our treaties with the country's first inhabitants with an additional \$2 billion annually for IHS.

Tribal casinos have been warged as an argument against additional funding. First of all, most tribes do not have casinos, and most tribal casinos

are not making significant profits. Most tribes and reservations are located in rural areas and do not have a population base to support gaming. People who live in urban settings (e.g., Southern California) have a skewed perspective on Indian gaming because the population base can support large, successful casinos. Second, successful tribal economic development does not absolve federal trust responsibility to provide health care to American Indians.

Another argument is that the successful casinos should fund the other tribes. This viewpoint advocates for socialism, and until the rest of the nation is willing to socialize medicine and other services, tribes should not be held to a higher standard. Each tribe is a sovereign entity, and it is not the tribes' responsibility to provide health care to each other—it is the federal government's responsibility.

### 3. THIRD-PARTY REVENUE

The resource disparities chart demonstrates significant underfunding of the IHS. However, as American Indians, we are eligible for other health care funding programs such as Medicaid and Medicare. In addition, the AI population has a significant number of veterans who are eligible for VA services, and we have increasing numbers of employed tribal members who have access to private sector health insurance. By far the most significant source of third-party revenue is Medicaid. Although Medicare is the larger national program that is designed to provide health care resources to the elderly and disabled, Medicaid is more significant in the AI population due to high rates of poverty.

Therefore, health care and health policy issues are not the only areas in which disparities exist. For example, high school graduation rates among American Indians is 65 percent compared to 75 percent in the general U.S. population; 32 percent of the AI population lives

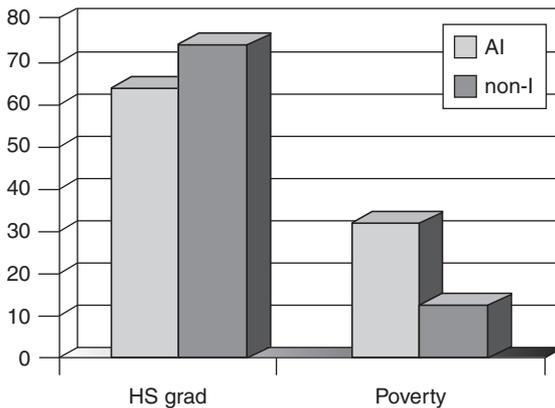


Figure 5. American Indian socioeconomics: percent high school graduation and poverty.

below the federal poverty level as compared to 13 percent among non-Indians.<sup>3</sup> Health status and outcomes are highly correlated to education and income,<sup>4</sup> however, making these socioeconomic markers significant factors in AI public health, and health care is among the top issues of concern to AI communities.

Disparities in high school graduation rates have resulted in continued disparities in the numbers of AI college graduates and subsequent AI health care professionals. Limitations in personal income also have resulted in limited means to purchase additional health care services, health promotion and disease prevention services, behavioral health interventions, and subsequent dependence on other public assistance programs such as Medicaid.

Unfortunately, third-party billing and collections have been historically inadequate in most IHS and tribal facilities. The role of the interaction among IHS-Medicaid, Medicare, and other third-party revenue sources in the business management of Indian health programs cannot be overstated. Because the funding coming to IHS and tribal facilities is from federal sources, tribes and tribal organizations should consider collections from Medicaid and Medicare as part of the federal government's fulfillment of the trust responsibility to provide health care services.

An emerging issue in third-party billing is the role for tribal self-insurance programs as part of tribal economic development and employment programs. Currently, IHS does not bill tribal self-insurance programs due to the trust responsibility on the part of the federal government to pay for health care services. However, tribal health systems can coordinate with their own self-insurance programs and can participate in their own managed care systems. Many tribes have chosen not to bill their own self-insured programs for health services primarily due to the federal trust issue. In this scenario, however, the tribal members and the tribal economic enterprises are paying into health insurance programs, and the resources are not being reinvested back into the local health system. The result is that health and resource inequities persist, and primarily non-Indian-owned benefits management entities and health insurance companies are collecting and keeping health insurance premiums. The new administration and tribal leadership, along with IHS, need to address the role for tribal self-insurance programs as part of the solution to improving resource inequities.

#### **4. CONTRACT HEALTH SERVICES**

Due to significant underfunding, many specialty care services are not available in IHS and tribal programs. In this setting, IHS and tribes utilize Contract Health Services (CHS) to purchase services from the

private sector. In this way, IHS acts more like an insurance company that purchases health care services through contracts with private sector providers as opposed to a direct provider of services. Unfortunately, due to underfunding, the CHS budget for most service units cannot keep up with demand for services, resulting in rationing of health care services and dire "life or limb" requirements for access to services toward the end of the fiscal year.

Another issue with CHS is the requirement that the patient is only eligible for CHS funds if he lives within his contract health services delivery area (CHSDA). For example, if a Lakota person lives in Phoenix, he is not eligible for CHS. In order to be eligible, that individual would need to move back to the Aberdeen area of the IHS and reestablish residency in order to have access to specialty care through CHS. It is not unusual that this process could take up to six months, and in the interim, the health issue can worsen and result in significant morbidity, disability, and death. The CHSDA requirement is a result of underfunded systems, but it is also a civil rights issue in that the federal government is essentially telling American Indians that they are only eligible for these services if they "live where they belong." The new administration needs to work with AI health policy experts and with tribal leaders to reexamine the CHS and CHSDA systems of care, to expedite needed health care services and to promote health and treat disease earlier in the diagnosis.

## **5. FACILITIES CONSTRUCTION**

It is estimated that the average age of an IHS facility is over thirty-five years, and that the average age of private sector facilities is nine years. The previous administration placed significant cuts on the IHS facilities design and construction budgets resulting in worsening facilities and inadequate mechanisms to address AI health disparities. The new administration needs to recognize that the dilapidated condition of multiple IHS facilities is unacceptable, and resources are absolutely needed to design and construct appropriate health care facilities.

## **6. SELF-DETERMINATION CONTRACTING AND CONTRACT SUPPORT COSTS**

Perhaps the most significant law affecting the provision of health services to the AI population is the Indian Self-Determination and Education Assistance Act of 1975 (PL 93-638), which allows tribes to assume control of health care programs from IHS and to increase flexibility in health care program development. Under PL 93-638, tribes have the option to contract or compact with the IHS to deliver health services using preexisting IHS resources (a formula-based shares table

determines funding for various IHS sites), third-party reimbursement, grants, and other sources. Typically, tribes develop their own nonprofit health care corporations to provide services to their community, and as a result are eligible for grants and other types of funding not available to federal agencies such as IHS.

As a result, "638 tribes" generally are able to provide more services in their communities than they were able to under IHS control due to increased revenue. Currently, one-half the IHS budget goes to "638 programs," providing numerous tribes with improved access to health care services and allowing increased flexibility of health programming for their communities.

In addition to increased local control and flexibility, the IHS is required to provide contract support costs to the tribes, which are essentially funds for administration of the "638 contract." Unfortunately, funding for contract support costs has not been increased to keep up with the demand as more tribes have exercised their rights to manage their own health systems under self-determination law. The new administration needs to recognize that contract support costs are a part of self-determination law, and thus include additional and appropriate funding in the budget line item for these costs. Tribes that have entered into self-determination contracts under the previous administration have had to manage their self-determination contracts without contract support costs. The Supreme Court ruled 9–0 in favor of the tribes in 2005 and required that the IHS provide funding for these costs. The Congress and the previous administration have failed to provide these resources, and the new administration must recognize its obligation to the tribes under self-determination law and increase resources.

## **7. ISSUES IN URBAN INDIAN HEALTH**

More than 60 percent of American Indians live in urban settings. The trend toward urban settings and away from reservations is rooted in a series of federal policies geared toward integration and assimilation. In the 1930s and 1950s, the federal government offered incentives for American Indians to move to cities, to find employment, and to "assimilate" into mainstream American culture. Many cities were intended to be welcoming locations for the AI population to integrate. Unfortunately, discrimination and other factors led to continued high rates of unemployment for the urban Indian population.

Currently, many American Indians move to the cities for educational and employment opportunities. When individuals move from the reservation into the city, they do not give up their right to health care services from the federal government. In 1976, as part of the Indian Health Care Improvement Act, a funding mechanism (Title V of IH CIA) was developed to establish Urban Indian Health Centers (UIHCs).

Although over 60 percent of the AI population live in urban settings, UIHCs receive only about 1 percent of the IHS budget. As a result, health care services, including pediatric care, have been limited in the urban AI population.

The previous administration tried several times to completely eliminate funding for the UIHCs. The new administration needs to recognize that American Indians do not give up their right to health care when they move to the cities, and the underfunding of the urban programs is adding to health disparities. The UIHCs need additional resources to continue to appropriately fulfill their mission as a health provider and health advocate for the majority of American Indians.

### **8. HEALTH PROFESSIONS SHORTAGES, EDUCATION, AND SCHOLARSHIPS**

Unfortunately, there is a shortage of minority, and specifically American Indian/Alaska Natives (AI/AN), health professionals and researchers. Whereas African Americans, Hispanics/Latinos, and AI/ANs together represent more than 25 percent of the U.S. population, they comprise less than 9 percent of nurses, 6 percent of physicians, and 5 percent of dentists. Of the more than 16,000 new students who entered medical school in 2003, only 2,179 were African American, Hispanic/Latino, or American Indian. The IHS estimates an overall 12 percent shortage in health professions, with a nearly 30 percent shortage in dentistry. Meanwhile, by the middle of this century, the U.S. population could be more than 50 percent nonwhite. The Sullivan Commission final report released in September 2004 brought to the fore a serious issue related to health care for minority populations: As fewer and fewer minorities become doctors, nurses, and dentists, the quality and availability of health care services for minorities will continue to suffer. Table 1 shows disparities in the numbers of health professionals for the AI/AN population.

<b>Table 1. Disparities in the numbers of health professionals for AI/AN population</b>			
	<b>AI/AN</b>	<b>US</b>	<b>Gap</b>
MDs	73.9	220.6	66% lower
DDSs	24.0	61.8	61% lower
RNs	229.0	849.9	73% lower
RPh	42.8	71.3	40% lower

MDs—Medical Doctors, DDSs—Dentists, RNs—Registered Nurses, RPh—Registered Pharmacists

Exacerbating the shortage of qualified health care professionals is the difficulty on the part of federal, tribal, and urban Indian health programs in recruiting and retaining health professionals in a competitive hiring market. Most Indian health facilities are located in isolated rural areas on or near reservations, making them extremely difficult to staff.<sup>5</sup> Increasing the number of AI/ANs serving their communities as health professionals and researchers has the potential to improve cultural appropriateness of care and research, and to decrease shortages of providers in remote communities. Ultimately, there is an opportunity to significantly reduce health disparities through expanding educational opportunities. Clearly, educating more AI/ANs in health sciences and research needs to be a national priority.

Adding to the problem in recent years have been the significant funding cuts in several key health professions education programs. These include federal, private, and tribal programs.

### **Federal Programs**

- Indian Health Service—Indian Health Care Improvement Act (Title I, PL 94-437). Funding has remained level since 2000, because the IHCA has not yet been reauthorized although it was due for reauthorization at the beginning of the Bush administration. The result is that as tuition and other costs rise for health professions education, the number of scholarships available to AI students has decreased.
- Health Resources and Services Administration (HRSA)—The Health Careers Opportunity Program (HCOP) and the Centers of Excellence (COE), funded by Title VII Public Health Services Act. The HRSA functioned to increase the number of underrepresented minority students into the health professions, and was eliminated in September 2006. Nearly 0.5 million minority students have participated in these programs (including the author). A 2006 survey conducted by the Association of American Medical Colleges showed that elimination of Title VII funding for these programs would result in complete closure of 83 percent of the HCOP and COE programs nationally.
- Department of Education—Indian Education Fellowship. The Indian Education Fellowship offered through the U.S. Department of Education was eliminated in the early 1990s. The Fellowship provided tuition, books, fees, and a stipend for living expenses for AI students pursuing higher education, including the health professions.

- U.S. Public Health Service (USPHS)—Commissioned Officer Student Training Extern Program (COSTEP). The COSTEP allows students to enter the Commissioned Corps of the USPHS while attending health professions schools. The advantage to students is that they are paid as a “commissioned officer” while in school, and earn credit toward retirement benefits during their enrollment. The author investigated the COSTEP when starting medical school, and learned the dress code for the program includes short hair length for males. There are no provisions for an AI male who wears his hair in a traditional way, and the program requires the hair to be cut, which is culturally inappropriate for many AIs.

### **Private Sector**

- Foundations (Robert Wood Johnson Foundation and W.K. Kellogg Foundation). The Health Professional Partnership Initiative (HPPI) that focused on the pipeline and encouraging underrepresented minority students to enlist in academic programs leading to master and doctoral degrees in public health and other health professions was not renewed, and ceased in 2005. The third and final round of funding was offered in 1999–2000.
- American Indian Graduate Center (AIGC). The AIGC, a nonprofit corporation based in Albuquerque, New Mexico, which provides scholarships for American Indians pursuing graduate school, is also facing funding limitations and less than optimal numbers of scholarship opportunities. In 2005, AIGC was able to provide over \$7 million in scholarships. Federal funding cuts have the potential to further decrease scholarship opportunities for American Indians through these programs.

### **Tribal Programs**

Numerous tribes have had success with various forms of economic development. As tribes determine their best investment opportunities, it is important that they invest in the education of their own community members in addition to AI education in general. From this perspective, the opportunity exists to blend economic development, social policy, education policy, and health policy at both tribal and federal levels to coordinate and expand these much needed scholarship programs. Tribes may consider offering scholarships to community members and

other American Indians who commit to return and to work in their community.

Historically, policy development at multiple levels of government, including tribal governments, has not been coordinated. However, decisions made in health, education, social, and economic arenas have an impact on each other, even if the administrators of these programs are not communicating regularly or coordinating their efforts. Again, coordination with federal and state programs is needed, and the new administration must refocus its priorities to include health professions education programs.

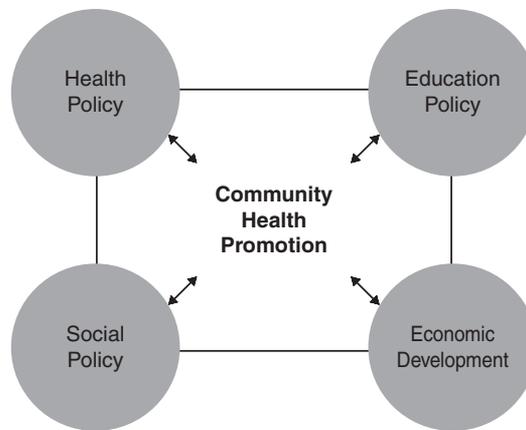


Figure 6. Policy coordination strategies: tribal, state, federal.

To be successful in increasing the number of American Indians in the health professions, these efforts need to be a priority for tribal, state, and federal programs. In addition, private sector foundations and corporations as well as colleges and universities should work in partnership to reestablish recently discontinued scholarship and academic support programs and to develop new opportunities for AI community members.

## 9. RESEARCH AGENDA

Advances in biomedical research have the potential to reduce health disparities in populations that have poor health status; however, population-specific research also entails collective risk for these groups—including American Indians. It is imperative to include these groups and communities in research plans and discussions of the potential impact of research findings. A long-standing history of nonparticipation in research processes and in policy development for AIs has led to an undercurrent of distrust and misunderstanding regarding the motivations of researchers and policy makers. To promote improvements in research and health status, AI communities must be closely involved in the research process, including agenda setting,

conduct of research, evaluation of programs, authorship, and publication. Collaboration between individual communities and researchers is particularly important for interpreting data and disseminating results. Additionally, issues regarding ownership of data and intellectual property need to be formally addressed before initiating research projects.

It is important to recognize that there is no single American Indian or Alaska Native culture. Over one thousand tribal groups exist in North America, each with a unique culture and system of beliefs. It is not appropriate to consider the "American Indian/Alaska Native Community" as a single, homogeneous population. Tribal communities are distinctive groups with significant variations in culture, language, and beliefs. The application of research findings, or effectiveness of future health care interventions, will involve cultural issues related to treatment, recovery, and healing as well as the distinctiveness of individual AI/AN communities.

Historically, advances in medical science have generally resulted in health care interventions that are costly, and research results have not been linked to policy development that ensures that the populations with the greatest health disparities and the greatest need for interventions have access to new technologies. Due to severe underfunding of the IHS and other health-related programs for AIs, advances in medical technology and health science typically have not been made available to AI communities, which are commonly impoverished.

Albeit not an exhaustive list, some potential benefits of biomedical research for AI communities include identification of markers for disease risk (e.g., kidney failure/end stage renal disease or ESRD), new and more effective prevention strategies and treatments, current treatment efficacy evaluations, economic development opportunities, and educational opportunities.

Even though rates of diseases such as diabetes are so high in some populations that essentially all community members are at risk, secondary prevention efforts such as preventing diabetes complications could be improved through biomedical and genetic research. If genetic markers are identified for diabetic complications such as ESRD, it is possible that standards of care regarding screening might be changed toward prevention and earlier identification of diabetic complications.

### **Potential Barriers to Conducting Biomedical Research in AI Communities**

Experience working in AI communities in health care reveals that perhaps the most significant barrier to conducting biomedical research in AI communities is *trust*. As stated by Malcolm Bowekaty, former governor of Zuni Indian Pueblo, "A large portion of research and researchers have been dishonest and unscrupulous when working among our American Indian and Alaska Native Communities." Many questions surface with

the prospect of advancing biomedical and genetics research in AI communities, including:

- Can community members trust that the research team will conduct research in an appropriate manner with respect to issues such as ownership of data and samples?
- Will the research team use samples only for the purposes approved by the tribe?
- Will the samples be handled respectfully, and will they be appropriately destroyed after a given amount of time?
- In terms of data ownership, who will house the dataset?
- Will the community be involved in authorship and publication?
- Will the research result in benefit to the community?

If communities do not believe that they have appropriate assurances of these and other issues, it is likely that they will not participate in research projects. The result is that the research process itself can lead to decreased research and increased health disparities if it does not include meaningful community participation. Involvement as a participating partner in all phases of research is likely to be a common goal for many AI communities. This process can be reinforced by appropriate informed consent agreements at the community level to protect tribal interests (e.g., with tribal councils) and at the individual level to promote individual safety (e.g., with individual community members).

Another potential barrier to conducting research in tribal communities is the *perception of benefit*. If there is a perception that a tribe will not benefit directly, this might limit participation in research projects. Also, the degree of direct *community participation* in all phases of the research process can have an impact on whether a tribe agrees to participate at all in the research project. If there is limited community participation, community members may decide not to allow the research to be conducted in their community. The historical model for research has fostered a sense of mistrust and a perception of little benefit, because many communities believe that they have been treated more like laboratories than partners in the research process.

### **Proposed Paradigm for Community Participatory Research**

The research paradigm itself can be a potential barrier to community participation and perceived benefit. The historical, and still current, research paradigm in most community settings can be considered in the following diagram.

Under the current paradigm, the research process is essentially a partnership between a research institution (e.g., academic institution)

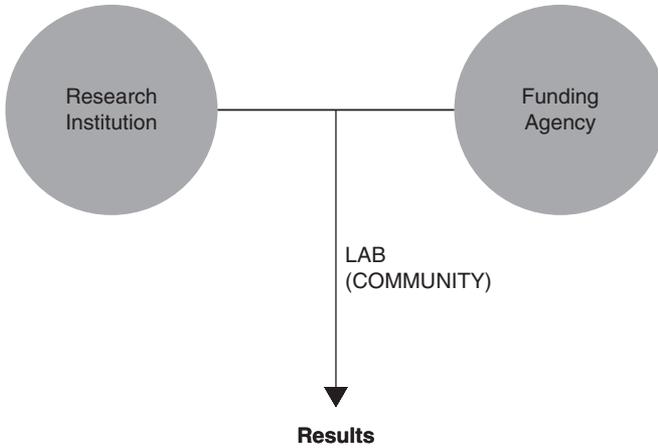


Figure 7. Current research paradigm.

and a funding agency (e.g., National Institutes of Health). The research institution and the funding agency work in partnership to obtain results. Research results can be defined as *publications* from the perspective of the research/academic institution, and results can be defined as expanding *scientific knowledge* from the perspective of the funding agency. In this setting, the communities being studied are often treated simply as a laboratory from which data are obtained, and the individual community members are treated as simply experimental subjects. In this setting, the community is not a genuine partner and does not play a role in setting the research agenda or in participating in the research development and implementation process.

A proposed new paradigm in which the community is treated as an equal partner in the research process can be envisioned through the following diagram.

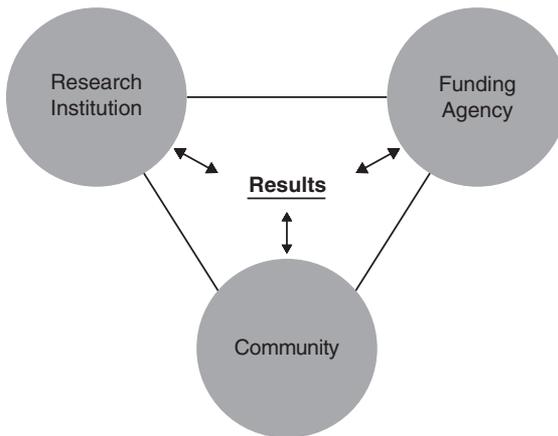


Figure 8. Community participatory research paradigm.

In this paradigm, the community is an equal partner in the research process, and community members can define results in terms of *benefits* of research to their community. This model also allows for discussion of unique community issues and barriers to improved health as well as those associated with research participants, their families, and the community in which they reside. Communities want to have an increased role in research agenda setting and in research design. Providing the opportunities for communal discourse and for community participation in the research process and education increases the likelihood of promoting cultural appropriateness, obtaining informed consent, and completing a successful study.

When AI communities become partners and coresearchers in the research process, potential benefits include: (1) improved trust by providing communities a voice in research agenda setting and design, (2) increased benefit by involving the community in linking research results to application in the community through policy development, (3) greater understanding in the research and academic communities of cultural factors and other issues that lead to health disparities in the AI population, and (4) improved cultural appropriateness of research design, implementation, and characterization of results. Through advances in education, the opportunity exists to place community members not only in the community circle, but also in the realms of research and academic institutions and funding agencies. This will also serve to promote culturally appropriate interactions among AI communities and the biomedical community, and can ultimately lead to reductions in health disparities. The new administration needs to recognize the nuances of conducting research in tribal communities and to place a higher priority on community-based participatory research in which the tribes are actively setting their own research agendas.

## **10. TRIBAL CONSULTATION AND REBUILDING TRUST**

One of the most significant and challenging policy issues facing the new administration is to continue the tribal consultation policy with improved outcomes. Tribal consultation at the federal level was initiated in the Clinton administration for the purpose of ensuring adequate tribal input into policy decisions and program development that had an impact on them. Over the previous eight years during the previous administration, tribal consultation continued; however, recommendations made by tribal leaders typically did not become policy. Tribal consultation seems to have evolved into a process by which federal agency administrators listen to tribal concerns regarding health care and other issues, but do nothing to effectively address the issues.

The new administration needs to continue the consultation process, and include reporting requirements and accountability in this process to ensure that the issues of importance raised by tribal leaders are being addressed. The founding principle of tribal consultation is the fulfillment of the federal government's trust responsibility to the tribes to provide for education programs and health care services. The federal government is not doing tribes a favor by conducting consultation. Rather, it is fulfilling its obligations to us. As American Indians, we exchanged vast amounts of land and natural resources for these programs and services. The resources that have made this country as great and powerful as it is are AI resources. From this perspective, we have the largest prepaid health plan in history, and the current underfunding of the health system and the lack of coordination at multiple policy levels is unacceptable. As tribal leaders and as health care and health policy professionals, we have the responsibility to hold the federal government accountable, and the new administration needs to be sensitive to the needs of its first inhabitants.

#### N O T E S

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