Policy challenges in American Indian/Alaska Native health professions education

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Abstract
Disparities exist in the numbers of American Indians and Alaska Natives (AI/ANs) in the health professions as compared with the general United States (US) population. Numerous factors contribute to this disparity, including inequities in education, healthcare and economic development opportunities. The basis for inequality is rooted in the policy arena. Issues in health professions education blend the arenas of health policy and education policy. Although AI/ANs have a birth right to healthcare and to education programs as a result of treaties signed between the US and tribal governments, these programs are severely underfunded. To understand the disparities in health professions education for AI/ANs today, it is important to understand the history of US federal Indian policy over the last two centuries. Following a history of removal, assimilation, reorganization and termination, the current phase of federal Indian policy is tribal self-determination. As a result, opportunities exist to reduce disparities in the number of AI/AN health professionals and in health disparities. AI/AN tribes have the opportunity to work in partnership to coordinate health, education, social and economic development policy to increase the numbers of AI/AN health professionals. Tribes can also make it a priority to coordinate political advocacy efforts to improve funding for AI/AN health and education programs.

Keywords: American Indian/Alaska Native, health professions education, health policy

Policy overview and history
Issues in health professions education for the American Indian and Alaska Native (AI/AN) population blend the arenas of health policy and education policy. Health Policy and Education Policy can be defined in the following terms:

- Health Policy determines who gets health services, what those services are and how those services are delivered.
- Education Policy determines who gets educational programs, what those programs are and how those programs are administered.

Two key differences exist between health policy and education policy for AI/ANs. First, healthcare is not a legal right in the United States (US), whereas everyone has a right to public education through high school. In the US individuals are not born with a legal right to healthcare services. Typically, citizens of the US either have enough resources to pay for health services/health insurance or they are impoverished enough to qualify for public...
assistance (e.g., Medicaid programs). The uninsured population is comprised primarily of individuals who cannot afford to pay for health insurance and who have an income above qualifying poverty levels. This is true for everyone in the US except the AI/AN population. Treaties signed between tribal nations and the federal government exchanged vast amounts of land and natural resources for certain social services, including housing, education and healthcare. The treaties are essentially inter-governmental agreements or contracts between the tribes and the federal government, and the federal agency responsible for providing education to the AI/AN population is the Bureau of Indian Affairs (BIA) and for providing healthcare is the Indian Health Service (IHS). As a result, the AI/AN population is the only population in the US that is born with a legal right to healthcare services. Unfortunately, the IHS is severely under funded, adding to the significant health disparities seen in the AI/AN population.

According to the US Commission on Civil Rights (2004), per capita expenditures in the 2003 federal budget for AI/AN people receiving healthcare services from the IHS were $1,914. In contrast, the per capita medical expenditure for Medicaid recipients was $3,879, for Medicare recipients was $5,915, and, for Veterans Administration beneficiaries, the per capita expenditure was $5,214. The per capita medical expenditures for federal inmates in the Bureau of Prisons was $3,803 – nearly double the per capita medical expenditure for American Indians. Limitations in funding and historically inadequate third-party billing have led to decreased access to healthcare services for the AI population. Figure 1 shows per capita funding for several federally funded health programs.

The second key difference between health policy and education policy is access to third party sources of revenue. Since IHS and tribal health programs are under funded, and since significant numbers of AI/ANs are impoverished, IHS and tribal health programs have become dependent on third party revenue from several sources, primarily Medicaid. However, third party sources of revenue for education programs do not exist, and these programs are therefore largely dependent on direct federal and state appropriations. When appropriated funding is inadequate, schools are forced to cut programs and limit opportunities for students. Unfortunately, the under funding of BIA schools combined with reduced scholarship programs for under represented minority groups has added to disparities in AI/AN representation in the health professions.

Healthcare and health policy issues are not the only areas in which disparities exist, for example: high school graduation rates among American Indians is 65% compared to 75% in

![Per Capita Healthcare Expenditures](image)

Figure 1. Comparison of per capita healthcare expenditures for several federally funded healthcare systems in US dollars [Indian Health Service (IHS), Bureau of Prisons, Medicaid, Veterans Administration (VA), and Medicare]. Figure adapted from US Department of Health and Human Services, Indian Health Service, January, 2006.
Disparities in health professions education in the US

the general US population; 32% of the AI population lives below the federal poverty level as compared to 13% among non-Indians (Indian Health Service, 2002). But, health status and outcomes are highly correlated to education and income (Deaton, 2002), making these socioeconomic markers significant factors in AI public health; and health care is among the top issues of concern to American Indian communities. Figure 2 shows high school graduation rates and percentage of population living at or below the federal poverty level for AI/ANs and for the general US population.

Disparities in high school graduation rates have contributed to disparities in the numbers of AI college graduates and subsequent AI healthcare professionals. Also, limitations in personal income have resulted in limited means to purchase additional healthcare services.

In order to gain a better understanding of the impact of policy on health disparities, education disparities and in the health professions, it is important to understand the history of federal Indian policy. According to (Deloria & Lytle, 1983), five phases of Federal Indian Policy can be summarized as follows:

- 1800 – 1840: Period of Removal
- 1849 – 1920: Period of Reservation and Assimilation
- 1930 – 1950: Period of Indian Reorganization
- 1950 – 1970: Period of Termination and Relocation
- 1975 – current: Period of Self-Determination

The Period of Removal (1800 – 1840)

As the US was growing in its early years, the need for land guided federal Indian policy. The newly arrived non-Indian inhabitants on the continent believed it was their God-given right to acquire the land through the concept of “Manifest Destiny” – a term coined by John L. O'Sullivan (1839, p. 430):

We must onward to the fulfillment of our mission – to the entire development of the principle of our organization – freedom of conscience, freedom of person, freedom of trade and business pursuits, universality of freedom and equality. This is our high destiny,

![American Indian/Alaska Native Socio-Economics](image)

Figure 2. Comparison of high school graduation rates and percent of population living at or below the US federal poverty level for the American Indian/Alaska Native population (AI) and the general US population (non-I). US Department of Health and Human Services, Indian Health Service, (2002).
and in nature's eternal, inevitable decree of cause and effect we must accomplish it. All this will be our future history, to establish on earth the moral dignity and salvation of man – the immutable truth and beneficence of God.

A key federal policy implemented during the period of removal is known as the "Trail of Tears" in which Southeastern Tribes (e.g., Cherokee Nation and others) were removed from their homelands and relocated to the Oklahoma Territory in the late 1830s. Over 4,000 tribal members died on the trail to Oklahoma.

*The Period of Reservation and Assimilation (1849–1920)*

This period of federal Indian policy focused on keeping Native people racially segregated on reservations until "civilized". This was a period in which children were taken from their families and placed in boarding schools with the purpose of civilizing the younger generation so they could be assimilated into the general US society. The motto for the Carlisle Indian School in Pennsylvania – one of the larger boarding schools at the time – was "Kill the Indian and Save the Man". In other words, the goal was to eliminate the cultural aspects of American Indians so that they could blend into general society. Assimilation eventually led to the dissolving of Indian nations and territories, which were coveted by farmers. The argument was that dissolving tribes, forcing Indians to give up their heritage, and making them property owners would civilize them. This policy became federal law with the General Allotment Act in 1887 and ignored Indian land patterns that were thousands of years old.

*The Period of Indian Reorganization (1930–1950)*

In the 1920s, there was growing concern that Indian affairs were being mishandled and reform movements such as the American Indian Defense Association championed rights for Indians. In 1926, the Secretary of the Interior authorized the Institute for Government Research to conduct a study of the BIA. In 1928, the Merriam Report marked a shift in government policy. The report recommended the end to allotment and more funds for health and education for American Indians because of significant health disparities. In 1934, the Indian Reorganization Act was passed, which implemented the recommendations of the report. The fundamental aims of the Indian Reorganization Act (IRA) were development of economic resources and restoration of Indian self-determination through tribal government revival. One of the key results of this phase of federal Indian policy was the establishment of "IRA governments" that were designed with an elected executive official (governor, chairperson, president, etc) and a legislative branch (tribal council). This type of government still exists in most tribes, with varying success largely depending on cultural match with this form of governance (Cornell & Gil-Swedberg, 1995).

*The Period of Termination and Relocation (1950–1970)*

During the Period of Termination and Relocation, federal government policy saw the solution of the "Indian Problem" was to end the relationship between Indians and the federal government. In 1953, House Concurrent Resolution 108 was adopted, which called for termination of the federal relationship with tribes as soon as possible. The policies and resolutions were a product of the backlash of the 1930 reforms which led to congressional studies of 1943 that again found serious problems in the administration of Indian Affairs through the BIA. The period was characterized by other attempts at socio-cultural
integration and the end of dependence on federal government programs. Responsibilities were transferred to states and many education, health and welfare programs became no longer available. An urban migration, which had begun with World War II, was now accelerated by massive government programs to relocate reservation Indians to urban settings as another tactic for the government to end its relationship with tribes.

The Period of Self-Determination (1975 – present)

The Period of Self-Determination has its roots in the Richard Nixon administration. President Nixon gave a speech in 1970 in which he announced, through executive proclamation, the end of the policy of termination and the beginning of the policy of Indian self-determination. In 1975 Self-Determination became law through PL 93-638, The Indian Self-Determination and Education Assistance Act. This law allows tribes to take over healthcare and education programs from federal management and control, via the IHS and BIA, respectively. Another key law was passed in 1976 – PL 94-437, The Indian Health Care Improvement Act (IHCAA). This law created the IHS Scholarship Program (Title I) that pays for tuition, books, fees and a stipend for AI/ANs to pursue health professions education in exchange for time working in IHS or tribal healthcare facilities.

The impact of policy: A personal story

My mother, Beverly Stabler-Warne, RN, MSN, has been a nurse for 45 years, and she has lived through and experienced multiple phases of federal Indian policy, including health and education policies affecting the AI/AN population. Upon entering grade school in the 1940s, Beverly was placed in the Pine Ridge Boarding School in Pine Ridge, South Dakota – a boarding school started as part of the Reservation and Assimilation Policy in the late 1800s and early 1900s. In the early 1950s, her family was relocated from the Pine Ridge Indian Reservation to Rapid City, South Dakota as a part of the Termination and Relocation Phase of federal Indian policy. A camp was developed along Rapid Creek for Lakotas and other Indians who were relocated to Rapid City. Her family lived in a tent along with several hundred other Indians, and, unfortunately, they faced significant discrimination from non-Indians – a common experience among many Native people who were relocated from reservations.

While working in a café as a dishwasher, Beverly met Elizabeth – the wife of the café owner. Elizabeth was a nurse, and she became an advocate for Beverly and encouraged her to attend nursing school. Beverly was the first member of the family to finish high school and to attend college. She graduated with her RN from St. John’s McNamara School of Nursing in Rapid City, SD in 1962. At that time there were very few Native people who worked in the health professions, and as a result, there were very few AI/AN role models. Without Elizabeth as an advocate, Beverly probably would not have pursued higher education in nursing.

In the 1980s Beverly went back to school to pursue her Bachelor of Science in Nursing (BSN) and her Master of Science in Nursing (MSN) with an IHS scholarship (Title I of PL 94-437) at Arizona State University. Without the Indian Health Care Improvement Act (IHCAA), Beverly probably could not have afforded to pursue higher education in nursing beyond her RN in 1962. The IHS Scholarship Program provides tuition, books, fees and a stipend. Many Native people have taken advantage of the scholarship program and have become health professionals and role models for younger generations.
Because there are relatively few AI/ANs pursuing higher education in the health professions, many of the individual students feel a sense of isolation. As part of the IHCIA, Section 112 allows for institution-based nursing programs that provide scholarships and stipends in addition to academic, social and cultural support. These programs have been successful in recruiting, retaining and graduating numerous AI/AN nurses. By having an institutional basis, the programs allow for social support and colleagues among AI/AN nursing students. The Section 112 programs are successful largely because of the social and cultural support programs. Since 2001, Beverly Warne has been the Director of the American Indian Students United for Nursing (ASUN), a Section 112 Program at Arizona State University.

American Indian/Alaska Native health professions disparities

The disparities in numbers of American Indians and Alaska Natives in the health professions are well characterized in other papers in this supplement. Generally, there are fewer AI/ANs in medicine, dentistry, nursing, pharmacy and, essentially, all health professions. Currently, IHS estimates that they have at least a 12% vacancy rate for health professions in their system, with nearly a 30% vacancy rate for dentistry (D. Pratt, personal communication, 26 September 2006). The majority of healthcare providers serving the AI/AN population are non-Natives. The result is that the cultural competency of the system is not as good as it could be if there were more people from the AI/AN population serving other AI/ANs. According to the Institute of Medicine (2003), cultural competence in the healthcare system has an impact on quality of care, and improved cultural competence in the healthcare system has the potential to reduce health disparities. In the arena of health professions education for under represented minorities, it can be seen how education policy has a direct impact on health policy and health outcomes.

Recent funding history for AI health professional education

In recent years, significant cuts have been made to numerous health education programs, and some educational opportunities are not culturally appropriate for many AI/ANs. These programs include:

Federal Programs

- Indian Health Service – Indian Health Care Improvement Act (Title I PL 94-437). Funding has remained level since 2000 because the IHCIA has not yet been reauthorized. The result is that as tuition costs rise, the number of scholarships for AI/ANs has decreased annually since 2000.
- Health Resources and Services Administration (Title VII Public Health Services Act). The Health Careers Opportunity Program (HCOP) and the Centers of Excellence (COE) that function to increase the numbers of under represented minority students into the health professions have been eliminated as of September, 2006. Nearly half a million minority students have participated in these programs. A recent survey by the Association of American Medical Colleges (2006) showed that elimination of Title VII funding for these programs will result in complete closure of 83% of the HCOP and COE programs.
- Department of Education—Indian Education Fellowship. The Indian Education Fellowship offered through the US Department of Education was eliminated in the
early 1990s. The Fellowship provided tuition, books, fees and a stipend to AI/AN student pursuing higher education.

- United States Public Health Service (USPHS) – Commissioned Officer Student Training Extern Program (COSTEP). The COSTEP Program allows students to enter the Commissioned Corps of the USPHS while attending health professions schools. The advantage to the student is that they are paid as a Commissioned Officer while in school, and they get credit toward retirement benefits while still in school. The author (Donald Warne) investigated the COSTEP program when starting medical school, and the dress code for the program includes short hair length for males. There are no provisions for a Native man who wears his hair in a traditional way, and the program requires cutting hair. This is not culturally appropriate for many Native people.

**Private Sector**

- Foundations (Robert Wood Johnson Foundation & W.K. Kellogg Foundation). The Health Professional Partnership Initiative (HPPI) that focused on the pipeline and encouraging under represented minorities to enlist in academic programs leading to masters and doctoral degrees in public health and other health professions was not renewed, and has ceased to exist since 2005. The third and final round of funding was in 1999/2000.

- American Indian Graduate Center. The American Indian Graduate Center, a non-profit corporation based in Albuquerque, New Mexico and focused on providing scholarships for AI/ANs 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 decrease scholarship opportunities for AI/ANs.

**Tribal Programs**

- Tribal Scholarships and Donations. Numerous tribes have had success with various forms of economic development including, but not limited to, gaming. 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/ANs generally. From this perspective, the opportunity exists to blend economic development, social policy, education policy and health policy. Tribes may consider offering scholarships to AI/ANs that commit to working in their communities, thereby also increasing the number of potential role models for younger community members. In addition, programs like AIGC that might face federal funding cuts should be supplemented by tribes that have the appropriate resources.

**Policy strategies to improve health professions education opportunities**

Historically, policy development in 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. The role for policy coordination in community health promotion can be seen in Figure 3.

Ultimately, the goal of increasing the numbers of AI/ANs in the health professions is to decrease disparities in disease rates and to promote the health of AI/AN communities
through the provision of culturally appropriate health services. Education policy alone will not have the effect of increasing the numbers of AI/ANs in the health professions without coordination of resources and efforts in health policy (e.g., Indian Health Care Improvement Act reauthorization), social policy (making health professions education a priority among under represented minority group (e.g., reinstating funding for Title VII PHSW programs), economic and workforce development policy (e.g., tribal investment in community member education) and education policy (e.g., appropriately funding reservation-based schools).

With advancements in self-determination among numerous tribes, the opportunity exists to coordinate policy and program development efforts to meet local needs. For example, the tribal schools can be connected to tribally operated healthcare facilities to promote the health professions among young community members. Tribal economic development efforts could also facilitate scholarship programs for community members that include the commitment from scholarship recipients to return to the community to work in the local healthcare facilities (similar to what is done with the current IHS Scholarship Program, Title I of IHCIA). Long term social policy development should also include formal and organized efforts to link AI/AN healthcare professionals to role modeling opportunities with local school children so that the students can meet AI/AN physicians, nurses, and other health professionals, and can start to envision themselves in these professions.

In addition to accessing role models, the pipeline of potential healthcare professionals is dependent on enhancing the quality of early education. Lobbying efforts on behalf of and by AI/ANs need to include attempts to improve funding for BIA, state and local schools. Limited funding for early childhood education puts AI/AN children at a significant disadvantage in pursuing higher education and leads to higher drop out rates in high school and college. These rates do not reflect intellectual capacity as much as they reflect inadequate preparation. Funding for schools is purely a policy decision made by governments, and they need to be held accountable for quality of education for all children, including those living in rural and impoverished areas. The result of inadequate early
education is that the role models students are exposed to in local communities are dominated by individuals who have not succeeded in higher education. This creates a social norm of educational failure, and leads to limitations in self perception of academic ability.

Several bridge and summer programs exist that offer educational enhancement to better prepare students for college and graduate school. These programs should be expanded to be available to all students who could benefit. Early success in college will have the effect of building confidence and reducing drop-out rates. With limited and reduced funding at the federal level, tribes may want to consider contributing funding to these bridge and summer programs.

To be successful in increasing the number of AI/ANs 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/ANs to pursue higher education in the health professions.

Finally, we need a renewed effort of inter-tribal cooperation in order to pool our financial and political resources. Considering the broad under representation of AI/ANs in the health professions among all tribes, we could significantly strengthen our lobbying efforts and we could improve educational opportunities and funding for all of our communities by working together. AI/AN health professionals commonly work with AI/AN populations, and improving the numbers of health professionals will have the effect of improving cultural competence in the healthcare systems, and could ultimately lead to reducing health disparities.

References