The New York Times

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December 2, 2009

New Hopes on Health Care for American Indians

By PAM BELLUCK

The meeting last month was a watershed: the leaders of 564 American Indian tribes were invited to Washington to talk with cabinet members and President Obama, who called it "the largest and most widely attended gathering of tribal leaders in our history."

Topping the list of their needs was better health care.

"Native Americans die of illnesses like tuberculosis, alcoholism, diabetes, pneumonia and influenza at far higher rates," Mr. Obama said. "We're going to have to do more to address disparities in health care delivery."

The health care overhaul now being debated in Congress appears poised to bring the most significant improvements to the Indian health system in decades. After months of negotiations, provisions under consideration could, over time, direct streams of money to the Indian health care system and give Indians more treatment options.

Some proposals, like exempting Indians from penalties for not obtaining insurance, may meet resistance from lawmakers opposed to expanding benefits for Indians, many of whom receive free medical care.

But advocates say the changes recognize Indians' unique status and could ease what Senator Byron L. Dorgan, Democrat of North Dakota, calls "full-scale health care rationing going on on Indian reservations."

"We've got the 'first Americans' living in third world conditions," Mr. Dorgan said.

Mr. Obama has emphasized Indian issues more than most presidents. He campaigned on reservations, created a senior policy adviser for Native American affairs and appointed Kimberly Teehee, a Cherokee, to the post, and gave Indians other high-ranking positions.

He has proposed a budget increase of 13 percent for the federal Indian Health Service, which provides free care to 1.9 million Indians who belong to federally recognized tribes, most of whom live on tribally owned land. The service, which had a budget this year of $3.3 billion, has also received $500 million in stimulus money for construction, repairs and equipment.

"This new administration has been much more positive," said W. Ron Allen, chairman of the Jamestown S'Klallam tribe in Washington State and treasurer of the National Congress of American Indians, adding that the Congressional proposals provide "a very impressive opportunity to close the gap in Indian health care."

On Thursday, the Senate Indian Affairs Committee is scheduled to discuss other Indian health issues that could end up in the overhaul bill.

Indians could benefit from broader overhaul programs for low-income and uninsured citizens, but they do not want to relinquish the health care they claim as a historical right.

"Indian people have given up a lot," said Dr. Yvette Roubideaux, director of the Indian Health Service. "They really feel like they have, in a sense, prepaid for this health care with loss of land, natural resources, loss of culture."

'List Goes On and On'

In the vast, varied territory called Indian Country, health care is stung with struggle.

Too few doctors. Too little equipment. Hospitals and clinics miles of hardscrabble road away.

In cities, where over half of the country's roughly 3 million Indians now live (and nearly 5 million including part-Indians), only 34 programs get Indian Health Service funding, providing mostly basic care and arranging more advanced care and coverage elsewhere.

While some Indians have private insurance, often through employers or tribal businesses like casinos, a third are uninsured and a quarter live in poverty. By all accounts, the Indian Health Service is substantially underfunded.

Money shortages, bureaucracy and distance can delay treatment of even serious conditions for months, even years.

Many Indians face multiple roadblocks.

Joanna Quotskuyva's breast cancer did not require a mastectomy, but she chose to have surgery because radiation would mean months of driving five hours round-trip from her home on the Hopi reservation in Kykotsmovi, Ariz.

Many make similar choices, because "unfortunately, we don't have the capability," said Dr. Joachim Chino, chief of surgery at the nearest hospital, the Tuba City Regional Health Care Corporation. Treating large swaths of the Hopi and Navajo reservations — the Navajo alone is the size of West Virginia — is inherently difficult.

Despite its dedicated medical staff, the hospital struggles "to bring, right here, appropriate state-of-the-art, specialty, critical-care medicine," said Joseph Engelken, the hospital's chief executive.

While the Indian health system has improved nationally and Indians are living longer, Dr. Roubideaux acknowledged problems, not all from underfunding, saying, "The list goes on and on in terms of areas that need improvement."

Sometimes urgent "life or limb" cases get attention, while others, some serious, must wait.

Dr. David Yost, clinical director at the White Mountain Apache reservation in Arizona, cited "piles of care we have to put on the back burner," including 150 cases this summer, some "waiting a year and a half." This budget year, he said, 40 patients are still waiting, and about "10 people a month" are added to the list.

Ronnye Manuelito, 56, a Navajo in Naschitti, N.M., said he "almost felt like giving up" after waiting for brain surgery to quell blackouts, seizures and headaches experienced over three years from a shifting metal plate in his head from a childhood carousel injury.

One time he "left the stove on in the kitchen and passed out," and another he had a seizure in a car, said his sister, Brenda. His Indian Health Service doctor "was trying to get him a referral to a specialist in Albuquerque, but they weren't approving it because it wasn't life-or-limb," she said.

Ultimately, two surgical procedures helped him.

Dr. Roubideaux, speaking generally, said, "There are some places where funding is so short and there are so few health care providers, unfortunately people may have to wait quite a long time."

A former reservation doctor herself, Dr. Roubideaux said she would see "someone who maybe had chronic knee pain and a little bit of surgery would help, yet the person was still walking," making it non-life-threatening. "It's really heartbreaking," she said.

In cities, scarce Indian facilities and patchwork insurance can mean "a woman with a lump in her breast — we can't guarantee we can get her into treatment in a reasonable period," said Ralph Forquera, the executive director of the nonprofit Seattle Indian Health Board. "A cardiac problem? We can't guarantee that person can get to see a specialist."

Sometimes, Mr. Forquera said, when that woman is treated, "the lump has metastasized." He added, "We've had people actually die on waiting lists."

Jackie BirdChief, 46, a single mother with thyroid cancer, did not have to wait. She just had to move 200 miles from Phoenix to the Apache reservation she left in 1983, leaving her city, her job and, for months, her daughter, then 14. She moved because cost containment rules link coverage for care to establishing residency on reservations.

Ms. BirdChief, a secretary, was lucky because the Indian Health Service, her employer, "manipulated the system to make it work out for her," Dr. Yost said. It found her jobs on the reservation, he said, "whereas someone working in a grocery store would have had to quit their job — or decide if they wanted to have the procedure."

Still, Dr. Yost said, Ms. BirdChief "was a victim of our system, and ironically, she worked for the Indian health system."

Living on a reservation, however, does not ensure accessible care.

Ruby Biakeddy's six-sided hogan, a traditional Navajo home, without running water or a phone, is an hour's drive on a dirt road from drinking water, and even farther from diabetes and blood pressure medication. Since her truck got swept away in a rain-swollen ditch five years ago, Ms. Biakeddy, 67, who tends sheep, must borrow her children's vehicles.

"I recently ran out of the medicine I inject for a week," she said in Navajo through a translator.

Serious cases, where getting care within the "golden hour" after problems start is critical, can also suffer. "For many of our patients," said Dr. Anne Newland, acting clinical director of a clinic in Kayenta, Ariz., "that hour is gone by the time they get to us."

Ciara Antone, 4, died on the Navajo reservation outside Tuba City from an apparent bowel obstruction. Her mother, Genita Yazzie, called 911, but said that with the distance and road conditions, the ambulance was two hours away.

"I kept telling the dispatcher, 'My daughter's coding, she's not breathing,' " Ms. Yazzie said. Desperate, she drove to the closer Hopi reservation to get an ambulance, but by then, "they couldn't bring her back."

Whether a closer ambulance could have saved her daughter is unclear (the family has sued the non-Indian hospital that treated her). Henry Wallace, director of Navajo Emergency Medical Services, which Ms. Yazzie called first for an ambulance, declined to discuss the case, but said, "the geographic area is so large that the time factor is probably the biggest problem we have."

"We really don't have a golden hour," he said. "Ours could be the golden three hours."

Staffing shortages exacerbate things. Recently, Kayenta began closing its emergency room overnight, making Tuba City, at 90 minutes away, the closest hospital. At Indian hospitals and clinics nationally, a fifth of physician positions and a quarter of the nursing slots are unfilled.

Patients contribute to the frustrations. Nearly a third do not show up for scheduled surgery at Tuba City, often citing distance or cost.

Richard White, 61, acknowledged taking his medicine sporadically and drinking, aggravating his diabetes. He went blind, lost a toe and, during a Navajo medicine-man ceremony that he hoped would restore his vision, burned his other foot, which was then amputated.

"Stare at these incredible statistics, you become overwhelmed," Dr. Yost said. "It's like drinking out of a fire hydrant."

Keeping a Promise

Congress's goal, in using penalty and co-payment exemptions, is to encourage Indians to enroll in proposed programs like subsidized private insurance or expanded Medicaid, while respecting their sovereignty and the conviction that they are owed health care.

That conviction and bureaucratic hurdles have kept many eligible Indians from enrolling in Medicaid. But getting insurance allows Indians to receive care from more providers and allows the Indian system to get reimbursed from Medicaid or other insurers.

That would generate “an influx of capital,” said Jim Roberts, policy analyst for Northwest Portland Area Indian Health Board, that “you can use to improve Indian health care.”

Some disagree. Senator Tom Coburn, Republican of Oklahoma, said exemptions could discourage insurance enrollment, raise premiums for insured people and further stress the Indian health care system, which he called “poorly managed” and in need of billions of dollars to “keep the promise to Native Americans.”

Even if more Indians become insured, it will not end the problems, especially if providers and insurers, daunted by the alarming health problems, continue avoiding Indian Country.

Proposed legislation would not give Indians everything they want, but the overhaul does include grants for preventive care and research. And the Indian Health Care Improvement Act, which stands a good chance of being reauthorized by Congress for the first time since 2001, would enhance programs, physician recruitment and hospital construction. Although it approves no funding, advocates hope it will prompt additional money.

Representative Frank Pallone Jr., Democrat of New Jersey, said that with the current climate in Congress, and “particularly the president, it’s definitely going to be easier to get Indian provisions in the health care bills.”

Easier, but no sure thing.

With expansions in public coverage or subsidies to buy private coverage, some lawmakers may question whether Indian Country should “still be getting direct payments to run I.H.S. clinics,” said Stephen Zuckerman, a health economist at the Urban Institute, a research group.

“Some people are saying, ‘We can’t make all these adjustments for you guys,’ ” Mr. Allen said, adding that some Indians reply: “Make us pay for health care, then the deal is off. Give us the land back, and we’re good.”

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