Statement of H. Sally Smith
Chairperson
National Indian Health Board
And
Alaska Native Health Board
On
Diabetes in Alaska Natives
May 11, 2000

Good Morning, Tribal Chairmen, Pueblo Governors and distinguished representatives of the National Institutes of Health and Tribal Communities. I am H. Sally Smith, Chair of National Indian Health Board (NIHB). I also have the honor of serving as Chair of the Alaska Native Health Board, Chair for the Bristol Bay Area Health Consortium and Treasurer for the Alaska Native Health Consortium. Locally, I serve as the Member Chief – Secretary and Tribal Judge of the Native Village of Dillingham. Nationally, I also serve on the Tribal Self-Governance Advisory Committee, on the Tribal Leaders Diabetes Committee and on the National Steering Committee on Reauthorization of the Indian Health Care Improvement Act (P.L. 94-437).

I am pleased to be here today to present an overview on diabetes afflicting Natives in Alaska and other native peoples throughout the United States. My presentation will focus principally on Alaska, however, in my capacity as Chair for the National Indian Health Board, I want to provide you with a brief glimpse of our work on Diabetes issues at the national level.

The NIHB serves all 558 Tribal Governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Areas of the Indian Health Service (IHS) and are generally elected at-large by their respective Tribal Governmental Officials within their regional area. We have the duty to ensure that the solemn treaty commitments made to our ancestors are upheld in all matters related to health and human services.

The NIHB has been active in advocating for improved Indian health policy since our inception in 1972. During the seventies, the NIHB was principally involved in helping to secure enactment of the Indian Health Care Improvement Act and the Indian Self-Determination and Education Assistance Act. We utilized our meetings with Tribal Leaders and our Annual Consumer Conference, as a means to secure feedback on development of new models of health care which would respond to the needs of Tribes. The Model Diabetes Programs were developed in large response to the concerns of Tribal Governments.

In the eighties, NIHB promoted the concept of IHS-Tribal Consultation sessions to address issues related to eligibility, resource allocation and other funding concerns. These consultation sessions provided an opportunity for the Indian Health Service to meet directly with Tribal Governments to secure input. Later in the nineties, the concept of Government-to-Government Consultation Sessions became memorialized at the highest level of the Federal Government, within The White House. And now because of President Clinton's Executive Order on Government-to-Government consultation, we are quite pleased to be provided the opportunity to be here today to meet with key decision makers within the National Institute of Diabetes and Digestive and Kidney Diseases to express our concerns on Diabetes in Indian Country.

In sum, the NIHB has been highly involved in working to bring Diabetes to the forefront of contemporary Indian health policy. We have worked progressively to ensure that the IHS budget continues to expand its resources dedicated to Diabetes prevention and treatment. Our efforts extend not only to the IHS, but to the Centers for Disease Control (CDC) and the National Institutes of Health (NIH) as recommended within the Department of Health and Human Services Budget Review Board. In fact, we are meeting later today with the Juvenile Diabetes Association to ensure that the next "Balanced Budget

Enforcement Act" or it's new rendition expands the funding directed towards Native communities.

We are also involved in providing technical assistance to the IHS and are proud of our work in providing a series of workshops on the range of Diabetes issues during our Annual Consumer Conference. In every instance, our Board Members and our staff work to bring greater attention to the disease of Diabetes affecting our Indian people. Five of our Board Members serve on the Tribal Leaders Diabetes Committee. It is this level of involvement, that we intend on directing towards other diseases, like Heart Disease, which is tremendously impacted by Diabetic complications.

We take our work seriously because we know that Diabetes, Digestive Diseases and Kidney failure is growing exponentially in our communities. In many tribal communities, Diabetes is three to five times the national average. And yet the IHS budget is funded at a per capita level that is equal to one-third of what someone on Medicaid might secure. The IHS per capita expenditure is one-fifth of what a Veteran might secure under the Veterans Administration's health care system. Our needs are staggering and yet we have failed to secure the interest of the National Institutes of Health in the development of major research efforts intended to address our needs. At the same, the National Institutes' budget has nearly doubled over the past few years with Presidential and Congressional directives for the agency to find cures for many of the diseases we suffer from. So I hope that our message today will prompt the NIDDK to break further ground with our goal to see that the research activity in our communities, is increased by 300 to 500 percent.

If you have ever visited Alaska, our mountain ranges and vast seas will simply astound you. Alaska is as wide as the lower 48 states and larger than Texas, California and Montana combined. There are 171 remote native villages in Alaska primarily accessible by plane. The population base of our native

villages range from less than 25 to over 1,000, and the norm is between 100 to 400 residents. The forces of nature, the land, our cultures and our governance structures are unique in many instances. And yet our history and interaction with non-Indian people greatly influences our health status today, as it does in many other parts of Indian country. Especially when the Chairman of the Senate Appropriations Committee is from your State. I mention this attribute because we constantly share our needs and successes with both of our Senators and Congressman because they work very hard to direct resources towards meeting our needs.

Many folks from the lower 48 States, think of Alaska as the last frontier. With remoteness and major distances, we certainly understand rural health care challenges. And we are extra creative in meeting these challenges. Providers in Alaska have to work a little harder – figuratively and literally – to reach their diabetic patients and make sure that follow-up takes place.

In Alaska, diabetes is still a relatively new disease, but increases have been observed in the past decade in areas throughout the state. I will turn to a set of slides now to present you with a better picture of how diabetes has affected our people.

Slide Presentation

This black and white slide series shown here is taken from a collection of pictures of Native Alaskans currently on exhibit at the Smithsonian Institute.

1. Historically, Alaska Natives lived in small, tight communities that relied upon cooperative efforts to harvest subsistence foods. For many today, subsistence foods continue to be the chief source of nutrition and economic lifestyle.

2. Physical activity was part of daily life in transportation.

3. Physical activity was part of hauling in goods over land, as well as by sea.

4. And all age groups participated in labor-intensive harvest of low carbohydrate foods. Here we see a boy carrying a bundle of wild celery.

5. Our people were slender, lean and strong as displayed by the body type of this individual.

6. Moving camp was hard, physically exhaustive work and many communities survived periods of famine each year.

7. Subsistence foods, such as the Cariboo here, were very low in fat content.

8. Fish featured prominently in the diet of nearly all Alaska Native peoples, as it does indeed today.

9. Higher fat foods, such as the Yukon River eels harvested here, were seasonal diet supplements which were highly welcomed during harsh winters.

10. And subsistence harvesting of traditional foods is an important part of Native Alaskan life today. This slide, of a bowhead whale jawbone, was taken by Dr. Kelly in 1997 during a village trip to Gambel on the St. Lawrence Island.

11. Dried seal, walrus and whale meat are staple foods in many villages. But patterns of food consumption are changing. Traditional foods prized by our elders may not be eaten by the children in our communities who now prefer soda pop, microwave pizza and pre-sweetened cereals.

12. Even in communities that hunt and fish, reliance on mechanization reduces physical activity. Here we see seal skins drying next to the ubiquitous four wheeler vehicles used in rural Alaska.

13. Airplanes and Sports Utility Vehicles have replaced kayak paddling and walking. And now you see an individual who is suffering from obesity riding an All Terrain Vehicle.

14. Fast food restaurants have sprung up in our smallest villages.

15. Our elders have changed their eating patterns, gained weight and are now developing diabetes.

16. This final slide displays a walrus-skinned umiak which is very much a part of our traditional lifestyle. A lifestyle which is still very much alive in Alaska, however I am concerned about the rapid changes that are occurring right now in our communities.

The rate of diabetes has increased by 200 percent in the past thirteen years in some Alaska Native villages. To demonstrate our dramatic increases, we are making available a Diabetes Prevalence map which shows how the twelve regions of Alaska have been affected by diabetes in the period between 1985 and 1998. For instance, in my region of Bristol Bay, diabetes prevalence has increased by 89 percent. In the Annette Island region, diabetes has increased by 146 percent. Nearly every region and village of Alaska has been greatly affected by changes in lifestyle, diet and behavior.

We are doing a good job of noting the epidemiological changes taking place, however, our research efforts have only been in the short-term. What has helped in the delivery of diabetes care is working with community health aides in

the remote outlying areas of Alaska. Our community health aides prepare in advance to support physicians who visit our villages. Two weeks before a physician visits, the aides will draw and submit blood and complete urine tests using lab panels. Working under the American Diabetes Association guidelines, we are testing more patients to provide for earlier diagnosis. These same aides are powerful allies in helping the patient to prevent diabetes and learn about the care they need if diagnosed.

The clinical accomplishments of our health care systems are extensive despite the differences in geographic distances. We are seeing more diabetes outpatient specialty clinics and fostering liaison between statewide medical providers and diabetes teams. And we are seeing more community activities oriented towards preventing Diabetes.

Under our Alaska Tribal Health Compact, we have chosen to collectively administer and manage our entire IHS program. Our Area was the first to enter into this policy relationship and we find that it enhances our ability to offer more services in care and prevention. Yet despite all of our best intentions, we are seeing Type II diabetes in pre-teen Alaska Native children which does not bode well for the future.

As you can see, a strong sense of community cohesiveness follows our people. While we are isolated, it is sometimes not a problem. Yet our modes of transportation have changed, our food and diet has changed, and we are living a different lifestyle. It is not just the food that has changed, it actually how we get the food.

I do want to share one approach or value base that drives our people. When we want to focus on a community problem, like Alcoholism or Diabetes, we find it very important to first think of the children. By focusing on the children first in solving a problem we tend to get positive results. It is not difficult for our

village people to consider the needs of children since they are very precious. When the topic or problem revolves around our children, community members will rally their best resources to meet their needs. To sustain our cultural integrity, we must be assured that health care services, health promotion and disease prevention activities and health research, is oriented towards our children first. Everything else will fall into place naturally and we join efforts to work towards getting positive results.

We invite the NIDDK folks here to come and witness the challenges and changes we have highlighted. I have great hopes for the future of our people, back home in Alaska and throughout the remaining parts of Indian Country. We may not put signs on our backs saying let me be a research subject, but we do welcome thoughtful, supportive and respectful research on the disease of diabetes. By operating under the principles of government-to-government consultation, we believe our people would be willing to engage in further dialog with the NIDDK about how the agency might enhance it's understanding of our needs, especially with our children first in mind. Thank you.