2011 Tribal National Health Care Priorities

Investing in the needs based budget is a critical first step to addressing Tribal health care priorities. The following priorities target the most immediate health disparities among AI/AN people. The need to address these disparities is acknowledged in President Obama's Principles for Stronger Tribal Communities.[5]

2011 Tribal National Health Care Priorities

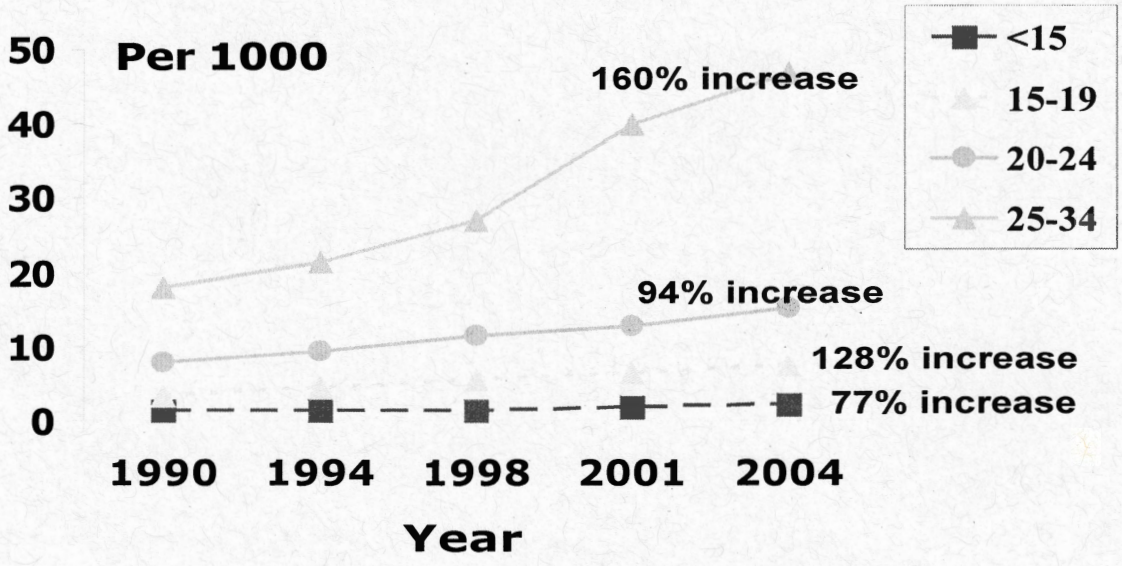
1. Diabetes
2. Cancer
3. Behavioral Health/Alcohol/Substance Abuse/Mental Health
4. Cardiovascular Disease/Heart Disease/Stroke
5. Health Promotion/Disease Prevention
6. Injuries/Injury Prevention
7. Maternal and Child Health
8. Dental Health
9. Water and Sanitation
10. Respiratory/Pulmonary

Below are descriptions and brief narratives for each of the Tribal national health priorities:

1. Diabetes[6]

Diabetes continues to rank as the number one national health focus priority for Tribes. The rates of diabetes for AI/ANs are the highest in the U.S., with rates of diagnosed diabetes in adults as high as 60 percent in some of our communities. Between 1997 and 2004, the prevalence of diabetes increased by 45 percent in all major regions (all ages) served by the Indian Health Service (IHS). The highest rate of increase has occurred among AI/AN young adults aged 25-34 years, with a 160 percent increase from 1990-2004. Alarmingly, type 2 diabetes rose 128% in AI/AN adolescents 15-19 years old.

Prevalence of diagnosed diabetes among children and young people, by age group, 1990-2004



The prevalence of diabetes in AI/ANs under the age of 35 increased by 133% between 1990 and 2004. In 2003, approximately 70% of AI/ANs over 35 had both diabetes and hypertension. Diabetes mortality is more than 3 times higher in the AI/AN population than in the general U.S. population (1999-2001). Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population. For instance, in 2000 in New Mexico, the age-adjusted lower-extremity amputation rate was 3.5 times higher for AI/ANs with diabetes than for non-Hispanic whites. In 2001, the age-adjusted ESRD incidence among American Indians in the Southwest was 2.4 times that of persons with diabetes in the U.S. In 2002, one in every four (24.8 percent) AI/AN elders over age 65 years had coronary heart disease.

The prevalence of diabetes varies among different tribes, but is increasing in all IHS Areas. A recent analysis of the IHS system patient data for AI/ANs under age 35 years showed that the prevalence rate of diagnosed diabetes *doubled* in just 10 years—rising from 8.5 cases per 1,000 people in 1994 to 17.1 cases per 1,000 in 2004. These data are based on the 60% of AI/ANs who used the IHS system for health care services during the 10-year period. Therefore, the effective rate of the remaining 40% could show even higher rates.

Although more recent data is not available yet to show what improvements have been made as a result of recently implemented diabetes treatment and preventions programs, there is general consensus among Tribal leaders that more funds are needed to successfully address this high priority disease burden in Indian country.