AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-24)

Introduced by: Minority Affairs Section

Subject: Cancer Care in Indian Health Services Facilities

Referred to: Reference Committee B

Whereas, cancer is the leading cause of death among American Indian and Alaska Native (AI/AN) persons in the United States (US)[1,2]; and

Whereas, AI/AN Tribes and Villages are sovereign governments that have unique needs and challenges; and

Whereas, AI/AN patients, as dual citizens of their Tribal Nations and the US, are entitled to the same rights and privileges of US citizens, including those relating to healthcare (H-350.976 and H-350.977); and

Whereas, the Indian Health Service (IHS) was established by Article I, Section 8 of the Constitution to provide adequate and timely healthcare, in honoring the government-to-government relationship between the United States and these Tribal organizations[3,4]; and

Whereas, federal IHS facilities do not offer on-site cancer care or provide payment for cancer treatment, unlike other federal health programs like the VA, unless funds are available for referral[5,6]; and

Whereas, several Indian Health Service Areas do not have a single comprehensive cancer care center, increasing the likelihood that AI/AN patients have to obtain care from other public and private payors and shoulder out-of-pocket costs[7]; and

Whereas, funding limitations to the IHS primarily limit health care to direct ambulatory care services, thus denying access to comprehensive, specialty healthcare services to their patients (H-350.977); and

Whereas, many cancers, including liver, stomach, kidney, lung, melanoma, and colorectal cancer have a significantly higher prevalence among AI/AN persons[8]; and

Whereas, for the ten most populated AI/AN reservations, the median travel distance to a National Cancer Institute (NCI) cancer center is 186.5 miles (range 77.8 - 629 miles), and the median travel time is 3.37 hours (range 1.32 - 10.42 hours), while 45.2% of the general US population lives <1 hour from an NCI cancer center[9]; and

Whereas, 14% of the US population lives >2 hours from an NCI cancer center, with 37% of these individuals being identified as AI/AN persons[9]; and

Whereas, a study analyzing the effects of distance on cancer treatment outcomes found that patients who traveled 50 miles or 1+ hour in driving time were associated with a more advanced

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1 disease at diagnosis, and patients in rural areas were found to be twice as likely to have
2 unstaged cancer and/or more advanced disease when compared to urban counterparts[10]; and
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4 Whereas, counties with poor access to healthcare are known to have statistically lower cancer
5 screening rates and higher cancer-related mortality rates[11]; and
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7 Whereas, oncology patients not first seen at NCI-designated Comprehensive Cancer Care
8 Centers have worse outcomes, even when adjusting for sociodemographic and clinical factors[12];
9 and
10
11 Whereas, it is unethical to deny appropriate and timely cancer care to American Indian and
12 Alaska Native patients; therefore be it
13
14 RESOLVED, that our American Medical Association actively advocate for the federal
15 government to continue enhancing and developing alternative pathways for American Indian
16 and Alaska Native patients to access the full spectrum of cancer care and cancer-directed
17 therapies outside of the established Indian Health Service system (Directive to Take Action);
18 and be it further
19
20 RESOLVED, that our AMA (a) support collaborative research efforts to better understand the
21 limitations of IHS cancer care, including barriers to access, disparities in treatment outcomes,
22 and areas for improvement and (b) encourage cancer linkage studies between the IHS and the
23 CDC to better evaluate regional cancer rates, outcomes, and potential treatment deficiencies
24 among American Indian and Alaska Native populations. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

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RELEVANT AMA Policy

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

Cancer and Health Care Disparities Among Minority Women D-55.997
Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment. [Res. 509, A-08; Modified: CSAPH Rep. 01, A-18]

Clinical Preventive Services H-410.967
The AMA: (1) recommends the USPSTF guidelines to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines. [CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Sub. Res. 517, A-12; Modified: CSAPH Rep. 1, A-22]

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