REPORT 31 OF THE BOARD OF TRUSTEES (A-24)
The Morrill Act and Its Impact on the Diversity of the Physician Workforce
Reference Committee C

EXECUTIVE SUMMARY

This report was written in response to Resolution 308 brought forth by the Medical Student Section at the 2022 Annual Meeting of the House of Delegates. This resolution was referred for decision due to concern about legal implications of the first resolve related to both federal and state laws regarding affirmative action, land grant status, and federal trust responsibilities. To inform this action, a management report was subsequently submitted to the Board of Trustees (BOT) entitled "University Land Grant Status in Medical School Admissions." The management report summarized concerns about implementing original Resolution 308-A-22 due to unknown legal implications and potentially unintended and negative consequences for communities that have been historically excluded from medicine. Also, it emphasized the importance of improving the health status of American Indian and Alaska Native (AI/AN) communities and increasing the number of AI/AN physicians who are uniquely qualified to provide care to these communities as well as the need be better understand the Morrill Act and its impact on efforts to diversify the physician workforce. Thus, the management report recommended that in lieu of Resolution 308-A-22, the AMA "study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce."

This report summarizes the extensive history of land acquisition, public education, federal recognition of tribes, the Morrill Act, economic impacts, and current physician workforce. It also reviews the role of the American Medical Association in that history as well as more recent improvement efforts. The report addresses concerns cited by the original author and notes the substantial role that medical education and organized medicine has played and can continue to play for the betterment of the physician workforce and AI/AN students and populations. Diversification of the physician workforce is imperative to meeting the health care needs in underserved communities across the U.S., particularly AI/AN populations. Medical education and organized medicine have much to learn from tribal nations, schools, and agencies to provide more culturally responsive information, understanding, and support. The report offers recommendations to strengthen its existing policies and provide leadership in more actionable efforts.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-24

Subject: The Morrill Act and Its Impact on the Diversity of the Physician Workforce

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee C

INTRODUCTION

At the 2022 Annual Meeting of the House of Delegates, the Medical Student Section authored Resolution 308 that asked the American Medical Association (AMA) to:

> (1) work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility; and (2) amend Policy H-350.981, "AMA Support of American Indian Health Career Opportunities," by addition to read as follows: (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect. (6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI/AN communities.

This resolution was referred for decision, due to concern about legal implications of the first resolve related to both federal and state laws regarding affirmative action, land grant status, and federal trust responsibilities. To inform this action, a management report was subsequently submitted to the Board of Trustees (BOT) entitled "University Land Grant Status in Medical School Admissions." That report noted the central issue is improving the health status of AI/AN communities and the need to increase the number of AI/AN physicians who are uniquely qualified to provide culturally humble care to these communities. Further, it noted there may be risks associated with implementing original Resolution 308-A-22 due to unknown legal implications and potentially unintended and negative consequences for communities that have been historically

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excluded from medicine. The management report identified a need to further understand all components of the Morrill Act that may impact efforts to diversify the physician workforce prior to developing any new policy recommendations. It recommended that in lieu of Resolution 308-A-22, the AMA:

1. Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Association of American Indian Physicians, and Association of Native American Medical Students to increase representation of American Indian physicians in medicine by promoting effective practices in recruitment, matriculation, retention and graduation of American Indian medical students. (Directive to Take Action)
2. Amend Policy H-350.981, "AMA Support of American Indian Health Career Opportunities," by addition and deletion to read as follows:
   (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for <u>stronger clinical exposure and a greater number of</u> health professionals to work among the American Indian population. <u>(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.</u> (Modify Current HOD Policy)
3. **Study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce. (Directive to Take Action)**

This BOT report is in response to Recommendation #3 above.

BACKGROUND

To better understand the Morrill Act and its impact, it is important to review the history of land acquisition and public education as well as the federal recognition of tribes.

Public education and land acquisition

Support for public education was realized early in the formation of the republic. According to the Northwest Ordinance of 1787, "Knowledge, being necessary to good government and the happiness of mankind, schools and the means of education shall forever be encouraged."[1] Those who did receive instruction were primarily white children. Financing for early schools varied and often charged tuition. Thus, many children were not included, depending on income, race, ethnicity, gender, geographic location, and other reasons. Some rural areas had no schools. The nation's leaders at the time "believed strongly that preserving democracy would require an educated population that could understand political and social issues and would participate in civic life, vote wisely (only white men could vote), protect their rights and freedoms, and resist tyrants

and demagogues."[2] Free public education began to expand in the 1830s, with states taking on the provision of public education. Land acquisition, however, was key to implementing such education widely. The largest occupier and 'owner' of such land at the time were American Indians — the native and original caregivers of what is now the United States.

By 1887, American Indian tribes owned 138 million acres. However, the passage of the General Allotment Act of 1887 (The Dawes Act) greatly impacted such ownership as their land became subject to state and local taxation, of which many could not afford. By 1934, the total had dropped to 48 million acres.[3] The Indian Reorganization Act of 1934 (IRA) tamed this era of allotment and marked a shift toward the promotion of tribal self-government. Subsequent Congressional acts impacting tribes and their land — ownership, use, and development — include the following:

- Indian Mineral Leasing Act: 1938
- Indian Self-Determination and Education Assistance Act: 1975
- Indian Mineral Development Act: 1982
- Indian Tribal Energy Development and Self-Determination Act: 2005
- Indian Tribal Energy Development and Self-Determination Act Amendments: 2017

There are approximately 2.4 billion acres in today's United States.[4] About 56 million acres of that land (2.3%) is currently held in trust by the U.S. for various American Indian tribes and individuals, making up the majority of American Indian land.[2] With trust land, the federal government holds legal title but the beneficial interest remains with the individual or tribe. Trust lands held on behalf of individuals are known as allotments. Fee land, on the other hand, is purchased by tribes whereby the tribe acquires legal title under specific statutory authority.

The Morrill Act and land-grant universities

In 1862, Congress passed the Morrill Act named after Senator Justin Morrill of Vermont. "This act made it possible for states to establish public colleges funded by the development or sale of associated federal land grants. The original intention was to fund colleges of agriculture and mechanical arts.[5] Over 10 million acres provided by these grants were expropriated from tribal lands of Native communities. The new land-grant institutions, which emphasized agriculture and mechanic arts, opened opportunities to thousands of farmers and working people previously excluded from higher education."[6] Much of this land was taken from American Indian tribes for the benefit of white people by way of treaties and agreements (many of which the federal government did not uphold its end) as well as seizure. In other words, "The government took the land for which it paid little or nothing, from tribes with little bargaining power, that were impoverished, and that were sometimes subject to threats to withhold rations and other benefits if they did not comply."[7] These now 'public lands' were surveyed into townships, and sections were reserved for public schools; however, the land itself was often sold off, with proceeds used to fund the school program. "The system invited misuse by opportunists, and substantial portions of the educational land-grants never benefited education."[6] Support for land-grants was a significant factor in providing education to white American children.

By way of the Morrill Act, the government granted each state 30,000 acres of public land, issued to its Congressional representatives and senators to be used in establishing a "land grant" university. Some of the land sales financed existing institutions while others chartered new schools. This allocation grew to over 100 million acres. The Morrill land grants put into place a national system of state colleges and universities. Examples of major universities that were chartered as land-grant schools are Cornell University, Washington State University, Clemson University, and University of Nebraska-Lincoln.

1 Following the Civil War, a Second Morill Act was passed in 1890 to address the exclusion of
2 Black individuals from these educational opportunities due to their race. "It required states to
3 establish separate land-grant institutions for Black students or demonstrate that admission was not
4 restricted by race. The act granted money instead of land."[6] The 1890 Foundation provides
5 additional information about these 19 historically Black colleges and universities (HBCUs), which
6 include Tuskegee University, Tennessee State University, and Alabama A&M University. In 1994,
7 a third land-grant act was passed — the Equity in Educational Land-Grant Status Act — that
8 bestowed land-grant status to American Indian tribal colleges. As a result, these colleges are
9 referred to as the "1994 land-grants."[8] Today's land grant university (LGU) system is comprised of
10 institutions resulting from the above-mentioned acts passed in 1862 (57 original), 1890 (19
11 HBCUs), and 1994 (35 Tribal). "LGUs are located in all 50 states as well as the District of
12 Columbia and six U.S. territories. Of note, the "1994 institutions receive fewer federal funds
13 administered by National Institute of Food and Agriculture — in total — than 1862 and 1890
14 institutions, and they are ineligible for certain grant types available to 1862 and 1890 institutions.
15 Whereas the 1862 and 1890 institutions receive federal capacity funds specific to agricultural
16 research and extension (which brings research to the public through nonformal education
17 activities), 1994 institutions do not. Although 1994 institutions have more limited enrollment and
18 offer fewer postsecondary degrees than 1862 and 1890 institutions, some argue that funding for
19 agricultural research and extension at the 1994 institutions is insufficient and should be increased."[9]
20
21 *Education of American Indians*
22
23 The inaccurate perception of American Indians as unintelligent and uncivilized led Congress to
24 pass the Indian Civilization Act in 1819 which paid missionaries to educate Natives and promote
25 the government's notion of civility. Most American Indian children at that time were forcefully
26 relocated and brought to these schools to begin the assimilation into the "Western way of life"
27 under the authority of that Act — thus beginning the troubled history of American Indian boarding
28 schools that is still felt by current generations. One such school built in 1879, the Carlisle Indian
29 Industrial School, coined the term "Kill the Indian to save the man" summarizing a belief system to
30 erase Native culture through assimilation.[10] These children were forcibly separated from their
31 families and not allowed to practice their spirituality, speak their language, or live according to
32 their culture under threat of punishment. They were even given new names. These practices
33 continued through the 1960s. In 1969, a Senate report of the Committee on Labor and Public
34 Welfare, entitled "Indian Education: A National Tragedy--A National Challenge"," summarized
35 the devastating effects of forced assimilation of Native children and the failures of the education
36 system where students also experienced physical abuse, sexual violence, hunger, forced
37 sterilizations, and exposure to diseases. The trauma associated with this contributes to a well-
38 documented historical trauma that has been correlated to the high number of suicides and health
39 inequities experienced by American Indians in the U.S.[11] This trauma has had a devastating impact
40 on the potential number of students who consider enrollment in higher education due to a distrust
41 of any system associated with the U.S. government. Many who have been directly affected by
42 historical traumas have to overcome barriers like depression or other chronic diseases to participate
43 in a system that still does not align to their way of knowing. There was little consideration for the
44 higher education of American Indians (nor how to include a non-colonial perspective) until 1972
45 with the formation of the American Indian Higher Education Consortium (AIHEC). Through its
46 network of tribal colleges and universities (TCUs), AIHEC "provides leadership and influences
47 public policy on American Indian higher education issues through advocacy, research, and program
48 initiatives; promotes and strengthens indigenous languages, cultures, communities, and tribal
49 nations; and through its unique position, serves member institutions and emerging TCUs."[12]

American Indian affairs and federal recognition of tribes

In 1775, Congress created a Committee on Indian Affairs under the leadership of Benjamin Franklin. The U.S. Constitution (Article I, Section 8, Clause 3) gave Congress the power "to regulate commerce with foreign nations, and among the several States, and with the Indian tribes." The Bureau of Indian Affairs (BIA) — known over the years as the Indian Office, the Indian Bureau, the Indian Department, and the Indian Service —was established in 1824 to oversee and carry out the government's trade and treaty relations with the tribes. The BIA received statutory authority from Congress in 1832; in 1849, it was transferred to the newly created U.S. Department of the Interior.[13] "Over the years, the BIA has been involved in the implementation of federal laws that have directly affected all Americans. The General Allotment Act of 1887 opened tribal lands west of the Mississippi to non-Indian settlers, the Indian Citizenship Act of 1924 granted American Indians and Alaska Natives U.S. citizenship and limited rights to vote, and the New Deal and the Indian Reorganization Act of 1934 restored self-determination and dictated a model the United States expected tribal governments to use. The World War II period of relocation and the post-War termination era of the 1950s led to the activism of the 1960s and 1970s that saw the takeover of the BIA's headquarters and resulted in the creation of the Indian Self-Determination and Education Assistance Act of 1975. This act as well as the Tribal Self-Governance Act of 1994 have fundamentally changed how the federal government and the tribes conduct business with each other."[13] Although the BIA was once responsible for providing health care services to American Indians and Alaska Natives, that role was legislatively transferred to the U.S. Department of Health, Education, and Welfare (now known as the Department of Health and Human Services) in 1954.[13] It remains there under the auspices of the Indian Health Service (IHS). However, funding for this continues to be a problem. In 2019, IHS spending per capita was only $4,078 while the national average spending per capita was $9,726.[14] At that time, it was also reported that American Indians and Alaska Natives (AI/AN) had a life expectancy 5.5 years less than the U.S. all races population (73.0 years compared to 78.5 years) and "die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases."[15] Groups such as the Tribal Sovereign Leaders on the national Tribal Budget Formulation Workgroup (TBFWG) have provided, and continue to provide, significant insights to inform IHS budget requests.

According to the BIA, "a federally recognized tribe is an AI/AN tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the BIA. Furthermore, federally recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States."[16] Over the years, most of today's federally recognized tribes received federal recognition status by way of treaties, acts of Congress, presidential executive orders or other federal administrative actions, or federal court decisions. In 1978, the Department of the Interior issued procedures for federal acknowledgment of Indian tribes to more uniformly handle requests — found in Part 83 of Chapter 25 of the Code of Federal Regulations.[17] In 1994, Congress enacted the Federally Recognized Indian Tribe List Act. It formally established three ways to achieve federal recognition: (1) by act of Congress, (2) by the administrative procedures under 25 C.F.R. Part 83, or (3) by decision of a United States court. Congress has the authority to terminate a relationship with a tribe, and only Congress can restore its federal recognition. The act also requires the Secretary of the Interior to annually publish information on federally recognized tribal entities.[18]

As of January 2023, there were 574 federally recognized Tribal entities.[19] There are also many tribes that are not state or federally recognized. There are 324 federally recognized American Indian reservations where 13 percent of the AI/AN population lives. The 2020 Census indicates that 87 percent live outside of tribal statistical areas. It also shows that 9.1 million people identify as AI/AN alone or in combination (2.9 percent of total U.S. population).[20]

DISCUSSION

Economic and educational impacts

The Morill Act, as well as the Homestead Act of 1862, had a significant impact on American expansion. The Homestead Act encouraged western migration by providing settlers with 160 acres of land. Such settlers were required to live on and cultivate the land. After five years, they were entitled to the property upon payment of a small filing fee. While they certainly fostered prosperity and educational opportunities for new American settlers, these came at the expense of the original people — American Indians. The economic significance of these acts cannot be understated. In 2019, sixteen land-grant universities retained over half a million acres of Indigenous lands, generating at least $8.7 million.[21] See Appendix A for a table of remaining Morrill Act lands and revenue by university.

In addition to the economic impact, thousands of American Indian families were affected by the Indian Civilization Act and boarding schools. Given the lingering effects to this day, it stands to reason that many AI/AN students have a negative attitude toward the education system. According to the Bureau of Indian Education (BIE), "Native youth have the lowest high school graduation rate of students across all schools. Nationally, the AI/AN high school graduation rate is 69 percent, far below the national average of 81 percent."[22] The BIE funds elementary and secondary schools on 64 reservations in 23 states, serving approximately 42,000 Indian students.[23] These BIE schools hold an average graduation rate of 53 percent. The BIE also serves AI/AN post-secondary students through higher education scholarships, supports funding for tribal colleges and universities, and directly operates two post-secondary institutions — Haskell Indian Nations University in Kansas and the Southwestern Indian Polytechnic Institute in New Mexico.

Medical education and the physician workforce

Significant school dropout rates and lower enrollment in higher education have negatively impacted AI/AN representation in medical education and the physician workforce. According to 2023-2024 data from the Association of American Medical Colleges (AAMC), 1,045l AI/AN students were enrolled in MD-granting medical schools (about 1percent of the total student population). Further, only 188 AI/AN students graduated from MD-granting medical schools.[24] This significant decline from enrollment to graduation is very concerning; medical education needs to figure out why and what to do about it. The entire educational pathway (PreK-12 and undergraduate) may need to be considered to help AI/AN students to prepare for their studies, promote a sense of belonging, and avail themselves of mentorship opportunities. Tribes have a vested interest in the training of AI/AN students, given they are more likely to return to and serve their own communities as physicians. Such efforts will ultimately foster tribal self-governance and self-determination.

Several universities have taken steps to increase AI/AN representation in medical schools. In 1973, the University of North Dakota launched the Indians Into Medicine (INMED) program, which has recruited, supported, and trained 250 AI/AN physicians. This program has served as a model for other health professions within the university as well as for other medical schools that receive IHS

funding. Since many students face financial hardship, INMED offers a free summer program called Med Prep that provides students with stipends, and it helps its medical school students identify potential scholarship options. The university went one step further in 2020 to launch the country's first PhD. program in Indigenous health.[25] Another example is Oregon Health & Science University (OHSU) School of Medicine and its Wy'east Pathway, a 10-month postbaccalaureate program for AI/AN students who unsuccessfully applied to medical school, have an MCAT score below a certain cutoff, or lack clinical experience. The program provides biomedical and MCAT classes as well as cultural support and skills-building to promote success in medical school.[26] Not only do programs like these directly support AI/AN students, but they also promote collaboration with and inclusion of non-indigenous allies. This combination can help to turn the tide on the workforce issue.

The impact of low representation in medical schools is evident when examining the diversity of physician workforce. In 2022, 0.3% of active physicians identified as AI/AN.[27] According to a 2018 report from the U.S. Government Accountability Office, the vacancy rate at IHS clinics among staff physician positions was about 29% across the eight IHS geographic regions; the highest vacancy was 46% in the areas servicing Bemidji, Minnesota, and Billings, Montana.[28] In addition to representation in practicing medicine, there are also deficits in AI/AN representation in academic positions. One study found that, compared with their white peers, AI/AN individuals had 48% lower odds of holding a full-time faculty position post residency.[29]

As mentioned in other parts of this report, there is distrust in colonial constructs (U.S. laws, policies, and institutions), but there may also be distrust in the colonial medicine through IHS because of the history of forced sterilization and because traditional forms of medicine were outlawed (as well as any religious/cultural beliefs associated with them). In fact, the Department of the Interior's 1883 Code of Indian Offenses noted that "any medicine man convicted of encouraging others to follow traditional practices was to be confined in the agency prison for not less than 10 days or until he could provide evidence that he had abandoned his beliefs."[30] This context has given rise to a distrust of medicine and medical education that continues today.

In June 2023, the Supreme Court of the U.S. (SCOTUS) issued a ruling on affirmative action that eliminated race as a consideration in college and universities' admission processes. This ruling should not change tribal colleges; however, will it likely impact AI/AN students who attend non-tribal institutions because most wrongly collect tribal identity as a racial category. "Most, if not all, mainstream colleges and universities rely entirely on self-reporting when it comes to determining tribal identity of students. This means if a Native student doesn't indicate they are a tribal citizen, then they are not counted as such."[31] This lack of data can impact the understanding of student enrollment as well as funding opportunities. It is critical to re-emphasize that "Native American" is not only a racial category but also the designation which gives those who are enrolled in federally recognized tribes a protected classification by treaty and is not subject to the SCOTUS decision on race/ethnicity. Many schools may not include identifying Native Americans in their admissions consideration as they may fear violation of the SCOTUS decision.

The AMA's role: accountability and restitution

The AMA and its members play a complicated role in the history of American Indians. AMA members were party to the claiming of land in the "Western territories" in the mid-1850s, as described in the A-1857 report "Report on the Fauna and Medical Topography of Washington Territory. AMA archives contain a 1865 report entitled "On Some Causes Tending to Promote the Extinction of the Aborigines of America" which details study of the Onondoga tribe, concluding "But those of us who pity and strive to arrest the downward course of this remnant of the original

lords of the forest, may delay what we are wholly unable to prevent, for I much fear that before the poor Indian has learned the laws of his physical nature and how to obey them, economy of time and means, industry, and reliance upon his own muscles and broad acres for his support, instead of looking for the government to hire his teacher and physician, and for his wants to be met by others, without forecast and plan of us own — before these radical changes in his habits are effected — the waning remnant of the Onondagas will forever have passed away."[32]

Physicians were involved in American Indian boarding schools, the development of the Indian Health Service, and the study of illnesses and healing practices on AI/AN tribes. Their works were published in JAMA and included:

- The Medicine and Surgery of the Winnebago and Dakota Indians (1883)
- Improved Sanitary and Social Conditions of the Seminoles of Florida (1896)
- Indian Method of Treating Measles (1903)
- The Indian Medical Service (1913)

Past harms also include the AMA's role in promulgating discriminatory practices resulting from the Flexner Report, a landmark 1910 criticism of U.S. medical education resulting in a reduction in the number of medical schools including the closing of 5 out of the 7 historically black medical schools. Past decisions such as these continue to negatively impact populations in need. The AMA acknowledges that AI/AN populations experience significant health disparities up to the present including lower access to care and underfunding of public programs such as the Indian Health Service serving AI/AN communities. In addition, AI/AN persons continue to be severely underrepresented in the physician and healthcare workforce.

The AMA launched various supportive efforts such as:

- Asked the federal government to step in to stop the spread of trachoma in Native communities (A-1924) and provide better health services for the population (A-1929);
- Issued AMA Statement on Infant Mortality (A-1968);
- Advocated for the transfer of functions relating to health and hospitalization of American Indians from the Bureau of Indian Affairs to the U.S. Public Health Service (I-1953);
- Appealed for more funding for hospitals and health services on reservations (I-1957);
- Collaborated with the IHS on efforts related to health care delivery and health aide training programs (I-1970);
- Led large-scale study of health care for American Indians that was used to guide the Senate's "Indian Health Care Improvement Act" of 1976 (I-1973);
- Created Project USA to recruit physicians to medically underserved areas, including AI/AN reservations (I-1975);
- Sought to exempt Indian Health Services from competitive procurement practices regulations (A-1984);
- Initiated a project with the AAIP to improve health care for American Indians (A-1995);
- With the National Medical Association, established the Commission to End Health Care Disparities in 2004 – a collaboration of health care organizations to address racial and ethnic health care disparities and diversity in the physician workforce.
- In 2013, the AMA launched its innovative "Accelerating Change in Medical Education" initiative to rebuild medical education from the ground up. Now known as the ChangeMedEd initiative, this effort has fostered collaborations with schools like Oregon Health & Science University School of Medicine and the University of Washington School of Medicine to increase the numbers of AI/AN students and faculty.

1 Although the Commission was retired in 2016, a new effort emerged in 2018 through the adoption
2 of policy calling for a strategic framework to address health equity on a national scale — resulting
3 in the creation of the AMA Center for Health Equity. Among other things, the Center is leading a
4 task force that will "guide organizational transformation within and beyond the AMA toward
5 restorative justice to promote truth, reconciliation, and healing in medicine and medical education.
6 …The task force will inform and advise the AMA on ways to establish restorative justice dialogues
7 between AMA leaders, physicians from historically marginalized racial and ethnic groups and their
8 physician associations, and other critical stakeholders."[33]
9
10 Recently, an AMA article from December 2023 addressed vacancies at the Indian Health Service.
11 Also, an AMA Update on January 8, 2024 discussed how tribal medical education programs could
12 solve the rural health care crisis. Featuring Oklahoma State University College of Osteopathic
13 Medicine's unique partnership with The Cherokee Nation, the discussion addressed the importance
14 of physicians truly understanding the communities they serve.
15
16 AMA Advocacy has been actively participating in efforts to support AI/AN populations and related
17 physicians. Federal efforts in just the last two years include:
18 - May 2022: Letter sent to Senators Mastro and Murkowski in support of the Indian Health
19 Service Health Professions Tax Fairness Act (S.2874).
20 - April 2023: Letter sent to U.S. Department of Agriculture addressing Menu Planning
21 Options for American Indian and Alaska Native Students.
22 - October 2023: Letter sent to U.S. Department of Health and Human Services and Indian
23 Health Service to highlight the importance of high quality, timely care for American
24 Indians, Alaska Natives, and Native Hawaiians, particularly as it related to physician and
25 medical student members.
26 - February 2024: Multi-organizational letter sent to both the House Appropriations
27 Subcommittee on Interior and Senate Appropriations Subcommittee on Interior,
28 Environment, and Related Agencies, Environment, and Related Agencies. This letter
29 detailed support for the inclusion of $30 million in new funding in the FY2025 Interior,
30 Environment, and Related Agencies appropriations bills to address chronic clinical staff
31 shortages across Indian Country through GME programming.
32
33 The AMA Foundation (AMAF) funds the Physicians of Tomorrow Program. This program
34 distributes a $10,000 tuition assistance scholarship to medical students approaching their final year
35 of school with the goal of creating a diverse cohort of students who are dedicated to serving
36 underserved communities. The AMAF is also bringing attention to AI/AN issues in medical
37 education, as seen in a 2022 article featuring AMA members.
38 The AMA Ed Hub™ offers a variety of equity-related educational opportunities — from its panel
39 discussion on Truth and Reconciliation in Medicine to its Prioritizing Equity series. Titles of
40 relevance include:
41 - For Us, By Us: Advocating for Change in Native Health Policy
42 - Getting to Justice in Education
43 - The Root Cause and Considerations for Health Care Professionals
44 - How the Past Informs the Present in Healthcare
45
46 RELEVANT AMA POLICIES
47
48 The AMA has several policies in support of AI/AN tribes and communities as well as students and
49 trainees in order to foster diversity of the physician workforce in an effort to improve public health
50 including AI/AN populations. For example:

- AMA Support of American Indian Health Career Opportunities H-350.981 promotes recruitment of AI/AN into health careers including medicine and the concept of AI/AN self-determination.
- Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980 establishes a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.
- Underrepresented Student Access to US Medical Schools H-350.960 recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
- Strategies for Enhancing Diversity in the Physician Workforce H-200.951 supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality.
- Cultural Leave for American Indian Trainees H-350.957 recognizes the importance of cultural identity in fostering trainee success and supports accommodating cultural observances.

See Appendix B for the full policies. Additional policies can be accessed in the AMA Policy Finder database, which include:

- Strategies for Enhancing Diversity in the Physician Workforce D-200.985
- Continued Support for Diversity in Medical Education D-295.963
- AMA Support of American Indian Health Career Opportunities H-350.981
- Indian Health Service H-350.977
- Desired Qualifications for Indian Health Service Director H-440.816
- Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
- Improving Health Care of American Indians H-350.976
- Plan for Continued Progress Toward Health Equity H-180.944

SUMMARY AND RECOMMENDATIONS

This report illuminates these concerns as well as the substantial part that medical education and organized medicine has played and can continue to play for the betterment of the physician workforce and AI/AN students and populations. Organizations like the Association of American Indian Physicians (AAIP) hold an esteemed role in such efforts. AAIP was established in 1971 by a group of 14 AI/AN physicians to support AI/AN communities and serve as an educational, scientific, and charitable nonprofit.

As stated in the AAMC's 2018 publication, Reshaping the Journey: American Indians and Alaska Natives in Medicine, "Medical schools are chiefly responsible for the development of what the physician workforce looks like today and what it will look like in the future…. We must view this issue as a national crisis facing not just the American Indian-Alaskan Native (AI/AN) communities, but all medical schools and teaching hospitals…. We need transformative thinking and a new systems-based approach if we are to resolve this crisis with a plausible solution."[34] Diversification of the physician workforce is imperative to meeting the health care needs in underserved communities across the U.S., particularly AI/AN populations. Also, medical education has much to learn from tribal nations, schools, and organizations to provide more culturally responsive information, understanding, and support.

The Board of Trustees that the following recommendations be adopted, and the remainder of this report be filed. That our AMA:

1. Amend AMA Support of American Indian Health Career Opportunities H-350.981 by addition to read:

   (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.

   (6) Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.

2. Amend AMA Support of American Indian Health Career Opportunities D-350.976 by deletion of clause (2) as having been accomplished by this report.

   ~~(2) study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce~~.

3. Amend AMA Support of American Indian Health Career Opportunities D-350.976 by addition of a new clause to read:

   Convene key parties, including but not limited to the Association of American Indian Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as Indian Health Service and National Indian Health Board, to discuss the representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students.

4. Reaffirm the following policies:
   a. Indian Health Service H-350.977
   b. Underrepresented Student Access to US Medical Schools H-350.960
   c. Strategies for Enhancing Diversity in the Physician Workforce H-200.951
   d. Continued Support for Diversity in Medical Education D-295.963
   e. AMA Support of American Indian Health Career Opportunities D-350.976.

Fiscal note: $1,000

APPENDIX A: Remaining Morrill Act lands and revenue by university

University	Total Morrill acres found	Endowment raised as of 1914	Remaining acres with surface rights	Surface royalties raised, FY 2019	Remaining acres with mineral rights	Mineral royalties raised, FY 2019
Colorado State University	89,321	$185,956	19,130	$77,526	42,572	$662,596
Kansas State University	87,290	$491,746	0	N/A	6,080	$163,345
Montana State University	140,385	$533,149	63,474	$623,941	77,929	$6,670
New Mexico State University	248,964	$241,909	194,571	$1,217,672	254,200	$353,587
North Dakota State University	130,471	$455,924	15,117	$308,142	66,109	$2,874,800
South Dakota State University	159,832	$128,804	36,617	$608,583	160,000	$27,365
University of Arizona	143,684	$450,000	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN
University of California	150,525	$732,233	0	N/A	441.6	$1,947
University of Idaho	87,445	$129,615	33,527	$358,258	70,000	$1,188
University of Minnesota	94,631	$579,430	0	N/A	240	$0
University of Missouri	270,613	$363,441	14,787	UNKNOWN	0	N/A
University of Nebraska	89,920	$560,072	6,173	$426,619	0	N/A
University of Wisconsin	235,690	$303,594	0	N/A	6,400	$0
University of Wyoming	89,849	$73,355	71,066	UNKNOWN	UNKNOWN	UNKNOWN
Utah State University	198,837	$194,136	27,577	$83,769	51,724	$943,843
Washington State University	90,081	$247,608	71,147	$4,250,000	86,657	$1,936

The land-grant universities still profiting off Indigenous homelands, High Country News, 2020.

APPENDIX B – RELEVANT AMA POLICIES

AMA Support of American Indian Health Career Opportunities H-350.981
AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980
Our AMA will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in

better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

Cultural Leave for American Indian Trainees H-350.957
Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with their requirements for a diverse student body and faculty. 5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population. 6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity. 7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers. 8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs. 9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities. 10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP). 11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. 12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population. 13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Continued Support for Diversity in Medical Education D-295.963
Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee

on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

AMA Support of American Indian Health Career Opportunities H-350.981
AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2)) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian

care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs. (7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

Desired Qualifications for Indian Health Service Director H-440.816
Our AMA supports the following qualifications for the Director of the Indian Health Service:
1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility. 2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health. 3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community. 4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care. 5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs. 6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people. 7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities. 8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations. 9. Experience with management, budget, and federal programs.

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers. 2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service. 3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction. 4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service. 5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations. 6. Our AMA supports an increase to the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) and encourages state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally driven health improvement programs.

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.

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

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