1975

Health and Wellness Projects in New Mexico Native Communities: An Activity Resource Kit

Unknown

ANCHORAGE SERVICE UNIT

Contract Dental Expenditures
North Pacific Rim Communities

Reportable Dental Services and Service Minutes Provided

Community	*FY 1974				*FY 1975				*FY 1976			
	Mode	Patients	Services	Service Min.	Mode	Patients	Services	Service Min.	Mode	Patients	Services	Service Min.
Cordova	Contract	66	267	3,610	Contract	191	817	14,297	Contract	160	620	10,380
Seward	Contract	217	961	13,328	Contract	177	764	10,852	Contract	282	1,246	18,946
Homer	Contract	222	1,164	16,321	Contract	80	367	6,153	Contract	52	271	4,144
English Bay**	Contract	1	3	28	Contract	20	100	1,656	Contract	14	55	979
Port Graham**	Contract	3	13	160	Contract	45	222	3,764	Contract	31	158	2,445
Seldovia	Contract	2	33	483	Contract	21	117	1,912	Contract	44	254	4,462
Valdez	Direct	26	67	928	Direct	48	100	1,710	Direct	31	142	2,145
Tatitlek	Direct	25	61	858	Direct	18	84	1,288	Direct	27	146	2,455
		562	2,569	35,716		600	2,571	41,632		641	2,892	45,956

* Reportable Services by IHS definitions are broad categories of clinical services and do not include frequently performed procedures as x-rays, diagnostic costs, prosthetic repairs, palliative treatments, consults, education sessions, follow-up visits, etc.

**Errors in reporting may account for lower services in these communities. The patients were probably reported as Homer patients.

6. Eye Disease*

Eye care has always been a neglected health need of the Alaska Native population. Presently, there are but two optometrists servicing the entire Native population of Alaska through the Alaska Native Medical Center.

North Pacific Rim communities, have been visited by an itinerant ANMC optometrist only once, in 1976 when a clinic was held in English Bay and Port Graham. ANMC optometrists have not been to Cordova, Seward, Tatitlek, nor Valdez.

The ANMC optometry section projects that 2/3 of the Native population requires optometric care. Within the Chugach Region this means that approximately 850 Natives are in need of optometric services. Of these 850, 1/3 or 283 persons should be seen each year. Based upon their experience 18% of the total population will need yearly prescriptions or approximately 230 persons.

In addition to these necessary refractions, other persons with pathologic eye conditions must be seen regularly. A 1968 statewide survey done by Comprehensive Health Planning identified visual impairments as the leading cause of disability and handicap among all Alaskans.

The survey of handicapping conditions carried out in 1968 by the Statewide Comprehensive Planning Project identified visual impairments as the leading cause of disability and handicap among all Alaska citizens. Among Alaska Natives, several eye conditions appear to exist at a magnitude disproportionate to other populations. They are corneal scarring, glaucoma, iritis, strabismus, and refractive error. In October of 1969, the Alaska Department of Health listed 93 recipients of Aid to the Blind. Of these, 89 were Alaska Natives, who comprised only 28% of the population, yet received nearly 96% of the Aid to the Blind.

Glaucoma is one of the major causes of blindness. Many people are blind in one eye because diagnosis and treatment were not available early enough. A few people have lost vision in both eyes from glaucoma. Glaucoma is one of the major causes of blindness, but it is a treatable disease when identified early.

Glaucoma surveys conducted as pilot projects in two widely separated villages in 1970 showed a rate of glaucoma suspects of 8% among villagers over the age of 40 years, a rate four times the national average. The estimated total population 35 years of age and over is approximately 12,500 and if larger surveys confirm the findings of the pilot projects, the glaucoma caseload will be 996. The estimated Chugach Native population over 35 years of age is 525. Projecting the incidence of glaucoma in this population based upon AANHS pilot projects yields a glaucoma caseload of 42 persons.

The very high prevalence of corneal scarring among the Alaska Natives is the result of the previously high rate of acute phlyctenular kerato-conjunctivitis (PKC). PKC is a condition of the eye usually associated with tuberculosis and characterized in the acute stage by painful, intense inflammation of the conjunctiva and cornea. Unless promptly treated, corneal scarring is left when the acute stage subsides. For some, these scars are so dense and opague that the patients are completely blind. The only method of treatment is corneal transplantation. Formerly, the results of this operation were very disappointing because the transplanted cornea also eventually became scarred. Recently there have been technological improvements so that most cases operated in the past several years have resulted in significant restoration of vision.

7. Health Aide Encounters

Attempts to gather statistical information about the Health Aide work load proved to be a cumbersome task. Health Aides are required to report to the ANMC outpatient and CHAP offices on a four-copy "log" the name, age, diagnosis, and treatment of each patient encounter. Upon inquiry into the destiny of these medical records submitted by the Health Aides it was learned: 1) they are destroyed by being shredded every three months by the CHAP training office, and 2) "discarded as the assigned field doctor sees fit after looking at them."[2]

Statistics gathered from Health Aide logs reveal that Health Aides are doing a tremendous volume of primary health care and should be regarded as the hub of the health delivery system of North Pacific Rim at the village level. Sample Health Aide encounters are shown on the following table.

*Information for this section is summarized from ANMC Annual Operating Plans and discussions with Dr. Bigelow, ANMC Optometrist.

2. Per conversation with Dr. Gloria Parks, ANMC Outpatient Chief, July 21, 1977.

SAMPLE HEALTH AIDE ENCOUNTERS IN PORT GRAHAM FOR SEPTEMBER 1976 - AUGUST 1977

Respiratory problem	480
*Diabetes	322
Ear problems	90
Hypertensive problems	76
Gastro/intestinal	110
Skin disorders	177
Cardiovascular	62
Neurological	52
Gynecological	44
Urinary	34
Arthritis	34
	1,401

Disability

Indicators of disability were hard to obtain. The only data that meet our criteria for an indicator are the number of individuals in state funded residential facilities.

NUMBER OF INDIVIDUALS IN STATE-FUNDED RESIDENTIAL FACILITIES FOR THE DEVELOPMENTALLY DISABLED FEBRUARY, 1977 CENSUS—CHUGACH REGION

Village:	
Seward	2 at Harborview Developmental Center, Valdez Birthplace: 1 Seward, 1 Anchorage
Tatitlek	1 at Harborview Developmental Center Birthplace: Valdez
Valdez	1 at Harborview Developmental Center Birthplace: Anchorage

SOURCE: DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES MENTAL HEALTH INFORMATION SYSTEM JULY 25, 1977.

Although regional Native specific data are not available, it can be assumed that the high rate of accidents cause substantial disabling activity among the Native population.

*One person's home was visited each day for injections.

Further, the disabling effects of alcoholism are significant. The State Office of Alcoholism has attempted to measure the economic cost of alcohol abuse within the state. Their report estimates an economic cost of $131.2 million in 1975, with the greatest proportion of amount (65.8%) attributed to loss of production, i.e., diminished productivity, occupational injuries, and excess mortality due to alcoholism and alcohol abuse (State Office of Alcoholism: 1975).

Additionally, the South Central Health Planning & Development has identified hearing loss, resulting from otitis media, as a significant disabling condition among the Native population in the South Central Health Service Area (SCHPD: 1977).

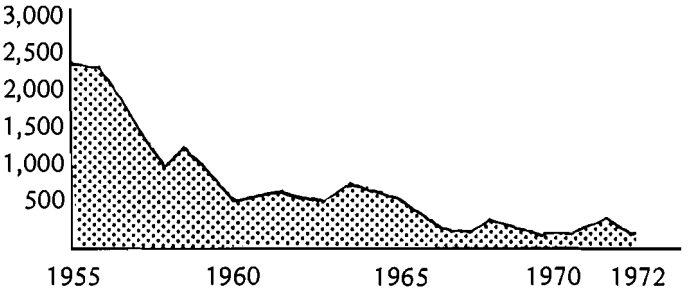
Health Status Trends

Major shifts in the types of mortality and morbidity have occurred in both the Native and non-Native populations. The types of disease now requiring treatment are often due to factors beyond the realm of the traditional medical care system.

For example, the Native population has experienced a tremendous decrease in the areas of tuberculosis morbidity and mortality (Figures 1 and 2) and infant mortality (Figure 3). The changing pattern of death rates (Table 1) and causes for hospitalization (Table 2) demonstrate clearly the dramatic trend away from infectious disease and toward the pattern of chronic degenerative diseases characteristic of our modern society at large.

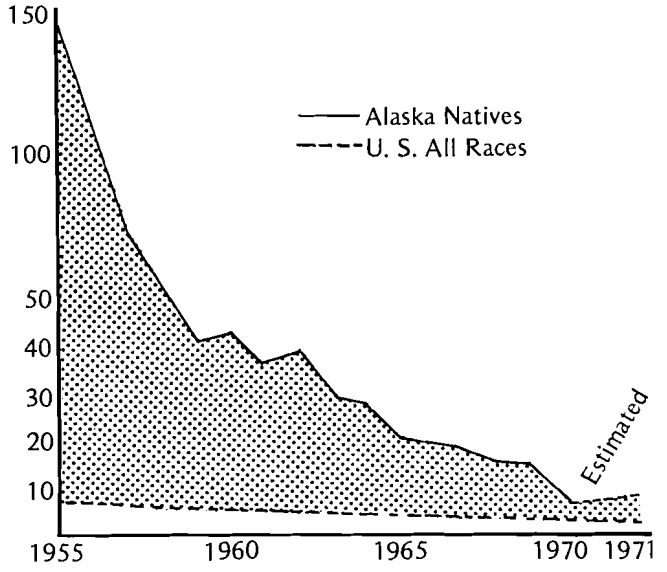
Many of the health status indicators outlined in this section have their etiology in the impact of rapid social changes and accompanying changes in lifestyle.

Figure 1
Alaska Native Tuberculosis Morbidity Rates (per 100,000)



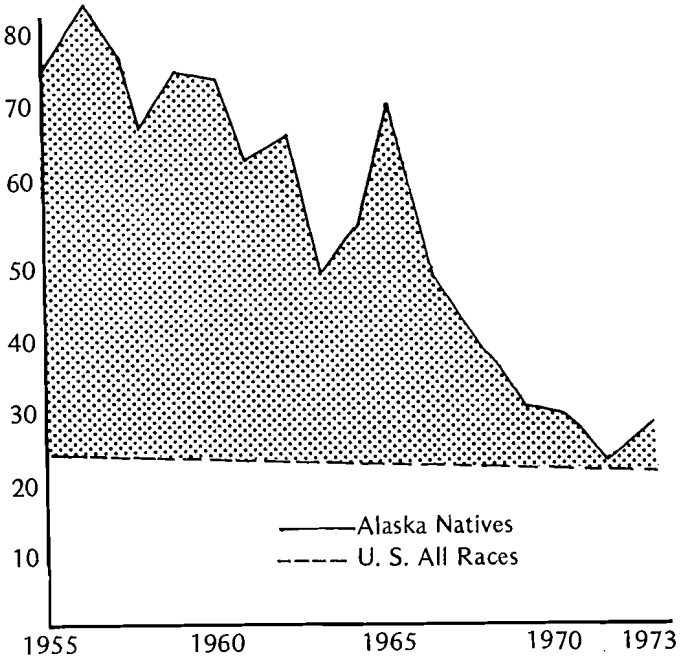
SOURCE: FORTUINE, HEALTH CARE AND THE ALASKA NATIVE.

Figure 2
Tuberculosis Death Rates (per 100,000)
Alaska Natives and U. S. All Races



SOURCE: (FORTUINE: 1975)

Figure 3
Infant Mortality Rates (per 1,000 live births)
Alaska Natives and U. S. All Races



SOURCE: (FORTUINE: 1975)

The following statements from a recent DHEW study *Trends in Health Care* highlight nationwide disease trends in the United States:

- Drug addiction is clearly on the rise.
- Alcoholism is increasingly recognized as a serious problem.
- Mental illness is growing.
- Death from suicide and homicide is rising.
- The incidence of venereal disease has reached epidemic proportions.
- Heavy cigarette smoking is increasingly being indicated as a contributor to such health problems as lung cancer, heart diseases, peptic ulcers, and chronic sinusitis.
- Cancer has continued to rise steadily.
- The prevalence of major cardiovascular diseases in this country has grown significantly.
- The death rate from accidents is lower today than it was in 1950, but the rate of injuries from accidents has climbed considerably.

With the exception of the first part of this last statement on accidents, these trends are particularly relevant to the health status of Alaska Natives today, and reflect the degree to which the Chugach Native's health is affected by elements outside the traditional realm of the health care system.

As Fortuine has noted . . . .

"Alcohol abuse, with alcoholism, is a substantial problem among the Native population and seems to be increasing. Coronary heart disease and high blood pressure, though still considerably behind the rates in the white population, are also in the increase. Cancer is being diagnosed far more frequently than formerly. The extent of dental disease seems almost overwhelming."

"None of these conditions is easy to treat or to prevent. The era of immunization and prophylaxis has to a large degree passed into history. Now the prevailing health problems of the Alaska Natives can be effectively addressed only by a coordinated system of care which involves health education, surveillance, screening and case finding, early and definitive treatment, rehabilitation, and continuing care." (Fortuine: 1975)

The next step is to analyze this present system of health care delivering services to the Alaska Native.

TABLE 1. COMMONEST CAUSES OF DEATH OF ALASKA NATIVES, 1926-30, 1950, AND 1971

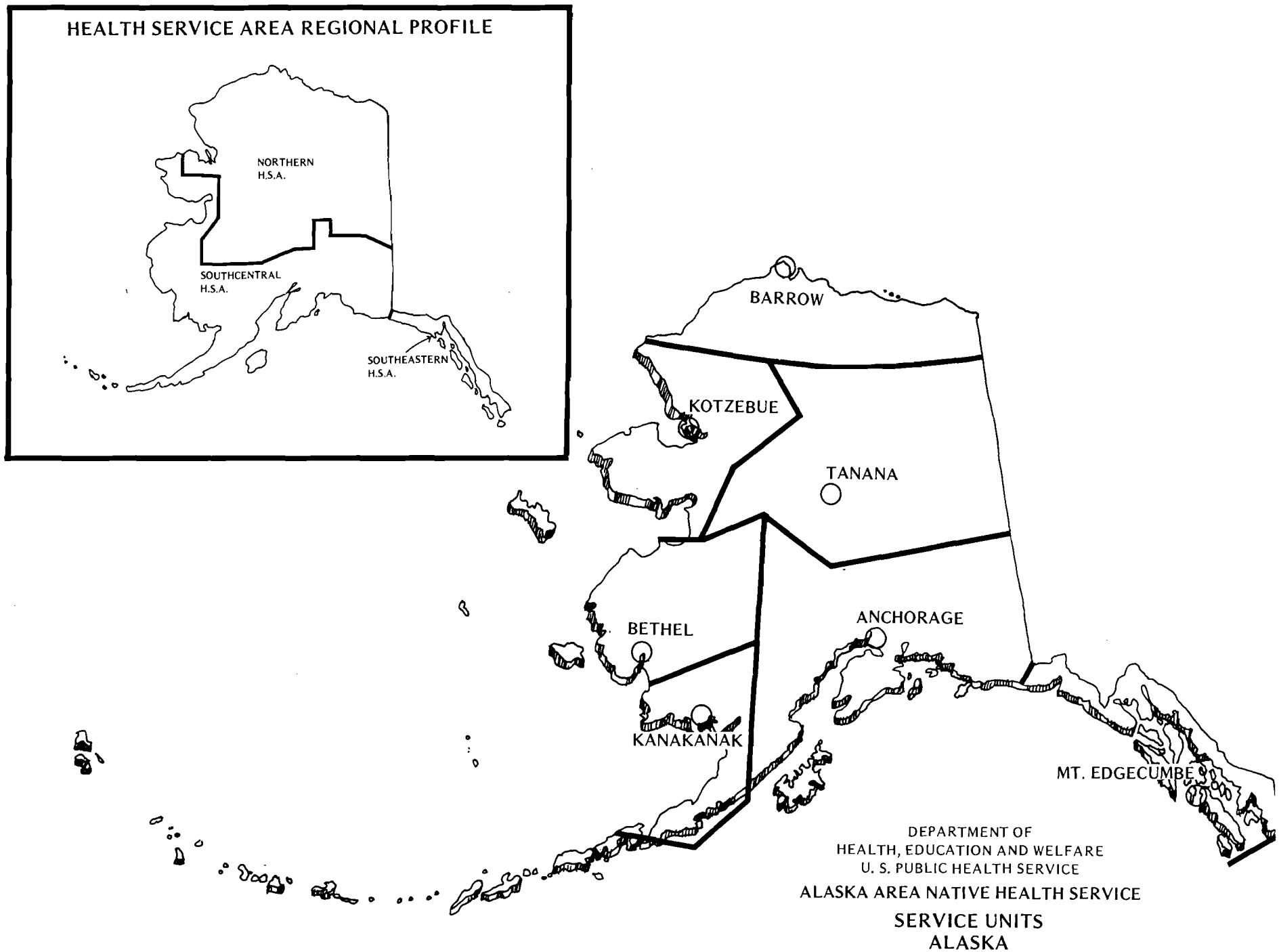
	1926-30		1950		1971	
Rank	Cause	Rate*	Cause	Rate*	Cause	Rate*
1	Tuberculosis	655	Tuberculosis	650	Accidents	230
2	Influenza and Pneumonia	282	Accidents	210	Cancer	95
3	Accidents	103	Influenza and Pneumonia	180	Diseases of Heart	91
4	Senility	71	Diseases of Heart	80	Vasc. Lesions of CNS	60
5	Diseases of Heart	63	Diseases of Early Infancy	70	Alcoholism	54
	ALL CAUSES	1,846	ALL CAUSES	1,690	ALL CAUSES	846

*Crude death rate (per 100,000).

TABLE 2. COMMONEST PRIMARY CAUSES FOR HOSPITALIZATION OF ALASKA NATIVES, FISCAL YEAR 1958 AND FISCAL YEAR 1974

	Fiscal Year 1958		Fiscal Year 1974	
Rank	Condition	No.	Condition	No.
1	Tuberculosis	894	Accidents	1,298
2	Influenza and Pneumonia	672	Del. w/o Complications	832
3	Del. w/o Complications	664	Otitis Media, Mastoid	713
4	Accidents	504	Influenza and Pneumonia	495
5	Upper Resp. Infection	302	Alcohol Misuse	476
6	Otitis Media, Mastoid	229	Dis. of Skin and Subcut. Tis.	359
7	Dis. of Bone and Organs of Movement	164	Dis. of the Eye	339
8	Dis. Female Genit.	129	Abortion	318
9	Dis. of the Eye	128	Dis. Female Genit.	265
10	Dis. Nervous System	126	Upper Resp. Infection	230
	ALL CAUSES	7,452	ALL CAUSES	10,524

SOURCE: FORTUINE, HEALTH CARE AND THE ALASKA NATIVE.


HEALTH SERVICE AREA REGIONAL PROFILE
NORTHERN H.S.A.
SOUTHCENTRAL H.S.A.
SOUTHEASTERN H.S.A.
BARROW
KOTZEBUE
TANANA
BETHEL
ANCHORAGE
KANAKANAK
MT. EDGECUMBE
DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
U. S. PUBLIC HEALTH SERVICE
ALASKA AREA NATIVE HEALTH SERVICE
SERVICE UNITS
ALASKA

Chapter 5

Health Systems in the Chugach Region

Alaska Natives receive health care via four primary health care delivery systems:

- Alaska Area Native Health Service
- Alaska State Department of Health and Social Services
- Regional health entities
- Private health care providers

1. Alaska Area Native Health Services (AANHS)

The central health delivery system for Alaska Natives is the Alaska Area Native Service which is responsible for providing, directly or indirectly, comprehensive health services to 68,000 Alaska Natives throughout the entire state. In addition, the non-Native population living in the remote areas is served where there are no private health facilities in these locations. These services include prevention, treatment, rehabilitation, and referral. The Alaska Area Native Health Service has its headquarters in Anchorage along with a central hospital, the Alaska Native Medical Center (ANMC). This hospital is a multipurpose facility serving as a referral hospital for Natives throughout Alaska.

The Alaska Area Native Health Service operates seven hospitals with a total of 416 beds, the facilities ranging in size from 14 beds at Barrow to 170 at Anchorage, and the two tiny units on the Pribilof Islands which came under the jurisdiction of the Anchorage service unit as a result of the Fur Seal Act of 1966. There are, in addition, USPHS clinics in association with private hospitals in Juneau, Fairbanks, and Ketchikan, and several other health centers staffed by a nurse or physician assistant.

In 1975, the program employed 1,200 persons, including 85 physicians, 29 dentists, and 187 professional nurses. The budget in fiscal year 1975 totaled just under $50 million, of which $31 million is in direct services, $5.5 million in contract services, and $13.4 million in environmental health activities, including sanitation facilities construction (Fortuine, 1975:26).

Organization

The AANHS system can best be viewed on three levels: village; regional; statewide.

A. Village

The cornerstone of the health delivery system is the 185 Community Health Aides (CHA's), located in 157 villages throughout Alaska. The CHA's serve as the physician's extension into the village through radio contact and written standing orders.

B. Regional

The Seven Service Units

The seven service units collectively cover the entire State of Alaska and provide comprehensive health services to all Native people and to those non-Natives (where private care is unavailable) living in remote areas. A hospital serves as the service unit headquarters and hub from which services radiate to all of the Native communities within its geographic boundaries. A service unit director administers the program with as much latitude as possible under Native Health Service policies.

The composition and size of the staff at each service unit varies according to the population served and its needs. Each service unit provides at least general hospital care, dental services, social and mental health services, preventive services, environmental health services, and field health services (Fortuine, 1975).

The Anchorage Service Unit

The Anchorage Service Unit measures about 100,000 square miles and would, if all the islands were consolidated into one land mass, equal the size of the states of Oregon and Washington combined. It includes five Native regions, Aleut, Cook Inlet, Copper River, Kodiak and the North Pacific Rim—and parts of Doyon and Bristol Bay.

The Alaska Native Medical Center (ANMC) is the focus of the Anchorage Service Unit, providing ambulatory and patient care for the Natives of the Service Unit. It also serves as the referral center for the six other service unit hospitals. Because of its location in Anchorage, ANMC also provides primary care to Natives residing outside of the Anchorage Service Unit.

ANMC provides the statewide clinical focus for this three-leveled health care delivery system, while, at the same time, operating on all three levels itself.

The North Pacific Rim Health Department has become an important and an essential link within these three levels of the system, assuming an integrating and coordinating role. One of the major results of this project will be to determine the future role that the Health Department will assume in this health delivery system.

C. Statewide

Although ANMC assumes a statewide clinical role within the system, the Alaska Area Native Health Service (AANHS) is the statewide administrative arm of the Indian Health Service.

2. Alaska Department of Health and Social Services Public Health Nursing Section

The Public Health Nurses in Alaska have a long and interesting history. They have been providing direct medical care, teaching health classes in nutrition, child care, dental care, first aid, hygiene, and giving immunization since the early 1900's. Traveling nurses served remote areas throughout Alaska. Communications were poor. Travel was commonly by dog sled, boat, or on foot covering long distances, with frequent, severe weather conditions and many hardships. The nurses were given room and board and free travel in return for their services. In many areas the Public Health Nurse was the community's only contact with medical care. Public Health Nurses have played a primary role in the control of communicable disease such as TB, smallpox, and venereal diseases which, until recently has been Alaska's number-one health problem.

By 1950, every community of 600 or more had a Public Health Nurse, each serving approximately 2,000 people. By 1967, there were 72 Public Health Nurses with 32 itinerant nurses, or traveling nurses, covering from 2-19 different villages.

The Public Health Nursing role has changed in the last few years with the control or reduction of communicable diseases. A new role has evolved with an emphasis on teaching and preventative health. Conducting well baby clinics, health surveillance screening, maternity clinics, health education classes, and general maintenance are the tools of the present-day Public Health Nurse.

The goals of Public Health Nursing is to raise the health status of Alaskans to the highest possible level and to motivate all Alaskans to participate in their own health maintenance and care. Public Health Nurses continue to serve the people of Alaska in a variety of ways.

3. **The 12 Regional Native Health Entities**

By the late 1960's the Alaska Natives determined that it was time for a change. In 1969, the Health Affairs Division of the Alaska Federation of Natives was founded by the Office of Economic Opportunity (OEO) to "promote regionally established and controlled health organizations" (AFN, INC.: 1976). Indeed, in the AFN 1976 Annual Report, the Health Affairs Division reported that "the greatest accomplishment and achievement of the Division has been to directly and indirectly support the formation of health organizations in each and every one of the twelve regions" (Ibid).

In 1968, the first of the twelve Native regional health entities was established with OEO funding. The Yukon-Kuskokwim Health Corporation, based in Bethel, began consumer direction of health services to the 57 villages in the Yukon-Kuskokwim Delta encompassed by the Calista Region, and the NSHC, based in Nome, began the "long way back to people-oriented health" for twelve villages on the Seward Peninsula in the Bering Straits Region.

The North Pacific Rim Native Corporation was established in 1973 as the regional nonprofit entity of the Chugach Region, and the North Pacific Rim Health Department, one of the last two of the twelve Native regional health entities to be organized, was established in mid-1976 by contract with the Office of Community Health Development, Alaska Area Native Health Service.

North Pacific Rim Health Department

The North Pacific Rim Health Department was established with the mission of developing the capacity of the Chugach Aleut people to direct their health care services. It was established within the North Pacific Rim Native Corporation regional nonprofit organization and as such is subject to its policies, bylaws, and executive administration. A Regional Health Committee acts as a standing committee to the Board of Directors and is comprised of one member from each village in the region. This committee, in conjunction with the Executive Director of North Pacific Rim, provides policy and direction to the Health Department.

The Health Department currently provides health outreach and health aide services to its people, in addition to the activities pursuant to the development of an ongoing administrative vehicle. The health aides provide direct primary care, and the outreach workers supplement this by fulfilling a liaison function between the village, the providers, and the regional health department.

The organizational structure of North Pacific Rim and of the health department is shown on the following page.

Community Health Aide Program

Specific community members have traditionally assisted their neighbors with health concerns for as long as history records. The community health aide concept was developed from these existing traditional patterns and a need for primary care to be available to remote isolated areas. The first "health aides" or "medical aides" served out of necessity. They served without pay and with little formal training. If training was given it was by the public health nurse or physician during a field trip. Dr. Walter Johnson wrote in 1956, "It is not a question of whether the village shall be treated by completely qualified medical personnel or persons with less than full qualifications, but a question of whether they shall be treated by a person with limited qualifications or go untreated altogether." Funds to implement a formal training program and provide salaries to the health aides became available in 1968. There are presently three health aide training programs in Alaska. They are located in Anchorage, Nome, and Bethel.

The role of the community health aide is similar to a nurse practitioner or physician's assistant who operates somewhat independently in an isolated setting. Community Health Aides provide primary care doing acute and emergency care services, health surveillance and preventive services and administrative and community health services.

North Pacific Rim Health Department assumed the health aide contract for the villages of Port Graham, English Bay, and Tatitlek in June, 1977.

4. Private Health Care Providers

There is no IHS Service Unit hospital within the boundaries of the Chugach Region. There are, however, three nongovernmental hospital facilities, five private physicians and two private dentsits.

The AAHNS provides care to Natives within the Chugach region via the Contract Health system. This allows AAHNS to contract directly with private health care providers in delivering comprehensive health care in those areas without an IHS Service Unit facility.

The Contract Health mechanism is the primary means of obtaining medical care for Chugach region Alaska Natives. This involves approximately 18 separate provider contracts and an annual budget of approximately $326,000 in FY 77.

Of the three delivery systems described, the Contract Health is the most significant to the Chugach region Alaska Native when seeking health care services. Virtually every Native in the region is familiar with the sign "Sorry—no Contract funds available". Signs like this often appear by the middle of each month in physicians' offices, pharmacies, and hospital outpatient clinics throughout the region.

It was, in fact, the Contract Health System that provided the major impetus for this project. Approximately $325,000 was being spent on a Native population of 1,200 persons and yet half the time, they were being turned away because of insufficient contract health funds. The NPR Health Department felt a definite need to study this complex method of delivering health care and to determine if there were more cost/effective, responsive, and satisfactory methods of delivering health care.

For this reason, a large part of this study will be devoted to the Contract Health System, how it works and why, the costs, and the consumer and provider's perception of it. With the passage of P.L. 93-638, the Indian Self-Determination Act, the NPR Health Department has the option of assuming the administration of the Contract Health Delivery System, thus gaining direction over the major means of delivering health care in the region. Before, or even if, this occurs, the NPR Health Department needs to learn all there is to know about Contract Health Care.

The Contract Health Mechanism

The administration of the Contract Health System is a complex procedure for both the federal government and the Contract Health providers. In addition, we found that it can often be an emotionally charged process for the consumers and the providers.

The first step was to determine the exact procedures for the procurement and the administration of the contracts. An analysis of this process is found in Appendix

Health Systems Assessment

Health Systems Assessment measures the quantity, quality, arrangement, nature, and relationships of people and resources in the provision of health care.

The six health system descriptors used in this project to evaluate the Contract Health System in the Chugach Region are:

1. **acceptability**, or the consumer's satisfaction with the delivered health care.

2. **availability**—a measure of the supply of health services and the resources for providing them.

3. **accessibility**—an individual's (or group's) ability to obtain or use services, given that are available.

4. **cost**—the expenses incurred in the provision of health services.

5. **continuity**—a measure of the degree of effective coordination of effort in providing services, regardless of whether care is provided in one setting or multiple settings.

6. **quality**—a measure of the degree to which health services delivered to a patient, regardless of by whom or in what setting provided, resemble satisfactory delivery of services as determined by health professionals. Quality of health care as defined by this strict definition is not to be addressed in this project. However, the broader aspects of the quality of health care are also a function of the first five descriptors, and by using this latter definition, quality will therefore be addressed.

There are many indicators that will be used within each of these six descriptors. They will be discussed in the following section.

Acceptability/Accessibility/Continuity

Regional summaries of acceptability, accessibility, and continuity were difficult to present due to the diversity of the three towns and three villages within the region. Therefore, these three health system descriptors will be addressed within the context of each of the six communities in the following chapter. In this manner, a more accurate evaluation of the Contract Health System will be presented.

Availability

A regional inventory of the health manpower, facilities, and services is presented in the following series of maps. A more detailed inventory and description of these services are presented in Chapter 6 within each of the six community/village sections.

Homer and Seldovia's health resources are included because the villages of English Bay and Port Graham utilize their health services.

Homer and Seldovia are within the Cook Inlet Region. However, for reasons of patient flow patterns, utilization, and contract health costs, they have been included in this study.

A comparative analysis of health care resources is presented in table below.

HEALTH CARE RESOURCES—COMPARATIVE RATIOS

Resources	United States		Alaska		Southcentral HSA		Anchorage		North Pacific Rim		Kodiak	
	#	Ratio per 1,000	#	Ratio per 1,000	#	Ratio per 1,000	#	Ratio per 1,000	#	Ratio per 1,000	#	Ratio per 1,000
Manpower												
Total physicians	350,000	1.66	547	1.32	315	1.13	271	1.46	5	.57	6	.95
Primary care	138,606	.66	297	.72	175	.63	138	.75	5	.57	3	.47
Specialists	211,994	1.0	250	.60	140	.50	133	.72	0	.0	3	.47
Dentists	107,300	.5	202	.49	145	.52	116	.63	2	.23	4	.63
Community Health Aides	N.A.		205	.50	136	.49	0	.0	3	.34	6	1.03
Physicians' Assistants	N.A.		52	.13	15	.05	11	.06	2	.23	0	.0
Optometrists	9,300	.044	47	.12	27	.10	13	.07	0	.0	1	.17
Mental Health Psychologists	35,000	.165	28	.07	21	08	20	.11	1	.11	1	.17
Hospital Beds												
Civilian Acute Care Beds	1,110,482	5.28	1,233	2.98	865	3.11	605	3.27	71	8.10	25	3.92
Civilian Long-Term Care Beds	1,327,704	6.28	542	1.31	271	.98	203	1.10	64	7.30	0	.0
Mental Health Inpatient	338,574	1.6	386	.93	386	1.39	236	1.27	150	17.12	0	.0
Population				413,487		277,952		185,179		8,762		9,366

*Includes private, public, and military physicians

The ratio of manpower and/or facilities to total population for the U. S., Alaska, Southcentral HSA, North Pacific Rim, and the Kodiak are included.

Kodiak's data are useful in that the Kodiak Region is very similar to NPR culturally, geographically, and populationwise.

Manpower

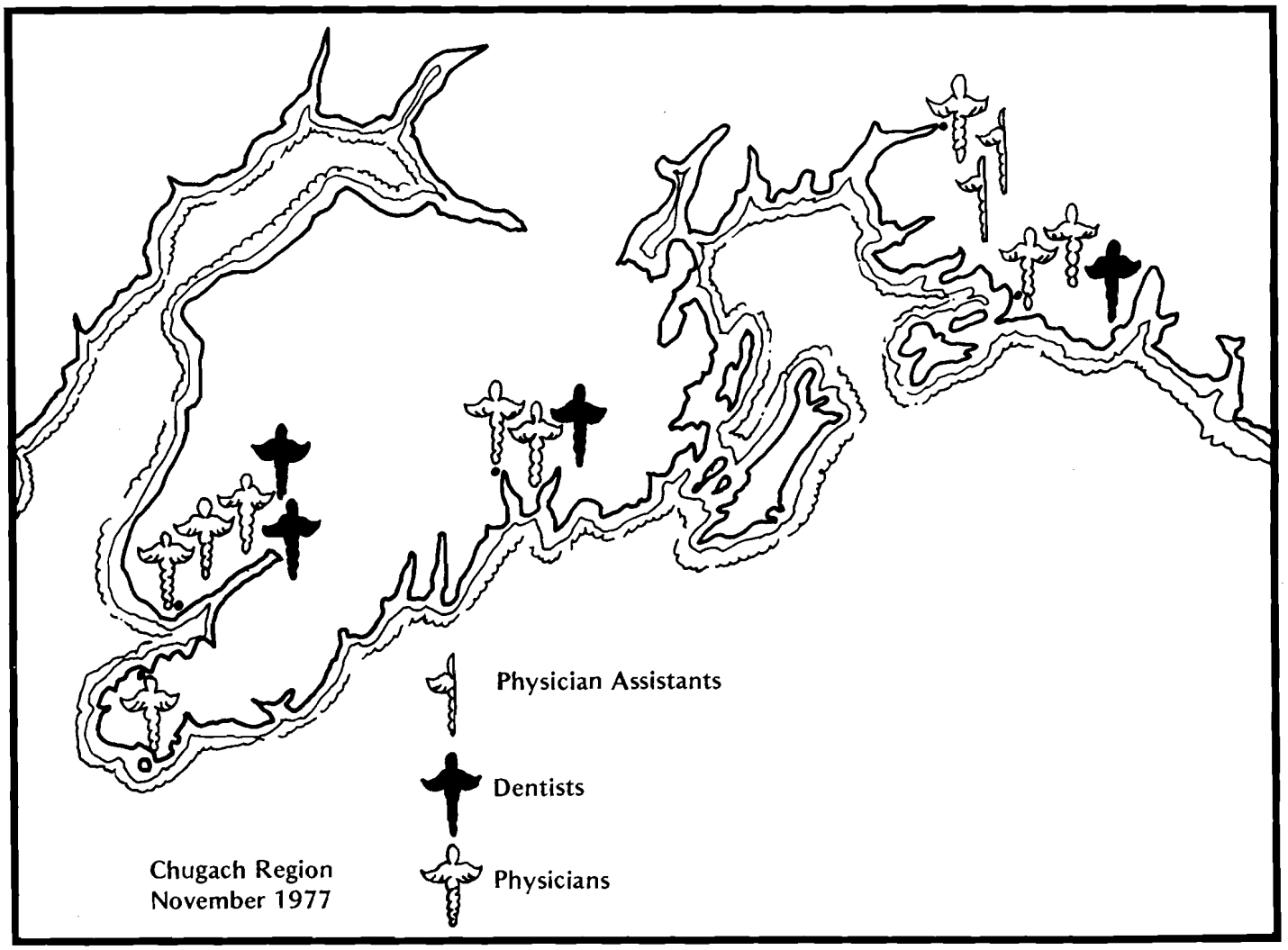
Physicians

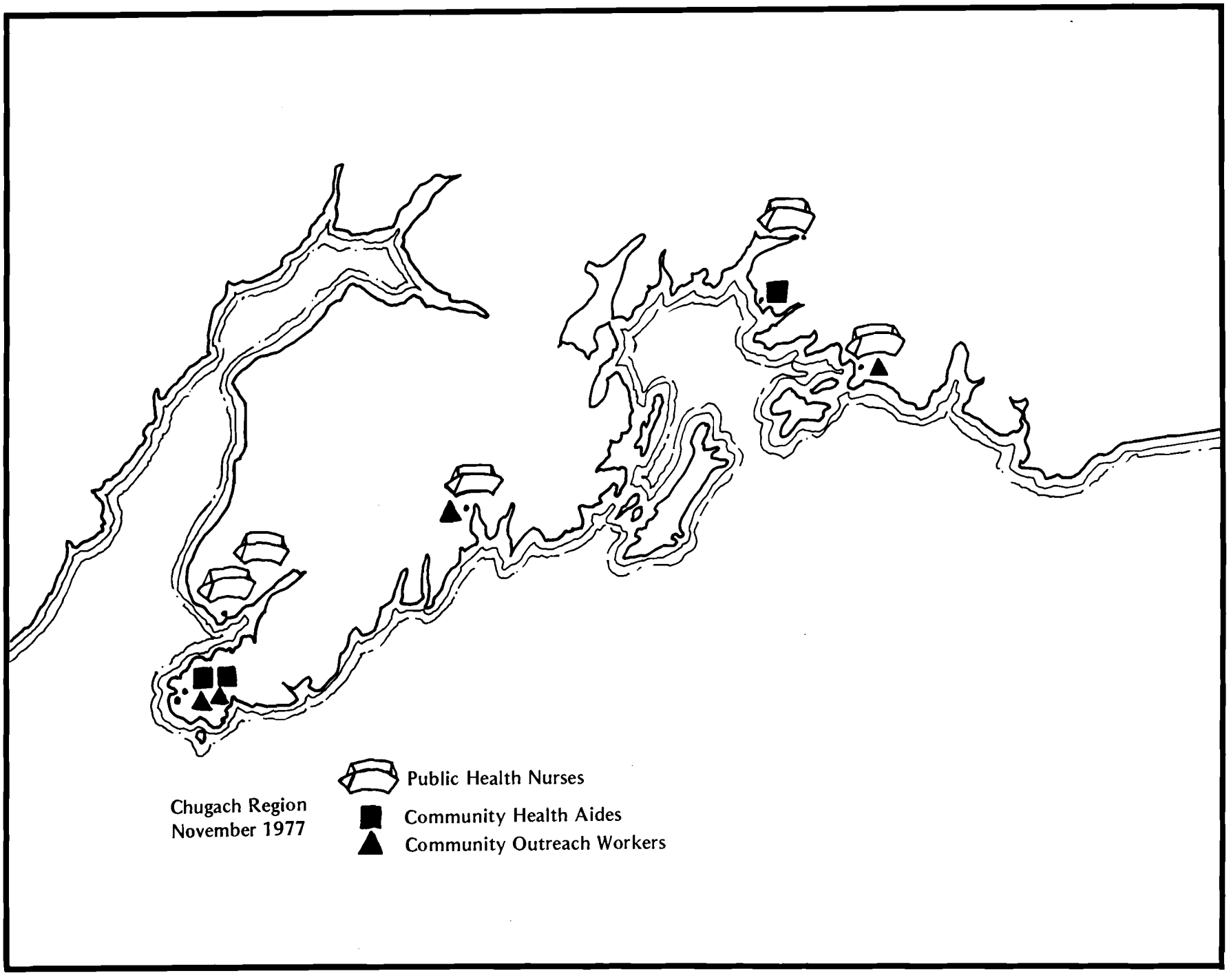
A comparative ratio of total physicians per population is misleading. For example, the U. S. has a higher physician to population ratio than either the United Kingdom or Sweden (Stimmel, 1975:69). However, in terms of 1) primary care physicians to total population, and 2) urban/rural distribution, the U. S. scores poorly.

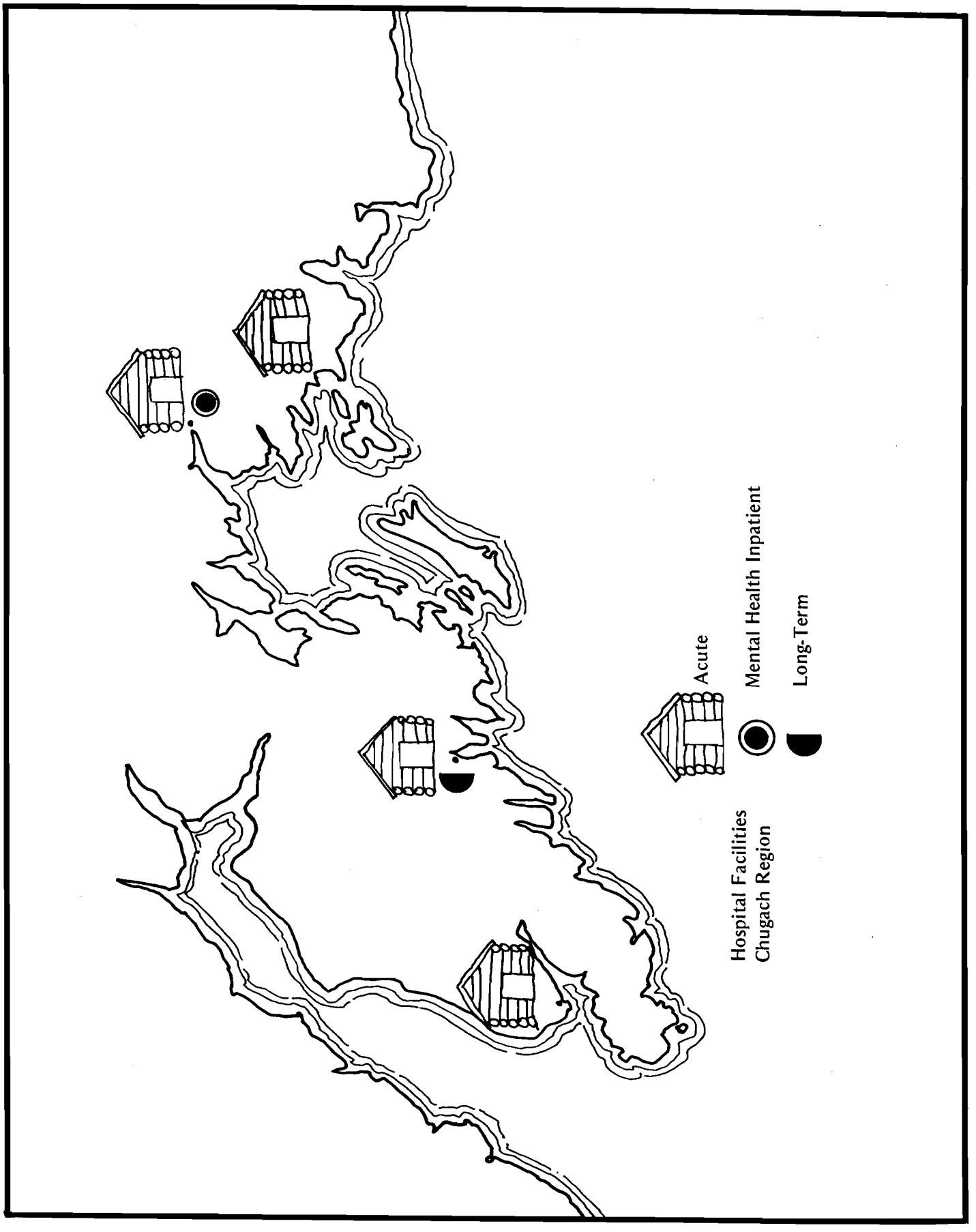
As shown in the table, there are only .66 primary care physicians per 1,000 population in the U. S. while there are 1.0 specialists for the same population. Even if we included those specialists that focus on primary care, i.e., internists, pediatricians, OB-GYN, the U. S. has less than 50% of its physicians focusing on primary care. By comparison the British Health Service has 74% of its physicians in primary care (DHEW, 1976:359).

A Yale University study projected that a primary physician ratio of 1.33 per 1,000 is necessary to provide adequate primary care. The North Pacific Rim is far below this necessary figure with a .57 per 1,000 primary care ratio.

The U. S. has an abundant supply of surgeons, on the other hand, with 3.9 surgeons per 10,000 population versus 1.7 in England and Wales. Surgical procedures are done twice as much in the U. S. as compared to Britain (Bunker: 1970).




Public Health Nurses
Community Health Aides
Community Outreach Workers
Chugach Region
November 1977


Hospital Facilities
Chugach Region
Acute
Mental Health Inpatient
Long-Term

The second area of physician maldistribution is geographic in nature. Doctors tend to cluster in wealthy, urban areas, e.g., New York State has 2.44 nonfederal physicians per 1,000 population while Alaska has 1.10, including federal physicians.

This urban-rural maldistribution is evident in Alaska from the comparative ratio table.

The Anchorage Municipality has 1.46 physicians per 1,000 persons while North Pacific Rim has only .57. Figure shows the location of the physicians within the region and in Homer.

Thus, in order to bring the Rim up to the ideal primary care level of 1.33 primary physicians per population, the Rim would require 7 additional primary physicians, over twice the present level.

Dentists

There is a definite shortage of dentists in the region, with one dentist in Seward and one in Cordova. The NPR ratio is half of the national average and would require at least two additional dentists to match the national average.

Community Health Aides

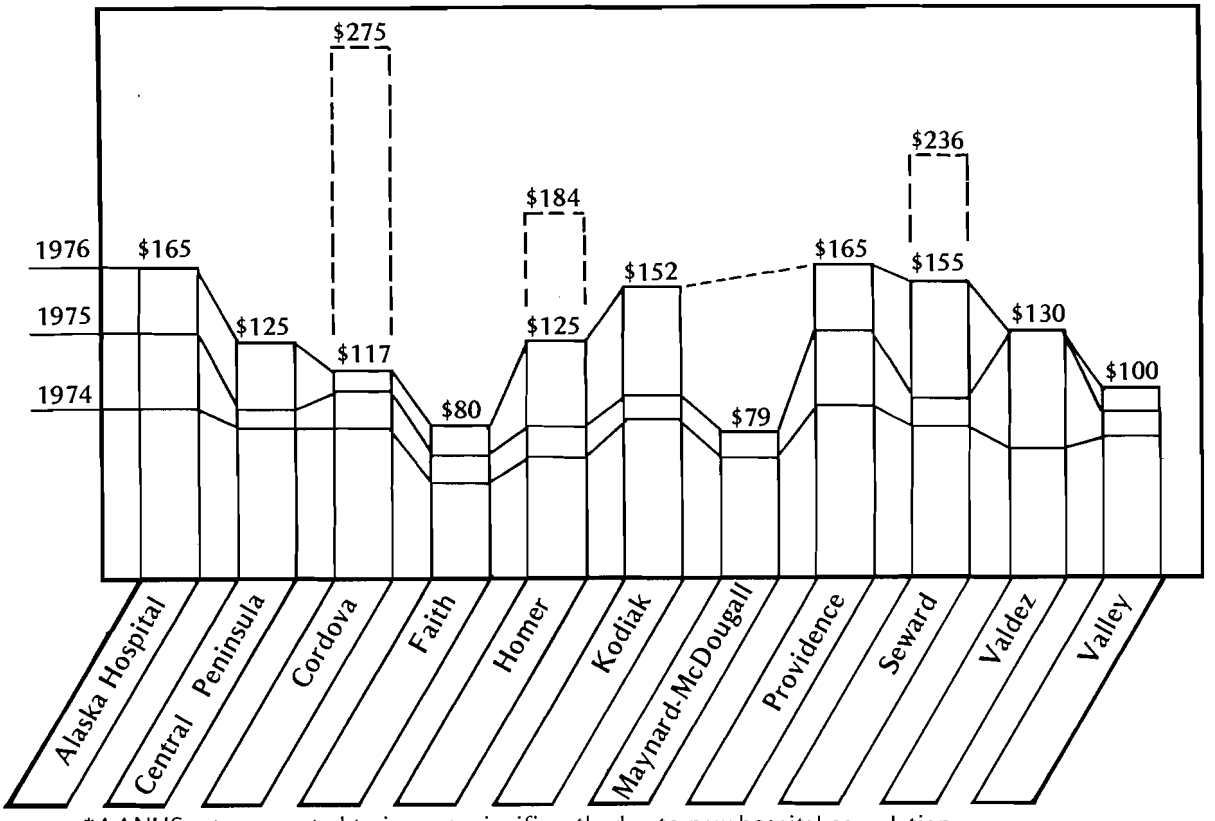
There are full-time Community Health Aides in the villages of Tatitlek, English Bay and Port Graham. There seems to be a sufficient number of Health Aides at this time although Port Graham residents definitely felt a need for a Health Aide's assistant (see Port Graham—unmet needs), and there seems to be a similar need for Tatitlek and English Bay.

Physician Assistants

There are two physician assistants in the region, both of them working out of the clinic in Valdez.

The P.A.'s seem to be ideally suited to complement the levels of care that exist throughout rural Alaska. The need for P.A.'s within the region will be further discussed in chapter 9, resource requirements.

SEMIPRIVATE ROOM RATES
SOUTH CENTRAL ALASKA COMMUNITY HOSPITALS (1974-1976)
SHOWING AANHS PER DIEM CONTRACT RATES FOR NORTH PACIFIC RIM HOSPITALS



*AANHS rates expected to increase significantly due to new hospital completion.

Note: AANHS rates are a flat per diem rate and include all hospital services, i.e., x-ray, laboratory, pharmaceuticals, etc. Physician fees are not included.

SOURCE: WASHINGTON-ALASKA BLUE CROSS, MAY 1977 AND SOUTH CENTRAL HEALTH PLANNING AND DEVELOPMENT, DRAFT HEALTH SYSTEMS PLAN.

CHARACTERISTICS OF SOUTHCENTRAL ALASKA COMMUNITY HOSPITALS* 1976

Facility	Licensed Beds	Available Patient Days	Admissions or Discharges	Patient Days Used	Average Length of Stay	Percent Occupancy
Alaska Hospital and Medical Center	85-154	35,600	6,157	28,715	4.6	81
Central Peninsula	30	10,950	1,246	3,614	2.9	33
Cordova Community	22	8,030	528	2,008	3.8	25
Faith Hospital	5	1,825	342	1,059	3.1	58
Homer Hospital	17	3,650	469	1,314	2.8	30
Kodiak	25	9,125	1,141	4,106	3.6	45
Maynard McDougall	24	8,760	967	2,803	2.9	32
Providence	150-228-268	69,274	11,796	53,082	4.5	77
Seward	33**	12,045	476	2,048	4.3	17
Valdez	16	8,395	346	1,763	5.1	21
Vally	23	8,395	1,119	3,358	3.0	40

* Dept. of Health and Social Services, Hill-Burton Study, 1976 (sent to individual facilities for verification)
**1975 figures.

SOURCE: SOUTH CENTRAL HEALTH PLANNING & DEVELOPMENT, DRAFT HEALTH SYSTEMS PLAN.

Optometrists

There are no permanent optometrists within the region. Itinerant optometrists and opthalmologists service the population on a periodic basis. The American Optometric Association maintains that at least one optometrist per 7,000 population is needed to provide proper care. Applying this to the North Pacific Rim highlights the need for at least one optometrist within the region.

Mental Health Psychologists

Given the health status problems of the population, a single psychologist within the region is hardly adequate for the broad range of behavioral health problems facing the Native population. The need for further mental health professionals is also discussed in Chapter 9.

Hospital Beds

As can be seen from the Health Resource chart, the North Pacific Rim has an abundance of acute care and long-term care beds, far surpassing national ratios in these areas.

Acute Care Beds

The Rim has a higher ratio of civilian acute care beds than anywhere in Alaska with a ratio of 8.10 beds per 1,000 population, as compared with the Anchorage ratio of 3.27 and the national ratio of 5.28.

Coupled with this high bed ratio are the lowest occupancy rates in the HSA Region. As seen from the chart, Seward, Valdez, and Cordova Hospitals operate at 17%, 21%, and 25% occupancy rates.

Homer Hospital, as well, experiences a relatively low occupancy rate of 36% and is already taking steps to convert at least 4 beds to long-term care.

Long-Term Care Beds

Wesleyan Nursing Home in Seward has 64 long-term care beds and serves more than just the regional population.

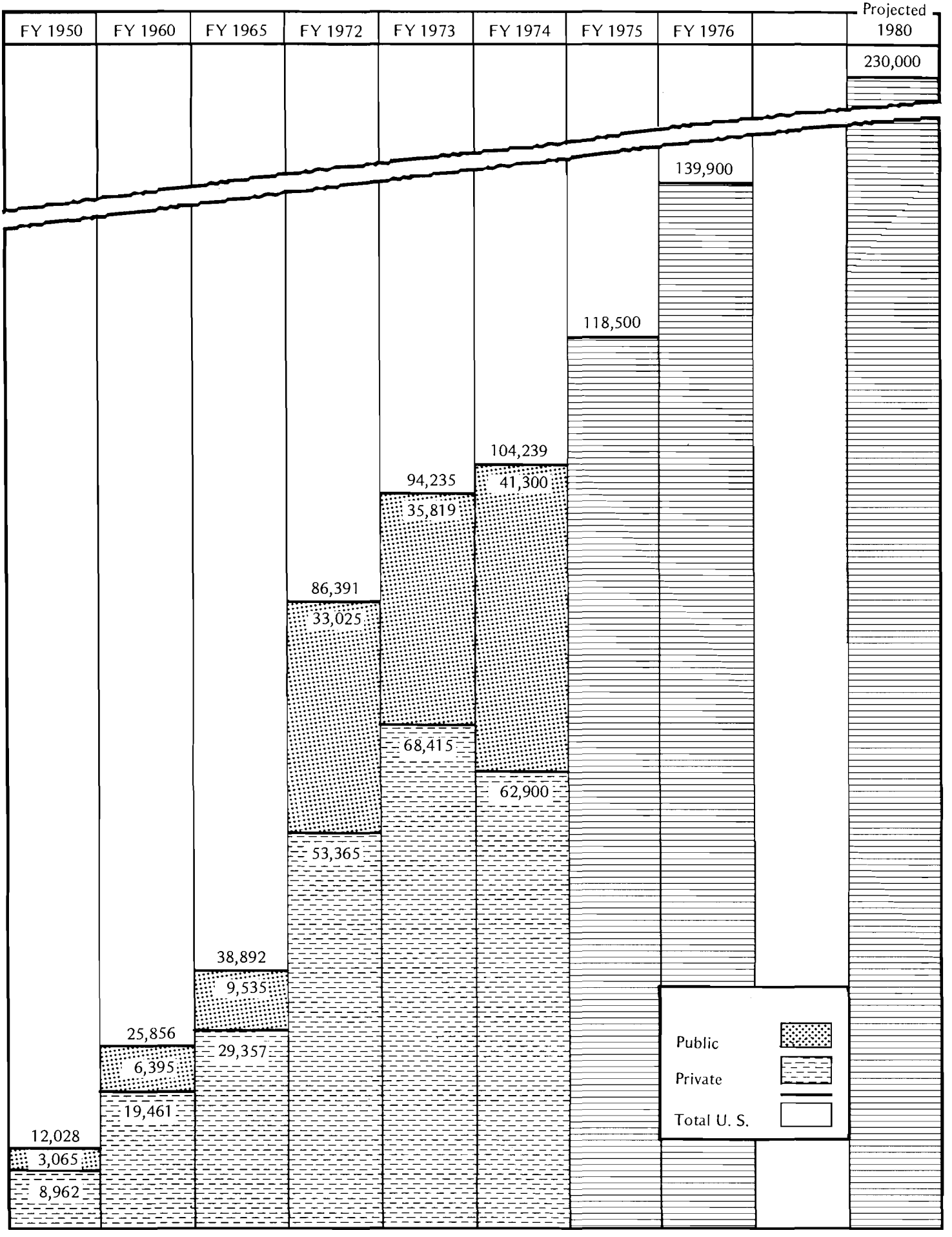
Mental Health Beds

Harborview Memorial Hospital is a state-operated facility and as such has referrals from throughout the state. The high bed ratio is thus distorted when using merely the regional population figure.

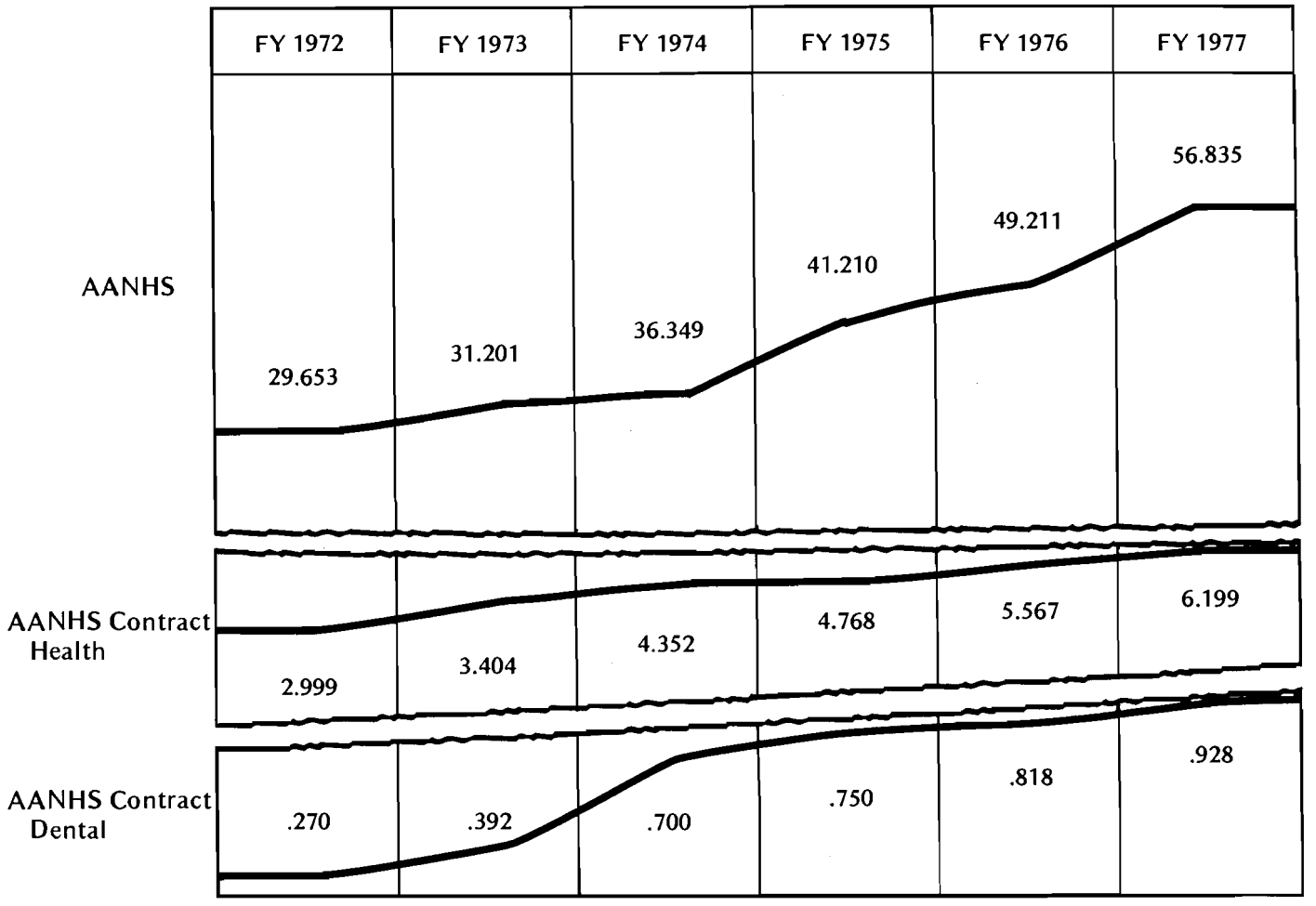
Costs

Health care expenditures in the United States have soared within the past two decades rising from $12 billion in 1950 to $140 billion in Fiscal Year 1976. The Department of Health, Education, and Welfare has projected that health care expenditures will continue to rise at an alarming rate, reaching $230 billion by 1980. (Califano: 1977)

HEALTH EXPENDITURES (In Millions)



HEALTH EXPENDITURES (In Millions)



Health care expenditures have increased from 4.6% of the Gross National Product in 1950 to 8.6% of the GNP in 1976 (Cooper: 1976). This means that, as a nation, each one of us is working an average of one month of every year to pay for our medical bills.

Translated into per capital amounts, health care expenditures rose from a mere $78 per capita in 1950 to a whopping $547 per capital in 1975.

The federal government is assuming an ever increasing burden of these rapidly rising expenditures, with public* sources increasing from 25% in 1969 to 40% in 1974. This has led to a gradual decrease of the percentage of total health expenditures by private* sources.

The major reason for the shift is the introduction of Medicare and Medicaid in 1966.

The greatest increase is cost inflation and a growing percentage of total health expenditures can be attributed to the growing role of institutions and complex and expensive medical technology.

Alaska

The Alaska Area Native Health expenditures reflect these nationwide trends of skyrocketing costs. The AANHS budget has doubled in the past five years, jumping from $29,653,000 in FY 1972 to $56,835,000 in FY 1977.

*Public health expenditures include both direct governmental payments and payments made by the government to private insurers who act as intermediaries for Medicare and Medicaid payments.

*Private expenditures or health expenditures by consumers include both out-of-pocket payments and payments made by individuals to private insurers for insurance coverage of health expenses.

The IHS population figure for the Alaska Native Service population for 1977 is 62,742 (IHS Memo: 1977). Using this as a basis, the per capita health expenditures for the Alaska Native population is $906. This excludes out-of-pocket expenditures and private insurance payments. If we were to include these private payments, it would most likely bring the per capita total to over $1,000, almost double the U. S. per capita average of $547.

The Anchorage Service Unit (Alaska Native Medical Center) budget has not increased as much proportionally as the statewide budget, going from $9,455 million in 1972 to $12,561 in FY 1976, this despite significant increases in outpatient services, social services, field clinics, and dental clinic work loads.

Contract health expenditures for the North Pacific Rim were analyzed for Fiscal Years 1974 through 1976.

The information was obtained through a review of the contract health billings for the 3-year period. Dental figures represent contract amounts rather than actual expenditures.

The data were analyzed by the 5 categories:

Pharmaceutical
Physicians
Hospital Outpatient*
Hospital Inpatient
Dental

The data were also analyzed by community. The communities within the North Pacific Rim Region that have ANS contracts are:

- Seward (2 separate contracts)
  1. The general Native population, and
  2. The Alaska Skill Center Native student population. Data were thus broken out in these areas separately.
- Cordova
- Valdez

Homer is not within the North Pacific Rim Region but does serve the Native population of English Bay and Port Graham. In order to include these contract health expenditures it was necessary to determine the percentage of English Bay and Port Graham residents in relation to the total Native population that utilizes Homer Contract Health Services. We determined that 50% would be an accurate percentage. This was determined by 1) estimate by the NPR person who reviewed all of the contract health bills (this same person also worked in the CHS office and had considerable experience in dealing with Homer expenditures), and 2) estimates from the Homer providers.

*Includes emergency room fees, x-ray and laboratory fees.

NORTH PACIFIC RIM
CONTRACT HEALTH EXPENDITURES (BY COMMUNITY—FY 74-76)

	FY 1974	FY 1975	FY 1976	Totals
Seward				
Pharmacy	$ 3,244	$ 9,669	$ 2,021	$ 14,934
Physician	15,164	16,142	16,433	47,739
Hosp. Outpatient	7,337	8,428	7,059	22,824
Hosp. Inpatient	16,188	14,942	15,761	46,891
Dental	7,000	9,000	11,600	27,600
	48,933	58,181	52,874	159,988
Seward Skill Center				
Pharmacy	8,576	3,303	9,967	21,846
Physician	12,466	12,464	7,207	32,137
Hosp. Outpatient	4,985	5,703	4,626	15,314
Hosp. Inpatient	13,891	15,404	8,751	38,046
Dental	10,000	8,000	12,000	30,000
	49,918	44,874	42,551	137,343
Homer				
Pharmacy	4,456	4,139	4,392	12,987
Physician	19,755	18,860	21,111	59,726
Hosp. Outpatient	3,549	4,999	5,509	14,057
Hosp. Inpatient	18,269	15,497	25,447	59,213
Dental	10,400	12,500	8,350	31,250
	56,429	55,995	64,809	177,233
Cordova				
Pharmacy	13,051	18,956	15,798	47,805
Physician	34,980	40,167	41,718	116,865
Hosp. Outpatient	14,593	16,025	16,481	47,099
Hosp. Inpatient	31,679	41,278	56,869	129,826
Dental	9,000	15,000	12,000	36,000
	103,303	131,426	142,866	377,595
Valdez				
Pharmacy	2,198	4,148	3,456	9,802
Physician	8,941	11,723	4,415	25,079
Hosp. Inpatient			14,914	14,914
	11,139	15,871	22,785	49,795
TOTALS	$269,722	$306,347	$325,885	$901,954

NORTH PACIFIC RIM
CONTRACT HEALTH EXPENDITURES
(BY SERVICE RENDERED—FY 74-76)

	FY 1974	FY 1975	FY 1976	Totals
Pharmaceuticals				
Seward	$ 3,244	$ 9,669	$ 2,021	$ 14,934
Skill Center	8,576	3,303	9,967	21,846
Homer[1]	4,456	4,139	4,392	12,987
Cordova	13,051	18,956	15,798	47,805
Valdez	2,198	4,148	3,456	9,802
	31,525	40,215	35,634	107,374
Physicians				
Seward	15,164	16,142	16,433	47,739
Skill Center	12,466	12,464	7,207	32,137
Homer	19,755	18,860	21,111	59,726
Cordova	34,980	40,167	41,718	116,865
Valdez	8,941	11,723	4,415[2]	25,079
	91,306	99,356	90,884	281,546
Hospital Outpatient[3]				
Seward	7,337	8,428	7,059	22,824
Skill Center	4,985	5,703	4,626	15,314
Homer	3,549	4,999	5,509	14,057
Cordova	14,593	16,025	16,481	47,099
	30,464	35,155	33,675	99,294
Hospital Inpatient				
Seward	16,188	14,942	15,761	46,891
Skill Center	13,891	15,404	8,751	38,046
Homer	18,269	15,497	25,447	59,213
Cordova	31,679	41,278	56,869	129,826
Valdez			14,914	14,914
	80,027	87,121	121,742	288,890
Dental				
Seward	7,000	9,000	11,600	27,600
Skill Center	10,000	8,000	12,000	30,000
Homer	10,400	12,500	8,350	31,250
Cordova	9,000	15,000	12,000	36,000
	36,400	44,500	43,950	124,850
Grand Totals	$269,722	$306,347	$325,885	$901,954

1. Homer Contract Health Expenditures are estimates based upon the percentage of English Bay and Port Graham residents that utilize Homer health care services.
2. Valdez physician retired in November, 1976.
3. Includes emergency room fees, x-rays and laboratory fees.

Summary

The expense of delivering medical care via fee-for-service private health care providers is extremely costly and will continue to rise steeply. DHEW has projected that health care expenditures will reach $230 billion by FY 1981, a 164% increase over FY 1976.

The Contract Health Budget for the six communities of the North Pacific Rim is shown in table . The Budget for Contract Health Services in the Chugach Region has risen an average of 10% per year for the three-year period and yet the Contract Health funds are now running out by the 15th to the 20th of each month. This means that almost one-half of the time, people were being denied access to health care due to lack of funds.

This steady increase in medical costs coupled with the constant depletion of funds by the middle of each month is typical of the situation nationwide—that of an evergrowing, insensate receptacle by which the medical industry gets richer and the consumers are left unhealthier.

Contract Health Services represent the fee-for-service financing mechanism whereby the clinic or facility is reimbursed on a fixed fee per service rendered. Overall the Contract Health budget within the Chugach Region increased from $269,722 in Fiscal Year 1974 to $325,885 in FY 76, a 21% increase.

As with the nationwide trends, hospital inpatient charges in the Chugach Region accounted for the largest proportionate increase in costs, rising 34% over the same three-year period.

Cordova received the largest increase among the "provider" towns during the three-year period with an increase of $39,563 in their total Contract Health budgets. Cordova Hospital inpatient charges accounted for a large part of this increase with $25,190 or an 80% increase during the three years.

Health care for the Chugach Region Native is delivered through a complex system of federal, state, and private providers, third-party insurers, and public and private facilities.

The newly emerging 4th system, the North Pacific Rim Health Department, has the opportunity to assume a meaningful unifying role by coordinating the three traditional health care delivery systems, and translating them into a comprehensive delivery system which is responsive to, and directed by, the consumers served.

Chapter 6

The Chugach Communities

The three villages and three towns of the Chugach Region are extremely diverse and very unique human communities, making it difficult to plan for health care services on a pure regional basis.

For this reason, it was necessary to treat each community separately, while utilizing a common analytical framework.

It should be noted that the term "ANS" is used throughout this section of the report. While this is an outdated phrase in the minds of the staff of Indian Health Service, it is still the phrase that Natives within the region use when referring to the Alaska Area Native Health Service (AANHS) or Alaska Native Medical Center (ANMC). Most Natives do not perceive nor understand the dichotomy between AANHS and ANMC. Therefore, ANS is used in this chapter in reference to the Alaska Native Medical Center.

Cordova

by Agnes Nichols

Cordova, "the friendly city", has a beautiful setting in the Chugach National Forest, surrounded by the Orca Inlet on her front door, Mt. Eyak, Queen's Chair, Mt. Eceles and Mt. Heney on the other sides. Adding to the overall beauty is Lake Eyak which empties into the Eyak River and then to the Copper River Flats. The principal occupation is fishing; salmon and crab being the products. There are four large canneries and a few small canneries.

The population fluctuates in the winter to summer from 2,000 to close to 5,000. The rise comes from transient cannery workers and out-of-state fishermen who fish this area.

We have some of the best schools, swimming pool, recreational activities, community health services in the state.

There are three village corporation offices here and the Native population numbers approximately 400 people. The ratio of elderly and children makes a good balance among the people.

Cordova is a good place to live and it's proven by the fact that the majority of the people have lived here for over 40 years or are Native born lifetime members of the community.

Inventory—Cordova

Facilities

Cordova Community Hospital

Owned by the City of Cordova, the facility has 22 beds, 8 of which are for extended care. General medical and surgical services are offered to the community. The hospital now houses an integrated health care program as a result of a Health in Rural Underserved areas grant. Combined in one setting are the outpatient clinic, Mental Health Center, Public Health Clinic and Social Services. Accreditation Status: AMA Category IV.

Cordova Medical Clinic

The clinic is located in the remodeled section of the Cordova Community Hospital. Staffed by two doctors. Offers general medical outpatient services.

Public Health Clinic

Located in the Community Hospital. Offers PHN Services as described in Chapter 4. Provides itinerant services for Tatitlek and Cape Yakataga.

Dental Clinic

The dental clinic is a private practice located in the dentist's residence.

Cordova Mental Health Center

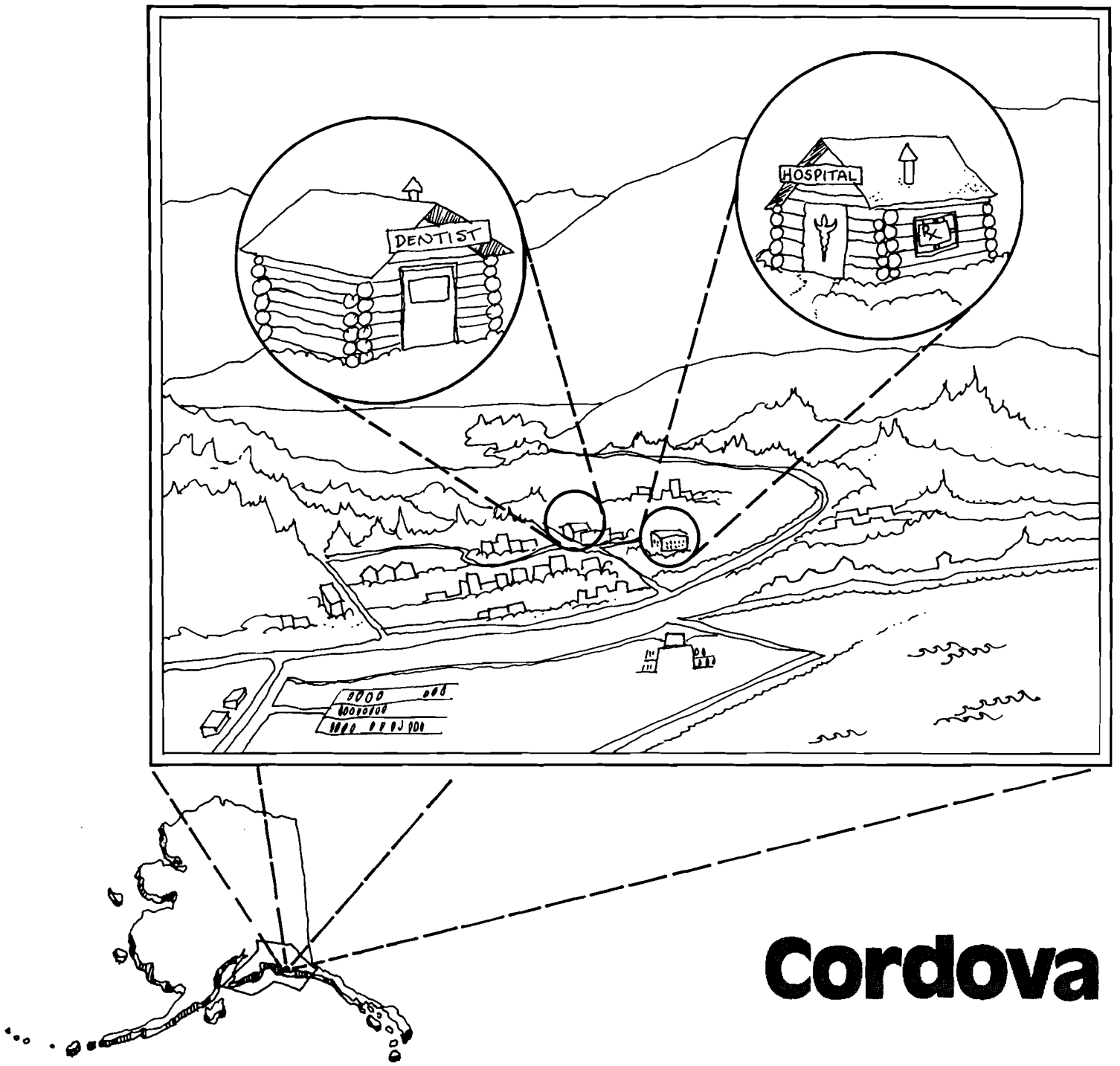
Located in the remodeled section of the Community Hospital. The program offers individual, family, and alcoholism counseling.

Cordova Drug Co.

Provides pharmaceutical services for the community.

Manpower—Cordova

Doctors—2 physicians; Family Practice
Dentist—1
Public Health Nurse—1
Pharmacist—1
Clinical Psychologist—1
Alcoholism Counselor—1
Itinerant Specialists as needed.



Cordova

Emergency Medical Services

The Cordova Ambulance Service consists of 24 trained Emergency Medical Technicians (EMT's), of which 12 are registered EMT-II's, and special Marine & Mountain rescue crews.

The ambulance is radio equipped, and responds to calls on all passable roads in the area (approximately 60 miles).

Emergency calls go through the Police Department to pagers worn by the EMT's, 24 hours a day, thus alerting all the EMT's (Endicott, 1977).

North Pacific Rim is presently in the process of supplementing and expanding the present emergency communications network to provide complete and comprehensive emergency communications. This will be completed November 30, 1977.

A Medivac flight pack is stored in the ambulance and can be quickly transported to aircraft responding to emergency calls from fishermen in Prince William Sound ("Ambulance", 1977).

Social Services

Offered through the State of Alaska, Division of Social Services. Staffed by one social worker. The program is located in the remodeled portion of the hospital.

CORDOVA

Ranked in Order of Total Diagnoses Including Supplemental Activity

LEADING CAUSE OF OUTPATIENT VISITS

Cause of Visits	FY 1974 Rank	FY 1974 Number of Diagnoses	FY 1975 Rank	FY 1975 Number of Diagnoses	FY 1976 Rank	FY 1976 Number of Diagnoses
Respiratory Problems	1	290	1	297	1	278
Accidents	2	161	2	161	2	87
Prenatal Care	3	98	3	77	3	82
Refractive Error		–	10	41	4	68
Inf. Female Genit. EX-VD		–	6	47	5	36
Well Child Care		–		–	6	35
Eczema, Urticaria, Skin Allergies	9	35	5	62	7	33
Tests Only		–		–	8	28
Disorders of Menstruation		–		–	9	26
Hospital Medical Surgery Follow-up	4	90	4	68	9	26
Urinary Tract Infections		–	7	45	10	19
Other Diseases of Skin		–	8	38		
Other Bacterial Skin Infections		–	9	38		
Neuroses	5	38	10	41		
Other GYN Problems	6	36				
Gonococcal Infections	7	35				
Other Diseases of Gastrointestinal Tract, Peritoneum	8	35				
Acute Otitis Media	10	33				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

CORDOVA

Ranked in Order of First Diagnosis

LEADING CAUSE OF OUTPATIENT VISITS

Diagnosis	FY 1974		FY 1975		FY 1976	
	Rank	Number of Diagnoses	Rank	Number of Diagnoses	Rank	Number of Diagnoses
Respiratory Problems	1	289	1	248	1	232
Accidents	2	159	2	122	2	144
Prenatal Care	7	35	4	51	3	60
Hypertensive Disease	3	101	4	51	4	59
Chronic Otitis Media	4	40	3	52	5	55
Family Planning		–	6	27	6	39
Urinary Tract Infection		–	8	21	7	38
All Other Infective, Parasitic Diseases	8	33	7	24	8	31
Infection, Female Genit. EX-VD		–		–	9	30
Eczema, Urticaria, Skin Allergies	5	38	5	34	10	26
Other Disease of Skin		–	9	20		
Other Bacterial Skin Infections		–	10	18		
Neuroses	6	37				
Other Diseases of Gastrointestinal Tract, Peritoneum	9	32				
Acute Otitis Media	10	30				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

CORDOVA

Ranked in Order of Inpatient Days

LEADING CAUSES OF HOSPITALIZATION

Cause of Hospitalization	FY 1974		FY 1975		FY 1976	
	Rank	Days	Rank	Days	Rank	Days
Accidents	1	104	1	104	1	194
Peptic Disease of Stomach and Duodenum		–		–	2	116
Other Diseases of Gastrointestinal Tract, Peritoneum	6	61	4	61	3	69
Other Forms Arthritis		–		–	4	58
Neoplasms	2	96	2	72	5	51
Other Diseases, Urinary System		–		–	6	49
Hernia, Abdominal		–		–	7	45
Disease of Gallbladder, Bile Ducts	9	45	7	32	8	41
Misc. Eye Diseases		–		–	8	41
Delivery without Complication		–	8	25	9	31
Hyperplasia Prostate		–		–	10	28
Other Compl. Pregnancy	8	48	3	65		
Pneumonia	10	40	5	42		
Acute Alcohol Intoxication		–	6	35		
Med/Surg. after Care Follow-up		–	9	23		
Disorders of Spine		–	10	21		
Heart Disease	3	74				
Cirrhosis Liver w/Alcoholism	4	73				
Osteoarthritis	5	68				
Depressive Neurosis	7	50				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

CORDOVA

Ranked in Order of Discharge

LEADING CAUSES OF HOSPITALIZATION

Cause of Hospitalization	FY 1974		FY 1975		FY 1976	
	Rank	Discharge	Rank	Discharge	Rank	Discharge
Accidents	2	11	1	18	1	19
Other Diseases of Gastrointestinal Tract, Peritoneum	1	13	3	10	2	8
Infection of Skin, Subcutaneous Tissue		–		–	3	6
Acute Alcohol Intoxication	3	9	2	11	3	6
Delivery without Complication	5	5	3	10	4	4
Abortion, Therapeutic		–		–	5	4
Disease of Gallbladder, Bile Ducts	7	3		–	6	4
Peptic Disease of Stomach, Duodenum		–	6	3	7	4
Other Alcohol Psychoses		–		–	8	3
Pneumonia	4	8	2	11	9	2
Acute Upper Respiratory Inf.		–	5	4	10	2
Respiratory Problems		–	4	5		
Med/Surg. after Care Follow-up	6	4	4	5		
Influenza		–	6	3		
Habitual Excessive Drinking, Alcoholism		–	6	3		
Neoplasms	5	5				
Other Compl. of Pregnancy	6	4				
Heart Disease	6	4				
Organic Mental Disorder	7	3				
Respiratory Allergy, Asthma, Hay Fever	7	3				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

CORDOVA

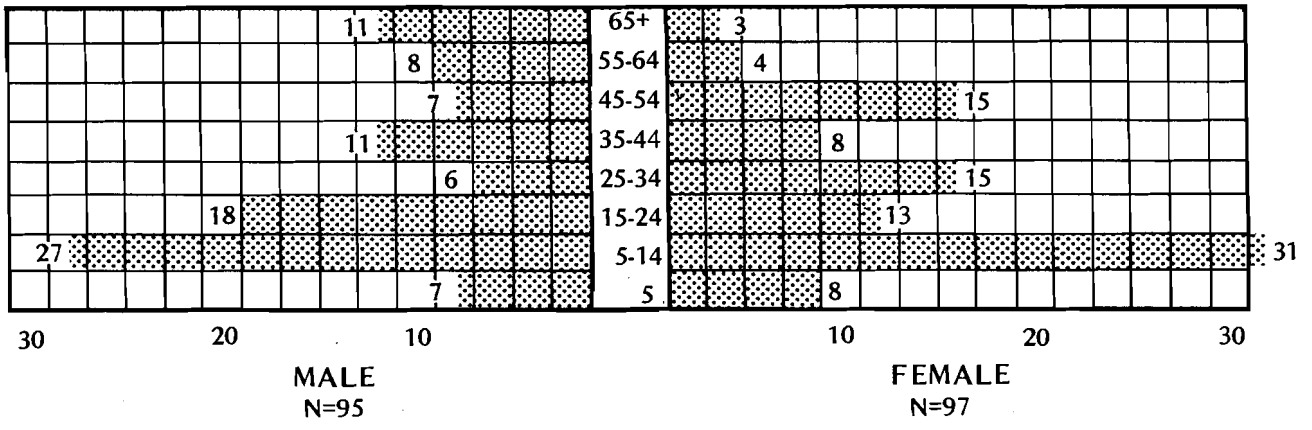
Ranked in Order of Total Diagnoses Including Supplemental Activity

LEADING CAUSE OF OUTPATIENT VISITS

Diagnosis	FY 1974		FY 1975		FY 1976	
	Rank	Number of Diagnoses	Rank	Number of Diagnoses	Rank	Number of Diagnoses
Respiratory Problems	1	384	1	334	1	315
Accidents	2	301	2	200	2	214
Prenatal Care	4	111	3	106	3	105
Hypertensive Disease	3	124	5	69	4	81
Chronic Otitis Media	7	54	4	80	5	75
Hospital Medical Surgical Follow-up	5	71	7	48	6	63
Urinary Tract Infection		–		–	7	51
Family Planning		–	10	35	8	50
Eczema, Urticaria, Skin Allergies	6	57	6	55	9	48
Infection Female Genit. EX-VD		–		–	10	45
Other Diseases of Skin		–	8	38		
Other Bacterial Skin Infections		–	9	36		
All Other Infective Parasitic Diseases		–	10	35		
Other Diseases of Gastrointestinal Tract, Peritoneum	8	51				
Neuroses	9	50				
Other GYN Problems	10	47				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

NATIVE POPULATION OF CORDOVA BY AGE AND SEX, 1970 CENSUS



INTRODUCTION

Cordova fishermen were preparing their boats and fishing gear as North Pacific Rim staff persons, Eloise Lambert, Lue Rae Erickson, and Nancy Davis, went to Cordova to learn about the Native consumer perspective on health issues.

In addition to the local village corporation of Eyak, two other village corporation offices are located in Cordova, those of Chenega and Tatitlek. Each village office was asked prior to North Pacific Rim's visit to select a research assistant to aid in the interview process. Four local residents, Belinda and Joe Cook, Barbara Olson, and Carol Komkoff, assisted in the Survey, and along with North Pacific Rim Health Department staff conducted interviews with the representative Native groups in Cordova.

Demographic Data on Contributors

This community health study is based on a consumer's perspective of one's own health. It represents what Natives living in Cordova have to say in regard to various health issues. But, who are the individuals contributing to this consumer perspective we take as representative? What are their backgrounds and personal characteristics which may ultimately influence the outcome of this consumer perspective? Knowing not only what people say about their health, but who says it, is an important initial step in research. This background gives the reader the necessary data through which to interpret the subsequent report and perspective presented.

For example, of the fifty-three Native people interviewed, and whose ideas are embodied in this report, forty are women and thirteen are men: women outnumber male contributors two to one. Thus, the orientation of Cordova's Native health perspective may reflect a "female" bias, expressing, for example, problems more often encountered by women than men. Similarly the average age of both males and females interviewed by Native research assistants is 45.3 years. Knowing this information the young or elderly can proceed, reading and evaluating the specific data and conclusions presented in light of this middle-aged representation.

Although the average age of contributors is in the mid-forties, a wide span of age is represented. For example, the youngest contributor's opinion included is that of a twenty-one-year-old female. The oldest informant's ideas represented came from an eighty-two-year-old woman. There is no representation from teenagers or children in this Native community health perspective. Additionally, there is no representation from males, ages 35-44 years old. These two "gaps" in representation and input must also be taken into consideration by those reading the following report.

Fifteen of the fifty-three contributors were born in Cordova, ten in Tatitlek and five in Chenega, representing a long-standing knowledge of the Cordova area, its problems and assets. Overall, however, thirteen different birthplaces within Alaska are represented in the sample. Five contributors come from the "lower 48". Included in this group are four non-Natives married to Natives living in Cordova. One resident contributing to this health perspective was born in the Philippines. Thus, with nineteen different places of birth represented, including numerous villages and towns in Alaska, as well as other United States cities and foreign countries, a broad geographic perspective is represented in this study.

Additionally, forty-six different households in Cordova are represented by the 53 interviews, illustrating a broad-based community input. The number of members living in each household ranges from a single-person dwelling to a seven-person living unit. However, the average-size household of those people contributing to this community health perspective is 3.8 persons.

Push-Pull Migration Factors

Affecting every community and thus, its population, are migration factors which influence movement of people into and out of the community. These influences are formally known as "push-pull" migration factors.

Simply stated, what do Natives like about living in Cordova? The people—their friendliness, easygoing attitudes and concern for others—is the most frequently mentioned factor which "pulls" or attracts Natives to Cordova. For women contributors, it is precisely this "people-centered" factor which ranks highest as a positive Cordova attribute. As one of these women states, "The people and town grow on you—it's friendly, everyone cares about everyone." Next, the small size and slow pace of life is attractive. "It's a small town, no hassles here like in Anchorage," is one man's comment which illustrates this "pull" factor. Similarly one woman notes that living in a small town, as Cordova, is a bonus because "you're within walking distance to your friends."

Third, the availability of services, specifically schools and medical care, is noted as an attractive feature of living in Cordova. Women, almost exclu-

sively, cite the convenience of educational and medical services as a factor "pulling" them to reside in Cordova. Fishing and hunting are also frequently mentioned as drawing points for living in Cordova. In fact, for the men contributors, it is the most frequently mentioned "pull" factor.

Conversely, migration factors which actively "push" or encourage disenchantment with life in Cordova include most often bad weather and the high cost of living.

Other push factors included "no roads out" (2), "dog mess in the streets" (3), "housing problems" (1), and the "presence of drugs and drug users" (1). Displacement from their place of birth in Chenega or Tatitlek, and longing for these familiar surroundings are also sources of discontentment with life in Cordova. Restrictive fishing rights and the invasion of fishing grounds by "out-of-towners" is similarly a factor which "pushes" residents, either physically or emotionally, from Cordova.

Awareness Level of Traditional Health Beliefs and Practices

Among contemporary Native residents of Cordova, what is the general level of awareness concerning traditional preventative and curative medical beliefs and practices? For example, are present-day Natives cognizant of what people did in the "olden days" to stay healthy? And, further, what are these indigenous approaches to health maintenance?

The level of awareness of traditional health maintenance beliefs and practices declines with age: older people more often than young, exhibit an awareness of traditional health maintenance behavior. Of twenty-four contributors over 50 years of age, only four or 17% did not suggest a traditional health maintenance technique. Among those twelve respondents, 35-50 years old, five or 42% demonstrated a low awareness level, marking a sharp decline from the older group. Similarly, those sixteen Native Cordova residents under 30 years of age, eight or 50% did not know what Native people in the olden days did to stay healthy.

Thus, going from a 17% nonawareness level among those over 50, to a 42% level of low awareness among contributors under 30, a marked decline of knowledge about traditional health maintenance is demonstrated.

The single most important practice used by people in the olden days to stay healthy that interviewees report, is to work and keep busy. This "keep active" philosophy as a prerequisite to good health is particularly adhered to by those over 50 years of age. Next, home treatments and self-care is suggested as a traditional health maintenance technique. Close behind, watching one's diet by eating good, natural Native foods is reported. Other techniques include exercise, fresh air, rest, dressing warmly, avoidance of harmful substances, and slow-paced living. Three people mention the consultation of physicians, hospital and nurses. Three others, all over 35 years of age, stress the need for social supports through interpersonal relationships as basic to health maintenance.

What is the general awareness of curative beliefs and practices by Natives living in Cordova? Fifteen of 53 respondents or 28% did not know or provide an answer when asked, "What did people in the olden days do when they got sick?" There is no significant correlation numerically between the number of responses and age, as with health maintenance knowledge. However, generally those over forty gave more detailed answers, indicating a more in-depth knowledge of traditional medical practices. Self-help and the use of home remedies is the most frequently mentioned technique reportedly used for ill health in the olden days, as this woman's quote illustrates:

> "Mom used to boil some kind of devil club roots and drink it. If any of us kids had fevers, she would wrap our feet in hot potato peels."

Another Cordova resident's comments also indicate a high level of awareness of traditional medical practices:

> "My mother was doctor in our area and took care of lots of people. She used herbs and plants, lots from out of the Sound. I can identify lots now, such as highbush currant bark for tea."

The influence of the Russian Orthodox religion on the healing practices and philosophies of Cordova's Natives is also intimated by this comment: "In the Orthodox religion, it is the holy water, different teas, steam baths that are used to get all the poisons out."

Consultation of traditional healers is also reported by interviewees as a health-seeking behavior. "Send for the midwife," "send for the village traditional doctor," "call the medicine man," illustrate this point.

Other curative practices included, "waiting until they were half dead, then going to the doctor,"

"taking prescription drugs and aspirin," "staying in bed to rest," and "praying". Four contributors note they had to "stick it out" or just "live with it", illustrating an underlying "grin and bear it" health philosophy.

Summary

The level of awareness concerning traditional health maintenance techniques among Cordova's Natives declines with age. Older residents, more often than young, express knowledge of traditional health maintenance techniques. The most frequent method reportedly utilized in the olden days to stay healthy is to work hard and keep busy. Self-treatment with home remedies and regulation of diet are also reported. The level of knowledge of curative techniques is fairly high. Only ¼ of the contributors did not offer specific suggestions. More detailed answers were given by older residents. Self-help with various home remedies is the most frequent curative health technique used in the olden days reported.

Awareness Level of Health Insurance

Of fifty-three contributors, thirty-eight or 72% have heard of health insurance. Fifteen people or 26.7% express that they do not know about health insurance. The level of awareness is essentially equal for both male and female contributors. Although over one-fourth of those Native Cordova residents interviewed do not know about health insurance, those who did generally could specify what kind of insurance coverage they carry. The health insurance policies residents cite range from Fishermen's Fund (4), Champus (U. S. Coast Guard), ILWU (1), Labors Union (1), to Pacific Mutual (1). Blue Cross is the health insurance coverage most frequently carried with ten contributors utilizing this company's insurance. Interestingly, government-sponsored health benefits through ANS (2), Public Health Service (1), Medicare (6), and Medicaid (3) are also cited as health insurance sources, though these programs do not purport to fulfill a health insurance role.

Although 72% of the contributors report familiarity with health insurance, in actuality, only twenty-nine or 55% report having a family member covered by a health insurance policy. (And, in some cases, insurance coverage is defined by Natives as ANS, Medicaid, etc.)

Summary

With limited data, it is difficult to establish an overall awareness level of present-day health care services by Cordova Natives. However, it can be clearly noted that ¼ of those interviewed do not know about health insurance. And, even less have a family member presently covered by an insurance policy which gives additional contact and awareness of policies and procedures. The depth of knowledge concerning health insurance appears, in many cases, superficial.

Health Maintenance and Health-Seeking Behavior

Health Maintenance

What do Natives living in Cordova do to stay healthy? What are the specific techniques which constitute their health-seeking behavioral patterns? And, are these actions or beliefs new cultural adaptations, or are they deeply ingrained, long-standing values of their cultural belief system?

Diet regulation is the most frequent health maintenance technique adhered to by Natives in Cordova today. Twenty-four contributors prescribe some aspect of diet as a prerequisite for good health, such as eating good foods, limiting calorie intake, curtailing alcohol consumption, or supplementing regularly scheduled meals with vitamins. Women, overwhelmingly (22) endorse this dietary regulation technique for good health over male contributors (2). Second, exercise through hunting and fishing, baseball and basketball or walking and running is viewed through Native eyes as contributing to good health. Rest is the third most frequent response cited by ten residents—all women.

Other health maintenance practices currently used in Cordova include: medical care such as check-ups by doctors and dentists (7), drugs (2), self-care (2), and having a good mental outlook on life (2). Eight suggest that avoiding bodily intake of harmful substances as liquor (5), smoking (2) and drugs (1) as health maintenance behavior. Other responses include staying home (2), staying away from excitement (1), and "doing as I am told" as methods to insure good health.

Health Seeking

As opposed to health maintenance techniques, what do people in Cordova do when they first feel lousy? Most people do one of four things: rest (8); keep busy (7); seek medical attention from a doctor, public health nurse or hospital (8); or take prescription or nonprescription drugs (7). Other significant responses to feeling lousy include "talking to the Lord and He makes me feel good" (5), or seeking social interaction (4). "I go uptown and let it all hang out," "call someone up" or "go visiting", illustrate

this social interaction adaptive behavior. Interestingly, four people avoid social interaction when they feel lousy. They "stay home," "isolate myself away from people who are depressing," "hide out in a corner" or "be alone and then I don't fight with anyone". Whether seeking or avoiding social interaction, these eight comments illuminate the postulated importance of balancing one's social or interpersonal relationships as a prerequisite for good health.

Finally, what do current Native residents of Cordova do when they are sick? To whom and what do they first turn? Overwhelmingly most "go to the doctor". Thirty-seven contributors at some time in their health-seeking process consult a physician, often after trying home remedies, aspirin, self-help, rest or prayer.

Health-Seeking Sequence ANS

Overwhelmingly, local doctors are the "official decision-makers" directing Cordova Native patients to th ANS Hospital.

Most patients go alone, by airplane, to Anchorage. Upon contacting the physician, most, but not all, are given instructions to follow. Most, but not all, follow them. The doctor provides follow-up services to many but there appears to be a break in follow-up services, interrupting continuity of care for many others.

Summary

Due to the high "no response"rate on the health-seeking sequence information, this summary should be viewed as tentative. Of special concern to NPR, however, is that fact that 1) not all Natives follow doctor's advice, and 2) many do not receive adequate follow-up services.

Recommendations

1. NPR must now ask, are medical instructions given in terms meaningful, understandable and culturally compatible with Natives' views of their illness? It is also suggested that local physicians be alerted to "gaps" in follow-up services from ANS. Auxiliary health staff, such as the Public Health Nurses, or Native appointees could be trained to fill this service gap thereby insuring continuity in medical care.

2. Regulation of diet is defined by Natives in Cordova as the most important step to maintaining good health, followed by exercise. Given these two indigenous health values, programs and interventions by NPR should build on these expressed health values. Encouragement of dietary education, and joint program planning with the Department of Parks and Recreation, will build on cornerstones already defined as "healthy" by the community.

Accessibility: Barriers to Medical and Dental Utilization

Medical Accessibility

Do Native Cordova residents find it easy to get in to see a doctor?

Ten or 19% find it difficult to "get in" to see a doctor. Their reasons include lack of ANS funds, waiting time and "runaround unless you really set your foot down".

Twenty of fifty-three or 38% of Cordova's Natives interviewed concede they put off going to the doctor even though concerned about their health. Additionally, three others stipulate that sometimes they don't go, or that they "never tell him all my problems", indicating marginal utilization.

Two attitudinal factors seem to lie behind this low utilization; 1) the belief that the Western physician's care "won't work anyway", is simply "no use", and 2) the general dislike of going to doctors are the major reported inhibitors restricting contributors' use of physicians's services in Cordova. Next, lack of money and the fear "that something might be wrong", contribute to a nonuse pattern.

Incentives Facilitating Medical Visits

By contrast, thirty-seven or 70% report, yes, it is easy to "get in" to see a physician. The reasons they cite for this ease in making an appointment or "getting in" include the fact that Cordova has "two doctors and they have time", and "because it's a small town; they just know I don't come unless I really need to."

Dental Accessibility

Forty-three percent report they put off going to the dentist even though concerned about their teeth. The major barrier seems to be attitudinal in nature. Ten contributors, all female, report they do not go to the dentist because they are scared and simply do not like the dentist. Other less frequently reported barriers include: conflicting dental and work schedules (2); limited amount of appointments (1); and no ANS funding for adults (1).

In fact, these and other barriers are perhaps reflected in the extremely low dental utilization rates among Natives in Cordova. Thirty-one or 58% of the contributors did not visit the dentist last year, while twelve others made only one visit during the preceding twelve-month period.

Economic Barriers

To what extent are economic barriers responsible for the nonutilization of both physician's and dentist's health services? For example, when going to a doctor or dentist in Cordova, does it cost local Natives anything out of their pocket? Must Native Cordova residents make cash expenditures before receiving health care? If so, what are these medical and dental expenses?

Twenty-three respond affirmatively: it does cost them dollars out of their own pockets to get medical and dental care. Additionally, six others state "occasionally it does, when funds run out". And three specify that dental, but not medical services cost the Native consumer. Thus, thirty-two or 60% indicate that out-of-pocket expenses are a prerequisite to receiving medical and/or dental care.

What are the sources of these medical/dental expenditures? The limited amount of contract health funds for doctors and hospital care is the most common reason for personal cash expenditures for health care. Dentures (1), dentist fees for adults (5) and trips to Anchorage (1) are other reported sources of health debts. Nineteen or 36% report no out-of-pocket expenses for medical or dental care received locally in Cordova.

However, when Natives leave Cordova to seek medical or dental care at ANMC in Anchorage are out-of-pocket expenses necessary? Twenty-one or 40% report "yes", they must "pay out" cash in order to receive ANS health services. This cash expenditure is most frequently to cover airfare from Cordova to Anchorage (19). However, other costs include telephone (16), meals (15), motels-housing (9), child care (10), expenses of relatives escorting patients (9), gas (6), cabs (6), rental cars (2) and train (1).

Seventeen or 32% report no out-of-pocket expenses when traveling to Anchorage's ANMC Hospital and clinics. Fifteen or 28% did not respond to the question.

Summary

Nearly one-half of the contributors put off going to both the doctor and dentist even though they are concerned about their health and teeth. And, in both cases, the most frequently reported barrier which results in this nonutilization pattern is attitudinal. The belief that Western medicine "won't work", or the general dislike of physicians are the attitudinal barriers to securing medical care reported by consumers. Similarly dental care utilization barriers rest on the dislike for dentists, founded on a general fear about dentistry.

Recommendations

1. To alleviate these attitudinal barriers to medical and dental services which are founded in part on consumer's unfamiliarity with the health care culture, NPR may consider conducting workshops in order to give Native consumers "behind the scenes" orientation to the medical world. This familiarization effort might include tours of medical/dental offices, hospital rooms, delivery rooms and examination of equipment such as dental drills, hypodermic needles, X-ray machines and other medical paraphernalia and procedures Native consumers find awesome, foreboding and thus anxiety-provoking.
2. NPR might also investigate integration of various valued traditional healing methods into the Western care system as an alternative for those who currently distrust Western institutionalized medicine.
3. Well over one-half of the contributors report out-of-pocket expenses as a prerequisite to receiving medical and dental care in Cordova. Slightly fewer report personal cash "output" when utilizing ANS health services in Anchorage. Beyond this dollar and cents cost, NPR must also consider and investigate the social costs involved in utilizing Western institutionalized health care.

Satisfaction Level with Western Medical Care

ANS

How do Cordova's Natives feel about going to ANS?

Only ten residents of fifty-three interviewed gave a positive, supportive evaluation of ANMC health services. "Concerned care", administered by excellent doctors and support staff were the reasons most frequently mentioned which contributed to a positive evaluation of ANS institutions. In contrast, the travel-

ing distance, long waiting period, drunks and transportation costs all contribute to Natives' negative feelings about ANS health services.

Local Health Services

What do Natives like about the present medical care program in Cordova? The most frequent response, given by 15 residents, is simply that it's O.K., no complaints.

Of those contributors specifically identifying features they like, their responses fall into four general topic areas. These broad categories include: 1) promptness and ease in appointments; 2) medical funds from government; 3) quality of health care services; and 4) positive attitudes of health care workers. For example, nine contributors note that the ease in getting a doctor's appointment is one feature they most like about the present health care system.

Second, consumers relay appreciation for the ANS health funds allocated to meet their health needs. Next, Cordova consumers express satisfaction with the health care personnel and system currently providing services. Eight people report that the local doctors and their care is the most satisfying aspect of the current health care system. The public health nurse and her work is also praised by Cordova health consumers (5).

Last, several consumers express satisfaction with the attitudes of health care personnel. "They think of you as a person", "they make you feel at home, not like a charity case", and "there are efforts to correct what's wrong", are quotes expressive of the general high level of satisfaction felt by various Native consumers towards attitudes of health care professionals in Cordova. Three people, two women and one man, succinctly state that they like "everything".

Consumer Suggested Changes

On the other hand, what do these same consumers feel should be changed about the present medical care program in Cordova.

Increase or reallocation of ANS funds for health care in Cordova is the single most important change residents desire. Twenty-one or nearly half of those interviewed are dissatisfied with the present funding system. There are several facets to this funding issue. First, some residents feel there is a shortage of funding: the present level of funds does not cover the cost for pharmacy bills, alcohol treatment, mental health counseling, additional hospitalization coverage and adult dental care. As one resident bitterly states,

> "The doctors, dentists, public health nurse and ANS should have to get sick before the 15th of the month."

To alleviate the problem of funds being depleted by midmonth, several residents suggest reallocation or monitoring of limited funds. Their suggestions range from "doctors should control so funds don't run out" to placing the monitoring with the people themselves.

> "People go in free when the problem could be taken care of at home. It's good to have ANS funds, but I don't believe in wasting tax dollars."

Similarly, another contributor says that "a lot of fishermen who make a lot of money use ANS, and I don't like Native people to use ANS funds if they have enough money to pay their own bills."

Several suggest that a special fund for the needy, particularly the elderly without earning potential, be given special consideration in funding matters.

On the other hand, one villager reports that the system in Cordova discourages the use of ANS—that monitoring by service agencies is an imposition. During the screening, health workers require ANS potential recipients to specify if they have an insurance policy; if so, they are encouraged to use that third-party source. Most often, these insurance policies require an outlay of cash, and "it's embarrassing if you don't have the cash". Thus, a controversy exists as to the benefits or positive value of caretaker screening of patients for payment purposes. It is neither the lack of funding, nor its allocation which needs change, rather communication with Native people about ANS funding procedures needs attention. "We need more communication with the health committee about the financial end. There is a large gap—people do not know what happens."

Additional medical personnel is the second item people would most like to change about the present medical care program. "More dentists" (6), "doctors" (5), "eye doctors" (2), and "specialists", are requested.

Other individual suggestions for change include "more community involvement in health", "sign up for Medicare more frequently than the present three-month schedule," and "every Native corporation should keep in contact with patients at ANS from their region."

Eighteen people or 34% say there is "nothing they would change, everything is O.K." One resident

said, "I don't know," and four others give no response.

Summary

The satisfaction level with health care services at ANS in Anchorage appears low among Cordova's Native consumers. Only ten gave positive, supportive evaluations based on the physician's quality care. The majority are ambivalent about ANS health care. The traveling distance, waiting period, costs both economic and personal, all contribute to the low evaluation of ANS services.

Promptness of health care workers in meeting consumers' needs, ideas and financial support by ANS, high quality of care and positive attitudes of health care workers are those things consumers like about the present health care system. In contrast, the ANS allocation system, and both the quantity and quality of health care workers are features of the present system Cordova's Native residents would like to see changed.

Recommendations

North Pacific Rim can, through direct participation with ANS staff, take steps to improve this health experience in Anchorage for its people. Both positive and negative Native evaluations of ANS should be communicated to the hospital accompanied with an intervention plan and clearly stated objectives in order to improve Natives' healing experiences in Anchorage.

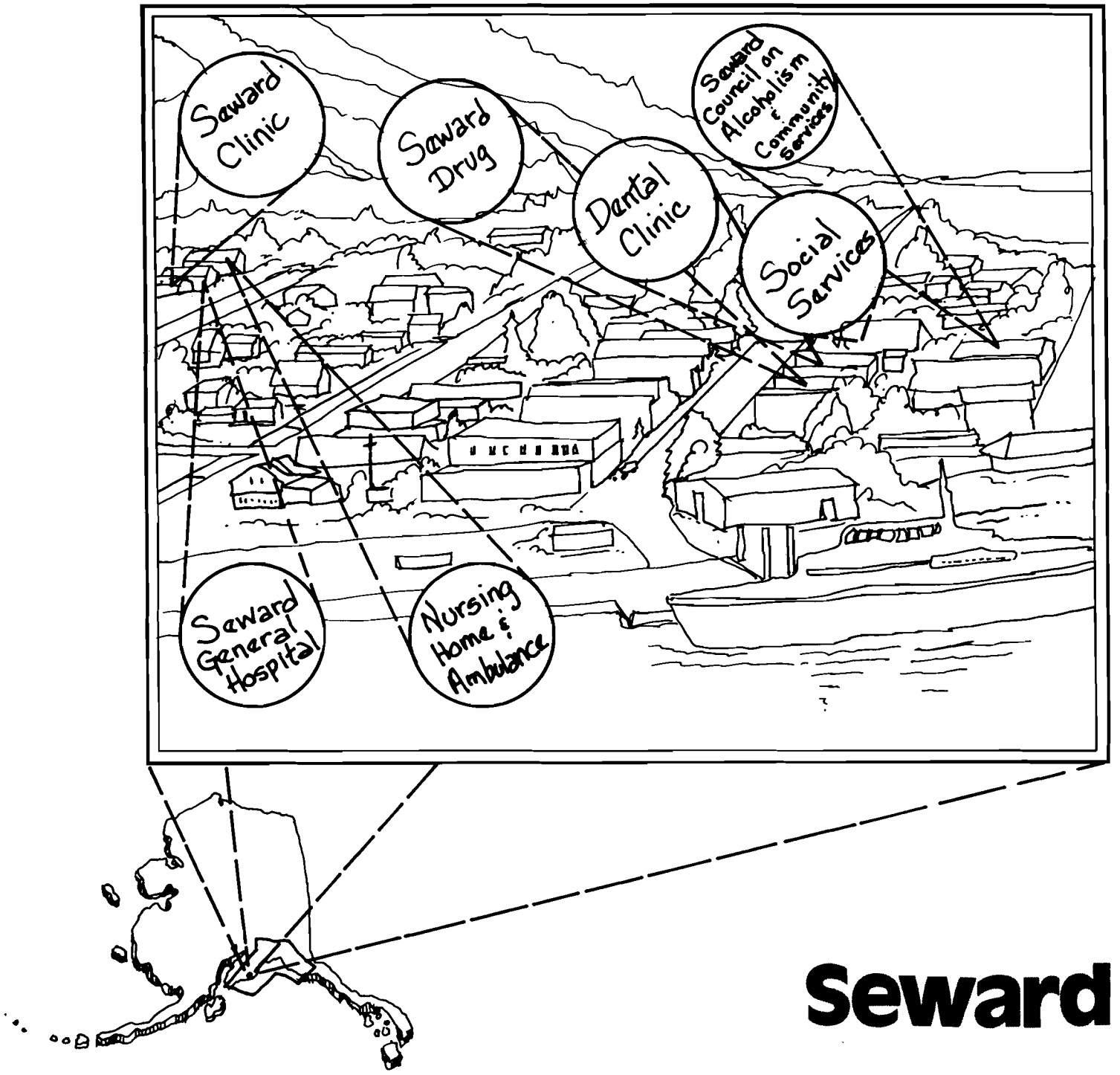
Unmet Health Needs

What additional health services would Native residents in Cordova like to have that currently are not provided?

The most frequent (9) request is for more hospital and pharmacy ANS funding. Next, residents (8) feel there should be a community-based dentist and eye doctor to care for local health needs. Three others express the need for a pediatrician's services. No requests are made for additional physicians. Initiation of medically related services, such as "starting our own drugstore" is also suggested by local Natives. Last, a need unmet by current health service agencies include support or auxiliary services such as a day care center, homemakers' transportation and recreation for the elderly. Despite the expressed needs of many, eighteen or 34% of the contributors gave no answer. Seven simply said, "We have all we need."

Summary

There are four general types of health services presently unavailable to Natives in Cordova. These unmet needs include limited 1) ANMC funding; 2) medical personnel; 3) medical programs; and 4) socially oriented programs. The most frequent request is for additional ANMC funding for the hospital and pharmacy.


Seward Clinic
Seward Drug
Seward Council on Alcoholism & Community Services
Dental Clinic
Social Services
Seward General Hospital
Nursing Home & Ambulance

Seward

SEWARD

by Ellen Setters

Seward, Alaska is located at the head of Resurrection Bay in southcentral Alaska. Connecting Seward and Anchorage, Alaska, is a northbound highway of 128 miles. Seward is also connected with all population centers (Kenai, Soldotna, Homer, Hope, Cooper Landing, Moose Pass) on the Kenai Peninsula except for Seldovia, Port Graham, and English Bay. These towns are not on the connecting highway system and the only way to get to them is to take a boat or fly.

Along with the paved highway access, Seward benefits from the Marine Highway route. Many barge companies use Seward's ice-free, year-round, deep port. Because of its location, Seward was a natural for being the southern terminus of the Alaska Railroad. Freight brought in by water is loaded on the railroad cars and transported to places north of Seward. The northern terminus is Fairbanks, with Anchorage and other towns being serviced in between.

Seward has scheduled and chartered air transportation. Seward is well placed, logistically, and handies its transportation of people and products efficiently. Seward has excellent commerce potential by utilizing the air, land, and sea transportation routes.

Seward's population of 2,340 (1,823 in the city proper) is making sure there is positive, planned growth. Seward is fortunate for being able to learn from towns who had no planned growth (boom towns).

People live in Seward because they like it. The people who like living here take advantage of the seasons of the year and have activities relevant to that season. There are always things going on and plenty to do. For example: sport fishing all year-round; commercial fishing; berry picking; making jams, jellies, preserves, and many other things from your own picked berries; gardening; smoking fish; seasonal hunting; mountain climbing; hiking, sail boating (complete with a yacht club); small aircraft flying; bowling; movies; walking; Bingo; nice restaurants; visiting; community Christmas celebrations (a choir gets together every year and does Handel's *Messiah*); Fourth of July celebrations; concerts; school plays and programs; watching local basketball. The list is endless for activities in Seward by her people. Also, there are thirteen bars and thirteen churches.

People living in Seward have interesting and varied livelihoods. We have a variety of educators and many others in professional fields. The University of Alaska's Institute of Marine Science is ideally located in Seward. Research is done here regarding Marine Biology and the Petroleum Industry. Also studied extensively are the red tides and how they affect marine life.

The Native community isn't as visible as in other Alaskan communities. They do not live in any certain area and are well integrated into the community.

Seward has a hospital with 32 beds and two doctors. We have a nursing home with 64 beds. We also have a Public Health Nurse and one dentist.

Located in Seward is the Alaska Skill Center which offers Alaska relevant job training, such as oil technology, welding, diesel mechanics, auto mechanics, accounting, clerk typist, food service, and building maintenance. In the planning, and soon to become a reality, is a "Cat" program. This program will graduate students qualified to be Caterpillar equipment mechanics.

Seward is surrounded by beautiful mountains. People race up to the top and back of Mt. Marathon to a finishing tape on Main Street. This happens on the Fourth of July each year. The record up this 3,022-foot-high mountain is 44:11 minutes.

The last Monday in March is celebrated throughout the state as Seward's Day, in honor of William H. Seward. Seward, the man, was President Abraham Lincoln's Secretary of State. Alaska was purchased from Russia under this man's leadership.

Seward is a good place to live.

Inventory—Seward

Facilities

Seward General Hospital
A 33-bed facility providing general medical service for the community. Accreditation Status: AMA Category IV.

Wesleyan Nursing Home
A 64-bed facility providing skilled nursing and intermediate care.

Seward Clinic
Located near the General Hospital, the clinic consists of two doctors and provides general medical outpatient services.

Public Health Center
Located in the basement of the General Hospital. Providing PHN programs as described in Chapter 4.

Pharmacy—Seward Drug Company
Providing pharmaceutical services to the community.

Seward Dental Clinic

Manpower

Doctors—2 physicians, Family Practice
Dentist—1
Public Health Nurse—1
Pharmacist—1

Emergency Medical Services

The Seward Volunteer Ambulance Corps consists of 15-20 active members, twelve of which are trained EMT's, and four ENT-II's. Service area coverage extends up the Seward Highway to Moose Pass, 28 miles north of Seward. In the event that the Cooper Landing EMS is inactive, the Seward Volunteer Ambulance Corps responds to calls as far north as Portage Flats, some 80 miles from Seward (Ging, 1977). The ambulance vehicles are housed in a garage at the Wesleyan Nursing Home. Emergency calls are placed to Wesleyan Nursing Home or the Police Department where standby volunteers are notified by telephone calls or paging devices. NPR is in the process of supplementing the emergency communication system to provide comprehensive emergency coverage. This will be completed November 30, 1977.

A VHF based at the Seward General Hospital provides direct communication to Corps members, state troopers, and city police.

Social Services

The Seward Field Office is staffed by a Social Services associate. Located in the State-City Building, services are also offered to Moose Pass, Cooper Landing and Hope.

Seward Council on Alcoholism and Community Services

The alcoholism program is housed in the basement of the Methodist Church. Counseling and referral services are offered by two staff members.

Mental health services are offered by one mental health clinician and one assistant to the clinician. The program is housed in the parsonage of the Lutheran Church.

Detoxification Facilities

Seward General Hospital.

SEWARD

Ranked by Inpatient Days

LEADING CAUSES OF HOSPITALIZATION

Cause of Hospitalization	FY 1974		FY 1975		FY 1976	
	Rank	Days	Rank	Days	Rank	Days
Respiratory Problems		–		–	1	40
Other Diseases of Gastrointestinal Tract, Peritoneum	5	18		–	2	33
Other Congenital Anomalies		–		–	3	29
Accidents	1	34	1	114	4	21
Urinary Tract Infection		–		–	5	19
Leukemia		–	3	33	6	18
Diabetes Mellitus		–		–	7	18
Delivery	2	28		–	8	14
Abortion, Spontaneous		–		–	9	9
Disease of Gallbladder, Bile Ducts		–	10	14	10	8
Osteoarthritis		–	2	35		
Organic Mental Disorders		–	4	29		
Strabismus		–	5	27		
Active Rheumatic Fever		–	6	25		
Cirrhosis of Liver		–	7	22		
Acute Alcohol Intoxication	3	22	8	21		
Habitual Excessive Drinking, Alcoholism		–	9	15		
Chronic Otitis Media	4	21				
Epilepsy, Convulsive Disorders	6	17				
Pneumonia	7	16				
Chronic Bronchitis Emphysema	8	15				
Abnormal Cytology	9	13				
Peptic Disease of Stomach, and Duodenum	10	13				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

SEWARD

Ranked in Order of Discharges

LEADING CAUSES OF HOSPITALIZATION

Cause of Hospitalization	FY 1974		FY 1975		FY 1976	
	Rank	Discharge	Rank	Discharge	Rank	Discharge
Delivery	1	8	3	2	1	7
Respiratory Problems	3	6		–	2	5
Urinary Tract Infection		–		–	3	4
Accidents	2	7	1	14	4	3
Diabetes Mellitus		–		–	5	2
Hernia, Abdominal		–		–	5	2
Abortion, Therapeutic		–		–	5	2
Other Diseases of Gastrointestinal Tract, Peritoneum	4	6		–	5	2
Abortion, Spontaneous		–		–	5	2
Acute Alcohol Intoxication	3	6	2	7		
Anxiety Neuroses		–	3	2		
Delirium Trem.		–	3	2		
Organic Mental Disorders		–	3	2		
Other Alcoholic Psychoses		–	3	2		
Other Disease, Urinary System		–	3	2		
Birth	5	4				
Pneumonia	6	3				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

SEWARD

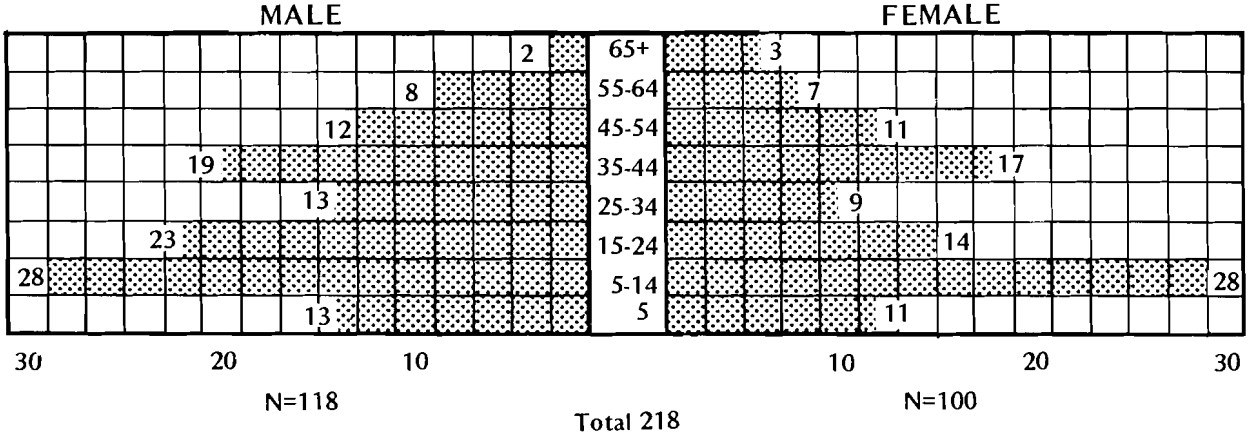
Ranked in Order of First Diagnosis

LEADING CAUSE OF OUTPATIENT VISITS

Cause of Visits	FY 1974 Rank	FY 1974 Number of Diagnoses	FY 1975 Rank	FY 1975 Number of Diagnoses	FY 1976 Rank	FY 1976 Number of Diagnoses
Respiratory Problems	1	215	1	225	1	182
Refractive Error		–	3	41	2	64
Accidents	2	122	2	110	3	61
Infections Female Genit. EX-VD	9	19	4	32	4	22
Disorder of Menstruation		–	9	19	5	16
Eczema, Urticaria, Skin Allergies	3	28	8	23	6	13
Other Diseases of Ear		–		–	7	12
Gastroenteritis Diarrhea		–		–	8	11
All Other Infect. Parasitic Diseases		–		–	8	11
Prenatal Care	5	23	8	23	9	10
Chronic Otitis Media		–		–	10	10
Other Bacterial Skin Infect.	6	22	5	29		
Urinary Tract Infection		–	6	27		
Other Diseases of Skin		–	7	25		
Neuroses	5	23	8	23		
Alcoholism Acute, Chronic		–	10	18		
Family Planning	4	24				
Gonococcal Infections	7	21				
Acute Otitis Media	8	20				
Other Diseases of Gastrointestinal Tract, Peritoneum	10	16				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

NATIVE POPULATION OF SEWARD BY AGE AND SEX, 1970 CENSUS



INTRODUCTION

Seward was the first community in the region to test the survey method used in this project. North Pacific Rim staff, Eloise Lambert, Nancy Davis, and Don Bantz went to the picturesque fishing community anxious to begin the process. Three local research assistants were interested in participating: Irene Hollman, Esther Ronne, and Lois Munson. North Pacific Rim Community Outreach Worker, Ellen Setters, also assisted the project team.

DEMOGRAPHIC DATA ON CONTRIBUTORS

A total of 54 persons in Seward helped out on the survey in April: 39 women and 15 men, between the ages of 17 and 72. One thing that is amazing about these residents are the number of places they come from. They were born in 34 different communities! Only nine people interviewed were born in Seward. The 39 women came from 27 different places, and the 15 men came from 11 different places. Although they are enrolled to six different Regions (Chugach, Cook Inlet, Koniag, Aleut, Bering Straits, and Sealaska), 70% are enrolled to Chugach Natives, Inc. Nearly 40% (21 persons interviewed) came to Seward during the ten-year period between 1947 and 1957.

PUSH-PULL MIGRATION FACTORS

Those who were born in Seward have lived there considerably longer than the "immigrants": an average of 35 years. Those who were born and raised in Seward also reported they like it and have few complaints about the town.

The following positive comments were mentioned in response to the question, "What do you like about living here?"

- Eight people referred to their relatives.
- A number of the special characteristics of Seward were mentioned.
  The small size was referred to by 13 persons.
  The school system was mentioned by six.
  The town as a "good place for children" was mentioned four times.
- Many people mentioned the people part of Seward.
  In addition to relatives, some people simply said: "the people" (5) or "friends" (4).
- The location of the town, the scenery and the country were mentioned by five people.
- Three persons even mentioned that they liked the weather.
- Certain aspects of the life style were noted 17 different times.
  For example, Seward is "quiet", "little traffic", "not crowded", "no rat race", "freedom", "wide, open space", and "I feel comfortable here" (2).
- Employment rated high on why they lived in Seward. Seven of the men mentioned employment, and ten of the women—if you include references to their husband's work (7 times).

Conversely, those factors that people dislike about Seward include:

- "The weather, especially the wind and rain."
- Just as there are advantages to knowing "a lot of people", there are some disadvantages in the accompanying gossip and the problem of "everyone knows everyone" (2).
- Five people did not like "the way the city fathers run the city".
- The lack of activities was mentioned by eight.
  For example, "nothing to do", "not enough recreational activities for the children", "only place to go is a bar", and "limited cultural opportunities". One person noted there is "no social center for Natives".
- Four persons referred to some aspect of discrimination in Seward.
- High prices in Seward were mentioned four times, and three commented there were too few services, such as "only one TV".
- Finally, two of the older people said they didn't like the fact that in Seward they have "no Native food, no seal oil".

AWARENESS LEVEL OF TRADITIONAL BELIEFS AND PRACTICES

Traditional Health Maintenance:

Only twelve persons gave no answer or said they just did not know what the people did in the old days to stay healthy. Of the people who answered they didn't know about the olden days, four of them were in their 50s, and two of those four had been raised in a government home or orphanage, and one of those came up with many cures later in the interview. But there were 31 different referneces to activity-related answers. For example, 14 mentioned a "lot of exercise" and nine referred to "working hard" or to "doing hard work", some being additionally specific to mentioning trapping (2), hunting (4), fishing (2), berry picking (1). Others commented:

> "They were busy people. Didn't even need welfare. Did not see many fat people."

"Seemed like they didn't have much chance to get sick—they were so busy to survive."

That ethic of working hard and getting a lot of exercise persists today.

Sixteen persons made reference to food, both what they didn't use to have (sugars 4), junk food (2) or additives (2), and also what they did have, a delicious-sounding list: greens, rabbit, ptarmigan, seal, salmon, clams, berries, whale blubber, dried fish and smoked salmon .

People also reported that in the olden days people spent more time outdoors (5) and got fresh air (2). One person had been instructed to "Live right. Learn all you can. Always be helpful."

There were two important people-related answers. One referred to "social gatherings" as a way to stay healthy and the other said, "they always had lots of people around".

One traditional institution, the steambath, was mentioned by one person.

Traditional Health Practices:

Only 18 people said they didn't know what people in the old days did when they got sick. Six others commented, "They had their own remedies," and five said simply, "They stayed in bed." Three persons were raised near medical facilities, said they went to the doctor or hospital. However, 22 gave specific answers, including a number of Native cures which are reported here. In light of the fact that many of these people have been removed from their traditional setting for quite some time, the range of knowledge they have and also their willingness to share it is impressive.

From people whose origins go to the Northwest, Eskimo part of Alaska, there were three references to ignoring illness:

"No time to be sick."

"Mostly they ignored it or called up the health nurse."

"I think they just put it out of their mind, and go about their business. But, if they had a broken leg, then everybody help out."

Two people from Southwest Eskimo communities were somewhat fatalistic; as well they might be considering the history of the area:

"They died if their own remedies didn't work."

"If they got sick, they just died. Can't do anything about their sickness."

Specific cures mentioned by people from Eskimo areas include:

- cod liver oil, castor oil and epsom salt
- leaves boiled and made into tea
- "dried onions for cold"
- "put a dirty sock around your neck"
- indigestion: "use boiled nonripe blueberries"
- cold: "eat cranberries"

Some remedies offered by Indians included the following:

- migraine headaches: open head
- bee sting swelling: red willow with green leaves, chewed up and put on
- cuts: pitch
- nail wounds: very finely sliced onion laid over wound
- fever: diced potatoes, put in sock and put around feet
- cough and fever: devil's club root
- stomach problems and diarrhea: boil salmon broth
- aching muscles: steam bath
- cure for eyes blind from measles: cranberry stalks, soak eyes

Other remedies given by people from other areas, including Seward:

- sulfur and molasses for a tonic
- "sugar in a teaspoon and a drop of kerosene in it"
- cure-all: "take a steam bath—cleansed yourself"
- flu: ate onions and drank hot whisky—used boose for cures
- eat ashes from stove—drink holy water

Three people mentioned the emotional support provided by elderly people. For example, "They would call [in] an elderly friend and that would perk her up," and "They would turn to my grandmother—after you talked with her, you felt like a million bucks."

Finally, one person said:

"They had their own remedies. They didn't run to a doctor for every little thing. Only went to a doctor when they were dying."

Reportedly, Seward is known among many Native Alaskans as a place where people go to die, a reputation resulting from the TB sanitarium which opened in the late 1940s.

SUMMARY

In sum, greater knowledge exists than expected, and there is also considerable continuity between what was considered healthy before, with what people think they should be doing now, namely, "Keep busy, work hard, and eat right."

RECOMMENDATIONS

The importance of other human beings and social contact with them was traditionally important, and may still be very significant both in terms of physical health and mental health. In our modern, frequent concern with diet and the body, perhaps the role other people have on health is given too little emphasis.

Perhaps the supportive, emotional role that the elderly can give to the younger, could be developed and enhanced in Seward.

AWARENESS LEVEL OF HEALTH INSURANCE

Forty-two persons, of 78% of this population sample, said "yes", they did know about it; 11 (20%) said "no", they did not; and one gave an answer not relevant to the question. This suggests a fairly high level of awareness of the health insurance concept, but it does not tell us its use.

Three persons (6%) said they had ANS insurance, indicating that to some people the ANS service is conceptually the same as regular health insurance, an idea which appeared a number of times (two answered they did not know and one gave no answer).

In response to the question of what they thought about health insurance, 36 (67%) of the responses were clearly positive, supportive statements. Six (11%) were negative, made by people who had experience with health insurance. Only four people gave no answer at all, and an additional six (11%) said, "I don't know," or, as one commented: "I haven't the foggiest."

Three persons made comments indicating that there are certain advantages to having both health insurance and ANS coverage. One is either covered by work insurance or not, but the ANS coverage is assumed to be constant, as long as one is Native. The complexity of switching from the paperwork involved when covered by work insurance back to ANS when out of work may partly explain why many people reportedly find it easier to continue with the ANS coverage during the periods they have other health insurance available. Also, as noted both here and informally in discussions, the disadvantage of the "hassle" of paperwork, the necessity to pay cash on the spot even though you are reimbursed later, highlights the value of the "easier", more convenient ANS coverage. One person said simply, "I would like to have health insurance."

Finally, one person who has health insurance stated:

> "We should use our own, and let other people use ANS funds."

SUMMARY

In sum, the Native residents of Seward who are employed have a wide range of health coverage. What remains unknown is how many specific individuals and family members are covered, and to what extent.

The overlap of double coverage was mentioned a number of times in different context within the interview schedule. Those with health insurance coverage are not always using it, partly because it requires ready cash, paperwork, and a significant change of behavioral patterns. If one is accustomed to ANS assistance and have had a lifetime of satisfactory experience with Indian Health Service, it may not be easy to drop those services when employed at a job which has compulsory deductions for health insurance. Several persons said they did not even know they had health insurance while they were employed, and therefore continued using ANS contract funds. Earlier note was made that people were using ANS funds for medication, when their health insurance covers it. Also there is some disadvantage of some coverage which is only 80%, when other health coverage is 100%, and when ANS has historically been 100%. To switch plans, especially from ANS to an 80% plan or even 100% plan which required immediate cash and much unfamiliar paperwork will be especially difficult for those persons who have had a history of satisfactory ANS assistance which perhaps led over the years to an ANS dependence.

However, it will also be difficult for those individuals who are proud of holding steady jobs, with excellent health coverage should they lose those jobs, and the coverage, and need then to "revert" to ANS contract funds. If pride is associated with the independence of a job and private health insurance, and we believe it is, then pain of the loss of a job is compounded by the concomitant necessity of having to "go back" to ANS.

RECOMMENDATIONS

1. If the North Pacific Rim Health Department is to seriously consider providing household health insurance, then it must be of a kind which will be

flexible enough to respond to the changing employment status of Native families and require a reasonable amount of paperwork with sessions on the format and reasons why the paperwork is required. If this is the direction which North Pacific Rim and/or Seward chooses to go, that direction would be encouraged if at the same time ANS began to require some paperwork and accounting to and from the patient, informing them of the costs involved in their care, and requiring validation of their actual real need for the service. Both would be difficult to establish a new routine. Certainly resistance can be predicted. However, if greater responsibility is desired by the Native people, and if the Self-Determination Act is to be implemented, then these are the kinds of steps which may need to be taken.

Those persons most likely to not use ANS funds when they are covered by other insurance are those who have pride in their job and recognize the importance of ANS funds being allocated to those who are not covered by other insurance. Also, as skills and familiarity with the insurance forms are increased, less ANS funds will be requested and used. An evening or house-by-house training in the paper-filling-out routine might well be worth the time and expense, especially if it is accompanied with a spirit of the dignity of being able and responsible to do it. Those persons least likely to be interested in new forms of health insurance are those who are completely satisfied with ANS service, and as we will see later in this survey report, there are some ANS satisifed customers.

2. Additional value to an accounting of health care costs to the consumers may be the increased awareness on their part of the expenses involved. Also some routine paperwork, generally required of private health insurance holders, may have an advantage of dignifying the intelligence of the consumer. Very few Native people would not be able to fill out some papers, and most are literate enough to fill out whatever forms may be necessary. For some, it surely must be at least indirectly demeaning to have all paperwork done by others, and be given no information about the costs and processes involved. Perhaps ANS coverage should be treated, increasingly, as any other kind of health insurance. This would make the contrast between "free' Native coverage to "paid" private coverage less sharp.

3. If North Pacific Rim Health Department were to undertake full responsibility of administering contract funds, then clear processes of accountability of those who need it, and those who do not, must be clarified. Also, it is highly recommended that information about costs and services be provided directly to the consumer, and that a percentage of the costs be paid by the consumer.

HEALTH MAINTENANCE AND HEALTH-SEEKING BEHAVIOR

Health Maintenance

The most frequent references were to diet and to the importance of actively "doing something".

Nineteen persons mentioned some aspect of diet or "eating well". Three mentioned natural foods. "Seafood" was mentioned twice, including to "eat fish heads, seal oil, seal flippers". Eight people said they take vitamins.

Working, keeping busy, social activities and exercise was mentioned a total of thirty-four times. For an example of the "keeping busy" answers, people mentioned, "I tackle the dishes," "work on the boat", "take care of my five kids", "do something fun". The importance of working is reflected by the person who said, "I'm working right now," as if in her mind working and feeling well were closely related, as well they may be.

Seven persons gave social activities, such as visiting friends (3) or belong to groups, like the health committee (1), or church (1). Other health practices given include "don't smoke" (4), "don't drink" (3), "a lot of rest" (4), "fresh air" (1), "stay clean" (1), "moderation in everything" (2). Only one gave getting a check-up as a way to stay healthy.

Specific practices, usually considered unhealthy, were given as how some people stay healthy. "I smoke," "drink a lot of coffee", "I do everything to stay unhealthy, like smoking, eating too much, stay too fat." Four men answered "drink beer", "take a drink now and then". Most frequently identified health maintenance activity (16). Seven mentioned walking, four—jogging, two—hiking, two—outdoor living and one each for fishing, hunting, and shoveling snow.

Health Seeking:

Keeping in mind the probable influence of many variables, the ambiguity of the question, the differences in response by age group is significant. Among the women, eleven of the fourteen between the ages of 17 and 39 gave the response of self-treatment and 50% of them go to bed. In contrast, the 14 women

between the ages of 40 and 49, only five or 36% of them viewed this as a physical question, and only four go to bed. Of the women over the age of 50, six or 55% treated themselves for a physical condition either by going to bed (4 or 36%) or taking something (2 or 18%). Most interesting of all, only three or 20% of the 15 men viewed the question as a physical condition and two of those reported they would seek a doctor.

In the second level response "if that doesn't work, then what do you do?" six who first went to bed would next see a doctor. Indeed, a total of 17 who gave other responses to the first question, would go to a doctor if that did not work. Also some who treated themselves for nonphysical ailments would if their treatment for example of hard work, did not improve the situation, then they too would seek a doctor. The "keep busy, keep working, be super-active" response was frequent, and I believe, significant to our understanding of Native response to feelings of illness especially emotional "lousy" feelings. Only three who gave nonphysical answers to the first part of the question said they would go to a doctor if whatever they did failed to work (two said they would keep on working, and the third said "drink" to the first response). Two of them made it clear it would have to be real bad to go to a doctor and the third referred to being "nature, real sick". The "grin and bear it" idea appeared four times, but may be indirectly implied in the six "take-your-mind-off-it" kind of responses, which may also not be so different from "keeping busy" to get your mind off your condition.

Of great interest are the unanticipated answers implying a nonphysical reading of the condition "lousy". Thirteen persons (24%) gave answers such as "keep busy, keep working, clean house, work on the boat, tackle something difficult". This perhaps is a keep busy, keep your mind occupied, work hard and maybe it (whatever it is) will go away. It may also be related to the work ethic reflected earlier in the questions about staying healthy.

SUMMARY

In summary, the people interviewed in Seward gave a wide range of responses to the "lousy" question reflecting two distinct interpretations of the question and a range of self-treatments. The anticipated "take-aspirin-go-to-bed-call-a-doctor" sequence was rare, and the unanticipated response of "working hard and visiting" was frequent.

If we should give a hypothetical anticipated response to "What do you do when you feel lousy?" it might be, "take aspirin and go to bed" with a follow-up answer of "go to a doctor" if that doesn't work.

However, not a single Native in Seward gave that response. Seven did say they went to bed and then sought out a doctor (all of them under 50), and two took aspirin and went to bed. A similar survey among non-Natives would be of interest and provide some comparable data which would be especially interesting on this question.

ACCESSIBILITY: BARRIERS TO MEDICAL AND DENTAL UTILIZATION

Medical Accessibility

Forty-four (78%) answered "yes", it is easy to get in to see a doctor, indicating a high level of medical accessibility.

Six people reported they did not find it easy to see a doctor, either because they did not like to have to wait or make appointments (3) or through past personal experience which made them stay away. For them it was difficult to get in because of their own feelings, not the lack of availability of the doctors. (Only two of those six do not have insurance.)

Finally, the four who gave other answers simply said they had no occasion to even try to get in to see a doctor. The reasons the six people answered it was not easy to get in to see a doctor include past experience of difficulty in community with doctor or "go through too many interns" and "I'm afraid of what they are going to say". These are patient-related problems, not the availability of the doctors. Two persons had difficulty in making appointments. "It almost has to be emergency to get in." Two of these persons who had difficulty did not have insurance.

Incentives Facilitating Medical Visits

When asked why they found it easy, ten mentioned the availability of the doctors in Seward. For example, three said there was no waiting list and that you could make an appointment. Three found it convenient because they are "nearby". Two commented you can always get in when there is an emergency.

The fact that the doctors know them or they know the doctors was the answer of three persons to the question of why they can get in. Other answers referred to how difficult it is to get in ANS in Anchorage, and how much easier it was in Seward, and the personal characteristics of the doctors. "We've got two very nice doctors here. I like them."

Dental Accessibility:

A dentist does practice in Seward, but apparently there is more demand for his services than he can meet at the present time. Reference to the need for additional dental care was mentioned frequently throughout many of the interviews and on many questions.

In sum, 25 (46%) said it was not easy to get in to see a dentist and 29 (54%) had not been into see a dentist within the last year. A few said they didn't need a dentist because they were already toothless.

Lack of accessibility was the main reason. Twenty of the 25 mentioned things like the "long waiting list", "he is booked up", "he doesn't take new patients", or they gave a history of waiting between eight months, one year, two years and even longer to get in to see the dentist. Three persons go out of town for a dentist, and a fourth said, "Anchorage is far away," suggesting that perhaps the person simply does not go. Fear of dentistry was mentioned by six persons. Five persons put off going because it costs money. Other reasons include having to go to Anchorage and a previous bad experience.

Twenty-nine (54%) answered they had not been in at all to see a dentist in the past year. Eleven (20%) reported they had been to a dentist once. Ten more (19%) had been in more than once; twice (2); three times (2); four or five times (3); six times and quite a few (3). A total of 22 or 39% had been to the dentist within the last year. For four (7%) the question was not applicable because they had no teeth, though the question of the need for plates was not asked. If the four are withdrawn from the sample, then a total of 58% of the Seward sample had not been in to see a dentist; and 42% had seen a dentist once or more within the last year.

Optometric Accessibility:

The results indicate that there is some difficulty encountered in getting to an eye doctor, but that if arrangements are made, an optometrist is available. Twenty-five persons said it was easy to see an eye doctor and gave a range of answers, including the fact that he comes to Seward on a monthly basis (5) and that you can see him if you make an appointment ahead of time (6).

Satisfaction Level with Western Medical Care

ANS

Fifteen persons gave positive, supportive statements about the ANS Hospital; ten gave rather ambivalent statements suggesting uncertainty, seven volunteered they had never been patients in the hospital. Finally, nineteen gave negative statements, some of them very strongly phrased.

First, the positive, supportive statements included simple straightforward answers such as, "I like it", "it's good" to even "I think it's great". Some were even more enthusiastic about going to ANS:

> "I think it's a terrific service for myself and my family."

> "Real nice up there. I'm going tomorrow for a checkup. They really helped me. If it wasn't for them, I wouldn't be alive today."

A loyalty seems to pervade statements by those who have had good experiences in the hospital. Another example:

> "I like to go to ANS. Get to see a lot of people I know. Feel more relaxed up there, than here."

Also there is the consideration that one's miserable hospital experience is a common topic for many people.

Eight simply said, "I don't like it," and several added they did not like the time it takes. One person's answer was an emphatic, "No! No! No!"

Several had bad experiences, including misdiagnoses. The observed lack of cleanliness bothered two, for example:

> "I don't think it is kept up clean. Even the doctors don't look clean. I feel contaminated when I come out."

Several referred to "second-rate service", but one of those then later countered with, "They do have some of the finest doctors in the state."

One person reported a recent change in service available there:

> "I'm not comfortable about going there, anymore. It's not the same as it used to be. I don't think the nurses take as good care of the patients as they used to."

Five people commented on the ANS Hospital referring to the "drunk problem at ANS" and concern that the "ward smells so bad". Two indicated that they much prefer staying in Seward:

> "We have a beautiful hospital here in Seward. No reason to go to the Native hospital."

Another person recommended a change in policy so that Natives would not have to be transferred to ANS after three days. Yet another recommended that if they have to go to ANS that that hospital should have more information about the care they get in Seward.

Six persons referred specifically to the way they had been treated which ranged from feeling like a "dumb Native", "drunk cow", and even "a slab of bacon shoved in and out of there". Also:

> "I would go there only if I were desperate. They treated me like an old drunk."

> "They shifted me around like a cow there. The last time it was so crowded, it was pretty bad. I like it though. It's all right."

Summary

Reflected in this last statement is both the anger in being treated with less than the desired dignity and at the same time, an appreciation for the service, which is after all free, and it may someday save your life. Because it is difficult to be critical of that which is free and given, the negative statements are surprising, especially when compared to the 2C study which indicated a high level of consumer satisfaction. This should be expected, however, not necessarily because of the quality of the service, but the very nature of the service which has indeed in the past saved people's lives, and may in the future save the life of the person interviewed. Public Health Service is difficult to criticize because the level of dependence is so well established and so pervasive. Those who feel negatively about ANS and their experiences there were themselves very lengthy in their discussions, much more so than those who found the service satisfactory.

Recommendations

The role of visiting, renewing friendships, keeping contact with relatives and shopping should be explored more extensively, for surely there is more in Anchorage than just the hospital which attract returnees to ANS.

Seward Health Services

A total of 18 (33%) gave responses which reflect they are clearly satisfied with the local services available to them and have no recommendations for changing them. For example, they gave answers such as "nothing", "no change", "no problem", "can't complain", and "the doctors are great". These eighteen are obviously among the more satisfied consumers.

Twenty-eight gave other kinds of answers, which do not mean they are all dissatisfied, but they do indicate areas where some improvements can be made. The concern mentioned the most frequently was the need for more dentists. Fifteen (28%) of the sample or 54% of the persons providing recommendations referred to dental care. Ten said, "more dentist", and five other made similar comments such as "dentist appointments should be available", "the dentist should be more accessible", and "the dentist should serve more Natives". One person commented:

> "He's got more work than he can ever handle. He needs a little competition, even a traveling dentist."

Six people made comments about Seward General Hospital. Three indicated concern about the reporting system, recordkeeping, and suspicion of ever charging and double billing insurance companies and ANS funds. Three made some reference to difficulties encountered at the hospital which they attribute to their being Native.

The confusion about ANS funds and insurance coverage causes some discomfort probably for both sides, the providers and the consumers. One person mentioned "harassment at the front office because of insurance". Four mentioned unsatisfactory pharmacy arrangements. Another recommended "more funds to cover services here in the hospital". One person said that ANS runs out of money, so—

> "That is why I am working. Makes me feel embarrassed when I go in and they say 'sorry, out of money.' "

This statement confirms other references to differential treatment at the local hospital. Two persons had specific recommendations to make concerning funding:

> "The Native people need to be aware of insurance (they have), and then not have to use ANS contract funds. The mechanics of the insurance forms need to be explained."

The need for this kind of explanation of insurance forms was indicated by others who have run into hassles over the paperwork and some who admitted they hated filling the forms out and found ANS funds easier and more convenient to use.

Finally, another recommendation comes from a 29-year-old man who said:

> "It (the medical care program) should come under the nonprofit arm (of the regional corporation). Everything should be covered by a hospital plan for the shareholders."

Unmet Health Needs

Clearly the strongest-felt need in the area of the health program available to the Native people of Seward is for additional dental care.

Seven (13%) indicated some concern about the doctor service available to them. Three thought there was a need for more doctors, and one requested that:

> "I think the doctor should tell us more what is wrong with us and also what the medication is supposed to do to us."

An eye doctor was mentioned by eight. Three persons mentioned that the pharmacy needs to be more fully funded. Concern for better care for the elderly was mentioned twice, as was preference for staying in Seward rather than going to Anchorage. The addition of a health education program was mentioned as was a rare reference to alcoholism. As for a specific recommendation for Seward's general health, two people said "a swimming pool!"

The theme of concern about running out of ANS funds locally came up yet again. For example:

> "Why does the emergency money run out?"

And here, at the end, three people indicate why the funds sometimes run low:

> "Sometimes it is used by the wrong people, the drunks."

> "I know people who charge ANS for medicine when they are covered by other insurance."

And even a suggestion for protecting those funds was given:

> "Limit the number of people who use ANS funds."

Summary

Along this line, one person noted that "Native health money causes friction in a small community—the white population feels like it's unjust. This kind of problem and the sensitive issues it raises would likely not appear in small, more unified villages such as Tatitlek, English Bay or Port Graham. But they are important potential arenas for conflict in mixed communities such as Cordova and Seward. Resolution of ANS contract funds and their distribution will inevitably be more complex in towns than villages, not just because there is white criticism potentially encountered, but also because the Native people themselves represent a wide range of ethnic groups and different levels or participation in the modern economic and social world.

Valdez

The Gold Rush years of 1897-98 led to the founding of Valdez. Located at the east end of Port Valdez and possessing an ice-free harbor, Valdez served as a debarkation point for miners en route to the Interior gold fields (Townsite Survey: 1964). The community became the coastal terminus of all American winter mail routes to all Interior points, and a supply center for prospectors and miners in the Copper River area (Longville, 1977: 99).

Copper and gold mining, fishing and timber industry, tourism, and road commission employment sustained the relatively small population of around 500 from the 1920's to the late 1960's (Baring-Gould and Bennett, 1974: 4).

The 1964 earthquake and tsunami devastated Valdez, and the community was relocated to more suitable ground some four miles to the northwest.

A new planned community was constructed under the guidance of the Corps of Engineers (Baring-Gould and Bennett, 1974: 4). In a rugged setting of steep snow-clad mountains, glaciers, and bordering on a bay, Valdez is laid out in a modern fashion. Rectangular in shape, the city has paved streets, a small boat harbor, ferry terminal, a business district, and a residential area with rows of cul de sacs separated by a central park strip.

Approximately fifty homes and business buildings were moved from the old townsite and stand interspersed among modern ranch-style houses and newly constructed hotels, banks, and office buildings. The tall frame buildings of old Valdez, some dating to 1903, are identified in a brochure distributed by the

Valdez Chamber of Commerce and Friends of Valdez Heritage Center.

During the ten-year period between the earthquake (1964) and the beginning of the pipeline construction (1974), the economy of Valdez rested mainly on government jobs. The regional headquarters of the State Highway Department and the State Harborview Memorial Hospital for mentally retarded children were located in Valdez, and along with the local government sector employed approximately 40% of the labor force (Baring-Gould and Bennett, 1974: 16). Tourism is an important, though seasonal, part of the economy. Located in a beautiful setting, and accessible by paved highway, air, and ferry service, the community offers a variety of charter tours over land water for the many yearly visitors. Trucking, trade, construction and a declining fishing industry were part of the economic base.

In the late 1960's news of the selection of Valdez as terminus for the all-Alaskan pipeline attracted an influx of job-seekers. During the construction phase of the pipeline project (1974-1976), the Valdez population swelled to a peak of 3,500 in July 1975, plus a population of 2,672 employed at the terminal camp (Baring-Gould and Bennett, 1974: 14). A rapid change in the occupational structure took place. Contract construction employment replaced the former reliance on public employment for an economic base.

Physical changes within the community included the development of large trailer courts to accommodate the rapid population growth, and enlarged airport terminal and modular units to accommodate the schools and medical clinic.

State impact monies were available during the "boom" period to assist the community in meeting the demands for more services.

Inventory—Valdez

Facilities

Harborview Memorial Hospital

Operated by the State of Alaska, this 140-bed hospital is an intermediate care facility for the mentally retarded (State of Alaska: 1977).

Valdez Community Hospital

Valdez Community Hospital is located in a wing of the Harborview Memorial Hospital. The City of Valdez took over the 16-bed general wing in 1975, which now offers general medical, laboratory, x-ray and emergency services for the community (Stasch: June 1977). Accreditation Status: AMA IV.

Valdez Medical Clinic

The Valdez Medical Clinic consists of one doctor and two physician's assistants who also serve as staff at the Community Hospital. The clinic is located adjacent to the hospital which provides the laboratory and x-ray services for the clinic's outpatients. The clinic accepts Medicare/Medicaid outpatients (Eaton: June 1977).

Valdez Public Health Clinic

The clinic is housed in the state trailer court located behind the Valdez Medical Clinic. The staff consists of a Public Health Nurse and one secretary. Services offered include well baby clinic, women's clinic, screening and immunizations, school visits, family planning counseling, home visits to new mothers, and Lamaze Classes (Ray: June 1977).

Personal Health Care Support Services

Valdez Rexall Drugs

Provides pharmaceutical services for the community. Staffed by three pharmacists (Bushman: June 1977).

Emergency Medical Services

Valdez Rescue

A volunteer ambulance crew of 20 volunteer EMT-I and 7 EMT-II persons provide ambulance services and medical emergency care for Valdez, and also as far as 70 miles up the Richardson Highway (Coxey: July 1977). The EMT's also assist in the Valdez Community Hospital Emergency Room (Stasch: June 1977). The Alyeska camps contribute to the ambulance services. The Sheep Creek Ambulance Service assists Valdez Rescue as many accidents occur in that area (Coxey: July 1977). A Mountain Rescue Crew is in the developing stages.

Manpower—Valdez

Doctors—1 physician, Family Practice
Physician's Assistants—2
Public Health Nurse—1
Pharmacists—3

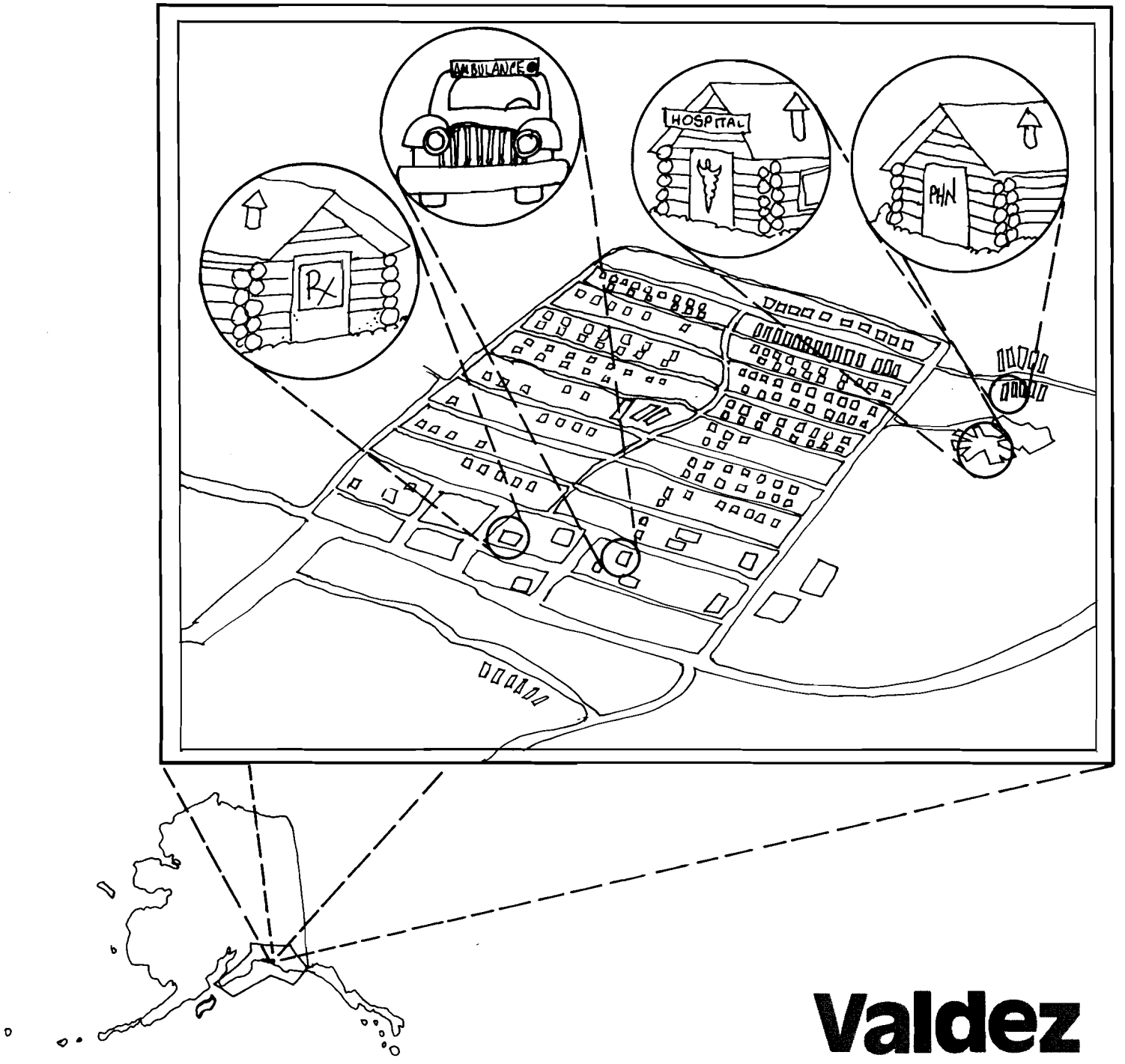
Mental Health Services are provided through the Cordova Mental Health Services on an itinerant basis at least once a month.

Alcoholic Services—Alaska Labor and Management Employee Affairs (ALMEA) provides alcoholism counseling services to Valdez and to the Alyeska Terminal Corp. Two counselors are available. There are no detoxification facilities.

Social Services—The State Division of Public Assistance Office is staffed by an eligibility worker.

Itinerant Specialists:

- Opthamologist
- Optometrist
- ENT Specialist
- Pediatrician
- Veterinarian



Valdez

VALDEZ

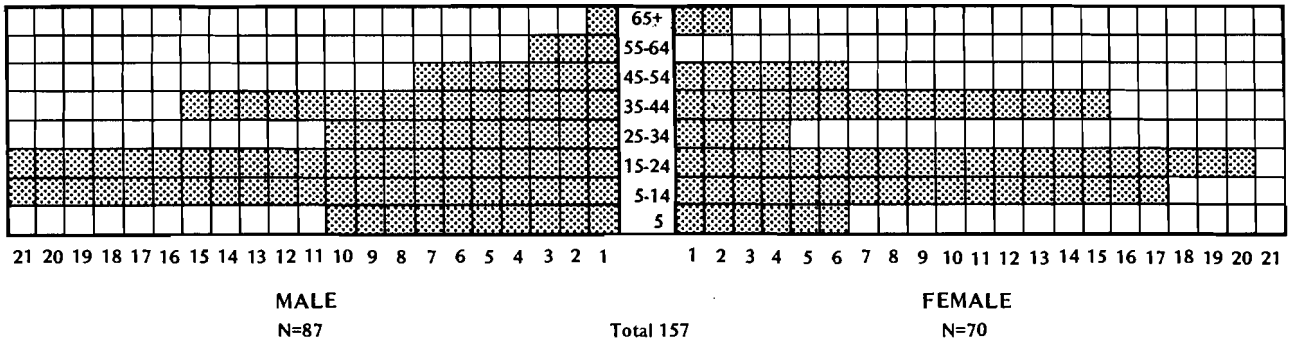
Ranked in Order of First Diagnosis

LEADING CAUSE OF OUTPATIENT VISITS

Cause of Visits	FY 1974 Rank	FY 1974 Number of Diagnoses	FY 1975 Rank	FY 1975 Number of Diagnoses	FY 1976 Rank	FY 1976 Number of Diagnoses
Respiratory Problems	1	62	1	69	1	20
Accidents	2	36	2	38	2	10
Epilepsy, Convulsive Disorders		–		–	3	2
Conjunctivitis		–		–	3	2
Diseases of Urinary Tract		–		–	3	2
Other Diseases of Skin		–		–	3	2
All Other Infective, Parasitic Diseases		–		–	3	2
Eczema, Urticaria, Skin Allergies	3	11	3	9		
Alcoholism, Acute, Chronic	6	4	4	4		
Chronic Otitis Media		–	4	4		
Refractive Error	6	4	4	4		
Urinary Tract Infection	4	8				
Diseases of Teeth, Gums	5	6				
Prenatal Care	6	4				
Other Bacterial Skin Infections	6	4				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

NATIVE POPULATION OF VALDEZ BY AGE AND SEX, 1970 CENSUS



VALDEZ

Ranked in Order of Inpatient Days

LEADING CAUSES OF HOSPITALIZATION

Cause of Hospitalization	FY 1974		FY 1975		FY 1976	
	Rank	Days	Rank	Days	Rank	Days
Accidents	2	49	2	110	1	74
Respiratory Allergy, Asthma, Hay Fever	5	12		–	2	19
Functional Psychoses		–		–	3	16
Respiratory Problems	7	9		–	4	14
Neoplasms	1	125	4	42	5	9
Acute Alcohol Intoxication	8	8		–	5	9
Delivery without Complication	10	6		–	6	7
Diseases of Gallbladder, Bile Ducts	9	7		–	6	7
Other Alcoholic Psychoses		–		–	7	5
Mental Retardation	8	8	3	51	8	3
Typhoid Fever		–	1	122		
Med/Surg, after Care Follow-up		–	5	32		
Pneumonia		–	6	25		
TB, Pulmonary, Active		–	7	22		
Misc. Eye Diseases		–	8	13		
Episodic Excessive Drinking		–	9	12		
Diseases of Blood Forming Organs		–	10	8		
Disorders of Menstruation		–	10	8		
Diabetes Mellitus	3	20				
Hernia, Abdominal	4	13				
Other Heart Disease	6	11				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

VALDEZ

Ranked in Order of Total Diagnosis Including Supplemental Activity

LEADING CAUSE OF OUTPATIENT VISITS

Cause of Visits	FY 1974 Rank	FY 1974 Number of Diagnoses	FY 1975 Rank	FY 1975 Number of Diagnoses	FY 1976 Rank	FY 1976 Number of Diagnoses
Respiratory Problems	1	99	1	106	1	26
Accidents	2	68	2	55	2	21
Prenatal Care	7	10	4	14	3	18
Tests Only		–		–	4	14
Epilepsy, Convulsive Disorders		–	6	8	5	10
Neoplasms		–	8	6	6	7
Obesity, Nonendocrine		–		–	7	5
Other Forms Arthritis		–		–	8	4
Other Eye Diseases		–		–	8	4
Eczema, Urticaria, Skin Allergies	3	21	3	17		
Alcoholism, Acute/Chronic	9	7	5	10		
Physical Examination		–	6	8		
Hospital Medical Surgery Follow-up	5	16	7	7		
Chronic Otitis Media		–	7	7		
Other Forms Arthritis		–	7	7		
Neoplasms		–	8	6		
Other Diseases of Gastrointestinal Tract, Peritoneum		–	8	6		
Tests Only	4	19				
Urinary Tract Infection	6	14				
Gastritis Duodenitis	8	8				
Warts	8	8				
Diseases of Teeth, Gums	9	7				
Refractive Error	10	6				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

VALDEZ

Ranked in Order of Discharges

LEADING CAUSES OF HOSPITALIZATION

Cause of Hospitalization	FY 1974		FY 1975		FY 1976	
	Rank	Discharge	Rank	Discharge	Rank	Discharge
Accidents	1	5	2	4	1	8
Delivery without Complications		—	3	3	2	3
Respiratory Allergy, Asthma, Hay Fever	3	2		—	3	2
Respiratory Problems	2	3		—	3	2
Functional Psychoses		—		—	3	2
Pneumonia		—	1	6		
Neoplasms		—	3	3		
Mental Retardation		—	3	3		
Disorders Menstruation		—	3	3		
Acute Alcohol Intoxication	2	3				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

INTRODUCTION

Winds were blowing across the Prince William Sound at up to 60 m.p.h., and snow stood 15 feet deep the day North Pacific Rim went to Valdez in late April to hear what Native residents had to say about health. Spring, however, was more evident in the Native people's optimistic spirits than it was reflected in the environment.

Two Alaska Native research assistants with first-hand experience in Valdez—the southern terminus of the famed Alaskan pipeline—were recommended by local contact person, Helen Dunlap. Inez Majerus and Ruby Mitvitnikoff, in conjunction with North Pacific Rim project staff, LueRae Erickson, began the two-day interview process. After compiling a list of Native families in Valdez, each selected homes and people they felt comfortable visiting and interviewing. The availability of people, and the fact that many live some distance out of town necessarily limited the number of people contacted during the 27th and 28th of April to ten or 10% of the Alaska Native adult population.

The interview itself consisted of a formal questionnaire lasting in most cases from 30-45 minutes each. However, the formality of the prestructured questions was balanced by the relaxed home atmosphere and informal socializing. With most potential contributors working during the day to survive Valdez's high cost of living, interviews were most often conducted in the evening after work.

Demographic Data on Contributors

Approximately 10 percent of the adult Alaska Native population of Valdez responded to the consumer evaluation questionnaire. These included seven women and three men. Their ages ranged from 24-64 years of age with half of them in the 25-35-year-old bracket. The youngest woman expressing her opinion is 24; the oldest is forty years her senior at 64 years of age. Similarly, the youngest male voicing an opinion on health matters is 29; the oldest man being 60.

Push-Pull Migration Factors

The migration factor "pulling" half of the Native respondents to Valdez is simply that they were "born here" or "it's my home". Close behind, employment is the "pull" factor four residents mentioned as influencing their choice of residence in Valdez. "My husband relocated for work", "Valdez is where I work", or "My husband works across the bay, we have no choice", are comments illustrating this operative pull factor. The presence of friends and family, the mountains and water, and the fact that it's just plain "good country" are other attractive features.

Conversely, what are the factors which actively "push" or encourage residents to leave Valdez? The lack of activities, with "nothing to do" coupled with the "high prices" are the most frequently mentioned objectional features about living in Valdez. The

rugged mountains and the fact that it's "hard to get out in an emergency because you can get weathered in" are highlighted as secondary features women residents dislike about Valdez living. "The boomtown thing", or overpopulation and growth due to the Alaskan pipeline is the feature two Native men find objectional. "The last two or three years, it's not like it used to be."

Awareness Level of Traditional Health Practices and Beliefs

The level of awareness of traditional health maintenance and health-seeking practices decreases with age. Those under 35 years of age have little or no awareness of what people did in the olden days to stay healthy or to deal with sickness, whereas those over 35 years old knew many specific practices and techniques. These practices primarily consisted of attention to diet and use of home remedies such as herbal, fern and vegetable teas.

Awareness Level of Health Insurance

The level awareness of health insurance is high. Eight of the ten respondents know about health insurance, although three of the individuals did not have any. All of the individuals agreed that health insurance "is a good thing". The insurance companies represented included Laborer's Union and Teamster's Union (50% consistent with insurance available via pipeline), Mutual of Omaha, Blue Cross, and Medicaid.

Summary

There is a high level of awareness and interest among Valdez, Alaska Natives in regard to health insurance. Despite this high level of awareness however, a number of unanswered questions remain. Are persons who are legally eligible for health insurance benefits receiving coverage? Or, do barriers exist such as culturally based unfamiliarity with Western bureaucratic forms and procedures, language, or conceptual differences and the need for larger initial cash advancements, etc., inhibiting rightful Native beneficiaries from utilizing health coverage? If so, what are these specific barriers and how might they be overcome?

Recommendations

1. Given the reality that ANS health funds are limited and the high level of actual insurance coverage by Valdez Natives (due most likely to unionized labor employment through pipeline-associated companies), an investigation by North Pacific Rim to ascertain whether eligible Natives are in fact utilizing their third-party health benefits is recommended.

2. If utilization is low and barriers high, North Pacific Rim may consider a mediating role to raise the level of awareness of health employment benefits among Valdez Natives.

3. North Pacific Rim working directly with employers and insurance representatives can seek to identify and correct unncessary barriers blocking Native utilization of their earned insurance benefits.

Health Maintenance and Health-Seeking Behavior

Health Maintenance

Valdez Natives identified three basic techniques for maintaining good health: 1) working hard; 2) exercising; and 3) taking vitamins.

"Taking vitamins" was reported most frequently. This is consistent with the cutom in traditional times of using various herbal and homemade organic remedies (reference Section 4.0). Indeed, "taking vitamins" appears to be the modern embodiment of a long-standing traditional emphasis on health maintenance techniques of a chemical nature.

Health-Seeking Behavior

The health-seeking behavior of Valdez Native consumers combines a self-initiated treatment when they "get sick", followed by a doctor consultation if the condition becomes progressively worse. In contrast, when people "feel lousy", they do not seek out physicians. Rather, they turn to people, such as friends or a spouse and techniques such as sleeping, walking, or busy activities, which are outside the conventional medical environment. "Feeling lousy" is defined in emotional rather than physiological terms and consequently individuals seek attention for these emotional pains. Note that "walking" and "keeping busy" are consistent with health behavior noted under health maintenance, i.e., exercising and working hard.

Health-Seeking Behavior Sequence

This analysis addresses the health-seeking behavior sequency as it proceeds from the point of determining the need to travel to ANS in Anchorage for health care.

Although there are a number of individual variations, most respondents (80%) personally make the

decision to go. Then they proceed to Anchorage alone by airplane or car. Upon leaving for the return to Valdez, they are given instructions to follow by the physician and most (75%), but not all, comply with "doctor's orders". Most often medical personnel do not check to see if these instructions were followed; rather the patient or "no one" provides follow-up services.

Summary

The activities Valdez, Alaska Natives do to stay healthy (health maintenance) and to get well when they are sick or feel "lousy" are remarkably consistent. These health activities are basically (1) keeping active, and (2) the ingestion of chemical agents.

Further, these activities are consistent with reported traditional activities of the same nature. One might postulate that the modern health maintenance technique of "taking vitamins" among Natives in Valdez is a modern expression of a long-standing, deeply engrained value of ingestion of various herbal substance.

Medical care and treatment will be more readily accepted and more effectively used by Valdez Native consumers when it is congruent with cultural behavioral norms, particularly norms that are grounded in long-standing tradition and custom. For example, present-day Western medical treatment, such as prenatal vitamin therapy might be readily accepted since it is analagous to and congruent with traditional health maintenance behavior.

The most apparent "gap" or "weak link" in the ANS health-seeking chain of events is with the local Valdez health services. The patient often bypasses the local physician in the initial screening and referral process. Similarly, at the conclusion of the health-seeking sequence, the local physician is again bypassed, not being routinely used for follow-up services.

Recommendation

1. Develop health programs that stress self-initiated examination and treatment.

2. Orient physicians and health care providers to cultural behavioral norms of Valdez Natives regarding health and illness.

3. Seek the assistance of auxiliary medical personnel, such as the Public Health Nurse or physician's assistant, in insuring (1) access to health care, and (2) continuity of care.

Accessibility: Barriers and Incentives to Medical and Dental Care Utilization

Medical Accessibility

Over half (60%) of the respondents report they have difficulty getting in to see a doctor in Valdez. In fact, due to barriers, most people (60%) say they will put off going to the doctor even though concerned about their health. The most frequently mentioned barrier is the necessity of making prescheduled appointments. "It takes too long to get in to see a doctor," one person said.

In contrast, access to more specialized services of an eye doctor is easier for residents to secure than those of a general practitioner. Apparently, the services of a traveling eye doctor from Anchorage has a significant impact on reducing barriers to care. As one woman summarizes, "Two eye doctors come to Valdez; it's easy to schedule an appointment."

Dental Accessibility

Difficulty is again encountered, however, when seeking dental care. In fact, Natives have a more difficult time getting in to see a dentist in Valdez than a doctor; as reflected in lower dental than medical utilization rates. Five or fifty percent of the contributors had not been to the dentist during the past year, whereas all have visited the physician at least once during that time with seventy percent making two or more visits. The reason for this access difficulty is basically the fact that there is "no full-time dentist in Valdez". Similarly, most parents (6) say their children have a difficult time getting dental care.

Economic Barriers

In seeking health care locally all of the respondents identified the need for cash as a significant obstacle to health care. A number of insuring policies require that the patient pay the bill in cash and await reimbursement. Additionally, they must pay the balance of that which is not covered by insurance.

Fewer individuals (60%) experience economic barriers in using ANS Hospital (Anchorage) health services as distinguished from local care. However, this is not to say that the total number of dollars expended is also less. Meals, gasoline, motels, cabs, child care, and telephone calls are all costs associated with the "free" health care of ANS. In actuality, cash expenditures may be more for those going to Anchorage rather than those seeking local care.

Sociocultural Barriers

The prescheduling of appointments is a norm, and therefore, expected behavioral rule in the medical culture. Physicians and other support staff allocate their time and services according to these prestructured schedules. In direct opposition, Native culture does not, as a traditional cultural norm, allocate time on a rigid fifteen-minute incremented 8 a.m. to 5 p.m. schedule. Similarly, when Natives traditionally needed health services, they went to the village healer when they were sick, they did not rigidly schedule a time block three days or three months hence to receive medical attention. Thus, the norm and expectation of making appointments is a Western notion, based on values of the medical culture—it is not a traditionally Native way of allocating time. As such, making appointments is a source of conflict and frustration for many Natives acting as a barrier to receiving doctor's care. The following comments illustrate this difference in time allocation perspectives between consumer and caretaker cultures: "It all depends on an appointment." "You have to make an appointment. I can't see the doctor the same day."

Summary

The majority of respondents report difficulty in seeing a doctor or a dentist. The primary reasons for this difficulty are health manpower shortages and cost. The issue of sociocultural barriers was also raised and discussed in terms of the practice of prescheduled appointments.

Recommendations

1. Examine feasibility of assigning an outreach worker to Valdez to assist individuals in making appointments and using the health system.

2. Examine feasibility of an educational program for consumers, i.e., health insurance and comparison of costs for health care in Valdez versus Anchorage.

3. Identify additional sociocultural factors affecting provider-patient interaction and orient both providers and consumers as to their existence and implications.

Satisfaction Level with Western Medical Care

ANS Health Services

Respondents voiced moderate satisfaction with ANS Health Services. Points of satisfaction were (1) good doctors, (2) thoroughness, and (3) continuity of care as evidenced the comment,

> "I'd rather go there because they give a thorough exam and have our family records from ten years back."

Points of dissatisfaction were (1) difficulty in getting an appointment, (2) long waiting time in the clinic, and (3) subhuman regimentation of services. Stated one person,

> "I dislike being herded like cattle or the hassle for appointments."

Valdez Health Care Services

In contrast, seven persons indicated extreme dissatisfaction with local medical care. In addition to concern about the shortage of doctors in Valdez, respondents were also qualitatively concerned about the delivery of present services:

> "We need a permanent doctor instead of changing every two weeks or so."

Doctors in Valdez are

> "too professional, too rushed, not enough concern for patients."

Twice the attitude of the medical receptionist, who initially interacts with Alaska Natives in the medical setting, is criticized:

> "Better attitude with the receptionist, she gives no personal touch."

Dissatisfaction was also expressed with the ANS Contract Health arrangement in Valdez. It appears that confusion as to services, procedures, and expectations exists on the part of consumers and providers, alike. As one consumer noted, "It has been a hassle trying to get medical help through ANS. The clinic and the hospital say they have no contract even though I do have a standing prescription through ANS from the same doctor that would not bill them otherwise."

Summary

The level of consumer satisfaction with conventional medical care was found to be moderately high with regard to ANS in Anchorage and very low in Valdez. Reasons for this discrepancy were identified. Perhaps this discrepancy explains why people will apparently pay as much or more money to leave Valdez and seek health care in Anchorage more than 200 miles away.

Recommendations

1. North Pacific Rim should actively seek to clear up the confusion or ambiguity concerning ANS funding procedures, allotments and coverage. This may be achieved by written or oral clarification to both providers and consumers in Valdez.

2. Caretaker sensitization to Natives' health needs should be attempted, i.e., what is a good healer through Native eyes, or what conditions are necessary for healing, etc. This could potentially have an impact on the quality and appropriateness of the physician's care.

3. Additionally, sensitization should also be extended to receptionists or intake workers, or others who make initial contact with the Native patient, thereby "setting the mood" for the subsequent medical experience.

Unmet Health Needs

Dental care is the service most Native residents in Valdez cite as a presently unfulfilled health need. Low dental utilization rates and expressed barriers to dental services validate this unmet need. Accordingly, dental care should be given high priority in the comprehensive health system plan for Valdez.

However, it must be stressed that the survey question, which specifically asks for what additional services Valdez Natives desire, does not address the total scope of unmet health needs: it taps only unmet service needs. What of unmet unfulfilled needs such as high-quality of healer-patient relations, health care with dignity instead of "subhuman regimentation" or medical advice that is congruent with culturally held beliefs and practices? These quantitative elements must be considered alongside of "additional services" for a truly comprehensive evaluation of a community's unmet health needs.

Tatitlek

Tatitlek is a traditional Native fishing village nestled in the tall mountains and islands on the eastern side of Prince William Sound, approximately thirty air minutes from Cordova. A large blue and white Russian Orthodox Church stands out on the horizon to guide visitors into this picturesque village. There is an interchange of traditional practices co-existing with contemporary values in Tatitlek.

In the early 1800's Tatitlek had a bird's-eye view of the early Russian and English trading, and exploring of Prince William Sound. Today's view is of large oil vessels in route from Valdez to the Lower 48. Tatitlek is in the pathway of much activity but has preserved many of the traditional lifestyles. Subsistence fishing (gill netting, seining, and drift netting), kelping, and hunting are the chief means of economic support. Many villagers supplement their income by working in the Cordova canneries.

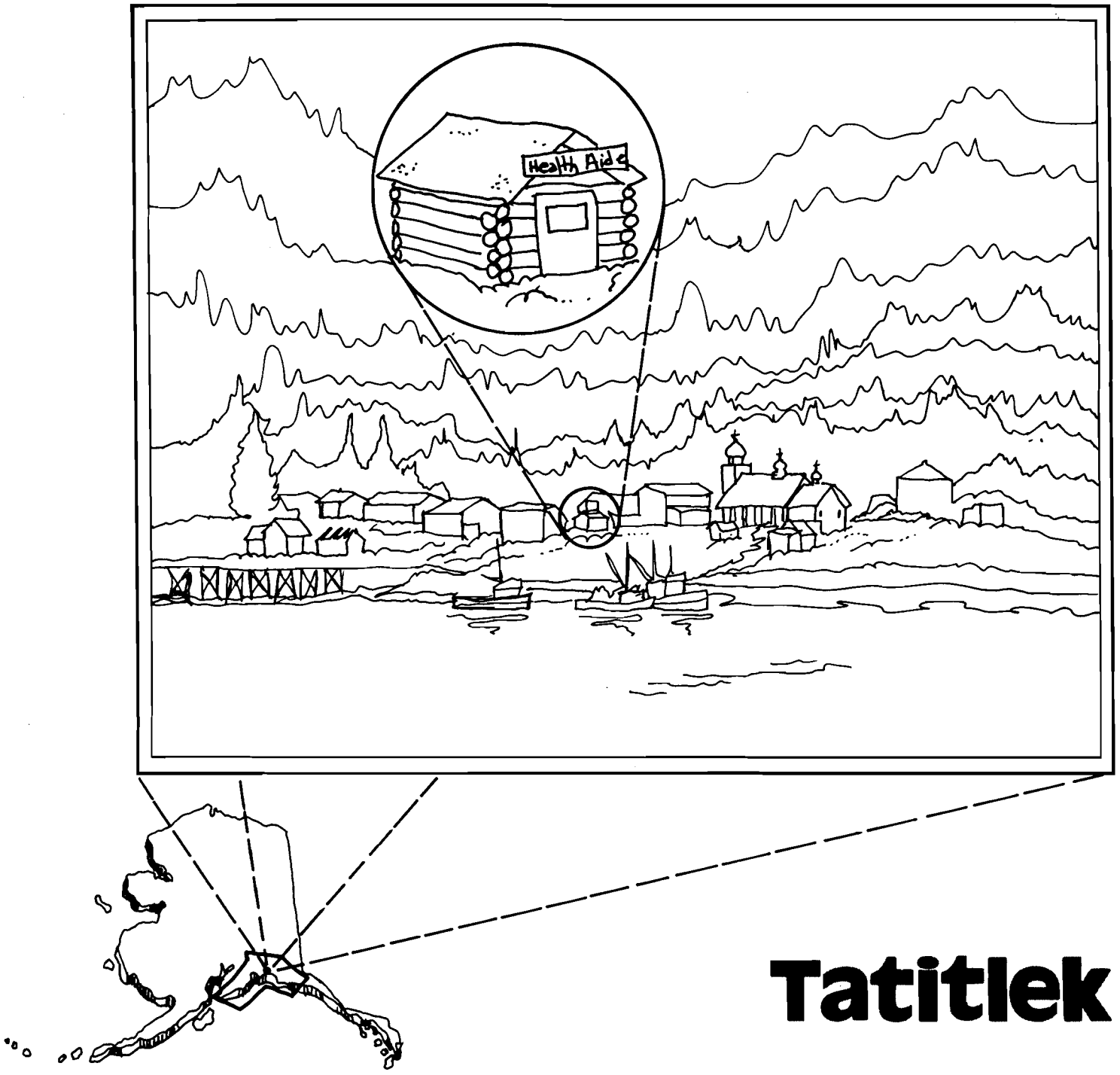
Fish is smoked, canned, salted, and preserved in all possible ways to provide food throughout the year.

Travel to Tatitlek is by small airplanes from Cordova or Valdez, by private boat (in reasonable sea weather) or the Marine Ferry System from October to April. The ferry stops at a point near Tatitlek and passengers are relayed via fishing skiffs, about a fifteen-minute ride to Tatitlek. The isolation of Tatitlek is accented by receiving mail only twice a month, the 15th and 30th, via a mail boat. An RCA Satellite earth station has recently been installed which gives the Health Aide twenty-four-hour communication to Alaska Native Hospital in Anchorage. A public direct line telephone system is also present, but has proven to be "out of order" more frequently than in order. In contrast to the apparent communication isolation, the village receives live television via the state experimental TV satellite.

There is a school with grades of kindergarten through 12th grade.

Tatitlek has experienced many changes through the years with rapid population increases and decreases.

Today Tatitlek is an active community maintaining strong traditional values.



Tatitlek

TATITLEK

Ranked by Inpatient Days

LEADING CAUSES OF HOSPITALIZATION

Cause of Hospitalization	FY 1974		FY 1975		FY 1976	
	Rank	Days	Rank	Days	Rank	Days
Birth, S/Liveborn		–		–	1	10
Other Diseases Blood Forming Organs		–		–	2	8
Infections, Skin Subcutaneous Tissue		–		–	3	7
Delivery without Complications	10	13		–	4	3
Other Disease, Male Genit.		–		–	4	3
Accidents	9	15	1	29		
Other Conditions Fetus, N/Born		–	2	21		
Habitual Excessive Drinking, Chronic Alcoholism		–	3	14		
Pneumonia	5	44	4	11		
Hypertensive Disease		–	5	6		
Other Disease of Gastrointestinal Tract, Peritoneum	2	60	6	5		
Neoplasms	1	67				
Nephritis, Nephrosis	3	52				
Ischemic Heart Disease	4	51				
Other Heart Disease	6	23				
Organic Mental Disorders	7	22				
Acute Alcohol Intoxication	8	21				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

TATITLEK

Ranked in Order by First Diagnosis

LEADING CAUSE OF OUTPATIENT VISITS

Cause of Visits	FY 1974		FY 1975		FY 1976	
	Rank	Number of Diagnoses	Rank	Number of Diagnoses	Rank	Number of Diagnoses
Respiratory Problems	1	24	1	22	1	17
Accidents	2	20	2	19	2	12
Hypertensive Disease		–	4	3	3	5
Other Bacterial Skin Infections		–		–	3	5
Infected Wounds		–		–	3	5
All Other Infective, Parasitic Diseases		–		–	4	4
Neuroses	5	5	4	3	4	4
Urinary Tract Infection	4	8	3	5		
Infection Female Genit. EX-VD		–	4	3		
Disorder of Spine		–	4	3		
Refractive Error	3	10				
Acute Otitis Media	4	8				
Other Musculoskeletal and Connective Tissue Disease	6	6				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

TATITLEK

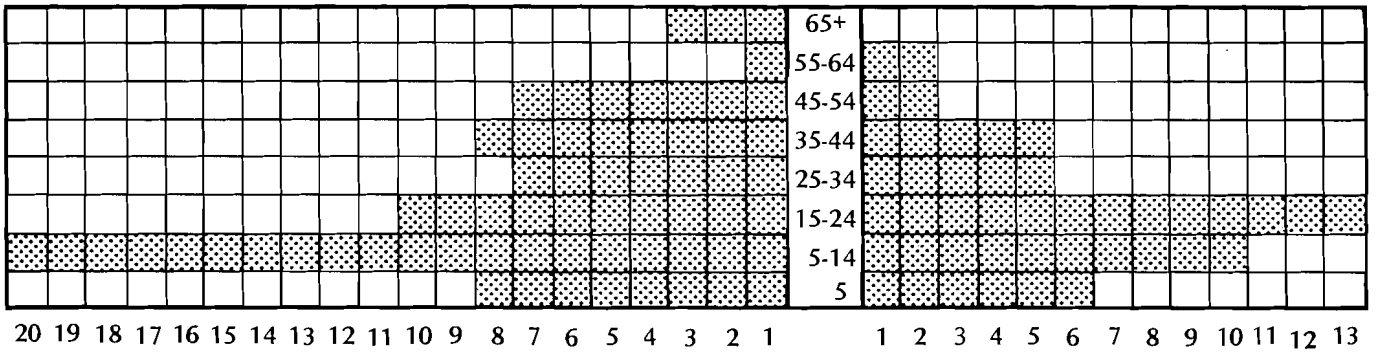
Ranked in Order of Total Diagnosis Including Supplemental Activity

LEADING CAUSE OF OUTPATIENT VISITS

Diagnosis	FY 1974 Rank	FY 1974 Number of Diagnoses	FY 1975 Rank	FY 1975 Number of Diagnoses	FY 1976 Rank	FY 1976 Number of Diagnoses
Respiratory Problems	1	36	2	27	1	25
Hypertensive Disease	5	11	4	16	2	19
Accidents	1	36	1	34	3	13
Prenatal Care		–		–	4	11
Other Bacterial Skin Infections		–		–	5	8
Infected Wounds		–		–	6	6
Diabetes Mellitus		–	6	6	6	6
Alcoholism, Acute/Chronic		–		–	7	5
Physical Examinations		–	3	23		
Urinary Tract Infection	3	16	5	10		
Neuroses	5	11	7	5		
Infection Female Genit. EX-VD		–	7	5		
Refractive Error	2	19	8	4		
Disorder of Spine		–	8	4		
Acute Otitis Media	3	16				
Other Musculoskeletal and Connective Tissue Disease	4	12				
Other Disease of Skin	5	11				
Hospital Med/Surg Follow-up	5	11				
Other Eye Disease	6	8				

SOURCE: INDIAN HEALTH SERVICE INPATIENT/OUTPATIENT REPORTING SYSTEM, APC REPORT 2C.

NATIVE POPULATION OF TATITLEK BY AGE AND SEX, 1970 CENSUS



MALE
N=64

Total 107

FEMALE
N=43

INTRODUCTION

A bright sunny day welcomed the beginning of the consumer health survey in Tatitlek. Spring had arrived and people were busy fixing nets and equipment in preparation for fishing season.

North Pacific Rim staff, Dr. Nancy Davis and Gregg Brelsford, recruited and trained four research assistants from the community to help with the survey. These were Myra Allen, Nancy Kompkoff, Clare Allen, and Rene Jackson, the village Health Aide. Training for the research assistants was spread over 1½ days and culminated with each person choosing which villagers they wanted to interview. The only restriction was that individuals could not interview close family members. The surveys were conducted and completed in a single day. This was a decision of the research assistants to reduce the possibility of a "village version" of the answers to the questions; that is, to prevent respondents from sharing the questions, and their answers, with people who had not yet been interviewed and thereby influence their response.

Approximately 70% of the adult population of the Village of Tatitlek responded to the consumer health evaluation questionnaire. This was 27 of the 38 adults who were regularly living in Tatitlek at the time of the survey and is comprised of 13 women and 14 men. Ages of the respondents ranged from 18 to 62 years of age with the average being approximately 35 years of age. Sixty percent of these individuals have lived in Tatitlek all their lives and the other 40% had been born and raised in the general Prince William Sound area.

All of these respondents are enrolled to the Chugach Region with 19 enrolled to Tatitlek village and 8 enrolled to Chenega Village.

Awareness of Traditional Health Practices and Beliefs

A moderate level of awareness with regard to traditional health maintenance or health-seeking practices is represented in the Tatitlek community responses. Over half (60%) of the individuals gave either a general or specific response while the remainder did not know of any traditional practices or did not respond at all.

On the part of both men and women, 40% of the individuals identified specific practices. These ranged from attention to diet, i.e., "eating lots of seal", and hard work, and exercise for health maintenance to health-seeking techniques such as putting cobwebs on cuts, hot iron on painful areas, or gargling with highbush cranberry tea. Another 20% of both the men and women gave general responses such as "take own medicine" or "help each other" for health-seeking behavior.

Knowledge of traditional health-seeking practices (cures, treatments) was higher than knowledge of traditional health maintenance (preventive practices). Sixty-three percent of the individuals gave a general or specific response to the former, whereas only 37% of the individuals did so for the latter. There seemed to be no correlation of age with knowledge of traditional practices. About half of the general or specific responses come from people under 35 and about half from people over 35 years of age. This was also as equally true for men as for women.

Awareness Level of Health Insurance

The level of awareness of health insurance is low to moderate. In general it was found that most people in Tatitlek do not have health insurance, many do not know about it and there is qualified interest in finding out more about it.

Only eleven (40%) of the respondents said that they even knew about health insurance at all, and twenty (75%) indicated that no one in their family has any health insurance. This is somewhat surprising in that the Trans-Alaska Pipeline Terminus, with its employment opportunities, and associated health insurance benefits, is only 25 miles away in Valdez.

In spite of the general lack of knowledge or experience with health insurance, 13 persons (48%) thought it would be "good", and 16 (59%) said they would like to learn about health insurance, including the comment, "I would like pamphlets on it."

Four persons (15%) seemed to associate their Indian Health Service benefits with health insurance:

> "The only health insurance we've had was ANS."

Recommendations

1. Encourage use of private health insurance through educational workshops with villagers to explain health insurance availability, accessibility, procedures, and financial implications.

Health Maintenance

Tatitlek respondents reported a number of ways to maintain good health. These included eating the right kinds of "healthy foods", taking vitamins, exercising (especially walking), plenty of rest and also, according to one area, taking a steam bath

"really helps . . . two times a week".

Without exception, each of these activities is a current reflection of traditional activities and customs for maintaining health. In the old days people paid attention to diet, exercise, used the steam bath and used a wide variety of herbs.

There were also alcohol-related answers, which suggest that drinking and not drinking are themes in health and illness in Tatitlek. Two persons recommend,

"drink beer, don't worry",

but a third person said,

"don't drink, the only time I get sick is when I drink".

One man said he kept from getting sick by:

"staying out in the rain and cold without proper gear".

In the "olden days", this kind of stamina and rigor was a routine part of child-raising practices, to toughen up the children for situations ahead. In the old days, the tough survived . . . .

Health Seeking

The health-seeking behavior of Tatitlek individuals combines a self-initiated treatment when they "get sick", followed up with a nurse's or doctor's assistance is the condition becomes worse. All (100%) of the respondents reported specific self-treatment techniques, including aspirin, bed rest, cough syrup, cold tablets, and having "a drink".

A number of these self-treatment techniques are also employed to "seek health" when someone just feels "lousy". No one in Tatitlek said they would go to the doctor if they just felt lousy.

Additionally, the self-treatment employed when feeling "lousy" depends upon whether it is defined in physical or emotional terms. About one-fourth of the individuals indicated self-treatment for a

"physical"

lousy feeling. First of all, they would

"go to bed", "nap",

and possibly further treat themselves by taking

"aspirin", "Alka-Seltzer",

or just plain

"medicine".

Conversely, about three-fourths of the individuals seemed to define feeling "lousy" as an emotional condition. Self-treatment methods include taking one's mind off it, particularly by keeping busy or engaging in some activity such as cleaning house, working, walking, or visiting. One woman indicated that her response to feeling "lousy" is to,

"go visiting with my relatives and just try to forget how I feel, or clean house".

Health-Seeking Sequence

This report concerns the health-seeking sequence beginning at the point that travel to ANS in Anchorage is determined necessary. The majority of the respondents (67%) have had direct experience as a patient at ANS. Of these, approximately 60% of them indicated that a doctor (in Cordova for the most part) makes the decision that they should go to ANS. Conversely, 40% decide for themselves.

Sixty percent of the respondents reported that they went to Anchorage alone. Whether or not relatives accompany the patient may be a function of the seriousness of the illness or to some extent the cost of taking relatives along. Transportation is by air and the cost of a round-trip flight from Tatitlek to Anchorage through Cordova was $190.00 at the time of this report:

"I chartered a plane from here, and paid for my own way up. They paid for my way back. My husband went, too, but they didn't pay for this fare either."

Eighty percent of the respondents indicated that they receive instructions to follow by the physician and 75% said that they indeed followed the instructions. In approximately 65% of the cases, the patient or "no one" checks to see if the instructions were followed. Twenty-five percent of the respondents indicated at least one of the following checks up on them: spouse, health aide, Public Health Nurse, and the Cordova doctors.

Summary

Health Maintenance

People in Tatitlek still do the same things today that their ancestors reportedly did to stay healthy. This includes attending to diet, exercise, using the steam bath, and using a wide variety of herbs and plants.

Health Seeking

They also continue their ancestors' traditional value on self-reliance.

Tatitlek people also rely on themselves initially for treatment when they get sick and only seek medical assistance if the condition becomes significantly worse.

The majority of the decisions that a patient should leave Tatitlek and travel to ANS for medical care are made by the Cordova doctors. However, neither is followed up with the majority of individuals once they return to the village from ANS. There is obviously a gap in this continuity of care available to a patient between the time he leaves the village for medical care and the time he returns.

Recommendation

1. One means of addressing this gap in the follow-up services might be to ensure that the patient's relatives, in addition to the village health aide, are instructed on procedures to be followed during recovery, especially after surgery. We know that an anxious, and sick person finds it difficult to understand instructions, and we also know that most villagers are surrounded with numerous caring relatives. These relatives, if they understood what the patient should do, would be the closest and the most supportive persons to see to it that they are done. In the case of severe injury or illness, it may be highly recommended that a close relative and the health aide be brought in and given complete written and oral instructions. Also, during the use of the telephone, it may be well that both the health aide and relatives of the ill person be present, to insure that the whole family be "educated" in the process of recovery of any member of the community.

2. In the case of follow-up instructions and inquiry from Cordova to Tatitlek, perhaps a scheduled time could be established to use the telephone, recently installed in the village house. A regular daily or weekly personal call from the family to the doctors in Cordova could be initiated. This would be especially helpful if the doctors knew the family members and could relay information to any one of them to the person needing advice. Again, the presence of the health aide to assist in translation of the medical "dialect" which is inherent in any village, would enhance the chance of meaningful communication.

Accessibility: Barriers and Incentives to Medical and Dental Care Utilization

Medical Accessibility

About 40% of the respondents stated that it is not easy for them to get in to see a doctor in Cordova. Of this group, most of the respondents indicated problems with weather and transportation. The extent to which transportation difficulties are related to weather problems or problems of "no money" is unknown.

One-third of the people associated difficulties of access with the clinic:

> "sometimes the clinic is filled up".

About half (48%) of the individuals indicated they had at some time put off going to the doctor even when they felt they should see one. The great majority (70%) of these were women. The primary reasons stated were: 1) time; 2) hospitalization; and 3) money, including the fact that ANS sometimes runs out of funds:

> "Mainly when ANS is out of funds (I put off going in). You can't get your prescription once you do see a doctor if ANS funds are out at the pharmacy."

Two persons reported that they were afraid:

> "Afraid I'd find out I'd die or have to stay in the hospital and leave my kids."

Of the 27 respondents, 12 or 40% had not seen a doctor in the past year, 60% had seen a doctor one or more times, and 30% had seen a doctor two or more times.

Dental Accessibility

Tatitlek individual's feelings on how easy it was to see a dentist in Cordova are about equally mixed. Those who found it easy were able to "walk right up there and see him" and be taken "right away". Those who found it difficult mentioned transportation, money, and the dentist being booked up as reasons for their difficulty. Just over 60% said they had put off going to a dentist even though they felt that they should, but almost 70% of these said it was because they were "scared" or didn't "like someone poking in

my mouth". Cost was the reason given by the others. Forty percent of the individuals had not been in to see a dentist in the last year and 26% had seen the dentist one or more times in the past year; 34% of the people either did not answer, or were not appropriate because for example, they had no teeth.

Eye Care Accessibility

Eight people (30%) said it was easy to get in to see one, especially due to the availability:

> "We can just go. If I tell them I can't stay very long, they will take me right in."

Twelve people (44%) said it was not easy, the major factor being the costs involved:

> "It's too expensive to charter a plane in and out and getting a motel room."

The absence of regular plane flights, plus the apparent periodic availability of the eye doctor combine to make it inconvenient to get into town.

Economic Barriers

Approximately 23 Tatitlek people (85%) indicated that it costs them money to see a doctor or a dentist in Cordova. These costs include not only medical costs, for example glasses, or funds paid when ANS funds had run out, but also peripheral expenses associated with the visit to the doctor or dentist. These costs are shown as follows in the order of prevalency of times they were specifically identified: meals (20), airplane fare (19), taxicabs (18), motel accommodations (14), relatives (12), telephone (9), child care (6).

Summary

The accessibility of Tatitlek villagers to Cordova health care is surprisingly high in view of all the factors involved with the direct medical costs, peripheral costs, timing of ANS funds, and weather.

In sum, over half (60%) of the contributors have no difficulty in getting in to see a doctor or a dentist in Cordova. And, all in all the Tatitlek people find it about as easy to see a dentist as a doctor but for different reasons. Weather and transportation pose greater problems to getting in to see a doctor than to see a dentist, reflecting the fact that seeing a doctor is more often an urgent undertaking, while dental problems are more easily postponed. Once in town, apparently there is no problem getting in to see a doctor, but the dentist was reported as being "booked".

Recommendations

1. Coordination of timing, transportation, and funds need to be fine tuned. Transportation costs are the single largest expense. Group travel, and sharing of these costs would spread limited personal resources further.

2. Reduce economic barriers through increased utilization of private, or third-party insurance. This would allow ANS funds to go farther than is currently the case.

   a. Provide encouragement for and assistance in learning the skills and taking the time to fill out required insurance forms.

   b. All Natives should be encouraged to fill out the same basic forms when receiving medical or dental care. The current health insurance coverage of the person could be requested. Employment status could also be requested to determine if health insurance is available through their employer. When this information is not known, an effort could be made to obtain it and the person could be encouraged to utilize any health insurance they may have available.

3. Initiate a billing system for information and educative purposes. The people of Tatitlek are aware of the presence of a funding problem, and many of them have experienced it directly. Therefore, they are likely to be amenable to discussions and a common search for solutions. Increased awareness of how expensive medical services are may help in understanding the system, and discourage misuse of limited funds.

Satisfaction Level with Western Medical Care

ANS

The majority of people in Tatitlek appear to feel ambilvalent about going to ANS for health services. Fifteen percent of the people made clearly positive remarks such as,

> "Glad they're there to help us when we need it; they have good doctors and do good work."

Twenty-two percent had clearly negative opinions, for example,

> "I don't like it—too big. I don't know very many people."

Two factors stand out in people's dissatisfaction with going to ANS from Tatitlek. One is with regard

to leaving one's home area where one is known and knows others. This is indicated by the remarks:

> "I'd rather go to Cordova, closer to home."

> "I don't want to go up there—because I don't know how they really are."

The other factor in consumer dissatisfaction is the waiting time. As one person expresses it,

> "It's pretty hard to see a doctor, because of the waiting."

The majority of individuals (60%), however, expressed neither a positive or a negative opinion about going to ANS. Rather, their remarks seemed to indicate a kind of "resignation". For example, ten of these 16 individuals indicated it was "all right", with comments such as

> "It's okay"; "It don't bother me."

Tatitlek-Cordova

In contrast to their ambivalence about ANS, Tatitlek individuals have a high regard for the health services in Cordova. Seventy percent of the people indicated they were satisfied with the services and their availability. Their comments ranged from "pretty good" to

> "they help me quite a bit",

and,

> "they take care of their patients well enough".

An equal number of positive comments focused specifically on the public health nurse, the doctors, and the dentist.

Consumer Recommendation for Change

Sixty percent of the individuals identified specific areas they would like to have addressed. These were: 1) easing the economic strain of chartering to Cordova by grouping appointments together for Tatitlek individuals, and 2) a strong emphasis on village-based health care.

The economic strain on individuals of flying to Cordova for care was the focus of two specific recommendations,

> "ANS should pay for trips in and out to the doctor . . . and . . . they should have certain days for the village people to see the doctor the same day, and then they can charter in and out together."

The desire for a broad range of increased village-based health services was clearly highlighted. This range of desired services includes physician care, eye care, and dental care. For example:

> "I'd like to see Dr. Tilgner from Cordova come out because he knows more about the kids' illnesses and I'd rather have him than have a new doctor see them . . . because I trust him," and

> "ANS should give the doctor in Cordova a contract to come here," a theme reflected by another person who said, "The Cordova doctors know more about the people here than the ANS doctors do."

Summary

Most (60%) Tatitlek individuals are ambivalent about going to ANS for health care and prefer to go no farther than Cordova where they are satisfied with the health services available. The changes in this aspect of the health system desired by most people are that an increased emphasis be placed on village-based health care and that medical appointments in Cordova be grouped together so individuals could more easily share the cost of air transportation.

Recommendations

1. Schedule certain dates for the village people to see the doctor the same day so that they can charter in and out together. This would be an efficient way of taking care of routine health care needs such as prenatal and infant care. Weekly, monthly, or even bimonthly clinic days could be scheduled and planned, the personal costs of individual families could be cut by sharing the plane fare, or if possible, further cut if part of the charter was funded. A "village day" reserved at the clinic might also be an efficient use of their time and facilities, if it took care of most of the routine village needs.

Unmet Health Needs

The overwhelming majority of Tatitlek individuals expressed village-based health services as their major unmet health need. This is consistent with the facts that: 1) economic barriers prevent people from traveling to Cordova for health care; and 2) Tatitlek individuals prefer to receive health care in a familiar environment as possible, with friends and relatives close by.

Four kinds of village-based service were identified as unmet needs: 1) strengthening the health aide

services; 2) having more specialized services brought to the village on a regular basis; 3) having medicine available in the village; and 4) an accounting to the village of health resources available to them and how they are used.

Desire for strengthening the health aide program included: 1) adding a health aide alternate; 2) providing the health aide with more equipment and skills; and 3) building a health aide clinic. Said one person,

> "I'd like to see a health clinic opened here for the health aide."

The specialized services that are desired in the village on a regular basis are: 1) a doctor; 2) having the nurse come more often; 3) an eye doctor; and 4) more dental services. One person would

> "have the doctor come out at least twice a year from Cordova with an ANS contract"

and another would have

> "weekly visits".

Preference for Cordova doctors is clearly emphasized.

Two comments express the desire for more accessible, i.e., village-based prescriptions and vitamins. There should be

> "medicine here to pick up" and

> "Why doesn't the health department issue vitamins?"

The interest in just what health funds are available and what they're used for is expressed by one person who suggested that the villagers be provided with

> "a show of health monies".

A final unmet health need that was identified was the need for "backup" pairs of glasses.

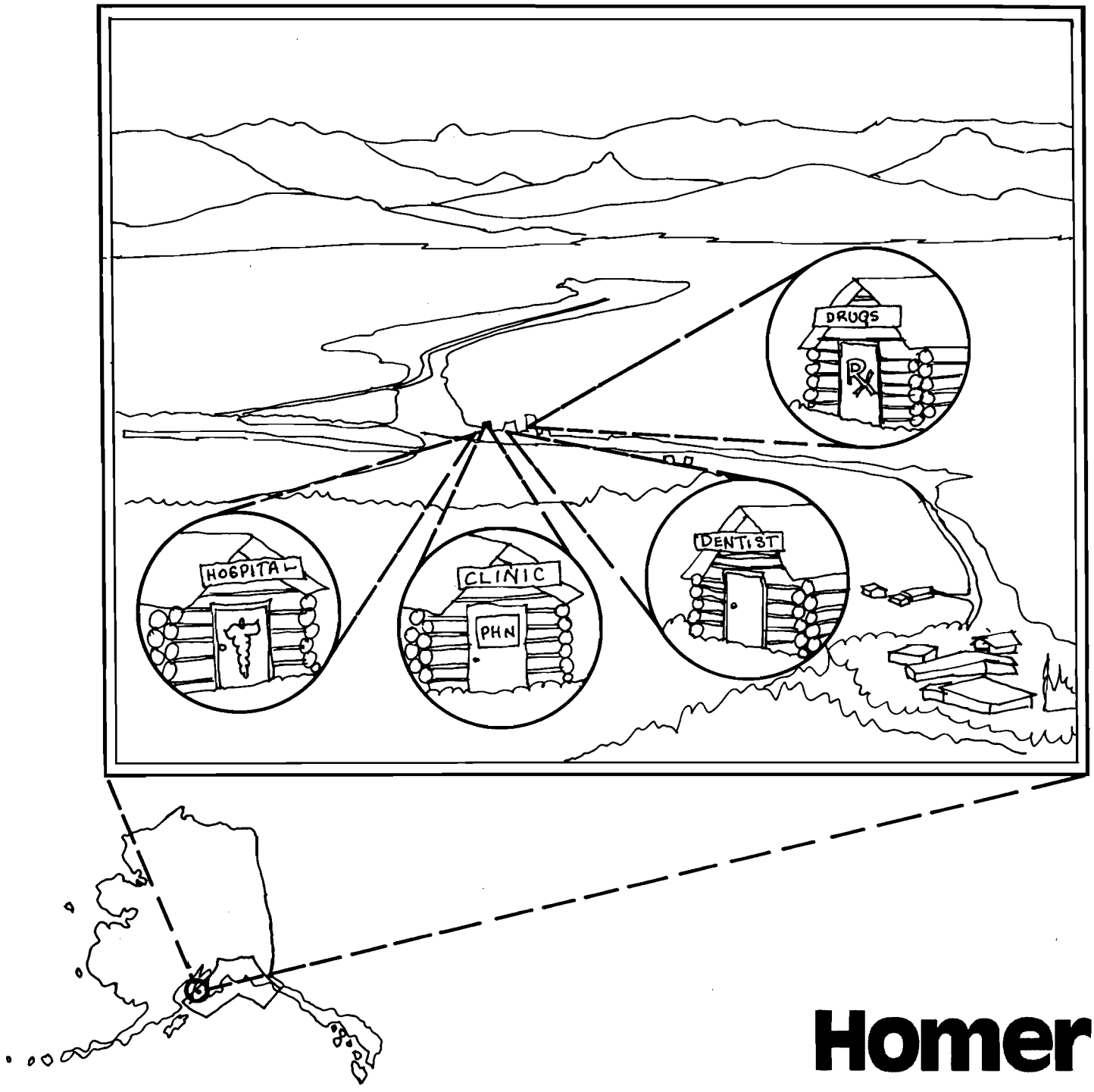
Summary

The major unmet health need was to have health services available in the village itself rather than merely available somewhere else for "when" or "if" you can get there.

Comments about additional health services in Tatitlek should be put within the context of a very small community which used to be more than twice as large, and which for a number of years after the 1964 Earthquake enjoyed many more services than are now available. For example, they used to have a health clinic, a store, a post office, regular mail planes and a lot more people. Life has changed greatly in Tatitlek, and memory of former health services surely must persist. A comparison of health services provided directly to the village ten years ago with the frequency of visits, now may give an indication of the withdrawal of those services as the population dropped.

Recommendations

1. Strengthen the health aide services of Tatitlek.
   a. Explore the feasibility of establishing a health aide clinic and adding a health aide alternate.
   b. Integrate the health aide into health care provided by Cordova doctors.
2. Explore possibilities of increasing availability of prescriptions and vitamins in the village. Perhaps a system for bulk ordering regionwide with local dispensation through the health aide could be developed.
3. Examine feasibility of contracting with Cordova physicians and dentist and an eye doctor to provide village-based services.
4. Examine feasibility of increasing Public Health Nurse's visits to Tatitlek.



Homer

Inventory—Homer

Facilities

South Peninsula Hospital
The newly constructed hospital, which opened in May 1977, has 17 beds, four of which are to be used for long-term care. General medical and surgical services are provided for the South Kenai Peninsula Service area. Accreditation Status: AMA Category IV.

Homer Health Clinic
Located adjacent to the South Peninsula Hospital, the clinic is staffed by three doctors and offers general medical outpatient services.

Public Health Clinic
Offers public health services to the community, and itinerant services to Port Graham, English Bay, Seldovia, Anchor Point, Ninilchik, and Nikolaevsk.

Dental Clinic
Homer has two dental clinics.

Pharmacy
Homer Rexall Drugs—provides pharmaceutical services to the community.

Manpower

Doctors—3
Dentists—2
Public Health Nurses—2
Pharmacist—1
Periodic visits by surgeons

Community Mental Health Center

Located in the Homer Hospital, the Mental Health Center is staffed by one psychologist who recently arrived in Homer and is in the process of setting up the Center's programs.

Social Services

Offered through the State of Alaska Division of Social Services and staffed by one Social Services worker.

Alcoholism Programs

Alcoholism counseling services are available through the State Division of Social Services.

The local AA is very active. AA counselors provide counseling services to the community and to the Homer Hospital detoxification patients.

Detoxification Facilities

South Peninsula Hospital.

Emergency Medical Services

The Homer Volunteer Fire Department provides ambulance services and emergency medical care for the vicinity of Ninilchik south to Homer, East Road (20 miles northeast of Homer), and outlying areas.

The volunteers consist of (numbers vary due to volunteer status) 21 firemen, 12 of which are Emergency Medical Technicians (EMT's) and 3 of which are certified Cardio Pulmonary Resuscitation (CPR) instructors.

Emergency calls are placed to a base answering service. UHF communications allow contact with the Fire Department, police, and state troopers.

A telephone alerting system at Homer Hospital notifies EMT's of emergencies (Sorenson, 1977).

Inventory—Seldovia

Facilities

Seldovia Health Clinic
The clinic is staffed by one doctor, one RN, and one LPN. General medical and obstetrical services are provided. A dental chair is available for itinerant use. Need for a new x-ray machine is indicated.

Manpower

Physician—1
Itinerant Services: Homer Mental Health Center
Homer Public Health Clinic

EMS

An unequipped van, owned by Cook Inlet Aviation, is used to transport patients to the clinic or to the airfield, if hospitalization in Homer is necessary. Pilots are available 24 hours a day. A direct flight to Homer from Seldovia takes six minutes and the Seldovia clinic has transportable air vac equipment. One EMT is available.