

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-24)

Introduced by: Medical Student Section, American College of Physicians

Subject: Indian Water Rights

Referred to: Reference Committee D

1 Whereas, the United States is a signatory of the 2007 United Nations Declaration on the Rights
2 of Indigenous People (UNDRIP), which states that Indigenous Peoples “have the right to own,
3 use, develop, and control the lands, territories and resources that they possess by reason of
4 traditional ownership or other traditional occupation or use, as well as those which they have
5 otherwise acquired”¹; and
6

7 Whereas, nearly half of American Indian/Alaska Native (AI/AN) households on reservations lack
8 access to clean water or adequate sanitation, including 6.5% of American Indian households on
9 and off reservations and 13.5% of Alaska Native villages and reservations (compared to under
10 1% of the general US population)²⁻⁶; and
11

12 Whereas, regardless of income, AI/AN households are 10 times as likely as white households to
13 lack indoor plumbing, an early correlate of high COVID rates on reservations^{2,7}; and
14

15 Whereas, only 42 AI/AN Tribes and Villages meet Environmental Protection Agency (EPA)
16 standards for water quality⁸; and
17

18 Whereas, a third of Navajo Nation residents lack access to clean water and are 67 times more
19 likely than other Americans to live without running water or toilets, due in part to drought and
20 heavy metals, such as uranium, leached from abandoned mining sites⁹⁻¹¹; and
21

22 Whereas, unsafe groundwater resources on the Navajo Nation and other Tribal lands, lead to
23 higher rates of cancer, kidney disease, autoimmune disorders, skin infection, diabetes, and
24 infant hospitalizations for pneumonia¹²⁻¹⁴; and
25

26 Whereas, water systems are part of Indigenous ways of knowing and ceremonies in many
27 Indigenous cultures, thus water insecurity impacts physical, cultural, and spiritual wellbeing in
28 AI/AN communities, with loss of culture itself a risk factor for many chronic conditions among
29 AI/AN individuals¹³⁻¹⁷; and
30

31 Whereas, individuals without adequate water sources require vehicles, sleds, or wheelbarrows
32 to travel miles to wells and water stations and haul water back to their homes¹⁸; and
33

34 Whereas, Navajo Nation families spend \$43,000 per acre-foot of water with hauled water,
35 compared to \$600 for the average American with running water¹⁶; and
36

37 Whereas, *Winters v US* (1908) ruled that Tribes and their members have a right to sufficient
38 water access for residential, economic, governmental, and other needs¹⁹⁻²⁰; and

1 Whereas, lengthy disputes over Indian water rights to settle claims of water rights holders and
2 improve water management in AI/AN communities are expensive to litigate²¹; and
3

4 Whereas, Congress must approve all Indian water right settlements between Tribes, states, and
5 the US, delaying implementation, funds, and land transfers for years²²⁻²⁴; and
6

7 Whereas, the Biden-Harris Administration is coordinating federal agencies to meet Tribal water
8 needs, support Indian water right settlements, and increase Tribal participation in stewardship of
9 federal lands and water systems of significance to Tribal Nations²⁵; and
10

11 Whereas, the Indian Health Service (IHS) investigates and manages environmental health
12 services on Tribal lands, including the provision of health services²⁶; and
13

14 Whereas, the IHS provides environmental engineering and sanitation facilities to AI/AN
15 communities, including the cooperative development and construction of safe water sources,
16 wastewater management, and solid waste systems²⁷⁻²⁸; and
17

18 Whereas, Indian water rights settlements harm access to health care, considering the year long
19 closure of a newly constructed hospital on the Navajo Nation due to inadequate access to on-
20 site water²⁹; and
21

22 Whereas, for every \$1 spent on water and sewage infrastructure, the IHS could save \$1.23 in
23 healthcare costs from diseases related to unsafe water³⁰; therefore be it
24

25 RESOLVED, that our American Medical Association raise awareness about ongoing water
26 rights issues for federally-recognized American Indian and Alaska Native Tribes and Villages in
27 appropriate forums (Directive to Take Action); and be it further
28

29 RESOLVED, that our AMA support improving access to water and adequate sanitation, water
30 treatment, and environmental support and health services on American Indian and Alaska
31 Native trust lands. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/10/2024

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RELEVANT AMA Policy

H-135.928 Safe Drinking Water

Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:

- (1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;

- (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations;
 - (3) Informing consumers about the health-risks of partial lead service line replacement;
 - (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
 - (5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers;
 - (6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health;
 - (7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
 - (8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead;
 - (9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and
 - (10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.
- [Res. 409, A-16; Modified: Res. 422, A-18; Reaffirmed: BOT Rep. 29, A-19]

D-440.924 Universal Access for Essential Public Health Services

Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions. [Res. 419, A-19; Modified: CSAPH Rep. 2, A-22]

H-350.977 Indian Health Service

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

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health

professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23]

DRAFT