The Challenge to the Indian Health Service

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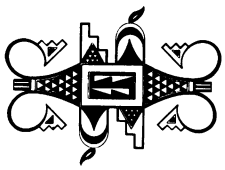

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THE Indian Health Service Program (IHS) is action-oriented, and its many activities reflect those elements that many planners have come to associate with the meaning of comprehensive health care—that it is available, appropriate, acceptable, accessible, and accountable. Providing services of this magnitude presents unique challenges for the Indian Health Service. Its consumer population—American Indians and Alaska Natives—live in circumstances that cannot easily adapt to traditional methods of health care delivery.

The majority of American Indians live on Federal Indian Reservations or in rural Indian communities. Alaska Natives live primarily in isolated villages. In general, they have maintained their traditional cultures in language, religion, social organization, and values, which often conflict with the demands of a modern society. They are among the most impoverished and isolated of any U.S. peoples, Barriers to the implementation of health programs in these settings are innumerable and are further complicated by major difficulties in transportation and communication. These economic, cultural, environmental, and geographic factors have influenced the development of the health care system of the Indian Health Service.

The IHS Program is carried out in 84 strategically located service units, using a facilities system of 51 hospitals, each with an ambulatory care department, 87 health centers, and more than

300 health stations and satellite clinics. Professional personnel assigned to the program include 500 physicians, 180 dentists, and 1,100 registered nurses. Some 435,000 American Indians, belonging to more than 250 tribes, and 53,000 Alaska Natives are eligible to participate in the Program.

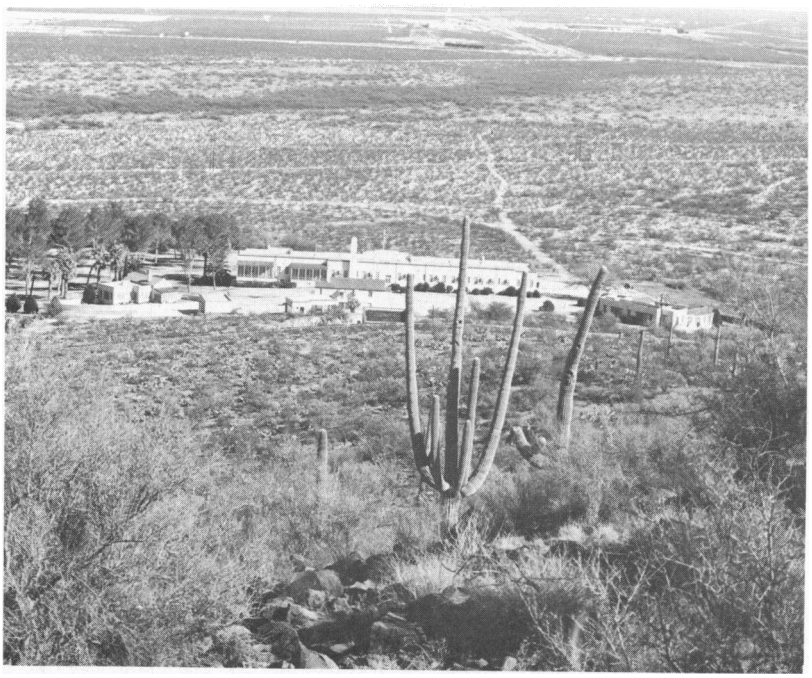
Health services of the IHS Program are comprehensive in scope. Traditional curative, preventive, and rehabilitative services, as well as environmental services, are all being integrated with community-oriented delivery systems that are cognizant of the social and cultural dimensions of health. One of the greatest contributions of the Indian Health Service has been in developing new methods for improving health care delivery. Both health services and delivery systems emphasize innovation and the team approach.

In this atmosphere, and within the developing systems, new roles are emerging for health professionals, paramedical personnel, and community residents. Consumers and providers alike recognize that each is involved in what are truly community programs. Together, they are designing the unique kinds of medical programs and new occupations to achieve community health goals.

Training programs conducted by the Indian Health Service have produced such novel health occupations as the community health medic, the community health representative, the Alaska Native health aide, and the mental health worker. Other Indian people and Alaska Natives are learning the more traditional health skills and are working as licensed practical nurses, dental assistants, laboratory technicians, radiology technicians, and in many fields associated with environmental health. Indian health boards and other committees are helping to develop policy, determine health needs, establish priorities, and allocate resources. Indians and Alaska Natives are also developing programs and the related manpower to meet their most critical needs; for example, nutrition programs, maternal and child health programs, alcoholism projects, and outreach services.

These health workers, most of whom are tribally employed, constitute an important segment of the manpower resources of the IHS health system. The Indian Health Service itself employs 7,400 full-time health workers, more than half of whom are Indians and Alaska Natives. This total pool of manpower, however, does not begin to meet the health program requirements of the Indian and Alaska Native people.

Although training of both auxiliary and professional health manpower is a continuing activity of the Indian Health Service, more staff is needed to fulfill present and future health needs of the Indian and Alaska Native communities. Dr. George Blue Spruce, director, Office of Health Manpower Opportunity, Bureau of Health Manpower Education, in his paper "Needed: Indian Health Manpower," emphasizes the need for more Indians to enter the health professions, both the medical and administrative services, to serve in their own hospitals, to treat their own people, and to improve the appalling health statistics that exist today. Presently, in the United States, there are only 40 Indian physicians, 1 dentist, 2 veterinarians, 2 optometrists, 9 pharmacists, 450 nurses, and no Indian osteopaths or podiatrists. According to Blue Spruce, a concerted effort must be made to provide educational opportunities for Indians in the



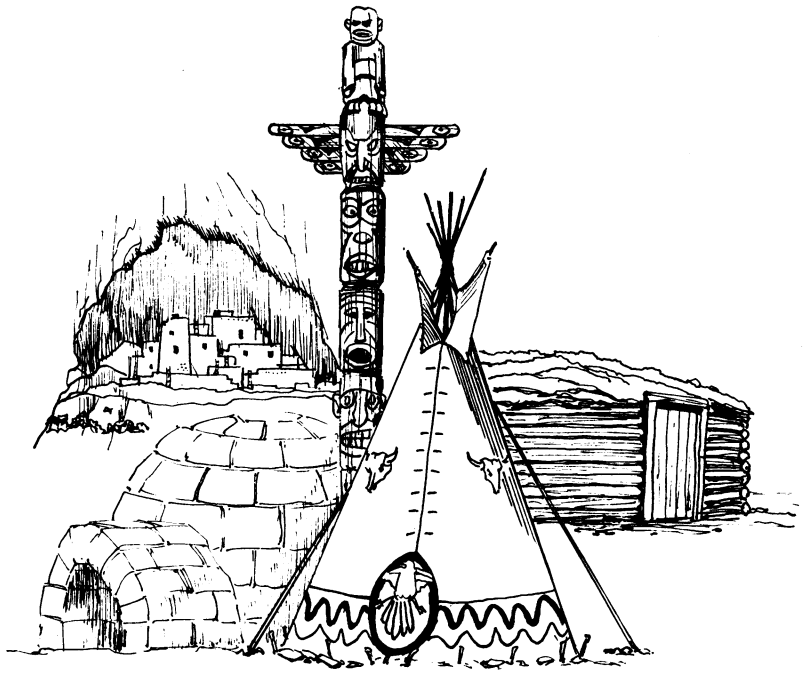
The Indian Health Service Center on the San Xavier Reservation, near Tucson, Ariz., is the site of the Indian Health Service's Office of Research and Development

health professions; changes, however, will be required in the existing elementary education system for Indians, since it neither encourages an Indian child to enter the health professions nor provides the proper science-oriented educational background for professional college training. Blue Spruce notes that, even though health professional schools are "willing to open their doors to Indians, they are finding it difficult to tap into a pool of qualified and available Indian students."

While training is a vital part of the IHS Program, immediate health needs for treatment and prevention of disease and illness receive the highest priority. The problems of Indians and Alaska Natives are more diverse and more severe than those of the general U.S. population. Except for heart disease, malignant neoplasms, and vascular lesions—and the cases of these incipient conditions are increasing—and for certain diseases of early infancy, the age-adjusted mortality rates are considerably higher for Indians and Alaska Natives. In 1971, the Indian and Alaska Native infant death rate was 1.2 times higher than the comparable U.S. rate for all races, the tuberculosis death rate was 4.6 times higher, and the diabetes rate was 2.2 times higher. The rate for influenza and pneumonia was 1.7 times higher, for accidents 3.3 times higher, and for cirrhosis 4.7 times higher.

Insights into some of these special problems emerge from papers in this special section of HEALTH SERVICES REPORTS.

Infant mortality, an accepted index of health status, is often associated wth lack of prenatal



care. While most Indian babies are presently born in hospitals, many mothers do not receive prenatal care, a fact which may account for the high rate of infant mortality among Indian newborns. Data on births in Indian hospitals during a 5-year period are examined in "Relation of Prenatal Care to Birth Weight, Major Malformations, and Newborn Deaths of American Indians," by B. Y. Iba and J. D. Niswander of the Human Genetics Branch, National Institute of Dental Research, and L. Woodville of the IHS. These investigators also consider the effects of a number of factors such as socioeconomic status and general nutrition and suggest that these may be important elements of prenatal care that influence the outcome of pregnancy.

Good nutrition and adequate diet are also important for general good health, and the staff of the Indian Health Service hospital on the Blackfeet Reservation in Browning, Mont., was concerned about possible iron deficiency among preschool children. As part of the Blackfeet Demonstration Nutrition Program, Indian health aides trained in nutrition conducted intensive nutrition counseling of parents. The project is described in "Diet Counseling to Improve Hematocrit Values of Children on the Blackfeet Reservation," by Gary Ruggera, a medical student at the University of Colorado Medical Center.

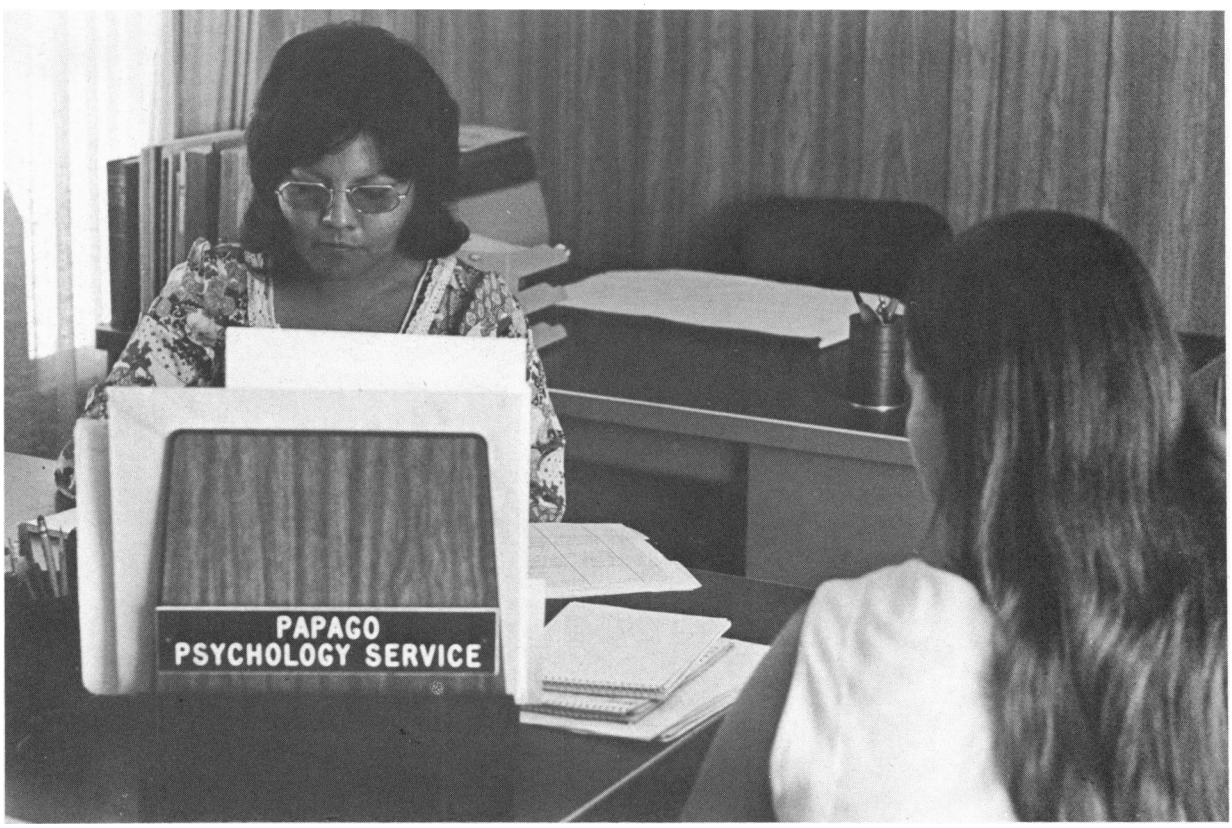
Poor nutritional levels usually are a concomitant of the low socioeconomic status of many Indian families. These families live in substandard housing, often without such necessities as running water, waste disposal, and heat. Documentation of the health effects of such poor micro-environments has been accumulating. A portion of the documentation is "Use of Health Services in Relation to the Physical Home Environment of an Indian Population," by Ashley Foster, Alice M. Haggerty, and Edwin O. Good-

man of the Portland Area Office, IHS. They compare the results of a survey of the homes and premises on a reservation in the Northwest with the health records of residents, including the reasons for visits to the Indian Health Service clinic.

The mission of a team of health professionals was to study the causes of diarrhea in Apache children and develop practical methods of treatment. But the physicians and nurses also learned from a group of young Apache women who worked with them in the hospital-based project during the summer of 1971. They report how they all learned to work together in "Insights Gained from Teaching and Working with Apache Nursing Assistants," by Grace Chickadonz and Lois Evans of Georgetown University School of Nursing and Norbert Hirschhorn of Johns Hopkins University.

While these papers deal with local health problems of Indian communities, the problem of managing resources effectively and efficiently pervades the entire Indian Health Service. It is a large, complex system operating with limited financial, physical, and human resources. If programs are to be realistically and meaningfully integrated into the system, the emergent management issues must be analyzed and resolved. In "A Management Approach to Monitoring Quality Assurance Health Standards," Dr. J. D. Felsen of the IHS Headquarters staff examines the system constraints and operating realities which must be considered if effective, purposeful application and monitoring of health standards are to be realized.

The papers in this section represent the beginning and end of the spectrum of activities that underlie the total health program of the Indian Health Service—the initial investigation of local health problems and the ultimate wide-scale implementation and operation of health management systems. Extensive research and program development are imperative intermediate steps. The continuing challenge of the Indian Health Service is the successful integration of all these vital components to insure the success of a dynamic and responsive comprehensive health program.



Summer student (left), working for the mental health program on the Papago Reservation in Arizona, counsels a young Indian girl

Main entrance of the Indian Health Service Medical Center in Phoenix, Ariz. This 200-bed referral hospital has complete inpatient and outpatient services.