The Organization of Health Services for Indian People

EVERETT R. RHOADES, MD
LUANA L. REYES
GEORGE D. BUZZARD

Dr. Rhoades is the Director of the Indian Health Service (IHS). Ms. Reyes is the IHS Associate Director for the Office of Planning, Evaluation, and Legislation. Mr. Buzzard is the Associate Director for the Office of Tribal Activities. Tearsheet requests to Ms. Reyes, Rm. 5A-27, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857.

Synopsis

The Indian Health Service (IHS) is a bureau of the Health Resources and Services Administration, an agency of the Public Health Service. It was formed in 1955 by a transfer of health services from the Bureau of Indian Affairs, Department of the Interior. Since that time, IHS has grown larger and more complicated and has become a truly complex national organization that is responsible for direct and contract health care services to approximately 1 million Indian people. The historical background of the Service, its present organization, and the services that it provides through a variety of organizational structures are outlined in this report.

DURING THE 1980 CENSUS, 1.4 million people identified themselves as Indian—96 percent as American Indians, 3 percent as Eskimos, and 1 percent as Aleuts. Indians represent less than 1 percent of the U.S. population—one-tenth the number of Hispanics and one-twentieth the number of blacks. Although we refer to American Indians and Alaska Natives collectively as "Indians" in this article and the others in this issue, they are an extremely varied minority, and many are quite different from the usual image of a homogeneous population living on reservations in the West. The 507 federally recognized Indian entities (tribes, bands, villages, communities, pueblos, Eskimos, and Aleuts) differ widely in their cultural and genetic heritages, economic resources, and lifestyles.

Indians differ from any other group in the United States in a very fundamental way. The Federal Government has a continuing relationship and certain legal responsibilities to Indian tribes and their members. The Commerce Clause of the U.S. Constitution, the Snyder Act of 1921 (*1*), the Transfer Act of August 5, 1954 (*2*), and the Indian Health Care Improvement Act of 1976 (*3*) all establish a government-to-government relationship between the tribes and the United States. Members of federally recognized Indian tribes and certain Indians of California are eligible for the services administered by the Indian Health Service (IHS), a bureau of the Health Resources and Services Administration, which is an agency of the Public Health Service. Congress has authorized the IHS to give services primarily to tribal members who live on or near Federal reservations. The majority of these reservations are located in western States, including traditional Indian territories in Oklahoma and Alaska.

As illustrated in table 1, Indians lag behind the general society in income and other socioeconomic indicators. In 1979, the median income of Indian families living on reservations, in villages, and in historic Indian areas of Oklahoma was approximately $12,250 per annum, which was $7,650 less than the median for the U.S. population as a whole. Compared with the U.S. population, Indians have approximately twice the number of unemployed and 2 1/2 times the number of families living in or near poverty. The lack of sanitation facilities is much more prevalent in Indian communities than in the general population.

IHS Authority

The provision of health care services by the IHS is based on various treaties signed by the United States and the tribes during the 19th century, laws subsequently enacted by Congress, and judicial rulings. Treaties committing the Federal Government to provide medical care to Indians began toward the end of the 18th century when the United States promised a group of Winnebagos the

Table 1. Household characteristics of the United States and service populations of the Indian Health Service, 1980

Area	Number of households	Median income	Persons per household	Percent employed	Percent below poverty level	Percent of households with— Complete lack of plumbing	No sewage disposal	No phone	No vehicle	Percent of population Under 6 years	Over 59 years
United States	80,800,000	16,841	2.75	93.0	12.4	2.7	1.2	8.3	12.9	8.6	15.8
All IHS Areas	223,437	11,471	3.44	53.3	31.1	15.6	14.3	36.9	19.6	13.6	8.0
Aberdeen[1]	13,478	9,625	4.02	49.8	42.7	12.5	11.6	53.2	22.0	16.6	7.2
Alaska	15,547	15,750	3.66	44.9	25.1	40.3	37.4	50.3	56.8	13.5	6.5
Albuquerque	10,668	12,226	3.65	57.3	30.2	14.2	11.6	43.4	17.8	14.9	7.4
Bemidji	11,152	10,464	3.44	50.5	26.9	7.3	5.2	22.8	19.7	13.9	8.4
Billings	7,966	10,967	3.87	51.0	34.0	7.6	4.2	46.8	15.3	15.0	6.2
California	26,737	13,235	3.01	55.2	20.4	3.2	2.2	16.3	11.2	10.8	8.2
Nashville	7,776	11,471	3.20	59.1	27.4	6.8	5.6	28.2	21.5	12.1	8.6
Navajo	34,443	8,412	4.29	47.2	43.7	49.1	48.2	74.6	24.8	16.4	6.5
Oklahoma	52,240	11,579	2.97	61.4	23.1	3.5	3.2	21.2	11.3	11.8	11.8
Phoenix	16,804	12,295	3.49	56.9	31.6	11.1	8.4	42.3	18.8	12.7	6.6
Portland	22,865	13,563	3.14	55.1	24.8	2.4	1.6	20.8	14.5	12.9	6.4
Tucson	3,661	9,432	3.67	52.4	38.7	27.3	24.1	50.5	30.5	12.2	8.5

[1] Data for 45 percent of Aberdeen Area households are missing. Therefore, data for Aberdeen Area households should be interpreted with caution.

SOURCE: 1980 Census of Population and Housing as reported in Indian People in Indian Lands, CSR, Inc.

services of physicians in part payment for rights and properties ceded to the Government. Although that treaty and most subsequent ones limited the duration of services, the Federal Government adopted a policy of continuing limited care after the original benefit period expired.

The Snyder Act, the legislation that authorizes the Indian Health Service, links the Service's activities to congressional appropriations by providing for the use of "such monies as Congress may from time to time appropriate, for the benefit, care, and assistance of Indians." This language establishes a discretionary program, not entitlement to specific services. In *Morton* v. *Ruiz* (*4*), the U.S. Supreme Court ruled that the Snyder Act did not constitute statutory entitlement to benefits. The Court also acknowledged the propriety of limiting benefits among those Indians within the scope of Snyder Act appropriations. Contrast this authorization for services by the IHS with the services provided by, for example, the Medicare Program, under which beneficiaries are entitled to a specific and limited set of services. Unlike most health care financing programs, the IHS provides a broad range of services for prevention, cure, and rehabilitation.

IHS Administration and Goals

The administration of the IHS is decentralized, with 11 Area Offices responsible for operating IHS programs within designated geographic areas. The map shows the areas and populations eligible for IHS services in each area. IHS operations are managed locally by the staff of service units, which typically serve populations who reside on or near a single Federal reservation. The IHS uniquely combines traditional public health services such as environmental health and public health nursing with clinical services such as medicine, dentistry, and optometry. The base of operations for such activities is typically a small hospital or health center. The level and type of services are determined by officials of the individual Area Offices in consultation with the tribes that they serve. The services are based on the needs of the Indian population and the availability of funds.

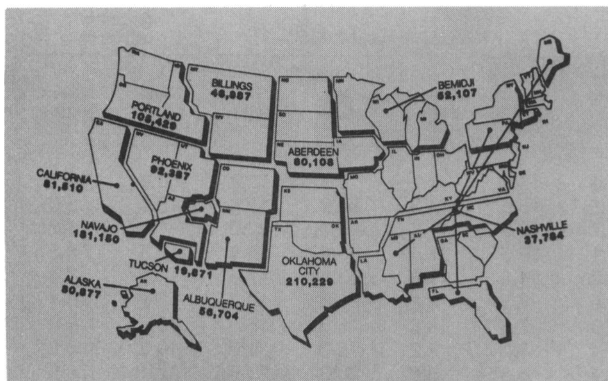
The preamble to the Indian Health Care Improvement Act (Public Law 94-437) identifies as the goals of the Indian Health Service (*a*) to raise the health status of American Indians and Alaska Natives to the highest possible level and (*b*) to encourage the maximum participation of Indians in the planning and management of IHS services. These goals have proven to be an important guide for the formulation of IHS programs.

The act further specifies the following three objectives for the IHS:

1. Assure Indian people access to high-quality, comprehensive health services appropriate to their needs.

2. Assist Indian tribes and Alaska Native corporations to develop their capacity to staff and manage health programs and provide these tribal organizations with the opportunity to assume oper-

Total service population of the Indian Health Service, by area: fiscal year 1988 estimate 1,045,043



ational authority for IHS programs serving their communities.

3. Act as the Indian people's advocate in health-related matters and help them gain access to other Federal, State, and local programs to which they are entitled.

Delivery of Services

Clinical service capacity. There are three modes of delivering IHS services: direct, tribal, and contract. Clinical services at facilities operated by the IHS or its tribal contractors are often the only sources of care available, especially ambulatory and primary care services. Contract care generally consists of services not available directly from the IHS or the tribes that are purchased through contract with community hospitals and private practitioners.

When the IHS was transferred from the Bureau of Indian Affairs to the Public Health Service in 1955, both its medical facilities and staffing were inadequate to meet the health needs of Indians (*5*). Since then, the IHS has built 30 hospitals and 90 health centers. As of January 1, 1986, the IHS operated 45 hospitals with a total of 1,988 beds, 65 health centers, and more than 200 other clinics where health care is available (table 2). IHS inpatient services vary from limited nonspecialty care to inpatient specialty services. Dental services are provided at virtually all facilities, and itinerant IHS dental teams with portable equipment visit isolated villages, principally in Alaska. The IHS employs 689 physicians, 269 dentists, and 1,895 nurses. Each year, the IHS negotiates more than 1,250 contracts with health care providers; about 1,000 hospital beds are available to IHS patients through contracts with local hospitals. Tribes operate 6 hospitals and 62 health centers and more than 200 other clinics where limited health care is available. Thirty-seven health projects in urban areas provide medical, dental, health education, mental health, outreach, referral, and related services (*6*).

The following table shows the increase in services provided to Indians between 1955 and 1985:

Activity	*Percent increase*
Hospital admissions	117
Outpatient medical visits	870
Dental services	964

SOURCE: Division of Program Statistics, IHS.

Total IHS hospital admissions (direct, tribal, and contract) increased 117 percent in the 30-year period; IHS direct, tribal, and contract hospitals provided approximately 510,000 days of care in 1985. Outpatient medical visits increased almost 9 times, to 4.4 million, and dental visits increased 10 times to 1.9 million from 1955 to 1985.

Data from the 1980 census indicate that 60 percent of the reservation Indians who received care from any source during the preceding 12 months had to travel less than 30 minutes and, for another 24 percent, travel time was less than an hour. Contract health service funds were used to purchase 106,000 inpatient days, 258,000 outpatient medical visits, 41,000 dental services, and 37,000 patient trips during FY 1985. Public health nurses performed more than 600,000 services, ranging from immunization to family planning counseling, and community health representatives provided 400,000 days of service.

Contract health care. For services not available in IHS facilities, the IHS expends approximately $180 million each year. This expenditure has certainly added a substantial dimension to health care, but it has also resulted in a great increase in the complexity of the system. With the development of the contract program, the IHS has become a health care financing organization with all the inherent problems and questions. The management of this activity, not surprisingly, has a reciprocal effect on the direct programs.

In 1981, Congress authorized a demonstration project integrating IHS direct care, contract care, and third party resources for the service population of the Pawnee Service Unit in Pawnee, OK. Patterned closely after insurance programs, the Pawnee Benefit Package Program precisely defines eligibility, benefits, and payment policies, including coordination of its patients' third party benefits. Formal evaluation of this program in 1985 con-

cluded that the services provided under this program were on a par with those of well-managed private insurance.

Environmental health services. Many health problems of Indians are caused by poor housing, unsafe water supplies, and improper waste disposal. By 1985, IHS's program of improving sanitation facilities for Indian homes had provided water supply and sewage disposal facilities to more than 149,000 Indian households. During FY 1985, IHS provided 62,000 environmental health services that included measures for safety and injury control, food and water inspection, and vector control.

Table 2. Number of facilities operated by Indian Health Service (IHS) and tribes as of January 1, 1986, by type of facility

Type of facility	*IHS*	*Tribes*	*Total*
Hospitals	45	6	51
Outpatient facilities:			
Health centers	65	62	127
School health centers	6	1	7
Health stations	66	48	114
Alaska village clinics	...	173	173
Treatment locations[1]	201	36	237

[1] Treatment locations are geographically described communities where direct or contract clinical services, or both, are provided but where no fixed Public Health Service health care facility is available—mobile unit sites, for example.

SOURCE: Division of Program Statistics, Indian Health Service.

Participation in New Roles

Indian self-determination. Tribes are assuming a leading role in planning and providing IHS services. Community, regional, and national health boards representing Indian tribes involve Indian people in the programs that serve them. The Indian Self-Determination and Education Assistance Act (Public Law 93-638) (*6*) gives the force of law to the exercise of tribal sovereignty so that programs originally managed by the Federal Government may be operated directly by the tribes, if the tribes so choose. Fifteen years ago, the IHS planned and operated almost all health services for Indian communities. Today, partly as the result of increased funding authorized by the Indian Health Care Improvement Act (Public Law 94-437), tribes and intertribal organizations operate 6 hospitals and nearly 250 clinics under contracts with IHS. Almost all tribes operate some health programs for their people. Alcoholism treatment, mental health, contract care, and environmental health services and outreach by community health representatives are typical of tribal health services.

In January 1986, the Southeast Alaska Regional Health Corporation (SEARHC) assumed control of the 78-bed Mt. Edgecumbe Hospital, the IHS' fifth largest hospital. Under the Indian Self-Determination Act, the IHS supports Mt. Edgecumbe's continued operation with a $10 million contract to SEARHC and the loan of IHS employees. The Native-owned, nonprofit organization is now responsible for health care programs throughout much of the Alaska panhandle. SEARHC also operates a medical and dental clinic in Juneau and administers community health aid, emergency medical service, substance abuse, and community development programs for Alaska Natives over a 38,000 square-mile area.

Health professions. Indians are seriously underrepresented in the health professions, and thus few are available to work in Indian communities. The IHS scholarship program authorized by the Indian Health Care Improvement Act supports the training of Indian students in various health professions. Since 1978, the IHS has awarded 28 grants to Indian organizations to stimulate interest among young Indians in health careers, and more than 2,200 scholarships have been awarded to Indian students to prepare them for health careers. More than 550 Indian students have received degrees in medicine, dentistry, nursing, and other health fields under this program to date, and they have either fulfilled or are fulfilling their service obligations within the IHS, tribal organizations, or Indian communities.

Community health representatives. Originally conceived of as community outreach workers, the health representatives program, now approximately 18 years old, has evolved into a series of general and specialized health workers. In this program, the IHS and the tribes have trained more than 6,000 Indians as emergency medical technicians, dental assistants, audiometric technicians, medical social workers, and environmental health technicians. These men and women, members of their respective communities and speaking the language of their respective tribes, often form the first line of medical care.

Summary

The IHS is a comprehensive, community-oriented health care system that combines both preventive and therapeutic programs. It is the primary mechanism employed by the Federal Government to meet its health obligations to the

various sovereign Indian tribes throughout the United States. In 30 years, the IHS has evolved into an exceedingly complex system of care, embodying several unique concepts and programs. It carries out its various functions through a system of service units, usually organized around a hospital with a number of clinics. In addition to "traditional" one-on-one physician-patient encounters, it operates a great variety of services such as emergency, environmental health, outreach, community health workers, and others. It enters into contracts with both tribes and the private sector under a wide range of circumstances. The decentralized organization has proved to be readily adaptable to new situations and conditions, and it serves as one model for the organization of health services on a national scale.

References

1. 25 U.S.C. 13.
2. 42 U.S.C. 2001 ff.
3. 25 U.S.C. 1601 ff.
4. *Morton* v. *Ruiz*. 94 S. Ct 1055 (1974), 415 U.S. 199.
5. Health services for American Indians. Public Health Service Publication No. 531. Washington, DC, February 1957.
6. 25 U.S.C. 450 ff.

The Indian Health Service Record of Achievement

EVERETT R. RHOADES, MD
ANTHONY J. D'ANGELO
WARD B. HURLBURT, MD

Dr. Rhoades is the Director of the Indian Health Service (IHS). Mr. D'Angelo is the Director of the IHS Division of Program Statistics. Dr. Hurlburt is the IHS Associate Director for Health Programs. Tearsheet requests to Mr. D'Angelo, Rm. 6A-30, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857.

Synopsis

The Indian Health Service (IHS) was transferred from the Department of Interior to the Public Health Service in the Department of Health, Education, and Welfare in 1955. At that time, the general health of Indian people substantially lagged behind the rest of the U.S. population. This gap was reflected in mortality rates which were several-fold higher for Indians, or reflected in time; there were decades between the dates when the U.S. population achieved certain lower death rates compared with the dates when similar reductions were achieved by Indians.

As a result of preventive health programs, improvements in sanitation, and the development of a number of medical advances, substantial progress has been achieved in improving the health of American Indians and Alaska Natives. Life expectancy of Indians has increased 20 years between 1940 and 1980. From 1955 through 1982, the death rate for Indian infants dropped by 82 percent. Also, the age-adjusted death rate for tuberculosis decreased from 57.9 per 100,000 population in 1955 to 3.3 in 1983. These and other improvements are summarized in this paper.

When the Indian Health Service was transferred to the Public Health Service from the Department of the Interior in 1955, the health status of the Indian people was substantially lower than that of the rest of the U.S. population. The disparity was most apparent in the death rates for Indians. In the more than three decades since the transfer, progress has been substantial.

An overview of the changes that have occurred is presented in this short paper. A number of benchmarks or indicators are used to document the gains. These include life expectancy at birth, age at death, maternal and child health, and age-adjusted death rates for certain infectious diseases.

Life Expectancy at Birth

In 1940, the life expectancy of Indians born in that year was 51.0 years. This was 13.9 years shorter than the life expectancy of U.S. whites