Jay Noren, MD MPH ■ David Kindig, MD PhD ■ Audrey Sprenger

CHALLENGES TO NATIVE AMERICAN HEALTH CARE

SYNOPSIS

NATIVE AMERICAN HEALTH care programs face complex and unprecedented challenges resulting from the increased assumption of clinical operations by tribal authorities, shortfalls in Federal funding, modifications in state and Federal health and welfare programs, and intensifying involvement with managed care organizations. These challenges are further complicated by service populations that are increasing at a faster rate than the growth in funding.

The authors conducted onsite surveys of 39 Native American health programs in 10 states in order to assess the organizational and management problems they faced. The trend toward transfer of health programs from the Indian Health Service to tribal operation seems likely to continue and accelerate. The survey results indicate that in order for programs to be effective in the long run, they will need to be guided by skilled managers able to adapt to these powerful changes in the health care environment.

NATIVE AMERICAN HEALTH CARE is facing challenges that are unprecedented in its history. External forces are intensifying those challenges; three are particularly powerful: (a) the gradual but accelerating assumption of responsibility for delivery of clinical services by tribal governments and the concomitant decrease in direct U.S. Indian Health Service (IHS) operational responsibility; (b) resource constraints resulting from Federal appropriations insufficient to cover inflationary costs and thus not capable of sustaining levels of services, particularly during the 1990s;[1] and (c) the growth of managed care and increasing interest by managed care organizations in contracting with tribes for delivery of clinical services.

A NATIONAL SURVEY

The response to these forces will profoundly impact the health status of Native American people. To gain insight into the challenges faced by health programs serving this population, we surveyed staff members of 39 Native American health programs in 10 states between August and November 1996. These sites included IHS, tribal, and urban Native American health programs. The survey assessed current challenges and management needs using a structured interview instrument combined with non-structured interviews of 85 clinic leaders: chief executive officers, physicians, nurses, and other administrative staff. Interviewees addressed major organizational challenges or crises, priority management needs, and critical issues in the relationship between Native American health programs and the regional and national administrative structure of the IHS.

The current challenges affecting Native American health care point to an increasing need for management development.

BACKGROUND

While there is little doubt that the overall health status of Native Americans has substantially improved in the second half of the 20th century, recent epidemiological data on the Native American population reveal several areas of concern: *(a)* the rise in chronic diseases, especially diabetes; *(b)* the persistence of infectious diseases, which despite a decline have stabilized at a level higher than in the non-Native population; *(c)* and the high prevalence of multiple "social pathologies" such as violence, unintentional injuries, and the ill effects of alcohol and drug abuse.[2–4] High prevalences of these chronic, infectious, and social diseases, called "Western" diseases by Trowell and Burkitt,[5] also characterize other indigenous populations around the world that are undergoing rapid sociopolitical, cultural, and economic changes.

Unlike most U.S. residents, IHS beneficiaries do not pay premiums, deductibles, or co-payments for their IHS health coverage regardless of personal or family income level. Because IHS services are thus essentially free of charge to eligible people, one might expect to see no significant differences in access to care by socioeconomic status among IHS beneficiaries, unlike the general U.S. population, in which clear differences exist.[6,7] Also while many in the general U.S. population live in medically underserved rural or inner-city areas where few private medical providers are available,[8,9] Native American facilities and resources are specifically targeted to areas where Native Americans live, including many rural and sparsely populated areas. Thus, ideally, IHS resources can be distributed to areas where need is highest without being affected by other factors that affect the location decisions of private physicians.

Despite these advantages, barriers to care still remain. Some of the areas inhabited by IHS-eligible people are among the most sparsely populated in the United States, and transportation problems make it difficult for IHS providers to reach all those who are eligible.

Funding is also unstable. Unlike Medicaid and Medicare programs, the IHS is not an entitlement program; its funds are obtained through an annual appropriation by the U.S. Congress. Thus, short of a special supplemental appropriation (extremely rare), no additional funds are available for a given year if more money is needed for health services. Consequently, access to care for IHS-eligible people may be inhibited due to resource limitations even when IHS facilities are located in an area. Access may be particularly limited for Contract Health Services—specific clinical services provided under contracts between tribes and the Secretary of the U.S. Department of Health and Human Services[10]—including expensive diagnostic and treatment services that can be delayed or denied to patients if funds are unavailable. At times in the past, such services have been restricted to emergency cases because of budget constraints.[11]

These resource constraints have compelled Native Americans to depend increasingly on outside sources of health care (both private and public sources). However, given the remote location and economic barriers to care for much of the Native American population, it is likely that IHS direct care facilities will continue to be the sole or primary source of care for people living in some of the most remote and sparsely populated areas of the United States,

Table 1. Characteristics of 33 clinics in 10 states providing services to Native Americans, 1996 survey

Site	Operated by tribe, IHS, both, other[a]	Annual budget[b]	IHS annual contribution to budget[b]	Number of staff, including MDs	Number of staff MDs	Annual total of patient encounters[c]
1	Tribe	$427,300	$399,700	11.25	0.25	2000
2	IHS	450,000	450,000	12	2.1	6000
3	Tribe	720,000	500,000	14	2	10,144
4	Tribe	940,000	700,000	11.2	1.2	11,000
5	Tribe	1,290,000	1,200,000	14	0	4500
6	Tribe	2,350,000	700,000	34	1	4500
7	Tribe	2,959,569	184,448	34.5	1	23,668
8	Tribe	2,990,000	2,700,000	37.6	2.6	24,000
9	IHS	3,543,680	3,063,035	65	3	28,656
10	Other	4,000,000	1,500,000	67	3.7	30,000
11	Both	4,801,563	4,103,425	79	6	39,400
12	Tribe	5,803,223	3,465,630	...	6	29,200
13	Both	6,147,000	5,817,000	52	5	42,000
14	IHS	7,112,000	5,000,000	137	7	47,054
15	IHS	7,250,000	6,000,000	87	5	...
16	IHS	7,969,000	4,500,000	156	16	78,000
17	IHS	8,062,470	3,862,397	148	11	57,675
18	IHS	8,300,000	3,700,000	72	5	...
19	Tribe	8,800,000	8,100,000	73	3	39,000
20	Tribe	9,400,000	8,000,000	170	4	76,000
21	IHS	10,140,861	7,288,767	330	20	95,000
22	IHS	11,733,086	9,316,318	104	7	65,000
23	IHS	14,250,000	7,000,000	238	15	80,000
24	Tribe	15,000,000	11,000,000	200	12	90,000
25	IHS	15,256,000	13,056,000	107	9	63,000
26	IHS	17,000,000	14,100,981	260	15	64,000
27	IHS	23,703,097	12,543,600	452	39	151,201
28	IHS	23,967,159	21,393,800	262	12	...
29	IHS	31,314,161	11,184,205	506	28	130,832
30	IHS	32,000,000	20,000,000	737	80	215,000
31	IHS	37,000,000	27,000,000	668	41	129,481
32	IHS	44,829,362	30,850,070	750	62	177,194
33	Both	...	...	165	9	40,000
Total		$3.63 X 10^9	$2.45 X 10^9	—	—	—
Mean		$11,547,173	$7,771,231	189.1734	13.14697	61,783.5

[a]"Other" refers to operation by urban community health boards, not tribal governments or IHS.

[b]Most figures are from 1995 clinic budgets; some are from 1994 budgets. Some figures are rounded because the individual clinics submitted them in this form.

[c]Predominantly Native American patients, although some clinics treated non-Native Americans

even for those Native American people who have private health insurance coverage.

SURVEY METHODOLOGY

We chose to work in 5 of 12 IHS Service Areas as representative of Indian health care systems nationally. Site visits and surveys were conducted at 33 clinics and six multi-clinic organizations or regional boards located in ten states—Wisconsin, Minnesota, Michigan, Montana, Wyoming, Washington, Oregon, New Mexico, California, and Arizona. The 39 sites were chosen to represent regional, organizational, and operational differences. We spent one to two weeks on site visits in each service area, seeking out the perspectives of tribal authorities, clinical staff, and management personnel.

Most of the 85 respondents completed the survey questionnaire and participated in non-structured interviews in personal meetings with the project investigator at the clinic or other program site. A small number of respondents completed the questionnaire independently without meeting the project investigator.

The 33 clinic sites surveyed varied substantially in size. Total annual budgets ranged from $427,000 to $44.8 million, with a mean of $11.5 million and a median of $8.1 million (see Table 1). Staff sizes ranged from 11 to 750, with a mean of 189 and a median of 104. Annual patient volumes ranged from 2000 to 215,000, with a mean of 62,000 and a median of 58,000. Of the sites and organizations surveyed, 51% were operated by the IHS, 31% were operated by tribal governments, and 18% were organizations with a combination of IHS and tribal management or some other variant such as regional health boards, which govern urban programs.

SURVEY RESULTS

The survey results indicate the emergence of a new era in the history of Native American health care. The survey respondents were united in their assessment of the current situation in several key areas. Our survey instrument addressed three main topics: major current and potential future organizational challenges or crises; priority management needs; and critical issues in the relationship between Native American health programs and the regional and national administrative structure of the IHS.

The most formidable and frequently cited challenges were: *(a)* overcoming problems resulting from inadequate funding; *(b)* recruitment and retention of professional staff; *(c)* conversion to tribal compacting or contracting of clinical services; *(d)* changes in the relationships between local clinical programs and the regional/national administrative structure of the IHS; *(e)* anticipated changes in Federal and state programs, including Medicaid, welfare, and Medicare; and *(f)* the need for culturally sensitive services.

Challenge #1: Inadequate funding of Native American health care. Native American health services are provided through three inter-related approaches: *(a)* IHS-operated clinics and hospitals, *(b)* tribally operated health programs (largely funded by Congressional appropriations administered through the IHS), and *(c)* urban programs governed by Indian Health Boards in metropolitan areas, partially funded by the IHS.

As a part of the U.S. Department of Health and Human Services, the IHS has operated a network of inpatient and ambulatory care facilities across the continental United States and Alaska since 1955 (although Federal health services to tribes date back to the late 1800s). In recent years, however, responsibility for an increasing number of health programs has been assumed by tribal authorities, predominantly through conversion from IHS operation to tribal governance. In addition, IHS directly subsidizes health care services through contracts with private providers (formally known as Contract Health Services), particularly for specialized services and other services not available in IHS direct care facilities or tribally operated clinics. (See Table 2.)

Recent appropriations for the IHS have been inadequate, and this problem has been compounded by increasing Native American populations served. Between 1991 and 1995, appropriations (in constant 1994 dollars) increased only 2.5% (from $2.003 billion to $2.053 billion) while during the same period the IHS service population increased 10.7% (1.24 million to 1.38 million). Additionally, as measured by lower per capita expenditures, Native Americans have less access to health care than the general U.S. population: the estimated per capita health care expenditure for Native Americans in 1995 was $1153,

Table 2. IHS, tribal, and urban health programs serving Native Americans in the United States

Program type	IHS funding, FY 1994	Percent of total IHS funding,	Total of ambulatory medical visits, 1993	Percent of total ambulatory medical visits, 1993	Number of ambulatory clinics[a]	Number of hospitals
IHS-operated	$1.339 billion	63.0	4,253,743	68.5	119	40
Tribally operated	763 million	35.9	1,722,547	27.8	342	9
Urban Indian Health Program	23 million	1.1	229,737[b]	3.7	34[c]	—
Total	$2.125 billion	100.0	6,206,027	100.0	—	—

[a]As of October 1, 1994; includes heath centers, school health centers, health stations, Alaska village clinics, and urban programs.
[b]"Medical" portion of "Urban Indian Health Program Workload"
[c]"Indian Operated Urban Projects" as of October 1, 1994
SOURCE: Reference 14

compared with $2912 for the U.S. civilian population (Michael Trujillo, MD MPH, Statement on IHS fiscal year 1997 budget before the Interior Subcommittee of the U.S. House Appropriations Committee, 1996).

Urban Indian health programs face some unique funding problems. These urban health programs were established in recognition of the growing trend of Indian people moving off reservations. The Indian Health Care Improvement Act of 1976 (P.L. 94-437, as amended) authorized Congressional funding of urban Indian health programs.

Census data show that 62.4% of American Indians/Alaska Natives resided off reservations in 1990, with over 56% living in larger metropolitan areas.[12] Yet despite this large percentage of Indian people living off reservations, the Urban Indian Health Program budget accounted for only 1% of the total IHS budget, or $23 million, in 1994. Federal funding for urban programs has been historically lower, in proportion to the population served, than funding for reservation health programs. This results from the fact that most IHS support has been directed to Federally recognized tribes, their members, and their descendants living on reservations, which are located predominantly in non-urban settings. Urban Indian Health Programs have a somewhat more limited relationship to the IHS, tribal governments, and other sections of Federal, state, county, and local governments than reservation health programs.

The Urban Indian Health Program budget meets an estimated 22% of the level of identified need for services at existing urban sites. This does not include the 19 additional sites identified as needed on the basis of the urban Native American population in a 1994 study commissioned by the IHS.[12] The rapid growth in the off-reservation Indian population in the United States necessitates a second look at the responsibilities of the IHS toward all Native people. In 1994, a committee of Urban Program Directors and IHS personnel suggested that services offered by Urban Indian Health Programs should be based on population size in a given location to reflect and accommodate the rise in the urban Native population.

Although urban programs differ significantly from reservation programs, health care delivery problems facing the Urban Indian Health Program are similar to those of reservation programs and include: limited access, limited availability of specialty consultation, culturally insensitive services, inadequate data systems, confusion regarding eligibility, inadequate funding, poor health status, incomplete infrastructure development, institutional racism, and state health care reform issues (Medicaid, for example).[12]

The resource problem is further exacerbated because IHS resources are not distributed evenly across all IHS service areas since the method of distributing these resources has been based on historical funding patterns rather than need (although this problem has been recently addressed through a revised "needs-based" formula).[3]

So it is not surprising that survey respondents' concerns about inadequate funding were preeminent. One respondent described his or her agency's funding status as "so unstable [that] it paralyzes budget planning and staff morale." The challenge of inadequate funding was also related to the problem of outdated equipment, facilities, and specific service shortfalls (particularly mental health care, prevention programs, and information systems management) as well as the reality of increasing tribal population growth. Summed up by one individual, the foremost challenge facing clinics is simply "limited clinical space and an insatiable demand for service."

Challenge #2: Recruitment and retention of professional staff. Recruitment and retention of professional staff were also repeatedly noted as critical challenges facing Indian health care. The lack of Native American staff and the turnover of clinicians hold particular importance. Clinical staff who remain for any length of time are typically "promoted" to administrative roles, which usually results in reduction or loss of their clinical services and inexperienced administrative leadership. The longer a clinician stays at one facility, the greater the likelihood she or he will be "elevated" into administrative work.

Commenting on the administrative versus clinical role,

one respondent explained, "Trying to serve both masters means one will be underserved, and since most clinical staffs' sympathies lie with direct patient care they perform incompetently as administrators." A clinician becomes more useful and effective as she or he acquires familiarity within a given community, noted another respondent: "[A clinician who] knows a community's values and idiosyncrasies and disease patterns is both more receptive and more efficient." Regarding recruitment of Native American managers, one individual explained, "Tribal directors need ways to train Native employees how to be managers so they can replace non-Indians who quit or leave."

The survey results reflect the emergence of a new era in the history of Native American health care.

Furthermore, the remote location of most Native American health services increases the recruitment problems. Often the lack of job opportunities for providers' spouses poses a serious barrier. These problems not only complicate recruitment but cause relatively high turnover among providers, often after only a few years' tenure.

Challenge #3: Tribal compacting or contracting of clinical services. Our survey revealed that compacting and contracting by tribes has emerged as a major issue in most parts of the country.

Compacts are government-to-government legal agreements between tribal governing bodies and the U.S. Department of Health and Human Services stating terms and conditions under which the tribes plan and conduct health programs. This transfer of Federal Native American health programs to operation by tribal organizations has grown steadily since the 1976 enactment of the Indian Self-Determination and Education Assistance Act (since amended). Contracts are agreements for specific clinical services between tribes and the Secretary of DHHS. Thirty-five percent of IHS funding now goes directly to tribes.[10] The extent of program transfer to tribes varies by region, with the largest concentrations of tribal control in Alaska, California, Washington, Oregon, Idaho, Minnesota, Wisconsin, Michigan, and Oklahoma. In 1996 IHS Director Michael Trujillo predicted that transfer of health programs to tribal operation would continue to increase such that half of the IHS budget would go directly to tribes in three to five years.[1]

Challenge #4: Relationships with the IHS administration. The intimate and evolving nature of the relationship between local health programs and the IHS administration, particularly the movement from dependence to much greater tribal independence, prompted us to devote an entire section of the survey to these issues.

We asked respondents to rank the benefits they received from the administrative structure of the IHS

through Area Offices and Washington, DC, headquarters and then list the three most significant problems or concerns individual organizations had with regard to these relationships. The key benefits were seen as: (*a*) funding, (*b*) technical support, and (*c*) representation in the legislative arena.

While every respondent cited funding as the most important benefit, affiliation with IHS was perceived as also offering clinical programs substantial administrative support. For example, IHS was routinely credited with providing objective technical assistance, general consultation, organized recruiting, epidemiological data, and public health/preventive health guidelines. Valued technical assistance was provided on a broad range of topics from administrative and budget directives to accounting guidelines and computer assistance.

Respondents cited as problems or concerns: (*a*) inadequacy of funding; (*b*) inaccessible and slow bureaucracy; and (*c*) communication problems and lack of trust in IHS. Interestingly, "funding" was cited as the top-ranked benefit and "inadequacy of funding" was cited as the greatest problem in relationships with IHS Area Offices and headquarters. One respondent described this dual characterization as "one of the ways IHS works for and against us at the same time."

Funding shortfalls were particularly serious in Contract Health Services. As one respondent described, "Fourteen years with this arrangement and we have made no progress on budget projections.... We annually go through fourth quarter shut-down of procurement, which disrupts [the operation of the clinic]." Bureaucratic processes were also routinely described as "autocratic" and "too slow." As summarized by one respondent, "IHS provides intertribal rules which may work well for office bureaucrats but not for workers providing services in the field." Ineffective bureaucratic processes were also pointed to as the cause of local clinics' management and personnel problems, difficulties with ineffective procurement systems, and poor computer service support.

Having specified both the value of and problems in their relationships with IHS, respondents were asked to state the three most significant changes in IHS that they felt would result in the most benefit to local health programs. The most frequently cited changes were (*a*) decentralization; (*b*) local (facility) control of budget authority; and (*c*) increased training and experience of senior local management (with an emphasis on improved training for clinical administrators, particularly physicians with administrative duties). Suggestions ranged from "changing IHS to only a support organization" to "an entire restructuring of IHS with an emphasis on more local economic and political control." Furthermore, it was routinely suggested that "decentralizing' and "localizing" IHS could potentially lead to better patient access to specialty care, individual facility improvements, more latitude in budget planning and hiring at the local level, the growth of billable service departments, and a decrease in tribal interference in clinical decisions.

Challenge #5: Changes in Federal programs—Medicaid, Medicare, welfare. Several of those surveyed expressed anxiety regarding the anticipated negative impact on health programs of recent and impending changes in Medicare and Medicaid and major welfare reform at the national and state level. This anxiety derived from the substantial reliance of Native American people on Medicare and Medicaid programs. Although direct IHS services or funding often serve as the primary source of care for Native Americans, Federal law states that IHS is required only to serve as residual provider of care not available from other sources, either private insurance or public programs (Medicare, Medicaid, or state services). In fact, IHS funding determinations by Congress take into consideration, at least indirectly, Medicare and Medicaid funding. The 1997 IHS budget request of $2.4 billion assumed $222 million in collections from third-party payers including private payers, Medicare, and Medicaid (Michael Trujillo, MD MPH, Statement on IHS fiscal year 1997 budget before the Interior Subcommittee of the U.S. House Appropriations Committee, 1996). The American Indian and Alaska Native section of the National Medical Expenditure Survey revealed that in 1987 40.9% of this population relied on private or public coverage (24.9% private, 16.0% Medicare, Medicaid, or other public) for the entire year, compared to 42.5% who relied on IHS services for the entire year.[13] (See Table 3.)

Reflecting these concerns as well as the expansion of managed care, one respondent suggested that a training program that brought "our leaders in contact with HMO industry leaders who are doing excellent work in implementing—improving—managed care in a way that benefits the satisfaction and health status of the enrolled" would help clinic leadership address these major system changes.

Challenge #6: Cultural issues. Finally, falling under the rubric of "cultural awareness," many respondents described concerns about staff morale, poor customer relations, and problems with conflict resolution among staff. Such problems were attributed to the fact that most clinical staff have little interaction with the population they serve outside of their professional capacities. Moreover, many tensions between clinical staff and other personnel were described as resulting from conflicts between Native and non-Native staff, ascribed by one respondent to "an ongoing lack of advancement of Native Americans in key positions of decision-making and power." Another respondent suggested, "Management training should focus on the different concepts, styles related to working with Native Americans; that

is, management training for Native American managers should be customized to include traditional approaches to management as practiced by tribes." Another concern noted was the difficulty in providing preventive health education sensitive to the unique cultural needs of the Native American patient population.

PRIORITY MANAGEMENT NEEDS

The current challenges affecting Native American health care point to an increasing need for management development. Little published information exists about the management needs and current resources of tribal clinics. However, valuable insights come from a comprehensive analysis published in 1995 by the Indian Health Design Team (IHDT), a team including many tribal representatives that made recommendations for restructuring the IHS.[10] While the IHDT report principally addresses the IHS, it nonetheless reflects many of the challenges faced by all American Indian/Alaska Native health care programs, including tribally operated and independent urban health programs. The IHDT proposed implementation of its recommendations over the next several years, with completion by 1998.

It is not surprising that inadequate funding was a preeminent concern.

The basic design strategy recommended by IHDT would place control of Native American health care at the local level. The elements of this strategy are: *(a)* restructuring IHS organizational levels above the local level and leaving the choice of local restructuring to the local clinics; *(b)* changing the IHS levels above the local clinic from controlling to supporting functions; *(c)*

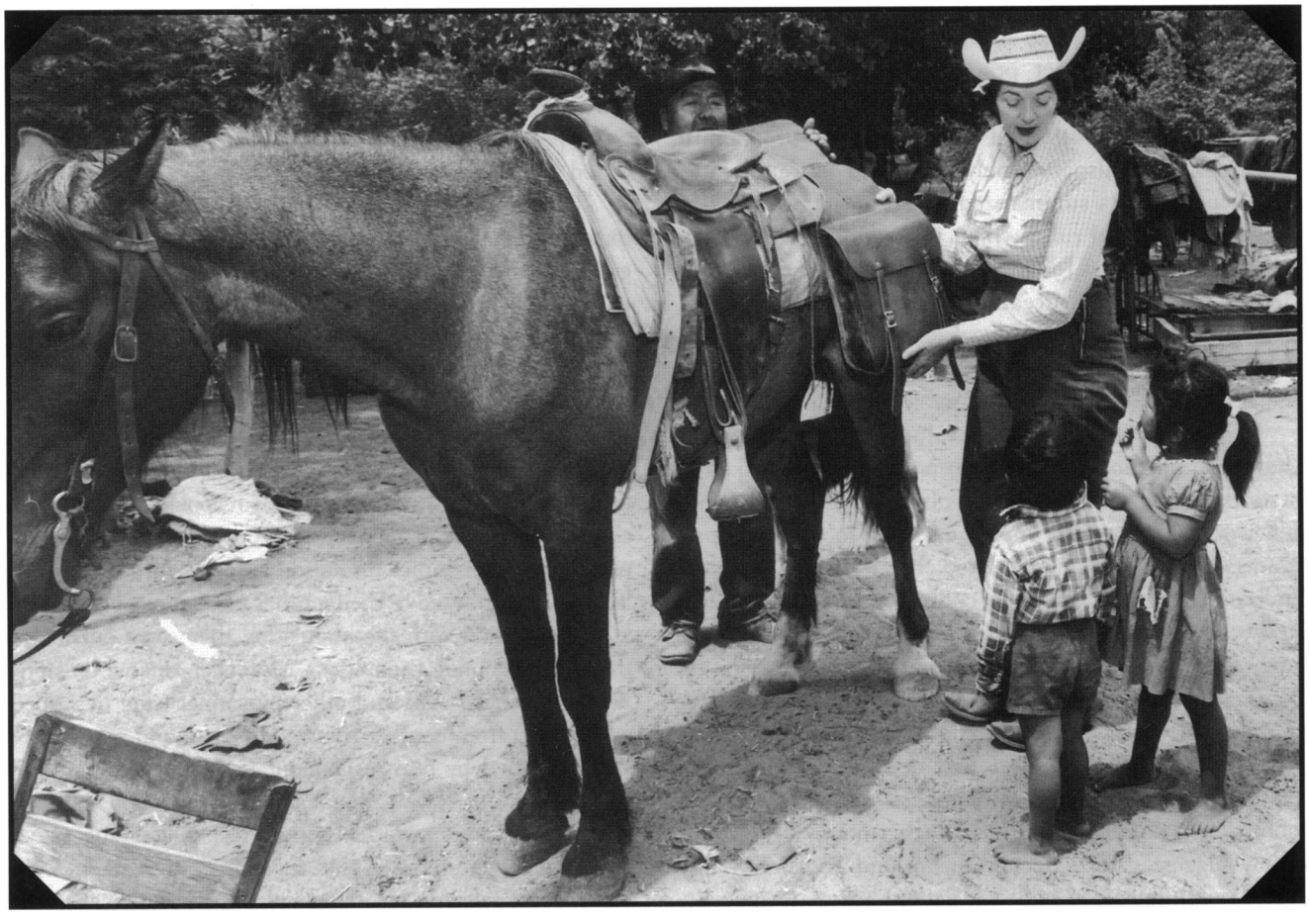

Table 3. Health coverage of Native Americans in the United States, 1987

Type of coverage	Percent of U.S. Native population
IHS only	42.5
IHS only part year, other part year	16.5
Private insurance only	24.9
Public only (Medicare, Medicaid, other)	16.0

SOURCE: Reference 13

pooling and consolidating IHS Area Offices and Headquarters resources and expertise to support local sites; and *(d)* investing resources gained as a result of Federal downsizing into local, direct clinical services. These principles of local control and independence clearly apply to all Indian health care, not just Federally operated programs, and are quite consistent with recent trends toward transfer of numerous IHS clinical programs to tribal control.

This rapid trend toward delegation of control to the local level makes enhanced management expertise very critical. We sought new insights into management needs by interviewing tribal health directors, chief medical officers, nursing supervisors, and other administrative staff. Respondents were shown a list of 48 management topics and asked to select the management topics/skills that would most benefit them in their current roles and rank order their top 10 choices. Additionally each respondent was asked to indicate the top 10 management priority topics/skills for other members of the leadership staff of their clinic or health program.

The results were scored by assigning 10 points to items ranked first, 9 points to those ranked second, and continuing down to an assigned value of 1 point for items rank-ordered 10. (See Table 4 for a summary of these rankings.)

We looked at the rankings within each of the four management groups—CEOs, medical directors, nursing directors, and other administrators—and then compared these rankings between the groups. This analysis revealed impressive agreement among the top-ranked priorities (Table 5).

Out of the 48 possible topics, 8 of the 10 top-ranked management priorities were the same for at least three of the four types of administrators. Fourteen of the 15 top-ranked management priorities were the same for at least three of the four types of administrators. Two topics were ranked in the top 10 by all four administrative groups, and four were ranked in the top 15 by all four.

Topics ranked in the top 10 by all four groups were:

- Continuous quality improvement/total quality management for the organization;
- Creating customer orientation in services delivery and assessing customer satisfaction.

In addition to these two, the topics ranked in the top 15 by all four groups were:

- Managed care trends and effect on programs, particularly Contract Health Services;
- Management of conflict among staff (communication and interpersonal relations, for example).

However, there were some glaring disagreements. Two topics ranked in the top 10 by CEOs, medical directors, and other administrators were ranked 20th and 40th by nursing directors:

- Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.);

Table 4. Ranking of management priorities from all 85 clinic administrators—CEOs, medical directors, nursing directors, other administrators—surveyed at 33 Native American health care programs, 1996

Rank	Mean score	Priority areas
1	3.49	Managed care trends and effect on programs, particularly Contract Health Services
2	3.19	Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.)
3	3.04	Continuous quality improvement/total quality management for the organization
4	2.87	Creating customer orientation in services delivery and assessing customer satisfaction
5	2.67	Management of conflict among staff (e.g., communication and interpersonal relations)
6	2.44	Contract negotiation for clinical services (e.g., HMO contracts or discounts for referral services)
7	2.34	Methods for recruitment and retention of staff including processes involved: contact of candidates, matching staff to sites, contracts
8	2.26	Methods of strategic planning
9	2.12	Budget planning
10	2.08	Quality assurance for clinical services

- Contract negotiation for clinical services (HMO contracts or discounts for referral services, for example).

A topic ranked 8th by clinical leadership (medical directors and nursing directors) was ranked very low by CEOs (36th) and other administrators (21st):

- Use of information systems for clinical services ("Grateful Med" and other reference sources, continuing education, and consultation, for example).

Nonetheless, the level of agreement among the 15 top-ranked topics is quite impressive. Not surprisingly, many of these top management priorities relate to the most formidable and frequently cited challenges to clinical programs. For example CEO priority items 1, 5, 6, 9, and 10 relate directly to the challenge of "inadequate funding." CEO priority items 3, 4, 8, and 9 address "staff recruitment/retention" or "cultural sensitivity" or both. Priority items 1, 2, and 5 have implications for the "tribal compacting and contracting" challenges.

Two characteristics of these management priorities merit further discussion. First, they all have substantial relevance to health care management generically. Second, the unique characteristics of Native American health care call

Table 5. Comparison of the management priorities of CEOs and other administrative personnel, survey of 33 Native American health care programs, 1996

Priorities ranked in top 10 by CEOs, with rankings by other categories of administrative personnel

CEOs' ranking	Priority	As ranked by Medical Directors	Nursing Directors	Other administrators
1	Managed care trends and effect on programs, particularly Contract Health Services	4	11	2
2	Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.)	1	20	4
3	Management of conflict among staff (e.g., communication and interpersonal relations)	11	9	6
4	Creating customer orientation in services delivery and assessing customer satisfaction	3	4	16
5	Contract negotiation for clinical services (e.g., HMO contracts or discounts for referral services)	6	40	8
6	Methods of strategic planning	19	6	5
7	Continuous quality improvement/total quality management for the organization	7	3	1
8	Methods for recruitment and retention of staff including processes involved: contact of candidates, matching staff to sites, contracts	2	18	7
9	Approaches to staff stress management and burnout prevention	12	12	38
10	Methods for billing and collections from Medicaid and other funding sources	13	23	9

Priorities not ranked in top 10 by CEOs but ranked in top 10 by other categories of administrative personnel

Rankings by Medical Directors	Rankings by Nursing Directors	Rankings by Other administrators	Priority	CEOs' ranking
9	27	15	Design and acquisition of information systems	11
9	27	15	Design and acquisition of information systems	12
5	7	13	Quality assurance for clinical services	16
14	1	3	Budget planning	17
18	2	11	Budget management	
16	5	32	Methods of evaluating staff performance	18
45	29	10	Contract negotiation for business and support services	33
23	10	34	Development and implementation of personnel policies	34
8	8	21	Use of information systems for clinical services (e.g., "Grateful Med" and other reference sources, continuing education, consultation, etc.)	36
10	13	15	Approaches to staff education/inservice in clinical area (e.g., continuing medical and nursing education)	38

NOTE: Rankings were based on the totals of mean scores.

for special emphases on several of these management priorities as well as some variation in emphasis by type of program and site (tribal, urban, or IHS).

Several priority areas involve complexities that are specific to Native American health care. For example, some of the management issues in the area of "contract health services" are unique to a type of contractual relationship that does not exist outside of Native American health care. Board relations, although a key issue in any health system, have unusual characteristics related to the tribal political structure, which has no parallel in non-Indian health systems. Tensions between Indian and non-Indian staff carry an additional complexity in management of staff conflict not usually present in other health care organizations. Provider recruitment and retention barriers differ from those in other health care delivery systems (as discussed above under Challenge #2). Billing and accounting systems for collections from third-party payers have only recently emerged as a critical issue, unlike in other health care programs that have developed these systems over many years. These are only some of the management issues specific to Native American health care.

Additionally, variation in emphases exist among IHS, tribal, and urban programs. IHS program managers have a longer history of support systems and frequently more employment security than tribal or urban program staff. Urban programs must deal with numerous and varied funding sources and a board structure which usually differs from that of other programs. Most tribal managers have assumed their positions more recently in settings with a shorter institutional history in a somewhat different political environment than managers in IHS clinics and typically with a less developed support services structure. Nonetheless, the similarities in management priorities among these three types of programs are much greater than the differences, and all three differ significantly in emphases from their counterparts in non-Native American health care.

DISCUSSION

Native American health care programs face formidable challenges. The deep desire for and vigorous pursuit of tribal independence in clinical operations is increasingly coming up against powerful external forces of managed care, welfare reform, and changes in Medicare and Medicaid. Reconciliation of these somewhat conflicting forces and trends is further complicated by funding shortfalls, changing relationships with the IHS administrative structure, and increasing Native American populations, which generate more demand for services.

Effective response to these powerful forces will require greater management sophistication in Native American health systems. Given the rate of change in the health care market and Native American health care systems' relatively recent entry into that market, management training for current Native American health care leaders is essential to the long-term viability of these programs.

Native American health care has embarked on a new era, at once both frightening in the complexity of the challenges it faces and exciting in the potential for improving the health status of Indian people.

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All authors are with the Univ. of Wisconsin-Madison. Dr. Noren is an Associate Professor of Preventive Medicine, Dr. Kindig is a Professor of Preventive Medicine, and Ms. Sprenger is a PhD candidate in Sociology.

Address correspondence to Dr. Noren, University of Wisconsin-Madison, Bradley Memorial, 1300 University Ave., Madison WI 53706; tel. 608-265-3407; fax 608-263-4885; e-mail <jjnoren@ facstaff.wisc.edu>.

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