PUBLIC HEALTH SERVICE

Chronicles

HISTORICAL PERSPECTIVES ON PUBLIC HEALTH ISSUES

Integrating American Indians and Alaska Natives into the Body Politic?

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PHS researchers Ruth Raup (foreground) and Margaret West (background) seated in a railroad boxcar, en route from Sioux Falls to Yankton, December 1955.

A snowplow diesel train chugged southwest through a brisk night in December 1955. The engine trailed an old-fashioned boxcar, one door ajar, letting in the crisp air outdoors. Inside, huddled in blankets and perched about a potbelly stove, Margaret West, Ruth Raup, and Burnet Davis of the Public Health Service (PHS) contemplated the enormous task before them.

The previous year, under the provisions of PL(Public Law)83-568, Congress had moved the Bureau of Indian Affairs (BIA) Indian Service, Health Division from the Department of the Interior to PHS. The transfer was part of the Eisenhower Administration's version of Federal "termination" policies intended to assimilate indigenous people into "Anglo" society by terminating Federal obligations originally established by treaty. With the transfer, PHS embarked on a temporary crash program to improve the health status of the 315,000 American Indians and 35,000 Alaska Natives (Indian, Aleut, and Inuit) formerly under BIA's care. PHS inherited the Health Division's 3500 employees, stationed mostly at remote locations west of the Mississippi River, and $40 million worth of real estate in 23 states and the Alaskan Territory. Congress also gave Surgeon General Leonard Scheele $250,000 to survey PHS's new holdings and submit a detailed request for appropriations. It was this survey that our trio of PHS researchers had been dispatched to conduct.

Between October 1955 and June 1956, West, Raup, and Davis interviewed reservation residents, inspected Indian hospitals, and observed maternal and child health clinics at reservations in Montana (Crow), South Dakota (Yankton), New Mexico (Acoma Pueblo), Arizona (San Carlos), Oregon (Warm Springs), Washington (Colville), Wisconsin (Lac Courte Oreilles), Minnesota (White Earth), and Idaho (Fort Hall). The threesome reported desperate circumstances and ill health, observations that echoed former Surgeon General Thomas Parran's findings during a 1953 survey of Alaskan villages.

The pairing of investigators from different branches of PHS—West and Raup were from the Division of Public Health Methods and Davis was head of the Bureau of Medical Services—reflected a key tension animating policy debate. Division of

Public Health Methods researchers brought to their quantitative studies a New Deal commitment to social justice and a belief that the Federal government was obliged to uphold this commitment. Bureau of Medical Services staff were more pragmatic. Their Bureau was pinched between new demands made by groups of beneficiaries added during World War II and postwar efforts by Congress and the Bureau of the Budget to divest PHS of the health care business entirely.

Transferring BIA's Health Division to PHS dramatically improved prospects for the health status of indigenous peoples. But the transfer legislation also split public health from BIA's economic development mission, despite widespread recognition that health measures would "be largely wasted unless the basic economy of the Indian groups makes provision of a sanitary environment economically possible" (in Burnet Davis's words). Would PHS be more successful than BIA in meeting Federal obligations? And what would the result be? An ongoing or permanent commitment to achieving social justice through public health measures, a stopgap measure supporting Federal termination policies, or both?

What PHS Inherited

BIA's Indian Service grew out of 19th-century treaty obligations. High morbidity and mortality rates from communicable disease and the shortened life spans of indigenous peoples compelled Federal officials to continue health programs into the 20th century, after most treaties had expired. Federal efforts were stymied by insufficient funds; by the difficulties of managing programs in isolated, remote areas, often with harsh environmental conditions; and by the sovereignty of reservation and village communities, which lay outside the jurisdiction of health departments. Until 1931, when authority was transferred to BIA, the United States Bureau of Education provided health care to Alaskan Natives, outfitting itinerant school teachers with first aid kits and instruction manuals.

Foundations for transferring BIA's Health Division to PHS were laid between the two World Wars. PHS's distinguished performance during World War I spurred initial discussions about a transfer. Starting in the 1920s, a handful of PHS medical officers were assigned to duty with BIA's Indian Service. Administrative mechanisms were set in place with the Snyder Act of 1921 (which authorized BIA to pay contractors), the Indian Reorganization Act of 1934 (which permitted Federal recognition of tribal governments), and the Johnson-O'Malley Act of 1934 (which allowed BIA to contract with the states). Mobilization for World War II boosted support for the transfer, as BIA lost health officers and funds reallocated to the military and as American Indians and Alaska Natives moved to urban areas for industrial jobs or service in the Armed Forces, breaching the relative isolation that previously had confined much communicable disease to reservations and villages.

Washington, DC, lobbyists and Congressmen alarmed by reports of high incidence rates for tuberculosis among indigenous communities campaigned vigorously and successfully for the transfer. U.S. Representative Judd of Minnesota and the National Tuberculosis Association attracted supporters across the political spectrum, including the American Medical Association. The proposed transfer was controversial. Opposition on technical grounds was tangled up with broader debate about Federal termination policies. The Eisenhower Administration advocated transfer as a means to improve health status before devolving Indian Service duties to the states, while BIA and the Bureau of the Budget opposed the transfer in favor of giving such obligations directly to the states. Neither was there agreement among the tribes. Factions within the Navajo Nation and among Oklahoma tribes, for example, expressed fears that existing services would deteriorate, resulting in the loss of benefits. After initial skepticism PHS leadership came to support the transfer, which advocates like medical officers Fred Foard and Joseph Mountin described as a natural complement to PHS's role working with the World Health Organization to bring Western-style public health abroad.

The transfer legislation (PL83-568), enacted in August 1954 and effective the following July, infused millions in new appropriations and fresh public health-oriented strategies into Federal Indian programs. PHS organized a new Division of Indian Health within the Bureau of Medical Services and split administration among a group of regional or Area offices, to which sub-area or District officers reported. PHS ran a more centralized operation in the Alaskan Territory, managing the Alaska Native Health Service, operating the Arctic Health Research Center (opened in 1948), and staffing key positions in the Territorial Health Department. The Alaska Native Health Service, in turn, split duties between a headquarters at its Anchorage hospital and a southeastern Alaskan field group at the hospital in Mount Edgecumbe, the base for the old Bureau of Education's school health programs.

Constructing hospitals and clinics. Under BIA, hospital space for Indians and Alaskans had been at a premium. The loss of funds during World War II made the situation worse and brought BIA's Health Division to an impasse. After the war, efforts to combat tuberculosis (TB) achieved some success; death rates declined significantly—for example,

between 1950 and 1955 TB mortality among Indians declined from 102 per 100,000 to 46 per 100,000, and among Alaska Natives from 630 per 100,000 to 100 per 100,000. Yet this decline did not reduce the demand for hospital services appreciably, as spaces reserved previously for the tubercular were occupied by patients with other complaints.

The transfer brought new funds to build staff dorms, hospitals, and field stations, and to outfit airplanes, railroad cars, boats, and automobiles as mobile clinics. PHS also tapped funds available for planning and building community hospitals through the Hill-Burton Act of 1946 (PL79-75). Legislation passed in August 1957 (PL85-151) transferred construction authority from BIA to PHS and blessed Division of Indian Health participation on the condition that the resulting new hospitals would treat both Indians and non-Indians. Advocates praised the 1957 statute for improving access to health care, while skeptics complained that Hill-Burton would divert resources away from reservations. However interpreted, Hill-Burton funds made a noticeable impact. While the first new PHS Indian hospital (a 75-bed facility in Shiprock, New Mexico) would not open until May 21, 1960, before then, in 1957 alone, Hill-Burton funds enabled the Division of Indian Health to establish 77 new beds at 10 hospitals.

Digging wells and laying sewers. Access to construction funds also allowed PHS to fight the enteric diseases and high infant mortality rates linked to polluted drinking water and the lack of sanitary means to dispose of sewage. Reservation and village communities suffered terribly from water-related gastrointestinal and diarrheal diseases.

If there were few resources for health services, there were even fewer for sanitation. Since 1928 PHS sanitary engineers and sanitarians had consulted for BIA, inspecting Federal plumbing and water supplies. During the 1950s PHS began programs to finance construction of municipal water purification and sewage treatment plants in non-Native communities under the Federal Water Pollution Control Act of 1948 but was hard-pressed to secure adequate funds.

Rather than work through the Federal water pollution statute, Division of Indian Health officials started their own program. Passage of PL86-121 on July 31, 1959, gave PHS authority to proceed. PHS planned and helped finance new projects and relied on motivated tribal and village governments to come up with matching funds and the labor, or sweat equity, to build wells, water systems, and sewage treatment plants. In addition, PHS trained young Indian and Inuit men as sanitation aides; they were dispatched to communities to work as liaisons, public educators, and technical experts to keep completed projects well maintained.

Training and staffing. BIA's Health Division had been perpetually understaffed. During World War II, BIA tried to compensate for vacancies by training young Alaskans and Indians: as nurses' aides at Oklahoma's Kiowa School and the Mount Edgecumbe Medical Center in Alaska; as dental assistants and laboratory technicians at Mount Edgecumbe and at Riverside, California's Indian School; as sanitarian aides in Phoenix, Arizona; and as community health education aides, who received "on-the-job" training supervised by university contractors. Hundreds of BIA-trained graduates

A nurse holds up a chest X-ray film, used to screen for tuberculosis, while members of a Navajo family listen, circa 1940s.

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Group portrait of the 1946 graduating class of nurses' aides from the Kiowa Indian Hospital, Lawton, Oklahoma.

delivered health services and acted as translators between patients and Federal medical officials. After 1949, BIA also benefited from Selective Service rules that allowed male health professionals to fulfill their draft obligation as PHS officers, many of whom were assigned to the Indian Service.

After the transfer in 1954–1955, PHS redoubled BIA's efforts. PHS let dozens of contracts for service delivery, dispatched Commissioned Corps officers on contract to states and clinics, and hired across the health professions (particularly nurses and sanitarians). Recruiters emphasized the challenge, variety, and uniqueness of clinical practice in these settings. PHS also expanded the BIA school programs it had inherited, adding more training opportunities for dental assistants, sanitarian aides, and chemotherapy aides (who assisted in home-based therapy for tuberculosis).

Vocational training was a mixed blessing. Graduates provided vital services in a time of great need. For the ambitious, however, training to be an assistant or aide represented a poor alternative to a career as an autonomous health care professional or policy maker. While PHS's activities in the 1950s brought dramatic declines in mortality and morbidity from infectious disease, these activities included training to indoctrinate reservation and village residents in Anglo beliefs and practices about health and sanitation. Often graduates were expected to return to their home communities to spread the gospel of Western scientific practices, to convince their neighbors to set aside traditional practices in favor of maintaining programs begun under PHS's auspices.

On the Eve of Self-Determination

Five years after the transfer, PHS had made headway toward the goals spelled out in West, Raup, and Davis's final report to Congress, namely, increasing the numbers of buildings and beds, lowering morbidity and mortality rates, and improving sanitary conditions. In fact, during 1964, when some 777,200 people qualified for PHS services, American Indians and Alaska Natives comprised over half (383,000) of this number, with merchant seamen and Federal workers ranking second (234,200), and institutionalized beneficiaries third (160,000).

As these numbers suggest, PHS would not get out of the "hospital business" any time soon. Once Kennedy Administration officials decided to halt Federal termination activities, PHS's initial efforts became the foundation for something more permanent, an agency now known as the Indian Health Service. The tension between commitments to social uplift and to privatization and related questions about the Federal government's role would continue as a new generation of policy makers and their constituencies pushed for self-determination as a principle to guide the Federal "war on poverty." Could West, Raup, or Davis have imagined the future their initial efforts would sow? ■

For more about the antecedents and history of the Indian Health Service, see:

Abel EK, Reifel N. Interactions between public health nurses and clients on American Indian reservations during the 1930s. Social History Med 1996;9:89-108.

Kunitz SJ. Public health then and now: the history and politics of U.S. health care policy for American Indians and Alaskan Natives. Am J Public Health 1996;86: 1464-73.

Kunitz SJ, Levy JE. Dances with doctors: Navajo encounters with the Indian Health Service. In: Cunningham A, Andrews B, editors. Western medicine as contested knowledge. New York: Manchester University Press; 1997. p. 94-121.

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