Health Services for American Indians

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INDIANS in the United States present certain unique problems in the field of public health. Indians are not the only group in this country with excessive rates of death and disease, nor are they the only group in which cultural differences complicate the application of accepted methods of preventing and treating disease. Indians, however, traditionally have received health and medical services through the Federal Government. The Indian health program, formerly administered by the Bureau of Indian Affairs of the Department of the Interior, was transferred to the Public Health Service on July 1, 1955, so that the full technical resources of an agency devoted to improving health might be focused on Indian health problems.

What are the most urgent health needs of Indians? What special problems arise in attempts to meet those needs? The Public Health Service has just published the results of a 16-month survey dealing with these and related questions. The survey was limited to the health problems of Indians in the continental United States, although the Public Health Service has responsibility also for health services to Alaska natives. Two years ago a study of health problems among Alaska natives was made for the Department of the Interior by the University of Pittsburgh.

Federal health services for Indians began more than 150 years ago in attempts by the War Department to control smallpox among tribes in the vicinity of military forts. Following the transfer of the Bureau of Indian Affairs to the Interior Department in 1849, services gradually were extended and improved. As early as 1926 the Public Health Service detailed physicians from its commissioned corps to help the Bureau of Indian Affairs in administering health aspects of the Indian program.

By the 1950's such diseases as smallpox and trachoma had been largely eliminated on most of the approximately 250 reservations under Federal jurisdiction. Less progress had been made in controlling tuberculosis, diseases of early infancy, gastroenteric diseases, and certain other communicable diseases, while accidents were increasing at an alarming rate. The Government had succeeded only partially in implementing its policy of having Indians wherever possible receive care through agencies and authorities serving the general population.

What accounted for the continuing lag in Indian health? Lack of adequate health services appeared to share at least part of the blame. Under the Bureau of Indian Affairs, the Indian health program had never had enough qualified staff, well-equipped facilities, or funds to extend services to all Indians needing them. This applied particularly to preventive services.

A basic problem facing the Public Health Service when it took over the health program 2 years ago was lack of accurate and up-to-date information on Indian health needs and services available to meet those needs. In making its first appropriation to the Public Health Service for Indian health purposes, the House Committee on Appropriations provided an ad-

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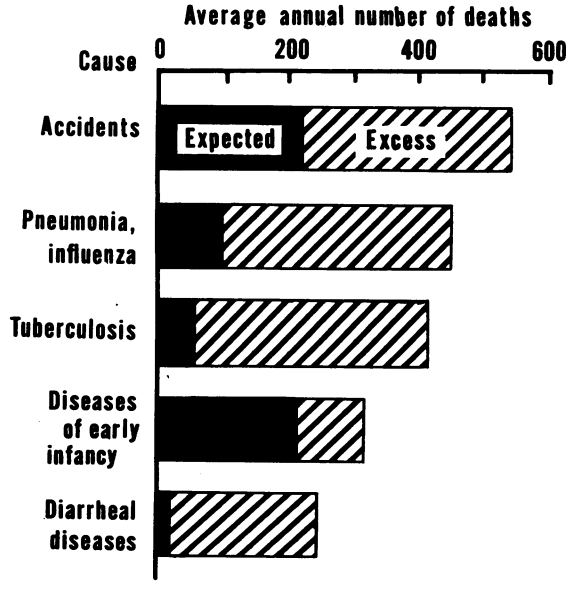
ditional $250,000 for "a careful comprehensive evaluation of the Indian health problem."

Method of Survey

The Division of Public Health Methods of the Office of the Surgeon General bore primary responsibility for organizing and carrying out the recent survey, with other units of the Public Health Service contributing staff and services. The study of economic and social resources was carried on under the general direction of a staff member of the Bureau of Indian Affairs detailed to the Public Health Service for this purpose.

Perhaps the most noteworthy means used for filling gaps in available information was the sample study of the populations of selected Indian reservations. On 9 reservations, chosen from 9 different States having substantial Indian populations, local Indian interviewers obtained information from each household on the reservation on extent of illness and receipt of medical care during the preceding year. On 5 of the 9 reservations, the interviews were followed by an intensive medical examination of a sample of the surveyed population. Indian

Indian deaths from selected causes, expected and actual: annual average 1949–53.



SOURCE: Data in support of this chart appear in the report, Health Services for American Indians, PHS Publication No. 531, 1957.

participation in both interview and clinical surveys was good, particularly in view of language difficulties, the geographically scattered nature of many Indian communities, and the Indians' general lack of familiarity with the types of questions and procedures in the survey.

Hospital and medical care services available through Public Health Service and contract facilities were studied both in the field and by means of questionnaires. Four special disease problems—tuberculosis, maternal and child health, mental health, and dental health—were singled out for special review by Public Health Service specialists and university consultants. Five universities or research institutions conducted field studies of social and economic resources available for Indian health purposes. Altogether 39 reservations in 16 States were visited in connection with one or more phases of the survey, while a statewide socioeconomic study was conducted in Oklahoma.

The Indian Population

According to estimates of the Bureau of Indian Affairs, Indians in the continental United States in 1955 numbered about 472,000. Of these about 280,000 lived on Federal Indian reservations. Although the total Indian population is not large relative to the total United States population, it is concentrated in certain States. Arizona's 66,800 Indians in 1950 constituted 9 percent of that State's inhabitants. Other States having a sizable proportion of Indians are New Mexico, South Dakota, Nevada, Montana, Oklahoma, North Dakota, and Wyoming.

Not all Indians in the United States live in areas served by the Public Health Service Indian health program. Of the total of 472,000, about 50,000 belong to tribes not under Federal jurisdiction. Another 85,000 or so live in places well removed from reservations or otherwise without ready access to Federal Indian health facilities. Public Health Service facilities actually are available to an estimated 335,000 Indians living on or near reservations.

For health and medical care purposes, the outstanding characteristics of the Indian population probably are its youth, its tendency to increase, and its cultural diversity. Half of

Indian Health Survey

At the request of the House Committee on Appropriations, the Public Health Service has made a comprehensive study of the health problems of the American Indian. This 16-month study was made by the Division of Public Health Methods, with the assistance and cooperation of the Division of Indian Health of the Bureau of Medical Services and a number of other offices of the Public Health Service. The Bureau of Indian Affairs also participated.

The report of the survey, Health Services for American Indians, is available from the Superintendent of Documents as Public Health Service Publication No. 531, 1957, 344 pp., $1.75.

the Indians in 1950 were under 20 years of age, compared with one-third for the general population, while the proportion in older age groups was considerably smaller than the United States average. The estimated Indian population has increased steadily since the late 19th century, its high death rates offset by still higher birth rates. Culturally, Indians range from isolated groups speaking their own languages and retaining many aboriginal customs, such as the Navajo, to groups scarcely distinguishable from their non-Indian neighbors, such as certain groups in Oklahoma.

Most Urgent Health Problems

Indians today have health problems resembling in many respects those of the general population of the Nation a generation ago. Although conditions vary widely among reservations in different parts of the country, the most urgent problems appear to be tuberculosis, certain other communicable diseases for which control measures are fairly well established, and accidents, which are recognized increasingly as a public health problem (see figure). These causes account for most of the excess deaths among Indians, that is, the excess of actual deaths over the deaths that would have occurred had each age group among the Indians had the average death rates for that age group in the United States. Together with obstetrical cases, the same causes also account for most of the patient-days in Indian hospitals.

Most of the health problems are especially acute among infants and children. In 1953, Indian children under 5 had a death rate more than double the national average. Their mortality rates for such diseases as tuberculosis, pneumonia and influenza, and gastroenteritis were proportionately much higher. Children under 15 in 1955 accounted for almost 40 percent of the patient-days in Indian hospitals; this contrasts with 12 percent for the same age group in all general and allied special hospitals in the United States.

The clinical examinations of this survey found a high prevalence of visual defects, ear diseases, and dental caries, as well as many cases of diarrheal disease, tuberculosis, and acute respiratory disease. Prevalence of visual defects was particularly striking. About three-quarters of those examined had defective vision, the proportion blind was very high, and there was ample evidence not only of old trachoma but also, on one reservation, of current, active trachoma.

Hazards of Reservation Environment

There can be no doubt that environmental conditions on Indian reservations tend to promote disease among Indians. Although conditions vary among reservations and within any single reservation, the typical Indian family lives in substandard and overcrowded housing. The number of families without a safe water supply or adequate means of waste disposal is very large. In many areas flies, rodents, and other vectors of disease are a serious public health problem.

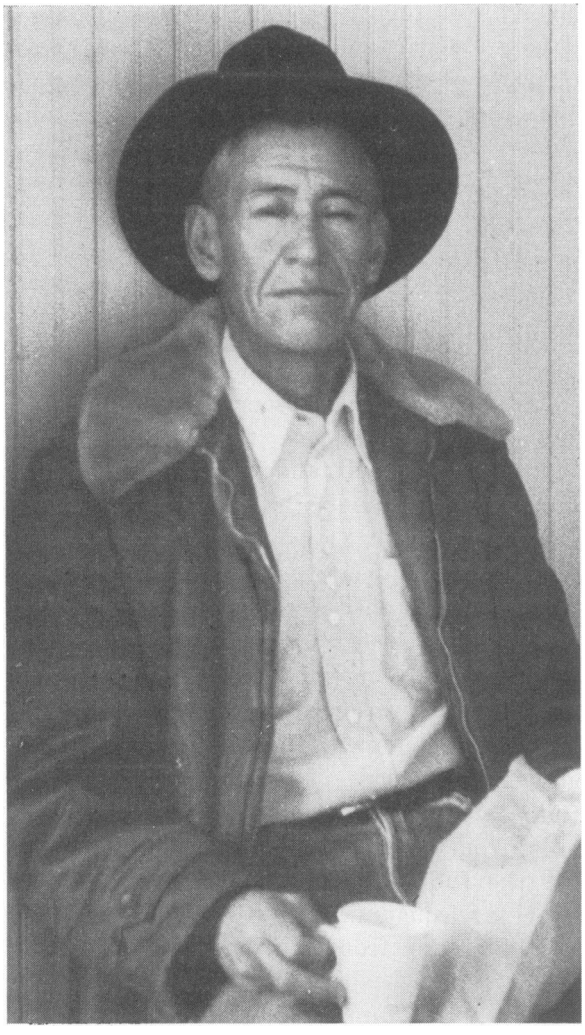
Insanitary living conditions are not the only hazard of reservation environment. Geographic isolation hampers efforts to extend health and medical services to sparsely settled areas that lack adequate roads or are located many miles from centers of population. In few areas has the Indian health program been able to provide adequate field health services for families living far from existing health facilities.

The Indian health program for many years has sought to improve sanitary conditions in Indian communities and to establish additional clinics or field stations in outlying districts of reservations. Recently developed use of Indian

sanitarian aides shows promise of helping to enlist local Indian cooperation in the elimination of certain sanitary hazards.

Poverty Among Indians

Findings of the social and economic surveys confirmed that the great majority of Indians living on reservations are poor and have limited opportunities for improving their economic status. Indians with larger incomes did not necessarily have more healthful standards of living. Apparently education, experience away from the reservation, or acculturation acquired in other ways played as much of a part in determining living standards as did dollar income. The clinical examinations of five selected reservations did suggest that medical need among persons in the lowest level was somewhat higher than among persons at higher economic levels.



Crow Indian receives hot coffee while waiting for his survey clinical examination. The outside temperature was well below zero.

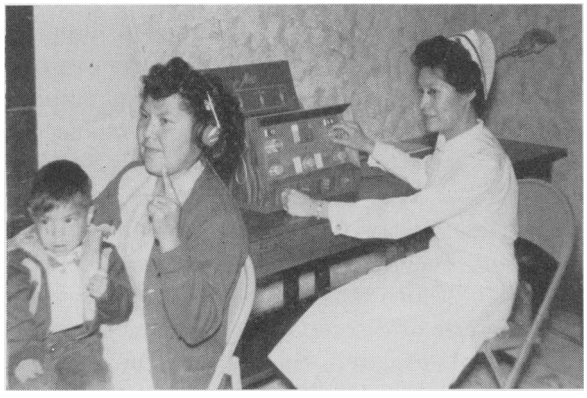
The fact that Indians are poor means that a large proportion of them cannot pay for medical care without depriving themselves of necessities of life; that is, they are "medically indigent." Medical indigency is not confined to Indians with the lowest money incomes. Some Indians have incomes that might be considered adequate to pay certain types of medical costs but which actually have been spent for other purposes when medical needs arise. In the case of medical care costs, many Indians still regard free medical care as a service to which they are entitled by right, regardless of their economic status.

Available information suggests that economic opportunities on reservations generally are becoming worse rather than better. As one means of reducing the imbalance between resources and population on the reservations, the Bureau of Indian Affairs in recent years has promoted voluntary relocation of Indians in communities away from the reservation where job opportunities are known to exist.

Problem of Staffing

Lack of adequate staff has plagued the Indian health program to varying degrees throughout its history. Supporters of the transfer of the program to the Public Health Service argued, among other things, that the health agency would be better able than the Bureau of Indian Affairs to recruit and retain competent employees. The total number of persons employed has increased since the transfer to the Public Health Service, but recruitment continues to be a problem.

What are the chief deterrents to employment in the Indian health program? Professional and social isolation appears to discourage many from accepting or keeping jobs in the service. This emphasizes the need for planned rotation of assignments in isolated areas, fewer lone assignments, greater access to professional literature and consultation, and more opportu-



Laguna Pueblo nurse tests the hearing of an Acoma mother at the survey clinical examination of Acoma Pueblo Indians in New Mexico.

nities to attend meetings with professional colleagues. Another deterrent is overcrowded and ill-equipped staff housing. The Public Health Service is attempting to provide for its employees on Indian reservations houses that are adequately heated, properly equipped, and big enough to meet normal living needs.

Can Indians themselves be trained to provide health services to their own people? Establishment in 1935 of the Kiowa (Oklahoma) School of Practical Nursing marked the start of a successful and still-expanding program to train Indian girls for auxiliary nursing work. The newer training program for Indian sanitarian aides represents another attempt to give Indians an active role in the provision of health services. The Indian health survey report notes the value of these training programs and favors extending them to include courses for dental assistants and medical technologists. Training of additional Indians for such professions as medicine, dentistry, and nursing may be possible in the future as greater numbers of young Indians complete the basic high school and college education requirements for these professions.

Use of Community Resources

Over the past half century, the Federal Government increasingly has arranged for Indians to receive needed services through resources available to the general population. This shift from direct to community services came earliest in the field of public education. It has occurred more gradually in the health field as communities in the vicinity of Indian reservations have developed public health and medical care services.

The extent to which Indians now receive services through community resources varies from area to area. On a growing number of reservations, the Indian health program has successfully arranged for hospital care in community hospitals, medical services by community physicians, and public health services under contract with local health authorities. Other Indian groups still are too far removed from outside communities to use community resources, have access only to limited community services, are refused care by the community, or will accept only Federal services.

Perhaps the greatest obstacle to widespread Indian use of community resources has been the fact that in so many areas Indian groups still lack access to community services adequate to meet their needs. In recent years, Federal grants under the Hospital Survey and Construction Act have helped to establish several small general hospitals near Indian reservations. One of the subjects singled out in the survey report as requiring further study was the possibility of adapting or supplementing

Crow nurse measures the height of a Crow boy at the survey clinical examination on the reservation in Montana.

existing Federal construction grant and loan programs to take special account of the health needs of communities having a large ratio of Indian population. In general, the Federal Government may be able to play an increased role in helping communities in the vicinity of Indian reservations to raise the level of their health and medical services.

An important distinction exists between use by Indians of community resources with the Federal Indian health program continuing to pay all or part of the costs of care, and such use with the costs paid by the Indians themselves or by some other non-Federal resource. An Indian may be willing to go to a contract hospital rather than to an Indian hospital, so long as the Government continues to pay the costs, but may object to receiving such care at his own expense. State or local health or welfare agencies may consent to furnishing preventive health or public medical services to Indians under contract with the Federal Government, but may be reluctant to provide such services out of State or local funds.

Federal and State Responsibilities

Precise distribution of responsibility for services to Indians between Federal and State or local governments has been a recurring problem in the Indian health program. The Federal Government for many years has provided health care to Indians in certain parts of the country. Indians as citizens of their respective jurisdictions also are entitled to receive available State and local services. The Indian health survey shows that the actual distribution of functions between the Public Health Service and State or local health and welfare authorities varies greatly from State to State.

Present Federal regulations on beneficiaries of Indian health services permit considerable local exercise of discretion in the determination of recipients of care. Such discretion is essential if the Public Health Service is to take account of variations in local circumstances such as size of local disease problem, prevalence of medical indigency, availability of alternative health services, degree of Indian acculturation, and other factors affecting the need for Federal care.

The survey identifies some of the questions that have arisen as the Public Health Service has attempted to form a workable concept of the scope of its responsibility for Indian health. Among these is that relating to the Federal responsibility for Indians who are eligible also for State and local services, particularly those financed in part by Federal grants-in-aid.

The Public Health Service in seeking to draw a clearer line between its obligations and those of the States and localities considers the policies pursued by the Bureau of Indian Affairs in the administration of other programs for Indians.

Research Training Program

Additional research training opportunity is available to outstanding students in 82 schools of medicine, dentistry, and osteopathy. The program is an extension of the research fellowship program administered by the PHS National Institutes of Health.

Established to increase the number of medical, dental, biological, and mental health researchers, the program will provide training to 140 undergraduate students during the first year. Outstanding students who have completed at least one academic year have been nominated by their deans. Each student will drop his regular courses during the research training, which starts in September 1957. Participants will receive tuition plus a stipend of not over $3,200 per year to be set by the school and an allowance of $350 per year for each dependent.