TurningPoint

Collaborating for a New Century in Public Health

Issues Affecting Public Health Delivery Systems in American Indian and Alaska Native Communities

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Purpose of the Report

This report is written for grantees of the Turning Point Program to provide general information about the health status, legal framework, organization and funding of the delivery of clinical and public health services in American Indian and Alaska Native communities.

Although great strides have been made in reducing the mortality and morbidity rates for American Indian and Alaska Native people (hereafter referred to as American Indian), significant gaps in health status between American Indian populations and the general population remain. This report will provide an overview of the health status indicators and risk factors affecting American Indian communities.

There is a unique relationship between Indian Tribes and the federal government. It is essential that those who will be working with tribes understand the major legislative history and laws that underlie health services to American Indian people. This report will provide a discussion of tribal sovereignty and the major legislation pertaining to Indian health.

The Indian Health Service (IHS) is the federal agency presently responsible for carrying out the health care responsibilities of the federal government. The roles and responsibilities of the IHS have continually evolved. This report will identify the major changes that have occurred and the consequences for the provision of health services in American Indian communities.

While the move to self-determination has greatly increased the involvement of American Indian people in planning, priority setting and fashioning delivery systems, it has also led to some fragmentation. This report will provide a discussion of the self-determination movement. Self-determination offers great hope for the future of Indian health. However, there may be some loss of capability from a regional standpoint that should be recognized, understood and addressed.

Urban Indian Programs do not command the same support as Tribal Programs. It is important to understand the differences both legislatively and programmatically between urban and tribal services. This report will provide information on the contrasts.

The financing of Indian health programs has changed in recent years. In the past, federal appropriations made up most of the funding. However, a significant proportion of the revenue now comes as a result of billing Medicare, Medicaid and private insurance. Federal appropriations make up an ever decreasing proportion of the funding. This report will discuss the resource shift and the consequences for Indian health programs.

As Turning Point grantees conduct their statewide strategic planning efforts, it is important that they reach out to American Indian communities and forge relationships and partnerships so that the public health needs of these communities are appropriately included in statewide plans. As states address the public health needs of their American Indian citizens, they might reflect on the words of the Director-General of the World Health Organization, Halfdan Mahler:

"Health is not a commodity that is given. It must be generated from within. Similarly, health action cannot and should not be an effort imposed from outside and foreign to the people; rather it must be a response of the community to the problems that the people in the community perceive, carried out in a way that is acceptable to them and properly supported by an adequate infrastructure."

Indian Health Status

The health status of American Indian people residing in IHS service areas has improved dramatically over the last thirty years. Better sanitation, immunization and better access to primary care are reflected in improved health status indicators. Since 1973, infant mortality has decreased by 54 percent, maternal mortality by 65 percent, pneumonia and influenza mortality by 50 percent, tuberculosis mortality by 74 percent and gastrointestinal mortality by 81 percent. American Indian life expectancy has increased by 12.2 years since 1973 but still lags behind the U.S. All Races rate by 2.6 years.

Despite closing the gap on some measures, American Indians have a poor overall health status compared to the general population. The leading cause of death for American Indians residing in the IHS service area (1991-1993) was diseases of the heart followed by malignant neoplasms (the same as for the total U.S. All Races population for 1992). However, the cause of death rankings differ by sex. For American Indian males, the top two causes of death were diseases of the heart and injuries. For American Indian females, the top two causes of death were diseases of the heart and malignant neoplasms. In comparison to the general population, the age-adjusted alcoholism death rate for American Indians was 465 percent greater, tuberculosis was 425 percent greater, injuries was 184 percent greater, diabetes mellitus was 166 percent greater, pneumonia and influenza was 51 percent greater, suicide was 46 percent greater and homicide was 39 percent greater. The prevalence of chronic disease such as diabetes, alcoholism, liver disease and HIV is a particular challenge for health service delivery and for prevention efforts.

Behavioral risk factor surveys show different prevalence rates in the American Indian population on a number of measures. Some of the important areas in which behavioral risk factors vary are nutrition, alcohol consumption, tobacco use, physical activity, injuries, teen pregnancy and dental care. These are all areas where the public health approach has the potential for the most impact. However, the approaches that will be successful in American Indian communities may not be the same as in non-Indian communities. Public health programs must relate appropriately to the cultural and linguistic needs of their intended audience. American Indian communities differ in culture and language as well as in the severity of their health problems.

While the above statistics provide an overview of American Indian health, it is important to recognize that there are significant regional variations within Indian country. For example, the prevalence of diabetes is a concern throughout Indian country, but the rates in the southwest are significantly higher than elsewhere, the rate among the Pima Indians being the highest in the world. Disease rates vary and lifestyle and risk factors vary. Each state needs to understand the health issues of their American Indian citizens.

The American Indian population is a younger population than the general population. The median age for American Indians in the reservation states was 22.6 compared to 30.0 for the general population in the 1990 census. Reservation populations generally have fewer educational and economic opportunities than the rest of U.S. society. Family incomes are lower, educational levels are lower, unemployment is higher and a higher percentage of American Indians live in poverty than any other minority group. Crowded living conditions, inadequate sewage disposal and unchlorinated water supplies are other problems contributing to poor health status. The geographic isolation of many reservations, and the small numbers of residents in some communities, have presented further challenges to providing adequate access to health care. Some rural American Indian communities lack 911 service, have poor roads and a limited emergency medical service.

In 1992 the Indian Health Care Improvement Act was amended to adjust the health status objectives for the year 2000 for the American Indian population. This was

a specific recognition that some of the objectives set for the general population could not be met for the American Indian population because the differences in current health status made them unattainable in the time frame.

As states address the public health concerns of American Indian communities, they need to examine the health statistics for the communities within their jurisdictions and understand the problems faced by their American Indian citizens. Working with American Indian communities, states may need to set specific health objectives that target critical health issues but build on the foundation already established.

Sovereignty

American Indians are citizens of their tribes and of the United States. They have a unique relationship with the federal government based on treaties signed between the United States and Indian tribes. The "treaty rights" give the federal government a "trust responsibility" that entitles American Indian people to participate in federal programs such as education and health care. Although all tribes were once sovereign nations, some never signed treaties with the United States and are not federally recognized by Congress. Others were disbanded during the 1950s when relocation and assimilation were federal policy. Others may be state recognized but not federally recognized. Only federally recognized tribes are eligible to participate in federal programs such as those provided by IHS. There is a substantial population of American Indians who are not members of federally recognized tribes.

The primary responsibility for administering governmental services lies with the IHS and the Bureau of Indian Affairs (BIA). Health care services were originally a responsibility of the War Department and then the BIA. In 1955 the responsibility for Indian health care was transferred to the Department of Health, Education and Welfare, now the Department of Health and Human Services (DHHS) and the IHS was set up as part of the Public Health Service. The 1990 census identified over 2 million people of American Indian heritage. Approximately 1.34 million of this group qualified for IHS and BIA services as federally recognized American Indians and Alaskan Natives. Most of these 1.34 million people live in the lower 48 states on reservations and in small rural communities.

In 1975, the Indian Self-Determination and Education Assistance Act (Public Law 93-638) was passed. This act, plus subsequent amendments, gives tribes the option of staffing and managing IHS programs in their communities. Since 1976, increasing numbers of American Indian governments have exercised their rights to operate a wide range of health programs.

As sovereign nations, tribes have sought to maintain the government to government relationship at the highest level, preferring in many cases to deal with the federal government through the IHS. Changing roles in health care, in particular, the devolution of responsibilities from the federal government to state governments in such areas as Medicaid, have meant that Indian nations have increasingly found themselves working with state governments. However, if public health concerns are to be addressed on a population-wide basis, particularly those relating to sanitation, environmental health, epidemiological surveillance and communicable disease control, relationships between Indian nations and state and local public health jurisdictions are vital. Since state health departments are often the conduit for receipt and distribution of funds rather than the provider of services, relationships need to be forged between tribal governments and local jurisdictions. Historically, many local government programs are overseen by governing boards composed of elected officials or district officials and participation by tribes has been limited to non-existent. Barriers to cooperation are found within the American Indian and the non-Indian communities. The non-Indian community may believe that the health issues of the Indian community are "taken care of" by the IHS. There may be a perception in the American Indian community that there is no point of access or communication with the local public health jurisdiction and that local officials do not respect the professionalism of their delivery systems.

As sovereign nations, Indian nations continue to be ruled by their own laws. So long as sovereign tribal rights are not voluntarily ceded by the tribes in other negotiations approved by Congress, or they are not extinguished by Congress, they continue in existence. Jurisdictional issues become complex. Most state laws do not extend to Indian country although some federal laws may give states certain powers regarding communicable disease. Reservations exist as jurisdictional islands within state boundaries. If jurisdictional issues and cooperative approaches are not developed, problems can arise with everything from surveillance and assessment, disease control and maintenance of sanitation systems to provision of emergency medical services, a critical issue to many American Indian communities given the long distances to hospitals and emergency centers. Laws relating to the licensing of health professionals and accreditation do not pertain to Indian reservations. If providers employed by tribal governments are not licensed in the state in which they practice, this can cause problems in

obtaining reimbursement. Attitudes of state licensing boards can vary. Some licensing boards do not consider the status of practitioners on reservations to be a matter of concern to them or may be reluctant to give a clear written ruling. In most cases, tribally operated programs and the IHS encourage and assist their practitioners to obtain local licensure. The push toward third party reimbursement and quality assurance considerations has also resulted in most facilities, whether operated by tribes, urban organizations or the IHS, seeking accreditation from an appropriate accreditation agency.

As states examine their public health infrastructure, they need to understand and respect the sovereign status of Indian tribes but also seek to address the public health needs of their American Indian citizens. They should examine their statutory definition of public health systems. Does that definition include tribal governments? States would be wise to examine jurisdictional issues and create forums in which to develop cooperative, complementary systems before problems arise. States have a responsibility to provide public health services to their American Indian citizens just as to their non-Indian citizens. Health status statistics of American Indian communities are included in statistics justifying allocation of funds. Accepting a responsibility for American Indians as citizens of a state, county, city or other local jurisdiction implies the need to develop methods to assure that the health of the tribe and its members are adequately protected. This means understanding how an American Indian community works and negotiating acceptable models for interaction. American Indian communities have both formal and informal governance structures and work on a consensus building form of governance. There are also community leaders who may not have any formal leadership position yet should be consulted and included in decision-making. Working with American Indian communities takes time, and decision-making may be slow and deliberative. But American Indian communities bring resources and expertise to the discussion of public health. Ultimately, all the citizens of a state will benefit when public health jurisdictions work with American Indian communities to develop infrastructure and systems that meet the needs of the entire community.

Indian Health Service

Federal health service delivery to American Indian people began in the nineteenth century. However, the federal trust responsibility for American Indian/Alaska Native health care is based on Article I, Section I, Section 8, of the United States Constitution, treaty obligations, laws, Supreme Court decisions, Executive Orders and the Snyder Act of 1921 (P.L. 83-568). The Snyder Act was a milestone in Indian health and for the first time authorized regular appropriations for health care. Another milestone was reached in 1954 when the Snyder Act was amended as the Transfer Act and the trust responsibility for Indian health was placed under the Surgeon General of the United States, removing it from the BIA. In 1955, the IHS was set up within the Public Health Service as the principal federal health provider for Indian people.

The initial goals of the IHS were to assemble competent health staff, establish adequate service delivery facilities, provide clinical services and develop preventive programs. It was a federally organized and staffed service designed around a hierarchical structure of a headquarters, area offices and service units. As was common in the 1950s and 1960s, the health system was organized around facilities—hospitals and clinics. However, the limited funding for the IHS (it was always the provider of last resort) together with the isolation of many Indian communities made it difficult to reach all Indian communities with IHS facilities, personnel and programs.

In the last twenty years, profound changes have occurred within the IHS system. In 1975, the Indian Self-Determination and Education Act was passed (P.L. 93-638). This Act was further amended in 1988, 1992 and 1994 and has given tribes the option of staffing and managing the IHS programs in their communities under Title I (self-determination contracts) or Title III (self-governance compacts). Another legislative milestone was the passage of the Indian Health Care Improvement Act in 1976 (P.L. 94-437) and its subsequent amendments. This act authorized higher resource levels within the IHS budget to increase the number of Indian health professionals, to expand health services, to build and renovate medical facilities and to construct safe drinking water and sanitary disposal facilities. Title V of the Indian Health Care Improvement Act established programs to improve health care access for Indian people living in urban areas. Title V programs have always been a small percent of the IHS budget and have been administered as contract programs—not direct delivery services. The Indian Health Care Improvement Act was important authorizing legislation but the appropriation of funds to adequately support all of its provisions has not been a reality.

The service delivery system established by IHS was focused on delivering services to American Indian people living on or near reservations. In fulfilling its trust responsibility toward American Indian people, IHS has developed a comprehensive service delivery system. The range of services includes preventive care, curative care, rehabilitative services and environmental services. Services are provided through IHS-operated facilities,

contracts with private sector providers, and more recently, through tribally-operated and urban Indian health programs. IHS has never had sufficient funds to develop, fund or provide access to a set of services comparable to those received through health plans traditionally provided as an employee benefit. The level of health services varies from reservation to reservation. Some reservations have health clinics and hospitals. Some have no health care providers and must purchase all of their care from the private sector. IHS funds a contract health service program (CHS) that is used to purchase care from private health care providers. Tribes with no direct care services use CHS to purchase all of their services. In other areas, CHS may be used to purchase specialty services and inpatient care. The distribution of funding is driven by such factors as population size, health status and isolation. In recent years, the IHS budget has failed to keep pace with medical cost inflation and population growth. Despite these financial realities, there is still a widespread belief in the non-Indian community that the IHS system adequately meets the health care needs of Indian people. There is little understanding that IHS has always been the payor of last resort looking to other programs such as Medicaid, Medicare or private insurance to pay for the care of American Indian patients.

The growth in self-determination contracts and self-governance compacts since the 1990s has resulted in greater autonomy, community involvement and direction of health care services by American Indian people. It has unleashed creative approaches to health care problems. However, it has also caused fragmentation of the IHS delivery system for clinical and public health services. Self-governance compacts involve the compacting tribe having the option of taking their tribal share of funds previously used by IHS for administration, technical assistance and coordination, epidemiology and surveillance at the service unit, area office and headquarters levels. IHS has therefore significantly downsized its administrative structure and reduced its role in technical assistance, coordination and planning. The funding for many functions previously handled at the service units or area office level has now been transferred to tribes.

IHS recognized the need for reorganization and in 1994 started a redesign process. IHS formed an Indian Health Design Team (IHDT) composed of Indian leaders and IHS staff. The IHDT took into consideration the external forces affecting health care practice (the move away from a facility based system, managed care, etc.) and the internal forces affecting IHS (the move toward contracting IHS programs to tribes and the government-wide mandate to decrease federal FTEs), and recommended a system that allowed for and supported local control and diversity. They recommended that instead of the hierarchical "top down" former approach of IHS, the new system be built around the concept of I/T/Us (an acronym that stands for local Indian health programs whether operated directly by IHS, or by a tribe or tribal organization or by an urban Indian health program). The I/T/U concept is intended to allow American Indian communities to take an active role in guiding change and allow local planning to address local conditions. Under the I/T/U concept, IHS is to change from being a controlling organization to empowering the front line and supporting local operations. It is intended that the potential downside of greater autonomy (loss of purchasing power, duplicative functions developed by small operating units) be overcome by networking systems among localities and by consolidating certain support functions hitherto provided by IHS in the hands of one or more of the I/T/Us with the expertise to conduct that function.

The changes envisioned by the IHDT are far reaching. Some have been implemented and many are being worked on. Operationalizing the I/T/U concept still has a long way to go. As of 1998, over one third of the IHS budget is contracted to tribes, tribal organizations and urban programs. It is possible that within the next two years over 50 percent will be contracted.

The significance of the changes within IHS to an agency or organization seeking information about Indian health, or seeking to form partnerships with Indian organizations, is that there are many more points of contact than in the past. IHS staff have been significantly reduced at the service unit, area office and headquarters levels; but the functions performed by each level have not always been clearly reduced to fit the downsized staff or clearly allocated between area offices and headquarters. There is a range of expertise on the part of the tribal organizations now operating the health services. Since contracting and compacting allows the tribes to negotiate to take over those programs that they wish to operate, some tribes have taken on public health responsibility and some have not. Data systems are more fragmented than in the past. IHS still operates the Resource and Patient Management System (RPMS) but not all I/T/Us participate in the system. Funding issues are causing problems in maintaining the RPMS system. The RPMS system is not a user-friendly system and does not necessarily meet the tribes' or urban programs' needs for planning, management and reporting. However, data is available from some tribal organizations and there may be considerable potential in combining data from multiple sources to obtain a more accurate picture of American Indian health.

Self-Determination and Self-Governance

The two vehicles by which a tribe may assume the responsibility for operating programs previously operated by IHS and/or the BIA are Title I and Title III of the Indian Self-Determination and Education Act (P.L. 93-638). Title I authorizes self-determination contracts and Title III authorizes self-governance compacts. Tribes may choose to take over all programs formerly operated by IHS/BIA or select certain programs for contracting/compacting. The process by which a tribe negotiates a Title I contract or a Title III compact is similar. First there is a planning process, then a budget/program negotiation process, and the end result is a formal agreement with a detailed annual funding agreement (AFA). The AFA specifies the specific programs, their funding levels and the amount included in the AFA for each service. Title III compacts may include 100 percent of the tribal share of programs/services hitherto operated by IHS at the service unit, area office and headquarters levels, except for funds identified for those functions designated as "residual" (i.e. functions that must be conducted by federal employees and cannot be compacted). The residual amounts and tribal shares are delineated by program.

Broadly speaking, Title I contracts allow tribes to take over the operation of services for their tribes formerly operated by IHS. Funds can be reprogrammed within certain limits without authorization from IHS, but the programs they contracted to provide must continue to be delivered. Title III compacts, on the other hand, give the tribes much greater control and flexibility. Funds can be reallocated and programs and services redesigned without federal approval. Furthermore, the Title III compacts involve the tribes not only receiving the funds previously allocated to operate services to their tribe, but also the tribal share of IHS activities and services that supported those services. Thus if a tribe takes over an MCH program, it is also entitled to its tribal share of MCH technical assistance that may be delivered from an area office or elsewhere.

While tribal shares increase the funds available to the tribe, they may also decimate the ability of IHS to deliver services that are best provided, or more cost-effectively provided, on a larger geographic basis. For example, epidemiological surveillance, research, evaluation and high level technical/professional expertise may be provided to a group of tribes but may be beyond the purchasing power of an individual tribe, even a larger tribe. Services such as third party billing may be difficult and expensive to provide on an individual tribal basis. The calculation of the "residual" funds that must remain within IHS so that it can perform the residual functions of federal officials is also a problem area. Some are concerned that the residual may have been set too low and impair the future functioning of IHS, even in its limited capacity, and impair the ability of IHS to continue service delivery to those tribes who have opted to remain within the IHS delivery system.

As tribes exercise their self-determination and self-governance rights, they may take over public health and clinical programs. They may have little experience in assessing public health issues. They may or may not have an infrastructure for public health assessment and management. They may or may not have access to specialized expertise in surveillance and management. As planning and delivery units are based on small populations, the ability to assess and address broader population concerns may be compromised. As in the non-Indian community, public health programs are often taken for granted until there is an epidemic or a problem. Funding of public health services tends to be overlooked in favor of the more visible services such as primary care or emergency medical services, which most people use or see themselves needing to use. In American Indian communities, where services are contracted or compacted, developing an understanding of public health and a decision-making system to support public health services will be key. There are likely to be challenges in maintaining public health funding when resources get tight.

Tribes that have compacted may have difficulty making their resources stretch over the programs when the IHS budget fails to keep pace with service delivery costs and population growth. On the other hand, compacting and contracting have often freed the tribe from the constraints of IHS and resulted in innovation and aggressive pursuit of other funding that has increased the resource pool. The Confederated Tribes of Warm Springs in Oregon have used tribal funds to build a new clinic and then leased the clinic back to IHS, thus overcoming the difficulties and long waits involved in IHS facility construction. The Confederated Tribes of Grand Ronde and the Coeur d'Alene Tribe have developed community health facilities designed for use by the local communities, both Indian and non-Indian. Such community health facilities then draw revenue from third party reimbursements, IHS and other community funds.

The extent of contracting and compacting varies across the country. State officials interested in working with American Indian communities need to determine which tribes have contracts and compacts and for which services to get a picture of public health delivery in their area.

Health Boards

In the 1970s, IHS organized health boards in the 12 IHS regions. The health boards were originally designed to be advisory boards for IHS. The board staff evaluate Indian health policy and legislation, identify unmet health needs and advise and work with the IHS area and the tribes to meet those needs. The boards provide a channel for input from the tribes to their area office.

Over the years the health boards have evolved. They may function as consortia, in most cases representing all of the federally recognized tribes served by the IHS area office. The boards continue to provide the advisory and advocacy functions originally envisioned but also have taken on technical assistance roles. Some boards have been actively promoting and organizing regular meetings with state officials to discuss and resolve the jurisdictional, planning and delivery issues with states. Some boards have developed services using grant funds and IHS funds. For example, the Northwest Portland Area Indian Health Board has a health statistics project, an HIV/STD prevention project, a tribal tobacco policy project, a Hanford tribal service project and one of four new epidemiology centers funded through IHS. The Northwest Portland Area Indian Health Board is using diabetes project funding to develop the infrastructure to accurately identify diabetes diagnoses and to get a complete picture of diabetes in American Indian communities. They are aggressively working on data systems attempting to obtain data on American Indian people from other databases.

There may also be service unit health boards and tribal health boards that have roles in determining health policy and management. States will need to identify the structures in their areas. Boards at all levels vary in their functions and effectiveness around the country. However, they are a source of information and contact with Indian tribes. Any state agency wishing to work with Indian tribes would be wise to contact the relevant health boards in their jurisdiction.

Urban Programs

Over half of the American Indian population does not live on reservations but lives in urban areas. This is partly because of a deliberate policy of relocation from reservations during the 1950s and 1960s and partly because the limited opportunities for employment on reservations resulted in a migration to urban areas. Once away from the reservation, members of federally recognized tribes are too far away to use IHS facilities and may not be eligible for CHS. However, many urban Indians lack adequate access to health care. A third of American Indian families live below the poverty level, 50 percent of the households with female heads live under the poverty level, and the same health problems noted in reservation populations are also present in urban Indian populations.

In the 1970s, a number of urban Indian health programs were developed by Indian communities responding to access problems in their area. It was not until 1976 and the Indian Health Care Improvement Act that any IHS funds were available to support these activities. Today IHS contracts with 34 urban Indian organizations throughout the United States to provide health services and referral services to urban Indians. The FY1998 IHS budget stated that the urban Indian health programs included 14 Federally Qualified Health Centers: about two thirds of which provided access to primary health care services and all of which provided community and behavioral health services. There were also 10 residential alcohol treatment centers. Despite the needs of urban Indians, IHS urban Indian health program funding constitutes approximately 1 percent of the total IHS budget.

Urban Indian health programs have developed many effective models of reaching their community members and providing preventive, educational and clinical services. They constitute a valuable resource for states wishing to ensure that all of their citizens are reached by public health services. The jurisdictional issues noted previously do not apply to urban Indian health programs. States and local public health jurisdictions could enhance their effectiveness if they negotiate formal linkages and support systems with urban Indian health programs.

Financing

Financing for Indian health programs consists of two major mechanisms: congressional appropriations for IHS and programs for which individual Indians may be eligible as citizens, such as Medicaid, Medicare and other third party insurance. Funds may also be available from grants from other sectors of the federal government, from private foundations and from other sources.

The congressional appropriations for Indian health are distributed through IHS. However, IHS is not an entitlement program or an insurance program and has no established benefit package. Appropriations have generally fallen far short of the need. Dr. Trujillo, Director of the IHS, estimates that the FY 1995 per capita health care expenditure for American Indian people was $1,153 as compared to the U.S. non-Indian civilian per capita expenditure of $2,912. IHS has dealt with the limited funding by restricting the services available, by using medical priorities, by establishing waiting lists (especially in the CHS program) and by pursuing extensive coordination of benefits and third party reimbursement.

Obtaining reimbursement from third party payors has become a major source of revenue for Indian clinics and

hospitals. Some facilities may be depending on these revenue sources for up to one third of their budgets. As managed care has developed among private payors and more recently, through state Medicaid programs and Medicare risk contracts, it has become more difficult for Indian programs to participate and obtain appropriate reimbursement arrangements. States moving their Medicaid programs to managed care have had to recognize the necessity of working out reimbursement issues with Indian programs as federally funded entities. However, Indian facilities and providers may have difficulty meeting the requirements of managed health plans for risk sharing, licensure, credentialing, reporting and 24 hour coverage. Indian programs may find themselves providing services to Indian people who are enrolled in a managed care program yet use Indian programs for care because they are more comfortable with a culturally competent delivery system. Obtaining reimbursement for such services may be extremely difficult. Moves to managed care in mental health systems have been particularly troublesome for Indian programs trying to make sure that their patients have access to services and that funding is available for continued support of their own delivery systems.

State public health officials may not be directly involved with Medicaid and other third party reimbursement issues but they should be aware of them. Policy changes may have unintended effects on Indian health programs. There may be advocacy or intermediary functions that state public health officials could provide to resolve problems. Public health officials should also be concerned that if funds for clinical services are diminished, it may well put pressure on re-deploying funds which hitherto have supported public health services.

The Range of Services Delivered to Indian Communities

The range of services funded through IHS is comprehensive. It can be summarized as follows:

Clinical services: hospital and clinic services, pharmacy and lab services, emergency medical services, dental services, alcohol and substance abuse services, mental health and contract health services.

Preventive health services: public health nursing, health education, community health representatives, nutrition and school based programs.

Environmental health and engineering: maintenance and improvement of sanitation and water systems, food protection, occupational health and safety, injury prevention and pollution control.

Special health concerns/initiatives: MCH, otitis media, AIDS and diabetes.

Support services: tribal management, self-governance, urban health, Indian health professional recruitment, training and retention and health care database management system.

The above groupings are somewhat arbitrary. Many services could be mentioned under several categories. For example, the nutrition program involves prevention but is integrated into treatment and rehabilitation.

Services may be delivered by the tribe or by IHS. In many self-determination and self-governance tribes, the tribe will operate certain services and leave others to be provided by IHS. The annual funding agreement delineates what the tribe is responsible for. The resource limitations of IHS, together with economic and logistical constraints and the small populations of many tribes, means that usually only a subset of the above listed services is provided on any given reservation. States and local public health jurisdictions will have to work directly with the tribes to determine what services are actually available to a given community.

Areas for Action

States wishing to work with American Indian communities to develop strategic plans and resolve some of the public health issues might consider the following courses of action:

- Set up a forum to meet with tribes and Indian organizations on a regular basis at the state level. The forum could be a place to bring and discuss issues (jurisdictional, service delivery responsibilities, surveillance, etc.) but also to determine a path for resolution of problems. Out of this forum, a state could set up a joint health planning committee to develop statewide strategic plans with intervention strategies.
- Meet with Indian tribes and urban Indian health programs. Listen and learn about their public health concerns, priorities and successes. Encourage and support the establishment and continuation of working relationships with local public health jurisdictions.
- Examine service delivery and prevention models developed by Indian programs. There are some unique and effective approaches that may be applicable in other arenas.
- Work collaboratively to improve the availability and accuracy of American Indian data. Look for ways to link data from different systems to correct errors and provide more complete data sets.
- Establish working relationships/partnerships with Indian epidemiology centers throughout the country. Coordinate surveillance systems (STDs, AIDS, HIV etc) and develop joint special interest morbidity and mortality reports.
- Establish partnerships and collaborative teams that can compete for funds to target special initiatives or inter-

ventions focused on Indian people. Partnerships that involve states, tribes, urban programs, university schools of public health or clinical schools can be effective in garnering resources from a variety of sources.
- Work together to assess and strengthen core public health capacity and develop standards. Provide resources and technical assistance to support the Indian health system in accordance with its needs.
- Develop partnerships for service delivery. Look at opportunities in rural areas to develop joint systems with IHS and tribes that serve the Indian and non-Indian populations.
- Identify any jurisdictional accreditation, licensure and payment barriers and facilitate a mutually acceptable resolution between the regulatory authority and the tribes.

There is great variation among states. Some states have many of the above steps in place. There is information to be shared as states move to improve their public health planning for the benefit of all of their citizens.

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7900 South "J" Stock Road
Tucson, AZ 85746-9352
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California Area IHS
1825 Bell Street
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Oklahoma City Area IHS
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Portland Area IHS
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