Indian Health Service

AN AGENCY PROFILE

Health Care Provider & Advocate for Indian People

The Indian Health Service (IHS), an HHS agency, is responsible for providing health services to federally recognized American Indian and Alaska Native tribal governments. The provision of health services to American Indians and Alaska Natives is based on treaties, judicial determinations, and acts of Congress which result in a unique government-to-government relationship between tribes and the Federal Government. The IHS is the principal federal health care provider and advocate for Indian people. Its mission, goal, and foundation are:

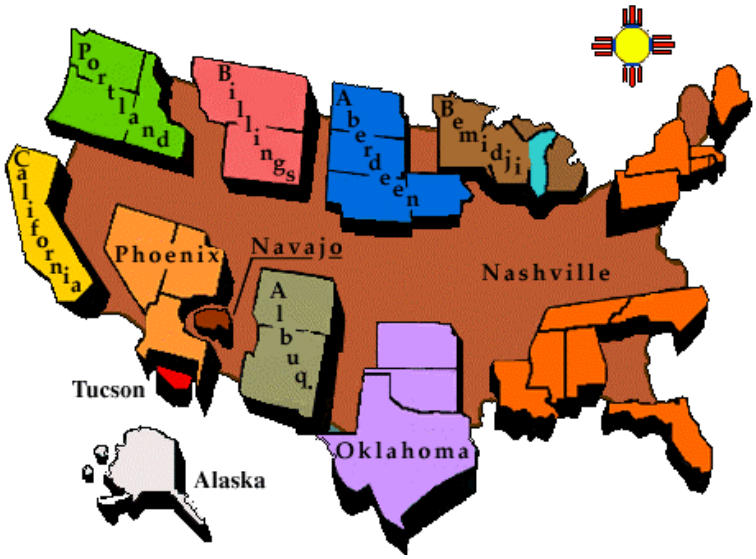
Mission— improve health of Indian people

The mission *of the Indian Health Service, in partnership with American Indians and Alaska Natives, is to raise their physical, mental, social, and spiritual health to the highest possible level.*

The goal *is to assure that comprehensive, culturally acceptable, personal and public health services are available and accessible to American Indians and Alaska Natives.*

The foundation *is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Natives, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.*

The IHS is the primary source of health services for 55% of the estimated 2.4 million Indian people. The majority of Indian people served by IHS live on or near reservations in some of the most remote and poverty stricken areas of the country where other sources of health care are less available. For many, the IHS is the only source of care. Urban Indian health programs provide limited services to more than 150,000 Indians living in 34 cities.



IHS is organized as 12 Areas operating over 500 facilities located in 35 States

A Comprehensive Network in 35 States

The IHS is organized as 12 "area offices" which are located throughout the United States. Within the 12 regions are 550 health care delivery facilities, including 49 hospitals, 214 health centers, and 280 health stations, satellite clinics, and Alaska village clinics operated by the IHS and tribes. The system delivers comprehensive personal and public health services including over 80,000 hospital admissions and almost 7 million ambulatory medical care visits per year. In addition, dental services, nutrition, community health, sanitation facilities (water supply and waste disposal), injury prevention, and institutional environmental services are provided.

The IHS budget in FY 2001 is $2.6 billion. Approximately 82% is for personal health care services to individuals and 18% is for facility construction, sanitation, and public health activities in Indian communities. The IHS is authorized to recover costs of services it provides to Indians with private insurance, Medicare, or Medicaid coverage. Supplemental collections for FY 2001 are expected to exceed $450 million.

Government-to-Government Relations with Sovereign Nations

The IHS was transferred from the Department of the Interior/Bureau of Indian Affairs to the HHS in 1955. This transfer started the HHS relationship with tribal nations that is based on tribal sovereignty and a government-to-government relationship. Sovereignty means that tribes can govern their own territory and internal affairs. Only Congress can override an Indian nation's authority. The Government-to-government relationship is a Federal policy about how the U.S. interacts with tribes. Because of this relationship, the U.S. must consult with tribes about how Federal actions may affect tribes. Both the HHS and the IHS have consultation policies for tribal consultation. The HHS was the first Federal Department to implement a tribal consultation policy.

Tribes often redesign health programs incorporating traditional cultural values.

Sovereignty gives tribes a self-governing status. Self-determination and self-governance have important meaning to tribes and effect how their health services are delivered. Public Law 93-638, the Indian Self-Determination and Education Assistance Act, as amended, provides that tribes can redesign their health programs if they choose to compact and/or contract under provisions of the Act. This authority provides that IHS will transfer its resources to tribes so that they can administer their own health programs if they decide to do so. Almost 44 percent of the Agency's $2.6 billion budget is transferred to tribes through tribal shares. The Agency retains the remaining tribal shares and delivers health services directly to the tribes that do not choose to administer their own programs.

Almost one half of IHS programs and budget is now operated by tribal governments.

In addition to tribal shares to operate programs that were formally the responsibility of the Federal Government, tribes also receive contract support costs (CSC). P.L. 93-638 authorizes Federal agencies to provide funds for CSC to tribes to pay for costs not included in the program amount. CSC appropriations were sufficient to pay 94% of CSC in FY 2000. In FY 2001, the Congress increased CSC appropriations to $248 million. The amount of any shortfall in FY 2001 is unknown at this time. However, tribes contend that they should receive 100% of their CSC need and any shortfall continues to be a topic of concern to tribes and the IHS.

Changing Disease Patterns and Troubling Disparities

The health status of Indian people has improved steadily since 1955. The improvement was mainly due to increased access to health services and public health measures which decreased morbidity and mortality from infectious disease. Unfortunately, health gains among Indians have slowed or ceased altogether in recent years as disease patterns have changed. Injuries, chronic diseases, and behavioral related diseases have emerged as new challenges.

The new diseases patterns are strongly associated with adverse consequences from poverty and cultural dislocation. Inadequate education, high rates of unemployment, discrimination, and cultural differences all contribute to unhealthy lifestyles and disparities in access to health care. Illness and death rate disparities for American Indians and Alaska Natives have emerged for alcoholism, diabetes, tuberculosis, heart disease, unintentional injury, homicide, suicide, pneumonia, and influenza.

In view of the troubling health disparities, the national goal to eliminate racial and ethnic disparities in health is especially important to Indian people. IHS is assisting tribes to develop local approaches to their health issues. Addressing today's health problems cannot be expected to yield quick results. The most serious health problems are long-term, intractable issues that will be greatly affected by social-economic conditions in Indian communities and the limited resources available to the Indian health system.

The Indian health care system continues to face enormous challenges in the decade ahead. Despite the collaborative relationships and partnerships that have been established, current resources will not meet the needs of a population that is increasing by 2% each year and facing emerging health problems. Prevention and treatment of chronic health problems requires long-term interventions that may not show measurable results for several years. Current funding of IHS is approximately $2.6 billion. For Indian people receiving Indian health system services this translates to health care funding at approximately 60% of the level enjoyed by people in mainstream health plans. Policymakers and Indian people are concerned about the health care funding deficiencies for Indian people.

Diabetes alone could overwhelm the system as some Indian communities struggle with 40-50% prevalence rates

American Indians have long experienced disproportionate health problems compared to other Americans. The disparity also applies to health care resources. A recent study found that IHS funding fell 40% short of the cost to assure a mainstream health plan for 1.4 million users. The resource gap severely restricts health care services and is one root cause of the failure to eliminate unacceptable rates of death and disease among Indians.

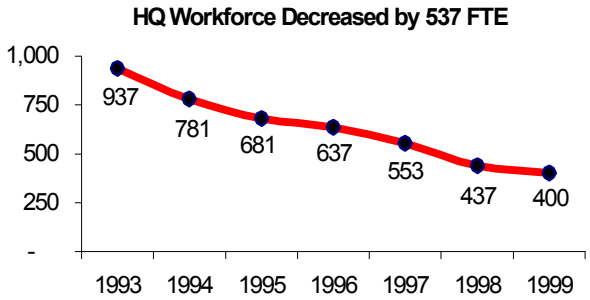
Relationships with the Congress

The IHS received its authority as the primary Federal provider of and advocate for the health of Indian people from the Indian Health Care Improvement Act (P.L. 94-437). This law is considered to be the cornerstone of Indian health care because it authorizes specific programs and activities to promote the health status of Indian people to the highest level possible. This authority builds upon the Snyder Act of 1921, which is the basic and first legislative authority for Congress to appropriate funds specifically for health care provided by the IHS.

One unique characteristic is the Agency's relationships with its congressional committees of jurisdiction. The IHS budget is appropriated through the Appropriations Committee for Interior and Related Agencies; not by committees of jurisdiction for HHS. The Committee on Indian Affairs is a key committee in the Senate. In the House, the Committee on Resources, the Committee on Commerce, and the Committee on Health and Environment have jurisdiction on various Indian health matters. The House Diabetes Caucus and the House Native American Caucus are

Reorganization and Accountability

The IHS employs more than 14,500 personnel of which 87% provide services at the local level. The Agency continues to decentralize control and expand opportunities for consultation and collaboration with local stakeholders in setting priorities and significant policies. In a major redesign, IHS administrative support systems were reorganized using designs from a stakeholder team of Indian health leaders. As a result of the reorganization, the administrative workforce at IHS Headquarters and Area Offices has been reduced by more than 50%. Even though the administrative workforce was reduced, efforts were made to protect critical oversight positions to insure and improve accountability. These efforts have allowed the Agency to implement new technologies and demonstrate a continued improvement in financial systems. Presently, IHS is in substantial compliance with applicable Federal accounting standards and is increasing capacity in procurement, manpower administration, and inventory management. These administrative controls provide assurance that assets are protected, transactions are properly executed and recorded, and policies are followed.

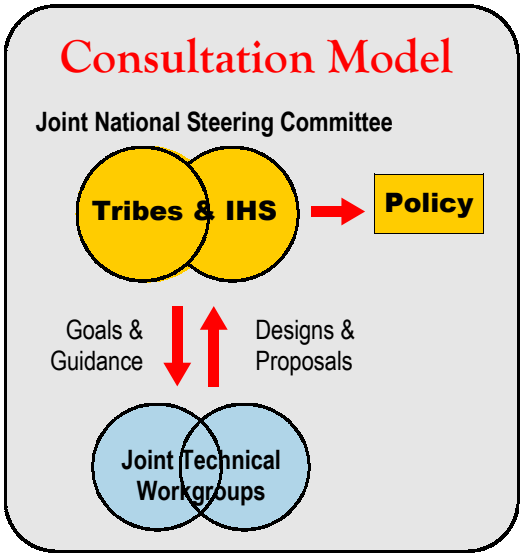


Relationships with Tribal Stakeholders

The IHS' relationship with its stakeholders is unique. As dependent, domestic nations, tribes entered into treaties with the United States. Current U.S. service obligations to Indian nations are traced to the treaties signed between tribal governments and the United States. These binding agreements between governments were usually made to gain rights to Indian lands in exchange for, among other things, services and self-governing rights to tribes. It is on this foundation that the IHS conducts relationships with 557 tribal governments.

Sovereignty and the right to self-determination, tribal leaders say, are the most important legal principles and rights that tribal nations possess.

Members of more than 557 federally recognized American Indian and Alaska Native tribes and their descendants are eligible for services provided by the IHS. The services are in addition to programs and services Indian people are entitled to as U.S. citizens. Unlike any other population group in the United States, American Indian and Alaska Natives also have treaty rights, they are not "just another minority group" as many assume them to be.



In addition to direct relationships with elected leaders of tribal governments, several national tribal organizations offer testimony on Indian health issues to the Congress and provide direct input to HHS and IHS policy making.

- *National Congress of American Indians*
- *National Indian Health Board*
- *Tribal Self-Governance Advisory Committee*
- *Tribal Leaders Diabetes Committee*
- *Urban Indian Health Board*
- *National Indian Council on Aging*

IHS and tribal leaders have developed a consultation model that includes from the very beginning tribal stakeholders in policy matters that might affect Indian health. The consultation model does not replace direct relationships with tribal governments, but does provide a vehicle for articulating the aggregate views provided from Indian country.

Sanitation Facilities and Health Care Facilities

Another unique characteristic is IHS' responsibility to provide water supply and waste disposal—forms of municipal infrastructure that are virtually non-existent in remote areas of Indian country. IHS has supplied clean water and waste disposal to more than 230,000 (92%) Indian homes. It is a remarkable disease prevention success story that the death rate from gastrointestinal disease among Indians has declined by 91% as a result of installing basic sanitation facilities and improved access to primary health care. However, over 20,000 (7.5%) Indian homes still lack safe water in the home.

Improving access has also meant constructing health care facilities on remote reservations. Many Indian communities are located in isolated areas where inhospitable climate, impassable roads, and populations spread over many miles create major challenges. Often, IHS is the only source of health care. While some Indian communities have modern IHS hospitals and ambulatory facilities, the average age of IHS facilities is 32 years, with some older than 60 years. Over one-third need replacement to increase clinic space and many need substantial modernization. It is difficult to properly support current medical practices in older facilities that were built before the modern emphasis on ambulatory care.

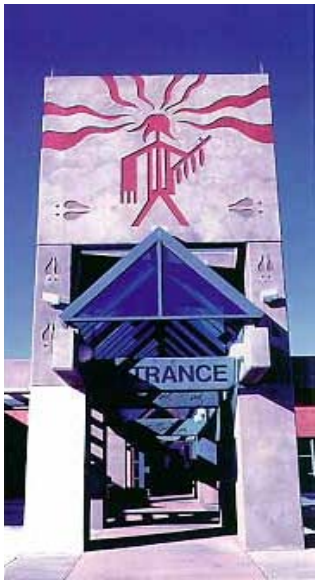
Community Water Supply Project

Health Issues from Tribal Leaders

Tribal leaders consistently express concern about the following Indian health issues:

Health and Funding Disparities — Disproportionately high mortality rates among Indians and a large gap in health care resources are unacceptable to tribal leaders – especially in view of the national goal to eliminate racial disparities and the unique obligations to the first Americans. Tribal leaders cite diabetes, unintentional injuries, and alcoholism and substance abuse as rising to crisis proportions in Indian communities. They say Indian health resources are completely inadequate to deal with the enormous needs—a claim consistent with a recent actuarial study that found IHS funding at 60% compared to mainstream health plans such as the Federal Employees Health Benefit Plan.

Contract Health Services Funding — Rising health care costs and steadily mounting patient needs have resulted in severe funding shortages to pay for critical services not available within the Indian health system. Recurring shortages of CHS funds have resulted in referrals for only the most urgent and emergent cases. Needed services are denied or delayed for thousands of patients due to lack of funding.



Resource Equity (Indian Health Care Improvement Fund) — Tribal leaders cite funding variations within the Indian health system as making the resource gap even worse for many Indian communities. More than one-half the IHS system has less than 60% of funding required for a mainstream health plan. Tribal leaders are troubled by both the funding gap with other Americans and the resource inequities within the Indian health system. Tribal views on a resource allocation formula to reduce resource inequities remains unsettled. Tribes will continue to seek substantial budget increases to close the funding gap and address resource inequity.

Contract Support Costs Funding — Most tribes take the position that existing law requires the Federal Government to pay 100% of tribal contract support costs (CSC) for direct and indirect costs of operating the health program under contract or compact. However, CSC appropriations are only 94% of estimated costs.

Eligibility Issues and Limitations — Because of limited funding, some tribes have sought to limit provision of health care services only to enrolled members of their tribe. Tribes emphasize that this is a sovereignty issue as they have the right to choose who they serve. It is also a funding issue because IHS budget allowances within the Indian health system are not tied to membership in specific tribes. Long standing regulations require IHS funded health care programs to serve any eligible Indian for which care is medically necessary without regard to specific tribal membership.

Reauthorization of the Indian Health Care Improvement Act (IHCIA) — The current authority of the IHCIA expired on September 30th, 2000. The IHS consulted with Indian health leaders on what amendments and additional authorities were needed. This consultation effort resulted in a legislative draft. The House Committee on Resources and the Senate Committee on Indian Affairs both introduced legislation based on the draft. Both bills contain provisions that would establish a congressional commission to study the feasibility of creating an entitlement for health care to Indian people.

Crosscutting Issues Involving HHS — There are several Department-wide cross-cutting issues that need attention.

- Consultation by all HHS agencies with tribes
- Focus on eliminating health disparities for Indians by all HHS agencies
- Strengthen partnerships among tribes, IHS, and other HHS agencies
- Access to and improvement of health data systems for Indian people
- Quality of work life for Federal employees

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Organizational Chart

DEPARTMENT OF HEALTH HUMAN SERVICES

INDIAN HEALTH SERVICE

- DIRECTOR
- DEPUTY DIRECTOR
  - Office of Tribal Self-Governance
  - Office of Tribal Programs
  - Office of Urban Programs
  - Public Affairs
  - Legislative Affairs
  - EEO and Civil Rights Staff
  - Headquarters Operations
    - Office of Management Support
    - Office of Public Health
  - Regional Operations
    - Aberdeen Area Office
    - Alaska Area Office
    - Albuquerque Area Office
    - Bemidji Area Office
    - Billings Area Office
    - California Area Office
    - Nashville Area Office
    - Navajo Area Office
    - Oklahoma Area Office
    - Phoenix Area Office
    - Portland Area Office
    - Tucson Area Office