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"An Overview of Indian Health"

by

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Good afternoon. It certainly is an honor and a pleasure to be here today to speak to all of you about the Indian Health Service (IHS) and the future of Indian health. And of course to be back in my wonderful home state of Oklahoma.

Let me begin by giving some background information on the IHS, and the Indian health care system, for those of you who may not be familiar with us. The IHS is an agency within the Department of Health and Human Services and is the primary Federal agency responsible for carrying out the treaty obligations of the U.S. Government to provide health care services, in partnership with Tribes, Tribal organizations, and Urban Indian programs, to approximately 1.4 million American Indians and Alaska Natives. Oklahoma has the highest user population of all the IHS Areas.

The 1.4 million users of the Indian health system are members of more than 560 federally recognized Tribes, representing a wide diversity of people and cultures. The IHS is committed to its mission, in partnership with American Indian and Alaska Native people, to raise their physical, mental, social, and spiritual health to the highest level. The goal of the IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population.

The Indian health care system consists of 12 regional (or Area) offices and 157 Service Units, which administer health care services through a system of 48 hospitals, 238 health centers, 167 health stations, 180 Alaska village clinics, and 34 urban projects. The location of these facilities range from remote rural locations to heavily populated urban areas, although most are in rural reservation communities in 35 states, mostly in the Western United States and Alaska.

Health services are provided either directly by the IHS or through tribally contracted and operated health programs, as well as through services purchased from private providers. The IHS directly provides services at 33 hospitals, 59 health centers, and 50 health stations. In addition, the IHS supports 34 Urban Indian health programs that provide a variety of health and referral services.

This text is the basis of Dr. Grim's oral remarks at the University of Oklahoma Grand Rounds on June 2, 2005. It should be used with the understanding that some material may have been added or omitted during presentation.

Through Public Law (P.L.) 93-638 Self-Determination contracts and Self-Governance compacts, Tribes and Alaska Native corporations administer 15 hospitals, 179 health centers, 117 health stations, and 180 Alaska village clinics.

All 33 IHS-operated hospitals and all 15 of the tribally operated hospitals are accredited by the Joint Commission on Accreditation of Health Care Organizations. In 2003, there were almost 9 million outpatient visits at IHS and Tribal health facilities.

The IHS strives for maximum Tribal involvement in meeting the needs of its service population, a goal backed by legislative history. Federally recognized American Indian Tribes and Alaska Native Corporations have a unique government-to-government relationship with the United States that has been reinforced through numerous treaties, Supreme Court decisions, legislation, Executive Orders, and the U.S Constitution.

The principal legislation authorizing Federal funds for health services to recognized Indian Tribes is the Snyder Act of 1921. It authorized funds "for the relief of distress and conservation of health . . . [and] for the employment of . . . physicians . . . for Indian Tribes throughout the United States."

Congress passed the Indian Self-Determination and Education Assistance Act (P.L. 93-638, as amended) to provide Tribes the option of assuming from the IHS the administration and operation of health services and programs in their communities, or remaining within the IHS-administered direct health system. Congress subsequently passed the Indian Health Care Improvement Act (P.L. 94-437), which is a health-specific law that supports the options of P.L. 93-638.

The goals of P.L. 94-437 are to provide the quantity and quality of health services necessary to elevate the health status of American Indians and Alaska Natives to the highest level possible and to encourage the maximum participation of Tribes in the planning and management of those services.

The IHS is strongly committed to the concepts of Tribal Self-Governance and Self-Determination, as upheld by Federal law. Self-Governance promotes a partnership between Indian Tribes and the United States based on mutual respect and input into the government-to-government relationship.

How to exercise the rights of Self-Governance and Self-Determination is ultimately the choice of each Tribal Government. Each Tribal Government determines its relationship with the United States and the IHS; a relationship that may include either direct Federal service delivery, Self-Determination contracts, Self-Governance compacts, or some combination of these options.

Whatever decision is made regarding the delivery of health services, the ability of Tribal Governments to determine their own destiny, their own future, creates a more meaningful government-to-government relationship between Tribes and the United States.

Tribal Self-Governance and Self-Determination are not only concepts that we embrace in the abstract; they are concepts that have practical applications in health care management and delivery. To put it briefly, Self-Governance WORKS. It works because it is based on a principle that all of us who work in Indian health are very aware of and dedicated to: that having health services planned and delivered at the local level is the most effective and efficient means of ensuring high-quality health care for our beneficiaries. And this planning begins with Tribal input and consultation.

A vital component of Self-Governance is Tribal/Federal consultation. We at the IHS are dedicated to the application and promotion of consultation for all Indian health issues. The agency's consultation with Tribal Governments and its facilitation of Indian people's involvement in policy development and agency decision making have led to their participation in setting program and budget priorities and advocating for their health needs. We have repeatedly seen the results and positive effects of involving Indian people in the formulation of health policies that directly affect them, such as in the development of the IHS budgets and other areas, and I am confident we will increase those benefits as we revise and refine the consultation process.

The Indian health care system presents a successful model for rural and urban health programs as well as for indigenous people around the world because of its respect for cultural beliefs, its blending of traditional practices with the modern medical model, and its emphasis on public health and community outreach activities.

Community-oriented primary care, with its emphasis on local control and implementation, is the backbone of the Indian health system.

The Indian health model and the participation of Indian people in decisions affecting their health has produced significant health improvements for Indian people: Indian life expectancy has increased by more than 9 years since about 1973; and mortality rates have decreased by approximately 82% for tuberculosis, 65% for infant deaths, 53% for maternal deaths, and 60% for unintentional injuries and accidents, to name just a few. The sharp decline in infant mortality rates represents a concentrated effort on the behalf of the IHS and Tribes to address this serious threat to the future of American Indian and Alaska Native people.

The IHS credits its sanitation constructions program with playing a key role in the long-term reductions it has achieved in infant mortality, gastroenteritis, and other environmentally related diseases.

Since about 1959, more than 275,000 Indian homes have benefited from IHS funding of water and sewerage facilities, solid waste disposal systems, and technical assistance for operation and maintenance organizations. Approximately 88% of American Indian and Alaska Native homes have been provided a safe water supply since the inception of the IHS sanitation construction program.

One obvious outcome of this sanitation improvement effort has been that the age-adjusted death rate from gastrointestinal disease for American Indians and Alaska Natives has decreased by more than 91% since 1955.

Despite these impressive advances in sanitation construction, almost 12% of Indian homes still lack a safe indoor water supply, compared to 1% of all U.S. homes (in some areas, such as Alaska, up to 35% of homes lack safe indoor water supplies).

The IHS also funds the construction of new and replacement hospitals and ambulatory care facilities and staff quarters. However, the average age of IHS hospitals and clinics is 33 years, compared to the average age of U.S. hospitals and clinics at 9.4 years. The oldest facility is 73 years old, and the newest facility was completed 1 year ago.

Although we are very pleased with the advancements that have been made in the health status of Indian people thus far, we recognize there is still progress to be made. The current Indian life expectancy of 72.9 years, while much improved from 20 years ago, is still about 4 years less than that for the U.S. general population.

And there are still wide gaps in the general health status between Indian people and the rest of the U.S population. Complicating the situation is the type of health problems confronting American Indian and Alaska Native communities today. Death rates from tuberculosis, alcoholism, diabetes, accidents, suicide, and homicide, among others, are significantly higher for Indians compared to the U.S. general population. As you can see on this chart, the mortality rates from tuberculosis and alcoholism are more than 6 times the U.S. all-races rate. Mortality rates from diabetes are 3 times as high as in the rest of the U.S. American Indian and Alaska Native death rates for unintentional injuries and motor vehicle crashes are 2 ½ to 3 times higher than the national rates. And suicide and homicide rates are nearly twice as high in the Indian population.

The IHS public health functions that were effective in eliminating certain infectious diseases, improving maternal and child health, and increasing access to clean water and sanitation, are not as effective in addressing health problems that are behavioral in nature, which are the primary factors in the current mortality rates noted previously. The prevalence of diabetes, in

particular, has reached epidemic proportions in the Indian community. Other factors impacting further progress in improving American Indian and Alaska Native health status are the increases in population and the rising costs of providing health care.

Although the IHS, Tribal, and Urban Indian health programs have demonstrated the ability to effectively utilize limited available resources to significantly improve the health status of American Indians and Alaska Natives, there is still concern about the health care funding deficiencies for Indian people.

A stakeholder workgroup has conducted an actuarial study to determine what it would cost to provide services to Indian people similar to those of a mainstream health insurance plan. The findings of the study indicated that in general, expenditures for personal health services for Indian people are approximately 40% lower than for other U.S. citizens. Here we see the IHS per capita appropriation compared to other Federal Health Expenditure Benchmarks, such as Medicare. As you can see, the IHS is at the bottom -- even below prisoners in the U.S.

As mentioned previously, the health disparities for American Indians and Alaska Natives cannot be addressed solely through the provision of health care services. Changing behavior and lifestyle and promoting good health and a healthy environment are critical in preventing disease and improving the health of American Indians and Alaska Natives.

Through Tribal consultation, self-governance, and self-determination processes, the IHS and Tribes have worked together to identify focus areas for Indian health that address these issues and make the most of limited resources. I want to describe three campaigns that the IHS and Tribes are working closely together on to help achieve significant improvements in health that are critical to the future of Indian communities. These focus areas are being targeted at health outcomes that will have a beneficial impact, demonstrate measurable achievements, and attempt to change basic practices and procedures as well as unhealthy behaviors.

These main focus areas include three closely related initiatives:

Behavioral Health
Health Promotion and Disease Prevention, and
Chronic Disease Management

It has become obvious to all of us in the Indian health system that addressing behavioral health and mental health issues in our communities is crucial. We need to focus on screening and primary prevention in mental health. The recent shooting incident at Red Lake Reservation, which I am sure most of you are aware of, has been a tragic reminder to all of us in Indian country, as well as to the Nation as a whole, of the importance of increasing our efforts to effectively address mental health issues.

In particular, the high level of mental illness and high suicide rates among American Indian and Alaska Native youth are of paramount concern to the Indian health system and Indian communities. Not only is suicide the third leading cause of death for Indian youth ages 15-19, but the tragic truth is that the rates of suicide among Indian youth are the highest of any racial group in the Nation, and are especially dramatic if you look at young males.

These are statistics that hit at the heart of the tragic effects of mental illness on the rates of disease and mortality in Indian communities. We know that mental health issues such as depression can make chronic disease management more difficult and less effective. In order to adequately address mental health issues, Tribes and the IHS are working in concert with Federal, state, public, and private organizations to address all the contributing factors to mental illness, such

as poverty, lack of educational opportunities, domestic violence, social isolation, and perhaps most devastating of all, low expectations, and the hopelessness of our youth.

As a Nation, we are struggling with chronic diseases such as diabetes, heart disease, obesity, cancer, asthma, and depression. This is an area that we have long been aware of in Indian Country. We must address the primary prevention of these chronic diseases if we are to critically influence the future health of our patients and our communities. To that end, the IHS and Tribes have taken a number of actions aimed at health promotion and disease prevention, which include the following:

- An Indian Health Summit held in D.C. last September;
- The establishment of a Health Promotion and Disease Prevention (HP/DP) Policy Advisory Committee;
- The appointment of Area HP/DP coordinators;
- The Healthy Native Communities Fellowship; and
- Various partnership efforts to promote healthy lifestyles, such as
    - Participating in the "Just Move It Campaign";
    - Increasing the number of Boys and Girls Clubs;
    - Establishing Memoranda of Understanding with Canada and NIKE to address these issues;
    - Participating in the Stop The Pop Campaign — 8 emerging leaders from the Department of Health and Human Services have been assigned to work on this campaign; and
    - Establishing an obesity workgroup to help address this important issue in Indian communities.

As I just mentioned, as a Nation and in Indian Country, we are struggling with chronic diseases such as diabetes, heart disease, obesity, cancer, asthma, and depression. We must address not only the primary prevention of these chronic diseases if we are to critically influence the future health of our communities, but we must also look at better chronic disease management in our clinical care of our patients. It is also vital that we continue to promote and develop community resources and involvement in order to target health promotion efforts at the local level.

The IHS also works to continually include current medical advances that show great promise for a healthier future for all Americans. Never before have we known so much about how to prevent chronic disease problems — and how to address the lifestyle changes that help prevent them**.** For instance, there have been more effective developments in the field of cardiovascular disease in the past 10 years than in the previous 50 years.

More recently, the Special Diabetes Program for Indians has significantly enhanced diabetes care and education in American Indian and Alaska Native communities, as well as building the necessary infrastructure for diabetes programs. Intermediate outcomes that have been achieved since implementation of the Special Diabetes Program for Indians include improvements in the control of blood glucose, blood pressure, total cholesterol, LDL cholesterol, and triglycerides. In addition, treatment of risk factors for cardiovascular disease has improved as well as screening for diabetic kidney disease and diabetic eye disease.

We work diligently to keep pace with new medications and treatment techniques as they are developed. And we also remain committed to innovations in service delivery methods that enhance outreach and access, while maintaining respect for cultural tradition and beliefs.

Within the IHS, we emphasize more than exceptional health care for those who are already ill. Our model of care also prioritizes preventive health, behavioral health, and chronic disease management. This model is developing based on the "chronic care model" of clinically supported patient self-management and empowerment. This model also includes new tools for prevention and treatment, tools that include improved applications of standards of care, community and organizational partnerships, and newer technologies and approaches to care, such as telehealth and case management.

Working together with Tribes and in concert with the principles of Self-Determination and Self-Governance, we can use these new tools to make a real difference in the health and well-being of our patients, families, and communities.

If we hope to successfully combat chronic conditions such as diabetes and cardiovascular disease, we must address a host of inter-related factors and illness contributors – the "causal web" – and we must do so in partnership with many other Tribal, Federal, state, and private-sector organizations that are targeting these issues. Health status is not just a health care issue. It is about ensuring that there are educational opportunities; it is about ensuring that we have safe communities; it is about ensuring that adequate housing is available; and it is about ensuring adequate economic and employment opportunities. These things and more all work in concert to affect health status. It is therefore vital that all available resources be brought to bear on Indian health issues.

The IHS and Tribes have actively pursed partnerships across the spectrum of health-related organizations. School-based and school-linked health care are making inroads in child and youth health promotion and disease and injury prevention. Partnerships with other Federal agencies, such as the Bureau of Indian Affairs, seek to reach kids where they live and learn. Public health nurses, school nurses, community health representatives, health educators, environmental health officers, optometrists, and dentists, to name a few, are working with students in the classroom, providing surveys and educating and training school staff as well as the children. And in partnership with Head Start program, the IHS supports children and families through preventive health services such as parenting, obesity and diabetes prevention, health and safety, and oral health. There are 68 American Indian and Alaska Native Early Head Start programs and 151 Head Start programs serving over 23,700 Indian children ages 0-5 and families nationally. Early primary prevention provides the opportunity to prevent chronic disease and promote healthy lifestyle development.

The IHS is also partnering with:

- *The National Congress of American Indians and the National Boys & Girls Clubs of America* to help reach their goal of increasing the number of Boys and Girls Clubs on Indian reservations to 200 by 2005. There are now approximately 185 Boys and Girls Clubs on Indian reservations;
- The *CJ Foundation*, a national Sudden Infant Death Syndrome (SIDS) prevention organization, on addressing SIDS in Indian communities;
- The *NIKE Corporation,* to focus on the promotion of healthy lifestyles for all American Indians and Alaska Natives; and
- The *United National Indian Tribal Youth* organization to focus on helping develop leadership qualities in our American Indian and Alaska Native youth and young adults.

These are but a few examples of our efforts to bring all relevant resources to bear on Indian health issues.

Another important example of innovation within the IHS is the deployment of the IHS Electronic Health Record (EHR). The IHS Health Record Program provides a full range of services, including managing millions of medical records nationwide, including patient scheduling, data quality control, medico-legal consultations, and various reports for practitioner and patients. Information managers also contribute to maximizing reimbursement rates, remaining compliant with accreditation and certification surveys and standards, protecting patient privacy, and providing information security.

The move from paper to electronic health records will help our health care providers make important health care decisions on a real-time basis, using clear, concise, and accurate information.

The IHS has long been a pioneer in using computer technology to capture clinical and public health data. The IHS clinical information system, the Resource and Patient Management System (RPMS), began nearly 30 years ago, and as a result, many facilities have access to decades of personal health information and epidemiological data on local populations. The primary clinical component of RPMS, the Patient Care Component, was launched in 1984 in close collaboration with the Veterans Administration. The IHS EHR represents the next phase of clinical software development for the IHS.

I would like to take this opportunity to mention an important milestone in the history of the IHS. In July of 1955, the IHS was officially transferred from the Bureau of Indian Affairs to the Public Health Service, making FY 2005 the 50th anniversary year for the IHS.

In FY 2005 we have embarked on a special year of celebrations and special events. A 50th Anniversary reference library of historical documents and photographs is being compiled, which will be available on the IHS Web site. Also, we are publishing a special edition of the "Gold Book," which was first published in 1957 as a comprehensive report to Congress on the status of the health of American Indians and Alaska Natives around the time of the transfer. The new version will show the progress made in the last 50 years, and our plans for facing the challenges of the next 50 years.

I hope all of you here will join us as we recognize this important date in the history of the IHS.

This is an exciting and very promising time in Indian health, as we strive in concert with Tribal governments and the American Indian and Alaska Native people to move closer and closer to our goal of eliminating health disparities and preparing our people and communities for a healthier future.

I hope that some of you students here today will join the Indian health team at some point in the future. I promise you the opportunity for a professionally challenging and personally rewarding career that will give back to you even more than you put in.

Please visit our Web site for comprehensive information on the Indian Health Service. Our Web address is www.ihs.gov

Thank you.

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