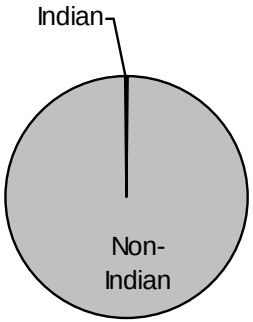
Then – 1955

A Program FOR Indians

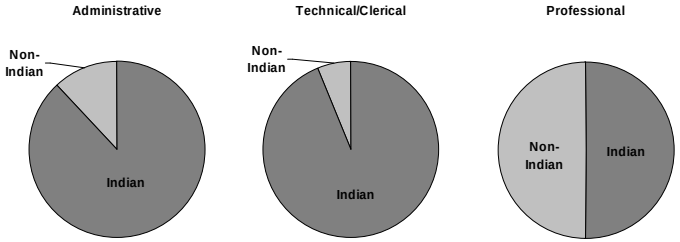
Few Indians were represented in the professional and management ranks. Recruitment and staff turnover were chronic problems.



Now – 2005

A Program BY Indians

Now, AI/ANs predominate in the IHS workforce: 88 percent of administrative FTEs, 94 percent of technical/clerical FTEs, and 50 percent of professional FTEs. Recruitment and turnover of health professionals are problems today as they have been throughout the history of the program.



The Indian Health Care Improvement Act (P.L. 94-437), passed in 1976, created a scholarship program to support the development of AI/ANs as health professionals. Since its inception, more than 8,000 AI/AN students have been supported through the program.

Facilities

In 1955, IHS facilities consisted of 48 hospitals, 18 health centers, 62 stations, 150 locations, and 13 school infirmaries. The Indian facilities were smaller than typical U.S. community hospitals and were widely distributed on and near reservation lands. Hospitals and services provided in inpatient settings predominated. Reports in 1957 characterized the state of facilities as "poor and outmoded."

In 2005, IHS and Tribal facilities consist of 48 hospitals, 238 health centers, 6 school centers, 167 health stations, and 180 Alaska village clinics. Facilities are distributed more widely than in 1955, including some in urban settings, but the geographic distribution continues to reflect historical Indian lands. Although hospitals are retained in similar numbers, the revolutionary shift in patient care away from inpatient settings to ambulatory settings is not readily apparent in the numbers. Despite many improvements achieved by a continuous program to replace, expand, and modernize facilities, the age of IHS facilities and inadequate ambulatory care capacity continue to be problems.

Services

The IHS services for Indians included an array of curative and preventive services ranging from hospital care to construction for safe water and waste disposal. Services in hospitals predominated, and care was primary in nature. Substantial staff efforts were focused on prevention activities, control of communicable diseases, and field health activities such as improvement in water supply, waste disposal, and other sanitary facilities on Indian reservations. Efforts to improve sanitation in individual homes began.

To the extent resources permit, AI/ANs served by the IHS receive a full range of preventive care, primary medical care (hospital and ambulatory care), community health programs, alcoholism programs, and rehabilitative services. Secondary medical care, specialized medical services, and other rehabilitative care are provided either by IHS staff or by non-IHS health providers under contract. The system approach is akin to rural medicine but with attributes that give it unique qualities and flair – teamwork among doctors and other staff, unwavering commitment to community-based primary care, and accommodation and respect for traditional Indian practices and beliefs. Extending beyond the medical model, IHS environmental and sanitation programs addressing conditions in Indian communities and homes have helped to lower dramatically the rates of communicable diseases, especially water- and waste-borne diseases.

Organization

The IHS took from the BIA some structural legacies but instituted new practices and approaches to management brought by leadership that came from the USPHS. The first priority was to establish competent and high-quality medical care. Extensive recruitment of health professionals; the remodeling and renovation of health facilities; and the establishment of clinical laboratories, radiological services, and surgical teams were undertaken. In the second phase, the IHS emphasis shifted to health program management, comprehensive health planning, health professional training for Indians, and formal health-management training for IHS administrators. In a phase leading to the present, efforts were undertaken to improve the efficiency and effectiveness of the service units and to expand the participation of Tribes and Indian communities in managing their health affairs.

While the IHS has retained a layered structure of administrative support services in Area and program offices, an emphasis on community-oriented primary care and attention to the diversity among Indian communities have gradually produced a more decentralized organization. The extent of decentralization and Indian community control accelerated with the Tribal "self-determination" movement and laws. Paramount to the success of the programs is the active involvement of the community members themselves — not only by participating in health programs and healthy living but also in directing and operating the programs. Tribal decisions to contract/compact health care programs or to continue to have the IHS operate them are equal expressions of self-determination. Today, approximately one-half of the IHS budget is allocated to fund tribally operated health programs.

The Future

The Early Years of the Indian Health Service

The heart of the Indian Health Service (IHS) has always been the small reservation hospital or health facility. Isolated and self-sufficient, often grappling with problems that stretch available resources to the maximum, these small facilities have delivered primary care to generations of American Indians and Alaska Natives (AI/AN). The health facilities formed the hub of a wheel – and in the center were the physicians, nurses, dentists, and pharmacists who delivered primary care. Radiating out from this center were public health nurses, sanitarians, engineers, social workers, health educators, and other community health workers. Whether serving a compact pueblo or the scattered clans of semi-nomadic hunters and shepherds, the IHS health facility was typically the only source of modern health care for a region. Most health services were managed locally, but extremely ill patients had to be transported to a more specialized city hospital for treatment. Transporting a critically ill patient by pickup truck or by dogsled might prove to be a dangerous course of action. Traditional healers practicing in their communities were viewed as a problem by many IHS providers. The Indian health care administration was paternalistic and highly centralized, with local service units reporting to Area Offices, which reported to Washington. Decisions were made in Washington, with little input from Tribal Leaders.

The Indian Health Service of Today

Although the character of remote reservation hospitals or health centers remains much the same, the Indian health care system of 2005 is far more complex than the one in 1955. Rural clinics are networked with large IHS medical and health centers that provide specialty care, such as surgery, coronary care units, and dialysis. Telemedicine connections bring subspecialist consultation to ice-bound villages in rural Alaska. Patients are routinely transported to tertiary care hospitals and trauma centers by helicopter and airplane. Even small facilities are supported with an impressive array of modern medical technology and information systems. A small army of community health representatives, diabetes educators, health educators, dieticians, and outreach workers deliver health promotion messages and services to the community.

The modern IHS is quite decentralized, with fully half of the Indian health care system now being managed by Tribal health departments under self-determination compacts. The IHS decisions are made in consultation with Tribal Leaders, and many functions formerly performed by Area and Headquarters officials are now locally managed by the Tribes or Tribal health boards. Tribal Leaders have developed a sophisticated understanding of health care and take an active role in advocating and planning for the health care needs of their own communities. Tribal communities expect and demand a high level of care.

Some things have not changed in 50 years: a sense of shared mission, the willingness to provide care under difficult conditions, and the integration of public health principles into clinical practice. Also persistent are the chronic shortage of human and financial resources and the challenges of providing care in the poorest and most remote corners of the country.

The Challenges of the Future – Progress Brings New Challenges

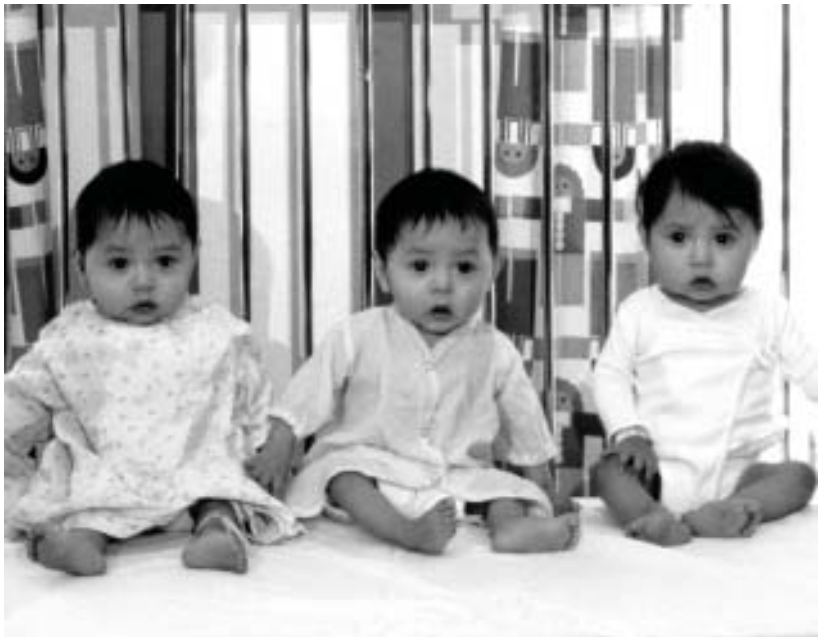
As we begin the next 50 years of service, the IHS will face new challenges and exciting opportunities. The medical and public health interventions that were effective in eliminating certain infectious diseases, improving maternal and child health, and increasing access to clean water and sanitation are still needed and very important to maintaining progress in decreasing the disparities in health status experienced by AI/ANs. But we are facing new challenges in dealing with chronic diseases that were not major issues in past years as well other challenges that are behavioral in nature and with which our traditional interventions are not as effective. We are being challenged to focus on the *health of communities* rather than the *medical needs of individuals*.

A complex set of conditions, including longer life expectancy, dramatic lifestyle changes, changes in dietary practices, pollutants, and a variety of other environmental changes, contribute to new challenges in managing chronic disease. If we are to critically influence the future of our communities, we not only must address the primary prevention of these chronic diseases but also must look at improved chronic disease management in our clinical care to patients.

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. The high level of mental illness and suicide rates among AI/AN youth is an indicator of the need to address a new set of very difficult behavioral health challenges. Not only is suicide the third leading cause of death for Indian youth ages 15-19, but the rates of suicide among Indian youth are the highest of any racial group in the Nation. We need to focus on screening and primary prevention in behavioral health.

The public health principles that have served the Indian health system so well in the first 50 years will be even more important in the next 50 years. With the challenges of chronic diseases such as diabetes, obesity, cardiovascular disease, cancer, and injuries as well as the challenges of behavioral health, prevention is more important than ever. We must continue to promote and develop community resources and involvement in order to target health promotion efforts at the local level.

As Tribes continue to mature in their capacity to assume the management of health programs, the partnership between the IHS and Tribal health programs will be more critical than ever. Our shared mission is vital to the health of AI/ANs across the Nation and in the generations to come.

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The mission of the IHS, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

The goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

The information included in this summary is derived from the full publication that updates the **1957 IHS Gold Book**, which is currently under preparation and is expected to be released in the coming year.

Materials used to compile this summary include:

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