The History of Health Services for American Indians

Health services for American Indians began in the early 1800's when U.S. Army Physicians took steps to curb small pox and other contagious diseases among Indian Tribes living in the vicinity of military posts. Treaties committing the Federal Government to provide ;health services were introduced in 1832, when a group of Winnebagos was promised physician care as partial payment for rights and property ceded to the U. S. government. Of the 400 Treaties negotiated with Indian Tribes from 1778 to 1871, approximately tow dozen provided for some kind of medical service. Although most treaties imposed time limits of five to twenty years for provision of care, the Federal Government adopted a policy of continuing services after the original benefit period had expired.

The transfer of the Bureau of Indian Affairs from the War Department to the Department of the Interior in 1849 stimulated the extension of physicians' services to Indians by emphasizing non-military aspects of Indian Administration and by developing a corps of civilian field employees. Within tweny-five years, half of the Indian Agencies had a physician; and by 1900, the Indian Medical Service employed eighty-three physicians including those providing part-time services.

Nurses were added to the staff in the 1890's and grew from eight in 1895 to twenty-five in 1900, with practically all of them assigned to Indian boarding schools. Beginning in 1891, Field Matrons were employed to teach sanitation and hygiene, provide emergency nursing services, and prescribe medicine for minor illnesses. These activities were later taken over by Public Health Nurses.

Indian Bureau policy by the 1800's clearly directed Physicians to promote preventive activities, but efforts were limited until well after the turn of the century due to the pressure of curative work.

The first Federal hospital built for Indians was constructed in the 1880's in Oklahoma and a concentrated movement was underway before 1900 to establish hospitals and infirmaries on every reservation and at every boarding school. The reasons for construction were because of the isolation in which Indians live, the lack of nearby facilities, and home conditions which made prescribing a course of treatment outside a hospital often useless and sometimes dangerous to the patient.

Professional medical supervision of Indian Health Activities was begun in 1908 with the establishment of the position of chief Medical Supervisor,and was strengthened in the 1920's by the creation of the Health Division and appointment of district medical doctors. The first appropriation earmarked specifically for general health services to Indians was made in 1911. In 1926 Medical Officers of the Public Health Service Commissioned corps were detailed to certain positions in the program.

Dental services were organized in 1913 with the assignment of five itinerant dentists to visit Reservations and Schools.

Pharmacy services were organized in 1953 with PHS Pharmacy Officers assigned to Headquarters, Area Offices, and hospitals to develop and institute dispensing, packaging, and distribution policies and practices.

Until the 1920's, Sanitation services did not extend beyond occasional " clean-up" campaigns and physician's inspections of homes, schools, and Indian Agencies. In 1928, Sanitary Engineers of the Public Health Service began assisting the Bureau of Indian Affairs in surveying water and sanitation systems and investigating other basic sanitation problems, usually restricted to Bureau installations. An expanding program to improve sanitation in individual homes was begun in 1950.

IN 1955, Congress transferred responsibility for Indian Health from the Department of the Interior to the Public Health Service. AT the time,both medical facilities and personnel were inadequate to meet the health needs of the American Indians.

The initial program priorities for the Public Health Service's new Division of Indian Health were to assemble a competent health staff;establish adequate facilities where services could be provided; institute extensive curative treatment for the many Indians who were seriously ill, and develop and initiate a full-scale preventive program which would reduce the excessive amounts of illnesses and early deaths, especially from preventable diseases.

Since 1955, the Division of Indian Heath, now the Indian Heath Service, has assumed more responsibilities and has expanded its staff from a small corps of health professionals to more than 9,000 skilled and dedicated men and women. The number o physicians in the program has risen from 125 to 770, dentists from 40 to 250 and registered nurses from 780 to 2000. Of its original health staff of clinical physicians and nurses, dentists, pharmacists and sanitary engineers, the program has added field health physicians, registered medical record administrators, public health nurses, registered dietitians,therapists, public health nutritionists;, community health representatives, practical nurses, dental assistant, maternal and child health specialists, environmental sanitarians, and auxiliaries in a number of categories.

Over the past 31 years (to 1986) 28 hospitals, 32 health centers and 58 health stations have been built. Major alterations have been made at many facilities and currently several are in various stages of construction.

Through Public Law 85-151, 165 beds to serve American Indians and Alaska Natives have been added to 20 community hospitals which were constructed with assistance from Hill Burton Act funding.

Additionally, capabilities have expanded through numerous educational and training activities designed to increase efficiency, augment manpower resources and promote career development.

Dramatic increases in the use of IHS services have occurred. Virtually all Indian births (99.1% in 1983) occur in hospitals today. Annual admissions to IHS and contract hospitals have more than doubled, outpatient visits made to hospitals, health centers and field clinics (including contract and tribal facilities) have increased 8.7 times, and the number of dental services provided is 9.6 times greater.

Many Indian Tribes and intertribal organizations are now managing and operating IHS programs and services in their communities. The Indian Self-Determination Act Education Assistance Act and the Indian Health Care Improvement Act have provisions to assist tribes desiring to assume responsibility for their health programs.

IHS is charged with administering the principal Federal health programs for American Indians and Alaska Natives. IHS serves approximately one million American Indians and Alaska Natives now eligible for services. IHS provides both direct and various contract methods to provide comprehensive health care. There has been a 19 percent population increase and a 23 percent increase in demand for outpatient services since the 1980 census.

IHS provides high quality preventative, curative, rehabilitative and environmental health services directly to eligible population through the operation of 45 hospitals, 72 health centers and several hundred smaller health stations and satellite clinics. The Tribal health delivery system administered by Tribes and Tribal groups through contracts with the IHS operates 6 hospitals and approximately 300 outpatient health clinics. the purchase of medical care from other providers through contract health services provides supplemental services.

The goal of the IHS is to elevate the health of the American Indians and Alaska Natives to the highest possible level. Its Mission is:

1. To provide the availability of high quality, comprehensive, and accessible health services;

2. Top provide increasing opportunities for Indians to manage and operate their own health programs; and

3. To serve as an advocate on health issues for Indian people.

Health Care Delivery System in California

Indian and Tribal organizations provide ambulatory medical and dental care at Tribal Facilities in California.

Health care is delivered through contracts with " nonprofit" Indian and Tribal organizations. As a result of this contract modality, the California Area Office (CAO) administers health care differently than other IHS Area Offices which provide health care services directly and through Contract Health Services from IHS facilities. All California Indian Health programs are managed by the Indian people,however,engineering and sanitation facilities services are still provided directly through IHS staff.

The health care delivery settings vary with the population and area served. Health care providers are for the most part Tribal employees. these Tribal systems employ in total 61 physicians, 5 pharmacists, 28 nurse practitioners, 29 ambulatory care nurses, and 33 public health nurses.

Minimum dental staffing varies form programs that provide care by a dentist and dental assistant three days a week to programs that provide care with tow full time dentists and dental hygienist along with the necessary auxiliary personnel. There are 38 full time and 36 part time dentists, 53 full time and 13 part time dental assistants, 7 full time and 13 part time dental hygienists. there are also 33 full time receptionists and clinic managers, many of whom provide chairside assistance.

There are no " service units " in the traditional sense, but instead " service areas " which evolved over time reflecting demographic concentrations and political negotiations by the Indian and Tribal organizations. The contractors are almost all incorporated in the State of California as nonprofit corporations with boards of directors governing the service area programs. Health center staff are employees of the individual corporations.

None of the " service area " programs operate a hospital nor dies the Indian Health service provide funds for IHS hospitals in California. Indian Health Service funded programs total 21 with each program being considered a service area.

There are 39 health facilities involved in he Tribal programs (20 health centers and 19 health stations) Twelve of these health facilities are located on reservations and are Tribally owned. All of the service area programs are contracted under the authority of P.L. 93-638, the Indian Self Determination and Education Assistance Act. Additionally, there are nine contracts with Tribal Governments which provide contract health care (CHS) and/or outreach services.

One of the unique and major differences between the traditional IHS service u;nit and these California service areas is that the administering Tribal organizations receive additional funds through contracts and grants with funding sources other than IHS. The State of California is on such funding source.

The California Area Office contracts with Urban Indian organizations to provide care in eight Urban areas of the State. All the Urban programs provide medical and dental services as well as the traditional outreach and referral services. Depending on available resources, special program services are provided such as maternal and child health, social services, family planning, mental health and substance abuse.

The California Area Office contracts with thirty three Indian and Tribal organizations to provide alcoholism services to Indians in California and Hawaii. the services provided range from basic counseling services to residential treatment, including special program focuses on youth, family and traditional Indian health.

The California Area Office with respect to program support essentially serves two purposes:

1. Contract administration
2. Contract program monitoring, consultation, training and technical assistance

Relative to #2 , the (CAO) professional staff is composed of one physician,one pharmacist, tow dentists, tow nurses one health educator, one diabetes coordinator and one psychologist. This staff does not provide direct care, but act as consultants, evaluators, monitors, provide technical assistance to health centers/clinics and develop scopes of work and quality assurance programs.

1991 California Area Operating Units

* These are independent programs, however, for planning purposes such as in the HSPS formula, they have been aggregated into one "operating unit."