

The Indian health paradox: Honoring a treaty right or raising real dollars?¹

By Mark N. Trahant²

Abstract:

The United States has a legal and moral obligation to provide health care for American Indian and Alaska Natives. This is a responsibility that has been expressed through treaties, executive orders and federal law. The Indian health system began when the government sent doctors to reservations to inoculate against small pox. Over nearly two centuries, however, the system has evolved into a complex example of government-run health care. Make that two alternative systems: There are direct services delivered by the Indian Health Service. Many tribes say that even though that system is underfunded, it represents the United States fulfillment of treaty obligations. A second system is tribally or tribally-sponsored community health clinics that receive money from a variety of sources, including the Indian Health Service. Is the second system the wave of the future?

A brief history of the Indian Health Service

The United States government has delivered doctors, medicine and health care services to American Indians and Alaska Natives since at least 1802 when government physicians vaccinated a small number of Indians to prevent contagious diseases at a nearby garrison. The first general appropriation was \$10,000 in 1819 for services to teach Indians living east of the Mississippi “the habits and arts of civilization.” (Rife & Dellapenna, 2009, p. 3) Money was distributed from this fund to a variety of missionary societies for a variety of reasons, including doctors and nurses. In 1834 the Office of Indian Affairs sent doctors to several reservations to inoculate against small pox. Perhaps that effort was more self-interest than preventative medicine however. By 1880 there were 77 physicians serving the entire American Indian population in the United States and its territories. Commissioner of Indian Affairs Thomas Morgan urged Congress shortly before the turn of the century, “in the name of humanity,” to fund hospitals and every agency because their absence was a “great evil that in my view amounts to a national disgrace.” (Rife, & Dellapenna p. 5)

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Congress slowly increased resources and a serious shortage of physicians remained. Moreover, many of those doctors were poorly trained or lacked adequate supplies to treat Native American patients. The first direct appropriation was made in 1911 for “relief of distress and prevention of diseases” among the Indians. President William Howard Taft followed up a year later with a message to Congress calling for even more funding. The president said Indian conditions were “very unsatisfactory.” The Indian death rate was more than twice that of the general population. The president also complained about the “smallness” of physician salaries, averaging \$1,186 per year, or half what other government employees were paid. He said the United States was obligated to give Indian people a “fair chance” at decent health. (Shelton, p 7.)

In 1921 Commissioner of Indian Affairs Charles Henry Burke created a health division within the agency with a chief medical officer. However poor salaries, training and inadequate supplies continued to be major problems. Dr. Michael J. Pijoan, a doctor at the Navajo Medical Center, wrote that the Bureau of Indian Affairs bureaucracy made it impossible to succeed. “All we really need,” he wrote in 1951, “are good doctors, facilities and pharmaceuticals. I am weary.” A month later he resigned, writing, “the system is no longer medical. It is only bureaucratic. No more ceremonies are allowed in hospitals. Indians are now numbers, not people. We are machines. This is intolerable. We leave.” (Rife & Dellapenna, p.16)

The intolerable bureaucracy was recognized and Congress created the Indian Health Service (IHS) in 1955. This was the beginning of a modern health care network. One of the first decisions the new agency made was to invest in sanitation and public health programs. Over the next decade the IHS working with tribal governments built more than four hundred water and waste disposal systems. The agency reported that “the people themselves have contributed more than one third of the total cost through donated labor, materials and funds.”

The legal rationale

The United States has a legal and moral obligation to provide health care for American Indian and Alaska Natives. This is a responsibility that has been expressed through treaties, executive orders and federal law. But it’s also a responsibility that the United States has ignored or poorly-funded. And, what complicates this notion is the contradictory nature of American Indian policy. Most of the time Congress is willing to support its treaty obligations. But it also, from time to time, takes steps to ignore those promises by removing land from tribal control or terminating tribal recognition.

The Yakama Treaty of 1855 is an example of a treaty obligation. The United States promised to employ a physician, erect a hospital, keep it supplied with furniture and medicine for a period of 20 years. That’s the literal reading. But a broader reading of that treaty -- and its practice -- reflects a different story, one where the United States has made multiple promises to provide medical care. (Yakama Treaty, Article 5)

The Snyder Act of 1921, for example, is a one-page law. It does not expire and gives authority to the Bureau of Indian Affairs to spend money “for the benefit, care, and assistance of the Indians throughout the United States for the following purposes: General support and civilization, including education. For relief of distress and conservation of health.” (Rife &

Dellapenna p. 8) The Snyder Act remains the primary legislative authority for Indian Health Service programs. The enactment of the Indian Self-Determination and Education Assistance Act of 1975 and the Indian Health Care Improvement Act in 1976 provided additional authority and flexibility. The self-determination act gave tribes as well as tribal and urban Indian organizations the right to contract for the management of federal programs. Today more than half of IHS is run under contract by tribes or independent health care centers – and that number could grow even more significantly because of changes under the Patient Protection and Affordable Care Act, or health care reform.

Measuring health data

In its fifty-plus year history, has the Indian Health Service delivered an effective, government-run delivery system? Consider this from a White House memo: “While there has been improvements in health status of Indians in the past 15 years, a loss of momentum can further slow the already sluggish rate of approach to parity. Increased momentum in health delivery and sanitation as insured by this bill speed the rate of closing the existing gap in age at death.” In other words, progress is slow. But Dr. Ted Marrs wrote the memo on April 26, 1976, and the subject was about the original Indian Health Care Improvement Act. “In 1974 the average age at death of Indians and Alaska Natives was 48.3. For white U.S. citizens the average age of death was 72.3. For others, the average age was 62.7.” Dr. Marrs wrote that the “bottom line” was an unavoidable connection between “equity and morality” when there is a more than 20-year differential in age at death between Indians and non-Indians. (Marrs, in author’s files)

What do the numbers look like now?

The most recent Indian Health Service data on general mortality statistics is now about a decade old. But it showed that the 20-year differential has been reduced to a difference of less than five years. “The American Indian Alaska Native life expectancy at birth (both sexes) for the IHS service area population was 72.3 years,” according to the recent IHS report: *Regional Differences in Indian Health*, 2002-2003 edition. Compare that with the average life expectancy for all U.S. races, 76.9 years.

But even those numbers reflect grave regional disparities within the Indian health system. An American Indian in the Aberdeen, South Dakota, area has a life expectancy of 66.8 years – or more than 10 years behind the U.S. average.

In March, 2010, the Centers for Disease Control and Prevention (CDC) released its report on the *Health Characteristics of the American Indian or Alaska Native Adult Population: United States, 2004-2008*. (Important note: The CDC’s definition of American Indian is broader than the IHS standard.) “In general, compared to other groups, non-Hispanic AI/AN adults are more likely to have poorer health, unmet medical needs due to cost, diabetes, trouble hearing, activity limitations and to have experienced feelings of psychological distress in the past 30 days,” the report said. The bottom line: The native community “faces many health challenges as reflected in their higher rates of risky behaviors, poorer health status and health conditions and lower utilization of health services.” (Barnes, Adams & Powell-Griner, 2010, p. 1)

That's really not news. But there are other items in the CDC report worth more thought and exploration. For example: Unlike another recent government report, this one counts clients of IHS as insured. That data shows nearly 40 percent of AI/AN has private insurance; another 41 percent with public insurance (IHS, Medicare, Medicaid and the Children's Health Insurance Program) and 19 percent are uninsured. That means AI/AN were about two to four times as likely as black adults (19.8 percent), Hispanic adults (14.2 percent) and Asian adults (9.1 percent), or white adults (8.9 percent), to have public insurance. (Barnes, Adams & Powell-Griner, 2010, p. 3)

In the era of health care reform, this means that American Indians and Alaska Natives have basic access to care. The CDC report says 84 percent have a "usual place for health care." That compares to 86 percent for white Americans, 85 percent for African Americans and 72 percent for Hispanics. (Barnes, Adams & Powell-Griner, 2010, p. 2) The numbers show most of us have regular contact with our medical team.

And, Native Americans are living longer. The CDC reports, "The AI/AN population has a life expectancy at birth that is 2.4 years less than that of all U.S. populations combined." There is not a health care parity with the general population, not by a long shot, partly because of the chronic nature of so many diseases that afflict Indian Country. But one measure, "closing the existing gap in age at death," has certainly been improving over the four decades. (Barnes, Adams & Powell-Griner, 2010, p. 1)

System One: Direct health care services under treaty obligations

The Indian Health Service -- an agency operating within the Department of Health and Human Services -- is a full-service, government-run health care delivery system. The IHS is organized through 12 "area" offices, managing 550 health care delivery facilities, including 49 hospitals, 214 health centers, 280 health stations, satellite clinics and Alaska village clinics operated by the IHS and tribes. The system represents Indian Country's single largest employer with more than 15,250 full-time workers in 35 states. The annual budget is nearly \$5 billion. It's an American-version of the single-payer, government-run health care agency.

"The Indian Health Service can and will be one of the leading prototypes for health care in America," said Dr. Donald Berwick, one of the nation's leading authorities on health care quality and improvement, and now the director of the federal Centers for Medicaid and Medicare. "The Indian Health Service is trying to deliver the same or better care with half the funding of other systems in the United States." Berwick said he would be the first to say IHS needs more money -- but at the same time the agency's ability to execute is "stunning." The very nature of the historical underfunding has resulted in a discipline that's "an example for us all." (Trahan, IHS paradox, 2009)

That example would begin with a culture that funds projects designed to improve the health of its clients (instead of limiting expenditures to direct medical care). Beginning in the 1960s, IHS invested in reservation and rural water systems, sewage and solid-waste facilities and pays for technical assistance for those facilities. The result, according to the Congressional Research Service, is an 80 percent reduction in gastrointestinal disease among American Indians

and Alaska Natives since 1973. (Trahant, IHS paradox, 2009) The same broad view of health care is the essence of an IHS Special Diabetes Program for Indians that began in 1997. The \$150-million-a-year project funds an extensive “best practices” network, incorporating the latest scientific findings into model and community-designed programs. This includes better training so patients can self-manage their treatment with more access to physical fitness programs, diet education and early diabetes screening. (Trahant, IHS paradox, 2009)

While diabetes remains at epidemic levels in Indian Country, there are hopeful signs of a turnaround. There has been a significant increase in the percentage of Indian diabetics who are maintaining blood-sugar control and, more important, there has been a 40 percent reduction in complications from diabetes such as kidney disease and retinopathy. This has implications for the rest of the country. Diabetes is already expensive, totaling \$174 billion in 2007. And, unfortunately, the disease is growing at rates that are all too familiar in Indian Country. About one-quarter of all Americans have pre-diabetes and if the disease fully develops, the health care costs will top \$13,200 per person compared to \$2,560 per person for those without diabetes. The Special Diabetes Program for Indians is inventing less expensive alternatives to treat and prevent the disease. (Trahant, IHS paradox , 2009)

The IHS has a frugal nature. The agency spends roughly \$2,130 per-capita – about the same as the average for other industrial nations. But that compares to the \$3,242 for federal prison inmates, \$4,653 at the Veterans Administration and \$7,784 for Medicare. (Trahant, 2009) It’s both ironic and maddening that the richest nation in the world appropriates far less for American Indian health care than it does for any other similar program. But as tribal leaders have pointed out repeatedly, that has resulted in a health care system that’s “starved, not broken.” Increasing those resources is something that could be fixed in the appropriations process.

Indeed, IHS director, Dr. Yvette Roubideaux, said during her confirmation hearing that the funding shortage is her top concern because IHS has not been able to keep up with its obligations. The General Accountability Office reported last year that because of shortages in budget, personnel and facilities, “the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population.” (Trahant, IHS paradox, 2009)

The primary reason for that inadequate spending is that IHS funding is based on appropriations. Other federal health programs, such as Medicare and Medicaid, are entitlements. That means if a person is eligible for services, then the money is available. On the other hand, IHS programs -- especially for medical services outside of IHS facilities paid for by contract -- can run short of funds. Patients are then forced to wait for non-emergency medical services, even if life threatening.

Many tribes, particularly the larger land-based tribes in the Great Plains and in the Western states, argue that the Indian Health Service is an extension of the promise to provide doctors under their treaties. They say that Congress should fully-fund the agency. Many of these tribes reject contracting under Public Law 93-638, the Indian Self-Determination and Education Assistance Act of 1975, because they say it lets the government off the hook from funding these promises. Other tribal leaders argue that the contracting process under the self-determination act is “termination by appropriation” because the tribes would be on the hook for program operation

during an era of shrinking resources. Other tribal leaders say there is no benefit in administering a program that is chronically underfunded.

The alternative under this scenario is to improve the baseline funding for federal Indian health programs. According to 2009 testimony by Robert Moore, a tribal council member from Rosebud, representing the Aberdeen Area Tribal Chairmen's Association:

What would it take to give the Indian Health Service (IHS) sufficient resources to address our health care needs? The current appropriation for IHS clinical services is about \$3.4 billion. Our estimated funding percentage based on documented level of need is approximately 50-60% of that need. In order to bring IHS up to a more appropriate level of funding, an additional \$2 billion for clinical service would be needed nationally making our annual Federal appropriation closer to \$5.4 billion. This would be a major increase, but a small one relative to the \$700 billion budget for the Department of Health and Human Services (DHHS). A significant portion of these additional resources need to be directed toward behavioral health, suicide prevention and holistic care that meets the needs of our young people and our future generations. (Moore, 2009)

President Barack Obama has improved the IHS budget since taking office in 2009. The administration boosted spending by 13 percent in fiscal year 2010 and is proposing another 9 percent increase for 2011. But this budget does not resolve the contradiction between "historic underfunding" and the larger reality about federal spending. The proposed budget calls for \$5.4 billion in spending for Indian health care, ranging from clinical services to facility maintenance and construction. (The bulk of that money, \$4.4 billion, would be from appropriations, the rest comes from health insurance collections and special grants.) The Department of Health and Human Services (HHS) Secretary Kathleen Sebelius said: "Our budget also contains a significant increase in funds for the Indian Health Service as we continue to work to eliminate health disparities. It is the principle that we are trying to establish in our health care system – that regardless of race, ethnicity, gender or geography, every American deserves high-quality and affordable care." (Sebelius, 2010)

But while spending on Indian health is increasing – is it growing fast enough to catch up? There remains a significant gap between what is spent on an American Indian/Alaska Native patient than a federal prisoner, \$2,130 per person versus \$3,985. One measure used by the federal government is a benchmark based on spending for federal employees. The Indian Health Service is currently appropriated about 55 percent of that standard on a per-person basis. The gap remains so large that a tribal task force suggested in April 2008 that Congress increase funding authority by an additional \$2.1 billion in the fiscal year (FY) 2011 budget. Tribal leaders called for a 10-year phase in of an additional \$21.2 billion to reach spending parity for health care delivery.

Perhaps the area that most highlights that shortage of need comes in the area of contract health care, services that must be purchased for IHS patients. There is a \$46 million increase, or more than 11 percent, from \$398 million in FY 2010 to \$444 million in FY 2011. That's important because it's increasing faster than medical inflation (about 5.7 percent) and the patient

population growth of about 2 percent. Contract care is often the primary narrative for the Indian Health Service in news accounts. The stories are often chilling accounts of people waiting for treatment; they detail what happens when the agency runs out of appropriated funds before the end of a fiscal year that begins October 1st. It's the source of the oft-repeated phrase, "Don't get sick after June."

Dr. Roubideaux said, unfortunately, there is not a better method to ration health care services. "It's a program where we know people are not satisfied because in general American Indian and Alaska Native people believe health care is something owed to them. Unfortunately, with the contract health service program we're struggling to meet the need with existing resources," she said. "That, unfortunately, results in some denials and deferments of services. We know that the patients don't like this; we know the tribes don't like that, but it's the reality of providing health care with a limited budget." (Trahant, IHS paradox, 2009).

System Two: A new kind of delivery system that requires fund raising

The quickest way to grow the budget for the delivery of Indian health care services is to tap into other revenue streams. When Medicare and Medicaid passed Congress in 1965, there was no consideration – none – about how those bills impacted Indian Country. It was as if the Indian Health Service, a federal agency, was off the books, a forgotten instrument. In fact there wasn't even a plan that allowed IHS to tap into Medicare or Medicaid dollars. That had to wait more than a decade until the Indian Health Care Improvement Act of 1976 became law.

This is important because Medicare, Medicaid and the Children's Health Insurance Programs are entitlements. If a person is eligible, the money is supposed to be there. That's not true for Indian health because the system is based on annual appropriations. So every time IHS, a tribal program or an urban clinic can bill Medicare, Medicaid or Children's health for patient care, it adds money to the IHS system. This is one way to fix the idea of "don't get sick after June." If a patient is eligible for Medicaid, the money is supposed to be there. It doesn't require passing the life-or-limb test.

However the administration of Medicaid is especially complicated. The program is officially a partnership between the federal and state governments. That means there are 50 different regimes, policies and procedures. Eligibility varies state by state. There's often a split in the state mechanism for behavioral health and other services. And then there's the money shortage. According to the Kaiser Family Foundation: The funding shortfall for state budgets could top \$350 billion by 2011. (Trahant, IHS paradox, 2009) Indian Country isn't supposed to be hit by these deficits; there's a 100 percent federal reimbursement for eligible patients in the Indian health system (a process that's supposed to be improved by the new health care reform law).

But nothing is simple when it comes to Medicaid and the Children's Health Insurance Program. States aren't keen to see these rolls expand even when there's a federal guarantee. It's even more complicated when you factor in those reservations that cross state lines. Utah would

set the rules for Navajos living on that portion of the reservation, New Mexico another set, and Arizona with still another situation.

One study enacted under health care reform will look at treating the Navajo Nation as a state for purposes for Medicaid, Medicare and Children's Health Insurance. This could be a huge win-win-win. It's a win for the states of Arizona, New Mexico and Utah because they would no longer have to process the paperwork for Navajos living on the reservation; the government should save money because the rules could be made simpler and easier to process with Navajo rules for eligibility instead of three different state standards, and the Navajo Nation should be able to better serve its citizens.

Medicaid and the Children's Health Insurance Program will be a critical block of funding either for IHS direct care agencies or tribally-controlled facilities. This will likely increase under health care reform as more people become eligible, especially single adults.

A few tribes have explored an insurance-based model. California's Pechanga Band of Lusieno Indians, for examples, has purchased a Blue Shield health insurance policy for all of its tribal members since 2002. "Only members able to prove that they had other insurance were allowed to "opt out" of this mandatory coverage," Chairman Mark Maccarro testified in a U.S. Senate hearing last September. "This has led to measurable improvement in the physical health of our Tribe. Earlier this year, we opened a new exercise facility that both contributes to and facilitates the health and wellness of our tribal citizens."

The Indian Health Service is now as much a contracting agency as it is a health care delivery agency. More than half of the IHS programs are operated by tribes or tribal organizations through self-determination contracts. The Alaska Native Medical Center is an example of a best-practice when it comes to contracting. The medical center is two facilities in one: Essentially, there is an inpatient hospital and some statewide services managed by the Alaska Native Tribal Health Consortium. And, outpatient services are administered by the Southcentral Foundation. The two management teams work closely together.

The Indian Self-Determination and Education Assistance Act of 1975 opened up contracting for tribal and native management of Indian Health Service programs. Southcentral (a non-profit affiliate of the Cook Inlet Region, Inc.) assumed some programs in 1987 and by 1999 ran the whole show. Today Southcentral serves some 55,000 people with 1,400 employees (including 10,000 in 55 remote villages). "I believe that Alaska is the only state that has enacted Indian self-determination to the fullest extent of the law in assuming health care," says Katherine Gottlieb, president and chief executive officer of the Southcentral Foundation. "We have taken what we had from the government and transformed it." Self-determination in Alaska means just that. It's not just federal programs managed by a native organization; instead, the federal money is redesigned to build a system based on Alaska Native ownership. So much so that Southcentral Foundation continually refers to its "customer/owners" as its foundation and inspiration. (Trahant, Customer/owners, 2010)

Southcentral's "Nuka" model of health care boils down to some basic ideas: that relationships are the key to health care; that patient care should be integrated, there should be

same-day access to primary care; customer-owners are partners in their own health care and ~~there~~ they should be given ample opportunity to offer advice and feedback. And to make all of this happen, there should be a culture where training and retraining is valued. Some two decades ago, the Indian Health Service asked Katherine Gottlieb to conduct a survey of its Anchorage hospital. “Are you sure you want to do that?” she asked. “I was, like, delighted because I knew what the answers were going to be. I was not surprised at all when the answers came back. Long waits. Everybody hated waiting.”

Most of the primary care back then was in the hospital’s emergency room where they were handling everything from “heart attacks, broken arms, strep throat, to you name it, and here we were coming in with our baby for just an appointment,” Gottlieb said. “I personally waited up to seven hours, waiting for an appointment, just to get in the door.” After contracting from the IHS, Southcentral Foundation made surveys and listening to customer/owners a key ingredient in its culture.

”We are literally customer-owners, Alaska Natives. Our board of directors are all Alaska Natives,” she said. So when people are hired they are told this system is customer-owned. That’s part of the deal: Every patient is one of those owners. And those patient owners aren’t keen on waiting. That explains the 15-minute signs in the waiting room – and the philosophy behind the service. Patients can communicate by e-mail or fax – and expect answers on the same day. The medical team approach is different, too. The team sits together without hierarchy. Members include doctors, medical assistants, nurses, care coordinators and often a behaviorist. Customer-owners can choose their own team – and make changes if unhappy. The ideal is integrated, so patients don’t have to make as many return visits. (Trahant, Customer/owners, 2010)

Consider how most health care dollars are spent: Expenses increase at the end of a person’s life. What if that was reversed? What if dollars instead were invested early on prevention? That means treating the root causes of diseases before they surface as heart diseases, diabetes, depression or domestic violence. When root causes are treated, there will be a reduction in the health disparities that are so much a part of the Native American experience. Gottlieb describes this model as even more imperative because as the baby boom generation ages, those costs will be unaffordable. (Trahant, Customer/owners, 2010)

The data backs up the Nuka model. There has been a 40 percent reduction in emergency room, urgent care; a 50 percent decrease in specialty care visits; a 20 percent decrease in primary care visits and a 35-plus percent decrease in admissions. But the Nuka model is not about money. “We still have a poorly funded IHS system. We are not fully funded,” says Gottlieb. In fact, she says, the government has not fulfilled its treaty-trust obligations to American Indians and Alaska Natives. “Not yet.”

Southcentral’s system is about 45 percent funded by the Indian Health Service, 50 percent from “aggressive” billing of third-party insurers or Medicaid and the remaining 5 percent from foundation or other government grants. “You won’t find anything in Indian Country like this campus,” said Douglas Eby, the Alaska Native Medical Center’s vice president for medical services. There is less direct funding from IHS and this is by far the biggest, most sophisticated campus in the Indian health system that’s far better off than most for a variety of reasons ranging

from leadership to the structure and resources of Alaska Native corporations. “We were smart enough to say we need to optimize revenue, and we’ve done very well at doing that,” Eby said. But the growth in population, people moving in from the villages, flat funding from IHS and health care being such a “wasteful” business drove a rethinking of business model. “Our real hope lies in controlling costs, doing things smarter, better and avoiding high care cost as much as possible.” (Trahant, Customer/owners, 2010)

Another model for delivery of health care is the community health center approach, such as the Benewah Medical Center in Plummer, Idaho, operated by the Couer’d Alene Tribe. Some 20 years ago the tribe contracted for a small IHS clinic and began replacing it with a local health care network. Tribally-run tribal Community Health Care Clinics (CHCs) are eligible for IHS funding -- and additional federal money for CHCs. Funding for community health centers started growing under President George W. Bush, who doubled the spending in 2008 to \$2.8 billion. Since then President Barack Obama has added money under the American Recovery and Reinvestment Act of 2009 for community health centers as well as an additional \$12.5 billion for expansion of these efforts over the next five years as part of health care reform.

“With an eye toward meeting the primary care needs of an estimated 32 million newly insured Americans, the recently passed Patient Protection and Affordable Care Act underwrites the CHCs and enables them to serve nearly 20 million new patients while adding an estimated 15,000 providers to their staffs by 2015,” write Adashi, Geiger & Fine in the *New England Journal of Medicine* (p. 1) “The new CHCs have arrived.”

The health care law identifies community health centers as a priority. There are new resources for the expansion, construction or renovation of clinics and to hire more medical providers. Nationwide, some 19 million people now use services at community clinics and the goal is to double that number (or about 10 percent of the U.S. population). And, Indian Country is included, if tribes and urban organizations choose to participate.

Community health centers generally operate by charging patients on a sliding scale and have historically served the uninsured population. In Indian Country this takes on a different twist because for eligible American Indian and Alaska Native patients, the Indian Health Service still picks up the cost as the payer of last resort (non-eligible patients would still be billed based on what they can pay).

Community health centers also are locally-governed. Federal rules require that more than half of any center’s governing board be patients of the facility. That means that local priorities are funded first, not last.

The significance of all this is that the community health center model represents an improved funding stream for the Indian health system. Currently a little more than half of the total Indian Health Service budget funds tribal or urban Indian facilities; a decade from now I could see that number at 90 percent or even higher. But IHS would only be only a portion of the funding story: Money would also come from insurance companies or the new insurance exchange; on top of that there would be Medicaid and Medicare; perhaps add in a foundation grant or two; and, finally, the funding would be completed by appropriations designated for

community health centers. The total might not be full funding of the Indian health system, but it will be a lot closer to that goal. Is this the wave of the future or an abrogation of treaty rights?

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