The Story of Indian Health is Complicated by History, Shortages & Bouts of Excellence

Abstract: One of the primary goals of the U.S. government's entry into health care was to protect soldiers by isolating tribal populations and inoculating them against infectious disease. When tribes signed the legally binding treaties, the United States promised them doctors, nurses, facilities, and basic health care. Yet this promise has never been fully funded by Congress. The Indian Health Service, which includes tribal and nonprofit health agencies, is tasked with defying gravity, and this has led to a regular cycle of heartbreaking stories about a system that fails American Indian and Alaska Native patients. Yet, at the same time, the Indian health system has achieved remarkable innovation and excellence.

Every so often, the "story" of Indian health is told by a news organization. For example, *The Wall Street Journal* reported the death of several Native American patients in Pine Ridge and Sisseton, South Dakota, and Winnebago, Nebraska: "In some of the

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itol Hill, a number of senators weighed in on *The Wall Street Journal* report. "The stories are heartbreaking," said Senator Lisa Murkowski, R-Alaska, chair of the Appropriations subcommittee that funds Indian health programs. She added that though the then-Acting Director of ihs, Mary Smith, had indicated that "the agency was committed to doing 'whatever it takes' to deliver quality care," Murkowski still found that serious problems continued, including hospitals operating without having received recertification from the Center for Medicare and Medicaid Services despite an additional $29 million approved to address these problems.[2] Murkowski stated that she was "very concerned" that the Trump budget request

> does not adequately meet the needs for health care in Indian Country. The disparities between health outcomes for American Indian and Alaska Native people compared to the population at large are staggering. For example, American Indians and Alaska Natives are three times more likely to die from diabetes. The drug-related death rate for Native Americans has increased 454 percent since 1979 to almost twice the rate for all other ethnicities. And, the suicide rate among our First Peoples is roughly twice that for the rest of the population. In order to improve health care delivery, the ihs must do a better job at hiring and retaining an adequate number of qualified doctors and nurses. The ihs must also do a better job of maintaining a large facilities infrastructure that serves 2.2 million American Indians and Alaska Natives. This requires significant resources. Currently, the vacancy rate for Indian Health Service doctors, dentists, and physician assistants is roughly 30 percent. The backlog of facilities maintenance at ihs hospitals is over half a billion dollars, and according to the agency's own budget documents, the average age of its facilities is roughly four times that of its private sector counterparts. Additional resources are not the only answer – the agency must also do more to improve the quality of its existing work force.[3]

Another member of the subcommittee, Jon Tester, D-Montana, was frustrated by the administration's budget request and the refusal of the agency's current acting head, Michael Weahkee, to admit whether there would be an increase or a decrease in the agency's ability to hire staff. When questioned directly about the budget, Weakhee replied only that the ihs was prioritizing "maintaining direct care services."[4] But this was not an isolated incident; there has been a long history of Indian Health Service directors who were unable or unwilling to answer that question. If we consider the Senate exchanges as a story, it becomes one that tells of incompetence, poor management, too few doctors, and, most certainly, not enough money.

Because we only have sparse evidence

state the consequences of a 90 percent mortality rate. This is the root of historical trauma: the collective memory of a people nearly wiped off of their homeland.

Greg Bourland, then-chairman of the Cheyenne River Tribe in South Dakota, shared in *The New York Times Magazine* a personal familial history of epidemic. He wrote about his great-great-grandmother Blue Earnings:

> She was a powerful Lakota medicine woman. They say that she drank water all the time. She got sick from smallpox, and when she was getting ready to die, she asked for a bowl of water. She said, "I'm going to show you part of my powers, and why I'm sick." They put the bowl in front of her, and she spit into it, and out of her mouth flew four little water creatures. Here in the Dakotas, around the edge of lakes, there are these insects. They look as if they can walk on the water. They skitter. Three of them were jumping around in the bowl, and the other was dead. She pointed and said: "See, that one got sick from this white man's disease, from smallpox. If that one can't live, I can't live, either." And she died.[6]

Indeed, it was the epidemics that defined the early public health initiatives of the United States. The Army sent doctors to military posts in order to protect soldiers from infectious diseases, leading Army doctors to care for tribal communities, at least on an irregular basis. In 1832, the War Department negotiated a treaty with the Winnebago Tribe in Wisconsin that promised two physicians as partial payment for ceded acres. The cost was budgeted at $200 per year. (As a comparison: an Indian agent's salary in that region was $800 per year and that was considered low. Missouri River agent John Sanford wrote to Superintendent of Indian Affairs William Clark and asked for a $400-a-year salary increase because he deserved a job with less risk and better pay.) Not every treaty was as specific, but most of the nearly four hundred treaties that Congress ratified includ11 99 10i6 Tw 10that w5 Tr

urban Indians' health is enough to warrant immediate action." The report cited dismal statistics: the infant mortality rate among urban American Indians and Alaska Natives was 33 percent higher than that of the general population; the death rate due to accidents was 38 percent higher; the death rate due to diabetes was 54 percent higher; the rate of alcohol-related deaths was 178 percent higher; up to 30 percent of all American Indian and Alaska Native adults suffer from depression, and there is strong reason to believe the proportion is even greater among those living in cities; and cardiovascular disease, now a leading cause of death, was virtually unheard of among American Indians and Alaska Natives as recently as forty years ago. The report concluded: "Urban Indians have less access to health care than other Americans. Often, their living conditions are literally sickening. Persistent bias against them and their mistrust of government keep many from getting the health care they need."[16]

Only about 1 percent of the Indian Health Service budget is spent on urban Indian health. There is another underappreciated impact from the growth of Indian health programs following the Indian Health Care Improvement Act. Around 1996, the Indian Health Service became Indian Country's largest employer. Indian health was once a small slice of the Bureau of Indian Affairs. But by 1996, the agency's budget was larger than the bia's and there were likely more workers as well. In 2017, for example, the bia employed approximately 6,770 full-time workers compared with the 15,119 at the Indian Health Service (including 1,928 uniformed Public Health Service officers). This makes sense and reflects what is happening with health care generally: clinics, hospital systems, and university medical centers are often a region's largest employer. But there is another story that has largely been missed by both policy-makers and the public: the shift of the Indian Health Service from a federal, government-operated health care system to one that's more than 60 percent operated by tribes, intertribal organizations, and nonprofits.

This is where the story gets lost in translation. Both the government-operated system – which includes the facilities profiled by *The Wall Street Journal* at Pine Ridge, Sisseton, and Winnebago – as well as the tribally operated health care initiatives do not have enough resources. The system as a whole spent $3,688 per capita on its user population compared with $9,523 for the U.S. population.

Don Berwick, who ran the Centers for Medicaid and Medicare, has called the Indian Health Service a model of efficiency: "The Indian Health Service can and will be one of the leading prototypes for health care in America. 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 added that the very nature of the agency's underfunding has resulted in a discipline that's "an example for us all."[17]

That discipline goes hand in hand with innovation. The Southcentral Foundation in Anchorage set out to reinvent its program by surveying its patients. "Are you sure you want to do that?" ceo Katherine Gottlieb was 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 handled 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."

The Southcentral Foundation set out on a new course, starting with a change in

the language. The phrase "patients" was swapped for "customer-owner": "We are literally customer-owners, Alaska Natives. Our board of directors are all Alaska Na-

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