



November 16, 2016

## AN OVERVIEW OF THE INDIAN HEALTH SYSTEM

### INTRODUCTION

The Indian Health Service (IHS), an operating division of the U.S. Department of Health and Human Services,<sup>1</sup> delivers culturally competent health services for American Indians and Alaska Natives (AI/ANs). IHS is one of four core federal health delivery systems.<sup>2</sup> IHS provides services in a variety of ways: directly, through agency-operated programs and through Tribally-contracted and operated health programs; and indirectly through services purchased from private providers. IHS also provides limited funding for urban Indian health programs that serve AI/ANs living outside of reservations. This varied system of delivery is commonly referred to by its initials: I/T/U (IHS, Tribal, and Urban). Tribes may choose to receive services directly from IHS, through contracting or compacting agreements, or they may combine these options based on their needs and preferences.

Indian health services were permanently reauthorized through the Indian Healthcare Improvement Act (IHCA), which was enacted as part of the Patient Protection and Affordable Care Act (P.L. 110-148) (ACA). In the IHCA, Congress declared: “it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians -- to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”<sup>3</sup> Despite challenges in the I/T/U system, it is a critically important component of care for AI/ANs and many others living in remote, rural communities. For those populations, IHS represents health care access in its entirety, both in terms of monetary resources but also facility access. Without IHS, and the Tribal clinics and hospitals it funds, there would be no care for hundreds of miles in some cases. The IHCA is entirely independent from the broader health reform authorized by the ACA and it must be preserved.

### THE VALUE OF THE INDIAN HEALTH SYSTEM

AI/ANs experience worse health outcomes compared with the rest of the U.S. population. High rates of poverty, accompanied by high unemployment rates, barriers to accessing higher education, poor housing, lack of transportation and geographic isolation all contribute to poor health outcomes. AI/ANs continue to experience historical trauma from damaging federal policies, including those of forced removal, boarding schools, and taking of Tribal lands, and continuing threats to culture, language, and access to traditional foods. Historic and persistent under-funding of the Indian healthcare system has resulted in problems with access to care, and has limited the ability of the Indian healthcare system to provide the full range of medications and services that could help prevent or reduce the complications of chronic diseases.

But IHS exists to serve the health care needs of AI/ANs and to address those disparities. Since the creation of the agency in 1955, the life expectancy of AI/ANs has increased from 60 years old to 73.7 years.<sup>4</sup> Today the Indian healthcare system includes 46 Indian hospitals (1/3 of which are Tribally operated) and nearly 630 Indian health centers, clinics, and health stations (80 percent of which are Tribally operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 34 urban programs offer services ranging from community health to comprehensive primary care.

### Community Care, Public Health & Innovation

The I/T/U system utilizes a community-based public health model with many approaches that are not found in typical American medical delivery systems. For example, Indian health programs include public health nursing, community outreach workers, prevention services, dental health aide therapists and even support community water and sanitation services. Indian health programs have pioneered new types of providers, such as community health aides and dental health therapists, as well as new approaches to delivering services in remote rural areas, including telehealth. Tribal governments manage a wide range of services, such as substance abuse treatment, the U.S.D.A. nutrition programs for pregnant women,

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<sup>1</sup> Congressional appropriations for IHS flow through the Interior, Environment and Related Agencies Appropriations bill.

<sup>2</sup> Other federal health systems include: Veterans Health Administration; Defense Health Agency; and Bureau of Prisons Health Services Division.

<sup>3</sup> 25 U.S.C. § 1602.

<sup>4</sup> It is important to note that the life expectancy of AI/ANs is still 4.2 years less than the national average, and in some states it is a full 20 years less than the white population.

infants and children (WIC), Senior Centers and elder nutrition sites, rabies vaccinations for dogs, and injury prevention programs, to name just a few. Tribal programs tend to be more grounded in the cultural practices and norms of the community members they serve, including offering language services and residing within remote Tribal communities.

## **FUNDING AND STRUCTURE OF IHS**

Direct Service Tribes (DST) are those Tribes that either in whole or in part, receive primary health care directly from the Indian Health Service. Self-Governance Tribes (SGT) are those Tribes that negotiate with IHS and assume funding and control over programs, services, functions or activities or portions thereof, that IHS would otherwise provide. DSTs choose to rely on IHS for their delivery of health care, citing a number of reasons for doing so, including: lack of resources and infrastructure, rural locations, and belief that the United States upholds its treaty obligations by providing direct services. However, IHS is only funded at about half of actual need, which creates challenges to the system overall. The funding that IHS receives is shared between DSTs and SGTs, with DSTs receiving roughly 40 percent of funding.

SGTs have achieved great improvements in health outcomes, and more and more Tribes choose to operate their own health programs. Self-governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level. In fact, many of the programs pioneered by SGTs are some of the most innovative, modern, health systems in the country. By investing their own revenues, pooling resources together and creating systems that are culturally appropriate and efficient, many self-governance Tribes are able to provide a continuum of care unparalleled in mainstream America. About 56 percent of the IHS budget is operated directly by the Tribes through self-governance contracts and compacts. However, it is important to note, that it is still the sovereign decision of each individual Tribe to choose to enter into self-governance compacts.

## **THE INDIAN HEALTHCARE IMPROVEMENT ACT AND OTHER ACA INDIAN PROVISIONS**

The IHCA was permanently authorized in 2010 in section 10221 of the ACA, even though it is entirely unrelated to the ACA or the underlying healthcare reform the ACA represents. The IHCA provides critical new resources and opportunities for Tribal health care institutions, families, providers and patients and is the foundation of the modern Indian health care system. IHCA updates and modernizes health delivery services, such as cancer screenings, home and community based services and long-term care for the elderly and disabled. It establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people. Some examples of IHCA authorities making a major difference in the delivery of Tribal health programs include the ability for medical professionals working at an I/T/U program to be licensed in any state; the ability for Tribes to participate in the Federal Employees Health Benefit program; and authority for long-term care services. It is critical that IHCA be preserved. Revoking this law would remove many important cost-saving and modernizing laws that have helped bring IHS into the 21<sup>st</sup> Century.

In addition, there are other Indian-specific provisions enacted as part of the ACA that are similarly unrelated to the broader health reform programs enacted by the ACA. These independent, Indian specific stand-alone provisions play an important role in modernizing the Indian health care system and ensuring that federal resources are maximized to lead to the best possible health outcomes. For example, Section 2901 of the ACA made IHS the payor of last resort, and Section 2902 granted IHS and tribal health programs permanent authority to collect reimbursements for all Medicare Part B services. And, Section 9021 of the ACA added Section 139D to the tax code to make the value of health benefits provided by a tribe to its members not includable as taxable income. None of these provisions have anything to do with the health reforms enacted by the ACA as a whole, but all are critically important reforms to the Indian health system. These important protections for the Indian health system must be preserved in future legislation. Finally, the ACA recognized the Indian health system as a critical component of health care reform and included many Indian-specific provisions to help the IHS and tribes leverage health reform to improve federal and tribal health services and outcomes, like premium subsidies, cost sharing exemptions, and monthly enrollment for Indians. These provisions have helped to increase revenues for I/T/U programs to begin to address the historic underfunding of these programs. As health reform continues to evolve, the importance of these programs to the federal health care system must not be forgotten.