

# Health Services for America's Indians

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*For most Americans, it takes only a telephone call to bring the family doctor when he is needed. If hospitalization is required, there is a community hospital nearby. Public health services—provided by State or local governments—are taken for granted. For some 370,000 Indians and Alaska Natives, however, who are scattered over 250 reservations and in small communities in the West and in Alaska, the U. S. Public Health Service fills the role of physician, hospital, and health department. The problem of Indian health and what is being done to solve it are outlined in the following pages.*

THE Indian health program was transferred to the Public Health Service from the Department of the Interior's Bureau of Indian Affairs on July 1, 1955. With this responsibility came approximately one-fourth of all the employees of the Bureau, together with about 970 buildings valued at \$40 million. The program operates 56 Indian and Alaska Native Health Service hospitals, about 85 health centers and field health stations, and 14 boarding-school infirmaries. Field health services are made available periodically at more than 200 other localities. Additional hospital beds are provided for Indian and Alaska Native patients through contracts with about 160 non-Federal hospitals. Thirty-two State and local health departments and the Alaska Department of Health provide public health services under contract.

Many services for Indians, including those in the fields of health, education, and welfare, have long been recognized as responsibilities of the Federal Government. During and after the Indian Wars, the Government dealt with Indian tribes as though they were separate nations, and numerous treaties and agreements were concluded between the Government and various Indian groups. Subsequently, impressive numbers of Federal laws pertaining to Indian affairs were enacted. Some 4,000 treaties, laws, and agreements are on the books, many of which set forth specific obligations for health

services that were assumed by the Government. In virtually all cases, however, the formal treaty obligations for health services assumed by the Government have long since been discharged.

## *Economic and Social Background*

Today, Federal health and other services are provided for the Indians because Congress recognizes the Nation's obligations to help its Indian and Alaska Native citizens to meet their needs that cannot be met at this time in any other way. Although State and local governments are assuming increased responsibilities in providing health and other services to their Indian residents, these governments are not yet able to assume the heavy costs of furnishing the wide range of services needed by the Indians who live on reservations. State governments find it difficult to finance special services to Indians because tax revenues from them are low. Although Indians are subject to essentially the same taxes that are paid by other citizens, many of them live on tax-free lands and many pay very little in the way of other taxes because of their generally distressed economic circumstances.

As citizens, the Indians are free to live anywhere they may establish themselves. The fact that most of them remain on their reservations is due to a combination of cultural ties with the past and economic and social realities of the present. Most reservations are sparse, thirsty lands that cannot support the Indian popula-

tions that occupy them. The Bureau of Indian Affairs recognizes that the long-range solution to what is popularly referred to as "the Indian problem" depends in part upon voluntary movement by the Indians to communities in which they can be self-supporting. The Bureau therefore conducts a relocation program, which assists Indians in preparing themselves for employment, leaving the reservations, and finding jobs. When Indians relocate in non-Indian communities, they must look to those communities instead of to the Federal Government for whatever help they may need in obtaining health services.

A large proportion of the 370,000 Indians and Alaska Natives in areas served by the Public Health Service—perhaps one-third of those over age 40—do not speak English. Most of them are extremely poor; more than half the families have annual incomes of less than \$1,000. Their housing, for the most part, is substandard and overcrowded. The homes of many are without sanitary facilities. Water is often scarce and from contaminated sources. Means of handling refuse and fly control are usually lacking.

## *Health Conditions*

In such an environment, ill health thrives. There are many measures of the unsatisfactory health conditions among the Indians. One of the most obvious is their average age at time of death—39—compared with 60 for the general population. Nearly one-third of all reported deaths among Indians in the continental United States, according to the latest figures, occur before the fifth year, whereas only 8 percent of the deaths in the general population are in this age group. Of every 1,000 Indian infants born, 65 will not survive for even 1 year. In contrast, only 27 infants per 1,000 in the general population die before age one.

Death rates from preventable diseases tell a harsh story in cold figures. In the continental United States the

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Indian death rate from pneumonia and influenza is nearly three times that of the general population. From tuberculosis, their death rate is five times greater, and from enteric diseases it is 10 times greater.

### **Health Resources**

To compensate as much as possible for their unfavorable and unhealthy environment, the Indians need more extensive health services than do surrounding non-Indian populations. The fact is, however, that over a period of many years their health resources have been much more meager than those usually available to other citizens. In no year before 1929 was as much as \$1 million appropriated for the entire Indian health program. As recently as 1948, no annual appropriation ever had reached \$10 million.

Medical services on reservations and in Indian communities have been hampered seriously by shortages of personnel, inadequate and wornout facilities, deficiencies in equipment, and shortages of supplies. Housing for staff members never has been adequate either in quantity or in quality and even now remains a major obstacle in recruiting and retaining personnel. Neither the Public Health Service nor the Bureau of Indian Affairs now has the legal authority or the money to construct urgently needed sanitary facilities for Indian communities, and in most areas of Indian population there are no local agencies able to do the job.

The wide diffusion of the Indian population, the shortage or absence of transportation facilities on reservations, the difficulties of communicating with the people, and their lack of knowledge about acceptable health practices all combine to make the cost of serving them abnormally high. To complicate the task of the Public Health Service still further, there are no clear-cut definitions of who is an Indian, and determination of precisely who may receive services under the program is often difficult.

Such is the setting in which the Public Health Service provides medical care and public health services to the Indians and Alaska Natives. When the Service took over this re-

sponsibility, the House Appropriations Committee asked the Surgeon General to make a careful study of the whole Indian health situation and to report on what is needed to bring Indian health to an acceptable level. The Service first took stock of the rundown physical plant and determined the urgent needs for new construction and renovations. Major deficiencies were itemized, and estimates of the cost of correction were reported to the Committee in November 1955. For the fiscal year 1956-57, the sum of \$7,762,000 was appropriated for new construction and \$1,000,000 for major renovation—amounts that permit a start toward putting the physical plant in decent shape.

A much bigger task was the comprehensive survey undertaken by the Public Health Service to determine more clearly the morbidity and mortality patterns of the Indian population, the effects of their environment on their health, their needs for health services, and the effects of social and economic conditions on their ability to obtain health services. The Service completed this survey in the fall of 1956 and made recommendations based upon its findings.

Upon assuming full responsibility for Indian health, the Public Health Service immediately began a substantial expansion and improvement of the program. Congress had directed that steps be taken to bring health conditions among the Indians to a satisfactory level as rapidly as possible and provided increased funds for inaugurating major improvements. The 1955-56 appropriation for Indian health activities amounted to \$35.0 million, exclusive of \$5.0 million for construction. This amount may be compared with \$24.5 million for 1954-55—the year preceding the program's transfer to the Public Health Service. The 1956-57 appropriation is \$38.8 million, plus the \$8.8 million for construction and renovations.

### **The Expanding Health Program**

One of the first steps in expanding the Indian health program was the addition to the staff of more professional health workers and supporting staff members. An increase from 121

to 229 in the number of physicians makes it possible to staff even the smaller Indian hospitals throughout the country with at least two doctors each. The number of dentists was increased from 46 to 76. Health educators, sanitary engineers, medical social workers, public health nurses, pharmacists, and hospital administrators were added to those already on the job and doing their best to function efficiently under excessive workloads.

In one professional category, however, the program actually has lost ground. Faced by stiff nationwide competition for nurses and unable to offer employment in ultramodern hospitals in metropolitan settings, the program has many vacancies for hospital nurses that are going begging. The condition continues despite the advantages that nursing careers in this program offer.

With the dual objective of increasing services to Indians and helping the Indians to take a greater part in their own health program, the Public Health Service is training Indians in increasing numbers to fill health occupations. Practical nurses for Indian hospitals and clinics are trained at accredited schools conducted by the Service in New Mexico at Albuquerque and in Alaska at Mount Edgecumbe. Sanitarian aides, to assist sanitary engineers, are trained in special courses at Phoenix, Arizona, and in Alaska. Dental assistants are trained at the Indian school at Brigham City, Utah, and plans are under way to begin training dental laboratory assistants. Community health workers, some of whom are college-trained Indians, are being given on-the-job training under the supervision of two university schools of public health under contract with the Public Health Service. These community health workers will assist health educators. Some Indians are undergoing professional education in health occupations at their own expense and plan to return to work with their own people. Many of the professional nurses in the Indian health program are themselves Indians.

It has long been the practice of the Federal Government to contract for health services for Indians where this

is practicable and where it is to the advantage of the Indians. With more money available for this purpose, care provided to Indians by contract physicians and dentists and in contract hospitals has been increased.

Important improvements have been made in virtually all the program's 56 hospitals. Administration, food service, outpatient activities, social service, medical records, and pharmacy operations are being revamped with the aim of improving the quality and quantity of services to patients. Acceptance of the improved services provided is reflected in increasing use of the 56 hospitals. During 1956 a total of 43,773 general medical and surgical patients and 2,445 tuberculous patients were admitted—increases of 9 percent and 15 percent, respectively, from 1955.

In addition to extensive renovations planned in the physical plant, four new hospitals and a number of health centers are to be built. Three of the new hospitals, including one in Alaska, will replace outworn existing structures. The largest of the new hospitals will be a 200-bed general hospital in the Southwest, which will serve as a referral facility for smaller hospitals in that area.

Since most of the illnesses among the Indians result from diseases that can be prevented and that are well under control in the general population, great emphasis is being placed upon public health activities. For the most part, services aimed at disease prevention are fully integrated with the therapeutic services of the Indian health program. All the hospital outpatient clinics, the health centers, and the field health stations, for example, provide both treatment and public health services. About 15 per-

cent of the total Indian health operating appropriation is available for disease prevention activities.

Health education, in its broadest sense, is a major function of the Indian health program. Through its many channels, Indians in their home communities are being helped toward a better understanding of the effects that sanitation, diet, and other practices of daily living have upon health. Home visits by public health nurses are being increased to locate more of those persons who need medical attention and to bring them under treatment earlier.

With the help of the Children's Bureau of the Social Security Administration, child health activities are being broadened in a concerted effort to reduce the excessive infant mortality rate and to lay sound foundations for good health in children and mothers. In the field of preventive dentistry, fluoride treatments are being brought to larger numbers of the school population in more communities. Both curative and restorative dental services are being provided for increased numbers in the Indian and Alaska Native populations. Sanitation services on reservations and in native communities have been expanded, and the Administration is recommending legislation to permit the Public Health Service to broaden these services much further by constructing sanitary facilities.

Necessary improvements in Indian health can be achieved only through a concerted and fully cooperative effort by the Federal Government, the States and Territory concerned, and the people themselves. While continuing a close collaboration with the Bureau of Indian Affairs, the Public Health Service makes use of the ex-

tensive resources of the Department of Health, Education, and Welfare in meeting the health problems of the Indians. Representatives of constituent programs of the Department, joined by members of the Bureau of Indian Affairs staff, work together in the interests of Indian health on an interconstituent committee on services for Indians. One of the aims of this committee is to assist States in making available for greater use by the Indians those State and Federal health and welfare resources to which all citizens are entitled.

To guide the Surgeon General in shaping and carrying out policies to improve Indian health, the Public Health Service systematically enlists the advice of a group of eminent authorities on Indian affairs. This group is organized as the Surgeon General's Advisory Committee on Indian Health and includes three leading Indians in its membership.

To operate the Indian health program, the Public Health Service organized within its Bureau of Medical Services the Division of Indian Health. Most of the employees of this Division previously served the program in the Bureau of Indian Affairs. For purposes of administration, Alaska and the 24 States in which the program operates are divided into six geographic areas, each under the direction of a medical officer who is in charge of all phases of the program within his area. These medical officers report directly to the chief of the Division of Indian Health.

Although the progress achieved so far in bringing Indian health in line with that of the Nation as a whole is small in relation to this ultimate objective, it is enough to indicate that the problem can be solved.