

# STATES AND TRIBES: A Healthy Alliance

Some of the health care models states and tribes are developing for Native Americans could be used for other residents.

By Therese Droste

The disparities in health between Native Americans and other Americans are nothing short of staggering.

American Indians and Alaska Natives rank at or near the bottom of nearly every social, health and economic indicator, according to a 2004 report from the U.S. Commission on Civil Rights. They are 670 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental deaths than members of other groups. Although the average lifespan of Native Americans has increased from 51 years in 1940 to 71 years today, it is still six years below that of other Americans.

## AN UNEASY ALLIANCE

There's a long tradition of the federal government working with tribes on health issues. The U.S. Constitution states that federally recognized tribes are sovereign nations with inherent rights.

"Health services were guaranteed by treaties entered into between the federal government and sovereign nations in exchange for land, mineral rights, resources and, during certain periods of American history, some personal rights and freedoms," says Charles Grim, assistant surgeon general and director of the Indian Health Service.

But for a number of reasons, tribal nations have not always worked closely with states. It's partly that tribal nations are accustomed to turning to Washington for help. But there are also gaps in culture and knowledge.

"Most state legislators don't have a good knowledge of who the tribes are, what our equal status is, or the unique legal, social

and cultural conditions of tribal regulations. They don't know how to reach out to us or who to talk to," says W. Ron Allen, tribal chairman and executive director of the Jamestown S'Klallam Tribe, Sequim, Wash.

Often, tribes are out of sight and out of mind on reservations, Allen added. "As a general rule in most rural communities, they are removed from mainstream society, and are often the hardest to reach."

Lawmakers may be baffled by the sovereign nation status of tribes, as well as the cultural differences and fragmentation of the 562 federally recognized tribes. Some 229 of these tribes are in Alaska; the rest are located in 36 other states.

There also is the impression that casino gaming has made nearly all Native Americans wealthy. "Only about 40 tribes make money on gaming, out of the 562 tribes total," says Dr. Craig Vanderwagen, chief

medical officer of Indian Health Services. The commission notes that half the Native American population is poor or near poor, compared with 25 percent of whites.

"There is an inclination for people to think, 'This is a federal problem, we don't have to deal with it.' That's not true, and it's also short-sighted," says Jim Crouch, executive director of the California Rural Indian Health Board, which operates 11 tribal health programs that provide health services to some 63,000 people in rural California.

Nevertheless, observers say that states are making progress in forging alliances with tribal nations. In some cases, they're developing models of care for Native Americans that could be used for other residents.

Alaska, for example, is "making headway toward having good relationships with the tribes," says Joyce Hughes with the Alaska Primary Care Office. "The mistrust is still there, but it's lessening." It stems in part from the fact that the health system is so complex, she explains. "There are two such different systems, the funding streams are different, and the urban areas have very different issues from the rural ones."

The 49th state is divided into nine health-care delivery areas, and each area is as large as a state in the lower 48, with low population density, no road systems, extreme weather conditions and a high cost of living. The cost of building clinics in frontier areas and of flying critically ill patients in air



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## A BIT OF HISTORY

The U.S. government first provided health care to Native Americans in the 1800s, when Indians who lived around army posts were infected with diseases brought over by Europeans. To protect their soldiers, Army doctors began treating the Native Americans.

In 1921, Congress passed the Snyder Act, which authorized federal funds for “the relief of distress and conservation of health” of Indian tribes. In 1954, the responsibility for delivering health care to Native Americans was given to the U.S. Department of Health and Human Services, and in 1955, the Indian Health Service was established.

ambulances from remote areas to urban hospitals is enormous.

One innovative solution that tribes and the state have developed—and that other states are looking at—is the community health aide. Currently, some 450 to 500 serve about 200 remote villages in Alaska. “They make sure there’s at least some kind of health care available in remote areas,” says Renee Gayhart with the Office of the Commissioner of Tribal Programs. “They can stabilize folks so they can be sent to urban areas.”

The aides are selected by their local communities to undergo training and have differing scopes of practice. They’re supervised by physicians based in regional hospitals. The state helps pay for training, and, in 1999, Alaska got approval to pay for the aides’ services with Medicaid funds.

The tribes want to create a similar position for dental care, and, in fact, students are being trained for that purpose in New Zealand right now. (New Zealand has pioneered training for rural dental “therapists” or “nurses.”) “But we’ve run into a lot of opposition from the American Dental Association,” Gayhart says.

### AN AMAZING JOB

Observers tend to agree that the Indian Health Service does an amazing job with the resources that it has—but they also agree that the agency’s budget (which is subject to annual congressional appropriations) hasn’t begun to keep up with growth in the population or medical costs. Facilities are old and medical equipment is often obsolete, as it is

used for twice the normal life span.

The IHS budget is about \$2.9 billion. If Native Americans are to begin to achieve parity with other Americans, the IHS will need appropriations totaling roughly \$18 billion, including a one-time appropriation of \$8 billion for facility construction and \$10 billion per year for health-care delivery for the next 10 years, the U.S. Commission on Civil Rights reports.

The low level of funding creates a huge disparity in what’s spent on Native American health care by the IHS, and what’s spent by other payers on other Americans. According to the commission, the service spends \$1,600 per person per year for all health care. That’s about a third of the \$5,775 spent by public and private payers on the average American, and half of what is spent by the federal government on federal prisoners.

“IHS doesn’t even keep up with general inflation, let alone medical inflation, each year. So of course you have to end up cutting services somewhere. It’s remarkable they are able to offer the services they do,” says Traci McClellan, legislative director of the National Indian Health Board, Washington, D.C.

With the Indian Health Service so poorly funded, states and tribal nations are working to maximize all available funding for health care. One of the most useful tools is a unique Medicaid funding match that dates back to the 1976 Indian Health Care Improvement Act.

Systems vary from state to state, but in general, under the act, Medicaid will reimburse states for services provided to American Indians and Alaska Natives at 100 percent of the federal medical assistance percentage—if those Native Americans are enrolled in Medicaid and if the services are provided by health-care systems that are run by the IHS or tribal organizations.

A 1975 law gave tribes the option of taking over the operation of IHS services. Today, tribes manage about 52 percent of the funds appropriated to IHS; they run more than 440 facilities, from full-service hospitals to clinics.

To get that 100 percent match, states have been educating Native Americans about Medicaid and about the availability of tribally managed services. Tribal health care may be more sensitive to Native American culture than private institutions, so patronage of the services can be a win-win for everyone, observers say.

“The states can’t delegate [to the tribes] the responsibility [for outreach], but some states may put an outstation of their own workers on a reservation [once a week or so],” says Kris Locke, an independent consultant in Sequim, Wash.

Increasing enrollment in Medicaid has not been easy. The Native American community has not been accustomed to having to apply for services that are seen as a birthright, guaranteed by treaties and laws. I

In January, the Centers for Medicare and Medicaid Services stepped up their efforts to reach out to the Native American community by creating a Tribal Technical Advisory Group. The advisory group is holding meetings to hear the needs and concerns of tribal leaders, and to better educate them about the centers.

### ALLIES IN NEED

Alaska has a great deal at stake when it comes to maximizing Medicaid reimbursement. Alaska Natives make up 16 percent of the state population, but they account for nearly 40 percent of Medicaid clients and expenditures, according to documents from the Alaska Department of Health and Social Services.

The state and tribes have managed to increase Medicaid payments to Alaskan tribes from \$9.6 million in FY 1991, to \$149 million in FY 2003, according to state documents. But state officials are worried about a looming cut in the state’s federal medical assistance percentage.

Next year, Alaska will lose about \$53 million because of changes in the FMPA formula. In subsequent years, the cut will grow to \$80 million or more. “It’s a big hit,” Gayhart says.

The tribal nations will be an important ally in the state’s efforts to make up for this cut, she adds. “We support each other—the tribes for the state on FMAP, and the state for the tribes on IHS negotiations.”

Another area where states and tribal nations can be allies is in improving and expanding Indian Health Service facilities and services. As of 2001, there was a \$900 million backlog in unmet needs for facilities. If legislators could help tribes find short-term, start-up money, to draw up a business plan and begin paying for staff, the IHS can pay for construction and tribes can provide the staffing. Once the revenue streams are flowing, the clinics can be self-supporting. ■