

Method of the Study

The purpose of this assessment of Indian health care was to evaluate: 1) the health status of American Indians and Alaska Natives who are provided health care through the Federal Indian Health Service (IHS), 2) the health services provided to them in view of their health needs, and 3) the health delivery systems in which these services are provided. Also identified as a more specific issue to be evaluated was the growing problem of paying for high-cost care that cannot be provided in IHS facilities and that must be purchased from non-IHS providers. (Letters from Congress requesting and supporting the assessment follow this narrative.)

The assessment began on October 1984. Project activities included: selection of an advisory panel; two advisory panel meetings and other extensive reviews; four regional meetings with tribal representatives; site visits to Indian reservations and IHS service units; meetings and consultations with IHS personnel; analysis of Indian social and economic characteristics, health services, and health status; and responding to a special request in addition to the overall assessment.

The advisory panel for this assessment of Indian health care consisted of 19 members from Indian tribal governments and private and tribal health programs for Indians, policy analysts of Indian issues, and representatives of State governments, public health, medical economics, public policy/health care administration, sociology, and law. Rashi Fein, professor of the economics of medicine at Harvard Medical School, chaired the panel.

The first panel meeting was held on January 29-30, 1985. OTA project staff identified the sources of available information and presented a preliminary analysis of these sources to the panel. The panel discussed the overall, study plan and provided advice on the focus of the study. Information for this assessment was obtained primarily from unpublished documents (more so than for usual OTA assessments), interviews, regional meetings, and site visits.

OTA project staff was also assisted by several contractors in preparing this assessment. In May-July 1985, four regional meetings were held by OTA in conjunction with the National Indian Health Board (NIHB), an organization that represents the tribes on health issues. The meetings were publicized in NIHB's newsletter, and a common agenda was used at the four meetings, which were held in Portland, Oregon; Phoenix, Arizona; Rapid City, South Dakota; and Tulsa,

Oklahoma (the meeting agenda is described below). Several advisory panel members participated in meetings in their localities. The objectives of these meetings were to provide tribes and OTA staff with the opportunity to communicate directly with each other, and to confirm or correct the area-specific health status, socioeconomic, and health services information OTA had sent in advance of these meetings. In conjunction with the regional meetings, OTA project staff visited many reservations to gain a sense of the diversity and special concerns of the tribes.

Projections of the future Indian population were developed under OTA guidance by Henry Cole and S. Ken Yamashita of the Futures Group; computer analysis of data sources on Indian health status was provided by Steven Bjorge of Washington, D. C.; and Paul Alexander of the law firm of Alexander & Karshmer provided a legal analysis of the Federal-Indian relationship. (The method used in the Indian health status data analysis is described below.)

The advisory panel met again on October 28-29, 1985, to review a draft of the final report. Based on that meeting, the summary chapter was rewritten and again submitted to the panel for their review. The draft final report was sent for review to nearly 200 organizations and individuals. The OTA project director also attended the annual meeting of the National Indian Health Board in Albuquerque, New Mexico, in November 11-14, 1985, at which time the draft report was discussed in an open forum, with several advisory panel members participating in the discussion. The final report was submitted to OTA's Technology Assessment Board on January 17, 1986.

During the course of this assessment, the House and Senate Appropriations Subcommittees for the Department of the Interior and related agencies requested that OTA conduct an analysis of the number of beds and whether a surgical suite should be included in the replacement hospital planned for the Rosebud Sioux in South Dakota. The request was made in June 1985 because of a dispute between the Rosebud tribe and the Public Health Service on the size and services of the replacement hospital. The analysis was completed and delivered on August 1, 1985, in the form of an OTA staff memorandum. OTA's conclusions were that, using PHS's own criteria, a 30- to 35-bed instead of a 25-bed hospital was warranted, but that a surgical suite was not.

Purpose of the Regional Meetings

The regional meetings and site visits were held: 1) to give IHS's client population the opportunity to comment on the information OTA was gathering at the national level and on whether this information reflected the local situation; and 2) to provide OTA with information and opinions on local health issues, problems, and priorities. The meetings covered the following areas:

- I. Characteristics of Indian peoples
 - A. Tribal membership: eligibility, trends, general demographics
 - B. Health status and special health problems
11. Delivery of health care
 - A. Direct IHS services

- B. self-determination (638) funds
- C. Contract care
- D. Other sources of funding (Medicare, Medicaid, private, etc.)
- E. Equity funding-criteria, application, impact
- F. High-cost ("catastrophic") contract care—impact on contract care funds, types of cases, trends, relationship to presence or absence of relevant IHS direct care services
- G. Health-related services: community health representatives, sanitation, housing, nutrition, other environmental services.

Health Statistics Information

IHS provided OTA with three data files on magnetic tape of the records of all American Indian and Alaska Native deaths during the years 1980, 1981, and 1982, as compiled by the National Center for Health Statistics (NCHS). In all cases, death rates computed by OTA represent the centered-average of the 1980-82 period.

There was a slight discrepancy between the number of records on the tape and the number of deaths as described in IHS publications. There were 20,200 death records on the tape supplied by IHS, while IHS publications list 20,210 deaths for this 3-year period. This was assumed to be a minor discrepancy and was not pursued further. IHS uses a matching program based on State, county, and community of residence to assign death records to an IHS service area. OTA excluded death records without an assigned IHS area. The number of death records assigned to all IHS areas during the 3-year period was 15,792.

These deaths were stratified into age-specific, sex-specific, and IHS-area-specific totals. Rates were calculated for each of the 72 selected causes of death that are used by NCHS in monitoring the health of the U.S. population. Age-specific, age-adjusted and cause-specific Indian death rates were computed: 1) for each of the 12 IHS service areas, and 2) for all areas, excluding California.

In California, especially in urban areas where most Indians in California live, health officials reported that Indian death statistics are not reliable

and are probably too low because of reporting deficiencies. Examination of the calculated death rates showed that rates in California were indeed improbably low, casting doubt on the reliability of the reporting system on Indians in California. (For example, calculations of California Indian death rates result in rates less than half the U.S. all races rate, as well as being far below death rates for people residing in some of the wealthiest counties in the United States.)

OTA also made preliminary computations of deaths by reservation States, by service units, and by Standard Metropolitan Statistical Areas (SMSA) as a surrogate for urban areas. Analyses by reservation State were not pursued because of Congress' request that OTA concentrate on health status in IHS service areas. Analyses by service unit and SMSA were not pursued because in most cases the populations and numbers of death were too small for meaningful analysis.

IHS service area populations that were used as the denominators for calculating death rates were computed in the following way. IHS used the 1980 census to determine population totals in IHS service areas. For succeeding years, IHS projects Indian population growth using actual birth and death data supplied by NCHS. OTA used these population estimates for each of the IHS areas, totaled for the 3-year period, 1980-82.

In order to arrive at age- and sex-stratified population totals for each of the IHS areas, tables sup-

plied by IHS were also used. These tables were derived from the 1980 census and list the percent of population in each age and sex bracket for each of the 32 reservation States. These tables were used as a "best estimate" of the actual age and sex distribution in the various IHS areas because the majority of the Indian population in most reservation States actually live in or near IHS service areas, but their use may introduce some error.

Using these sex-stratified and age-specific death rates, age-adjusted death rates were computed, using the 1940 Standard Million Population and standard methodology. Each death rate was multiplied by its appropriate percentage of the standard million (based on sex and age), then these rates were summed to obtain the weighted averages that represent age-adjusted death rates for each of the selected causes in each of the IHS service areas. Age-adjusted death rates for the U.S. all races population were obtained from NCHS mortality reports and used to compute the ratio of Indian to U.S. all races death rates.

OTA also obtained published and unpublished data on the use of IHS health care services from IHS

and used this information to analyze morbidity (illness and injury), needs for health care services, and access relative to that of the general population. Information concerning morbidity (illness) was derived from two IHS data sources: 1) the Inpatient Care System (IPC), which contains IHS direct care and contract care general hospital discharge data; and 2) the Ambulatory Patient Care System (APC), which contains information on the number of outpatient visits at IHS facilities by various patient characteristics (age, sex, diagnosis, community of residence, etc.). IHS provided OTA with computer tapes pertaining to its IPC and APC systems, its publications on hospital utilization by area (IHS, 1978, 1979, 1985), and printouts of the 15 leading diagnoses for outpatient visits by reservation State, county, IHS area, and IHS service unit. NCHS publications and unpublished data were the primary sources of information on U.S. all races health care utilization.

The limitations of all data sources on health status are discussed in chapter 4.

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STAFF DIRECTOR

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, D.C. 20515

May 16, 1984

Dr. John H. Gibbons, Director
Office of Technology Assessment
U.S. Congress
600 Pennsylvania Avenue, S.E.
Washington, D.C. 20003

Dear Dr. Gibbons:

The Committee on Energy and Commerce has oversight and legislative jurisdiction over all Federal health programs funded through general revenues, including those relating to the discharge of the Federal trust responsibility to the Native American population. In considering the revision and extension of the Indian Health Care Improvement Act, P.L. 94-437, it has become apparent to us that an in-depth study of some of the issues raised by current Federal Indian health efforts is necessary if the Congress is to fashion effective legislative solutions.

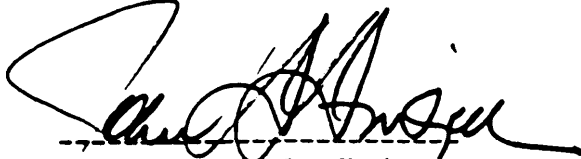
We would therefore request that the Office of Technology Assessment conduct a study of health technology and services in the context of Federal Indian health programs administered by the Indian Health Service (IHS). To be most helpful to the Committee, the study should address: (1) the health status of American Indian and Native Alaska people who are eligible for care through the IHS (whether directly or by contract); (2) the most appropriate mix of medical and health services and technologies in light of the health needs of the eligible population; (3) the organization of health delivery systems, with emphasis on adequate and equitable access to services and technologies, health outcomes, and cost effectiveness; and (4) catastrophic health care needs, and current and alternative financing arrangements for those needs.

In conducting this study, we would urge you to assemble and consult with an advisory panel of knowledgeable individuals who are representative of the tribes, tribal health organizations, and urban Indian projects throughout the country that receive or deliver care

under current arrangements. The expertise that such individuals can bring to bear would, in our view be of invaluable **assistance** to OTA in analyzing the issues to be considered by the study.

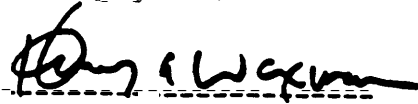
we understand that **delivery** of the printed report may not be possible until **the fall of 1985**. However, we would request that we receive an interim progress report on the **study**, interim briefings on specific issues as the need arises, and a formal briefing in July of 1985.

We look forward to your response. If you or members of the OTA staff have questions concerning this request, please contact Andy Schneider of the staff of the Subcommittee on Health and the Environment at 225-4952.



JOHN D. DINGELL, Chairman
Committee on Energy and
Commerce

Sincerely yours,



HENRY A. WAXMAN, Chairman
Subcommittee on Health
and the Environment

HAW:asl

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United States Senate

SELECT COMMITTEE ON INDIAN AFFAIRS

WASHINGTON, D.C. 20610

June 19, 1984

Congressman Morris K. Udall
Chairman
Office of Technology Assessment
United States Congress
600 Pennsylvania Avenue S. E.
Washington, D.C. 20003

Dear Mr. Udall:

As you know, the Senate Select Committee on Indian Affairs has recently reported to the Senate floor, a bill to reauthorize the Indian Health Care Improvement Act of 1976 through fiscal year 1988. In considering the need for that legislation, a number of issues surrounding the provision of contract health care were raised, and it is our understanding that a request for a study of those issues has now been formally submitted to you.

We are writing to join Congressman John Dingell, Chairman of the House Committee on Energy and Commerce, and Congressman Henry Waxman, Chairman of the House Subcommittee on Health and the Environment, in requesting that the Office of Technology Assessment conduct a study of health care programs administered by the Indian Health Service, a bureau of the Public Health Service within the Department of Health and Human Services. We also wish to endorse the modifications to the proposed study that you have recommended on behalf of the House Interior and Insular Affairs Committee.

As Chairman and Ranking Minority member of the Senate Select Committee on Indian Affairs, we look forward to the opportunity to make recommendations to the Office of Technology Assessment for the selection of the proposed advisory panel, and to make available to the office of Technology Assessment, any materials or information, including Committee hearing records, that may be needed for the study. We have designated Indian Affairs Committee staff attorney, Patricia Zen, to provide any assistance that the Office of Technology Assessment may require.

Warm regards,



Mark Andrews
Chairman



John Melcher
V Ranking Minority Member

Congress of the United States
House of Representatives
Washington, D.C. 20515

Dr. John H. Gibbons
Director
Office of Technology Assessment
U.S. Congress
Washington, D.C. 20510

Dear Dr. Gibbons:

As Chairman and Vice Chairman of the Office of Technology and Assessment Board, respectively, we take this opportunity to comment on the request of the Committee on Energy and Commerce for a study by OTA in the field of Indian Health. Additionally, Mr. Udall, as Chairman of the Committee on Interior and Insular Affairs, whose Committee has primary jurisdiction over Indian Affairs matters in the House of Representatives, brings to this issue a perspective and expertise which we feel OTA will be able to appreciate and utilize to the benefit of such a study as has been requested by the Committee on Energy and Commerce.

We feel that we can support the request of the Energy Committee for such a study and that this study can be helpful to the Congress and the Administration in meeting our responsibility to the Indian tribes for health services. However, in developing your schedule and plan for the OTA assessment, we ask that you take into consideration the following comments:

1. We are concerned about the implication in the Energy letter that the study 'be focused' on the responsibility of the United States to provide health care to individuals on the basis of the racial identity. The Indian health care responsibility of the United States is founded upon the legal, moral and historical relationship between the United States and Indian tribes as political entities. In this regard, we refer you to the decision of the Supreme Court in the case of Morton v. Mancari, 417 U.S. 535 (1974). We suggest that your study be guided by the political relationship of the Federal government and Indian tribes rather than by the racial background of individual recipients of health services.

Page 2 - John H. Gibbons

2. This Federal-tribal relationship must encompass any review of unmet health needs and resource allocation and must be identified as the basis for a comprehensive health care system to meet that special responsibility. The review must also incorporate other factors besides population data, e.g., geographic location, accessibility to IHS and other health services, and lack of local infrastructure (roads, water and sewer systems, etc.).


3. We are supportive of Energy's request for an OTA assessment *in* the area of treatment of catastrophic illnesses, but with two reservations. First, Mr. Udall does not support that portion of the study as a substitute for the catastrophic illness provision in the Interior version of H.R. 4567. It remains Mr. Udall's intent to *secure* enactment of that provision into law. second, we hope that this portion of the study not be shaped solely by the elements of the debate on that issue as a national health care issue. There are significant differences between that issue as a national issue and as an issue and problem for the Indian Health Service in providing health care to Indians. In this regard, we refer you to the discussion of the H.R. 4567 provision in the dissenting views of Mr. Richardson, et al. in the Energy Committee report on the bill (H. Rept. 98-763, Part 2).

4. Finally, we would like to recommend for OTA on the selection of members of any Advisory Board for this study.

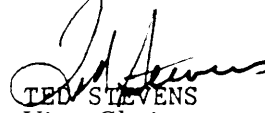
Again, we thank you for keeping us and our Committee staffs advised on this matter. We would appreciate it if your office would continue to stay in touch as the development of the study progresses.

with warm regards,

Sincerely,



MORRIS K. UDALL
Chairman
Office of Technology Assessment



TED STEVENS
Vice Chairman
Office of Technology Assessment