Appendix C
Overview of Indian Health Service

The U.S. Department of Health and Human Services (U.S. DHHS), primarily through the Indian Health Service (IHS) of the Public Health Service (PHS), is responsible for providing Federal health services to American Indians and Alaska Natives. Federal Indian health services are based on the laws which the Congress has passed pursuant to its authority to regulate commerce with the Indian Nations as explicitly specified in the Constitution and in other pertinent authorities.[1] The goal of the IHS program is to raise the health status of American 1ndians and Alaska Natives to the highest possible level (Indian Health Care Improvement Act [Public Law 94-437 as amended]). IHS defines its service delivery responsibilities to include a comprehensive range of inpatient and ambulatory medical services, dental care, mental health and alcoholism services, preventive health (immunizations and environmental services such as sanitation and water safety), health education, and Indian health staff development programs (322).

IHS provides these health and health-related services to eligible Indians in a variety of ways. The approximately 1 million Indians[2] (355a) who live on or near reservations are theoretically eligible to receive the comprehensive range of services at no cost to the individual Indian, regardless of other health insurance coverage or ability to pay. This program of services is provided in facilities owned and operated by IHS, and is known as the direct *care program.*

Although in principle II-IS services are comprehensive and readily available at no user cost, in fact they are limited by IHS budget constraints and by the uneven distribution of services among IHS areas that has developed over the years (322). When no IHS facility is accessible or when specific services are not available from IHS facilities, Indian patients may require referral to private providers under the IHS corm-act *care program.* It is important to note that contract care is a separate item in the overall IHS budget, and that contract care budgets sometimes have been so limited that needed referrals cannot be made. Thus, while they may not be directly affected by ability to pay, Indians may face serious obstacles in obtaining health care services through IHS. Another obstacle to obtaining contract care is that eligibility for such services is more restricted than for direct care.

Another factor in the IHS delivery system since the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638), amended in 1988 (Public Law 100-472), has been the operation of health facilities and service programs by Indian tribes. Direct care facilities, contract care programs, facilities construction, and special programs such as community health representatives, mental health and drug abuse, and health education initiatives may be administered by tribes under *self-determination* or 638 contracts. Most of these services, like IHS'S own services, are reservation based, and they are provided to IHS-eligible Indians at no cost to the individual. But Indian tribes may also use non-Federal sources of payment and may treat non-Indians (322).

About half of Indians today reside in urban areas rather than on reservations.[3] However, *urban Indian health projects* operate separately from the reservation-based IHS system. Unlike IHS-direct programs, urban projects may receive funds from non-IHS sources, are likely to treat non-Indians, and may request payment from Indians and non-Indians alike based on a sliding fee scale. Urban projects are similar to tribally operated programs in that they are more active than IHS programs in treating and billing non-Indians and in coordinating their efforts with other non-IHS health delivery programs (322). Primarily, urban programs must be more active in securing other funds because IHS only partially supports urban programs.

Although IHS programs provide health, dental, mental health, alcoholism, and preventive health services, most of II-IS'S resources are, apparently of necessity, used to provide hospital-based and ambulatory services for acute and chronic physical conditions. As shown in table C-1, for example, $723 million (77 percent) of IHS'S total fiscal year 1988 budget of $935 million was used for hospitals and clinics, exclusive of dental, mental health, and alcoholism services. Another 9 percent of the budget was used for direct clinical dental, mental health, and alcoholism treatment services: 3 percent for direct and tribal dental services, 1.3 percent for direct and tribal mental health services, and 3.1 percent to direct and tribal alcoholism services. Of the clinical budget, $183 million

[1]Social and health services have been provided to Indian tribes since the time the United States became an independent nation. Until 1921, when the Snyder Act (42 Stat. 208; 25 U.S.C. section 13) was passed, Congress provided funds without specific authorization. Since 1921, the Snyder Act has been the basic authorizing mechanism to provide funds for Indian health services (322). However, while Congress has consistently provided funds for Indian service programs, the courts so far have ruled that these benefits are voluntarily provided by Congress and not mandated under the Federal Government's trust responsibility for Indian tribes. Appropriated funds are "public moneys" and not treaty or tribal funds ''belonging really to the Indians" (*Scholder* v. *United* States, 428 F. 2d 1123 [9th Cir., 1970], *cert. denied, 400* U.S. **942 [1970].**

[2]The exact number of Indians in the service population is not known with certainty (322).

[3]Historical reasons for this are discussed in U.S. Congress, OTA (322).

Table C-1-IHS Allocations by Budget Category, Fiscal Year 1988

Activity/subactivity	Total area allocations	Percent of total
Clinical *services:*		
Hospital and clinics	**$533,614,000**	57%
Dental	**28,974,000**	3
Mental health	**12,466,000**	1
Alcoholism	**29,335,000**	3
Maintenance and **repair**	**11,359,000**	1
Reimbursements	**6,227,370**	·
Total health care delivery	**$621,975,370**	66%
Contract care.	**183,481,000**	19
Total clinical services	**$805,456,370**	86%
Preventitive health		
Sanitation	**$23,907,000**	**3**
Public health nursing	**14,113,000**	**2**
Health education	**4,413,000**	—
Community health reps	**27,282,000**	**3**
Immunization	**395,000**	—
Total preventive health	**$70,110,000**	7%
Urban projects	**9,624,000**	1
Indian health manpower	**7,646,000**	1
Tribal management	**3,094,000**	—
Direct operations	**39,104,000**	4
Total allowances Issued	**$925,034,000**	1 00%

[a]less than 1 percent of total.

SOURCE: U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, "Fiscal Year 1990 Justification of Appropriation Estimates for Committee on Appropriations, Volume XI-Indian Health" (Washington, DC: U.S. Department of Health and Human Services, Public Health Service, 1989).

(25 percent of the clinical budget) was used to provide contract care services.[4]

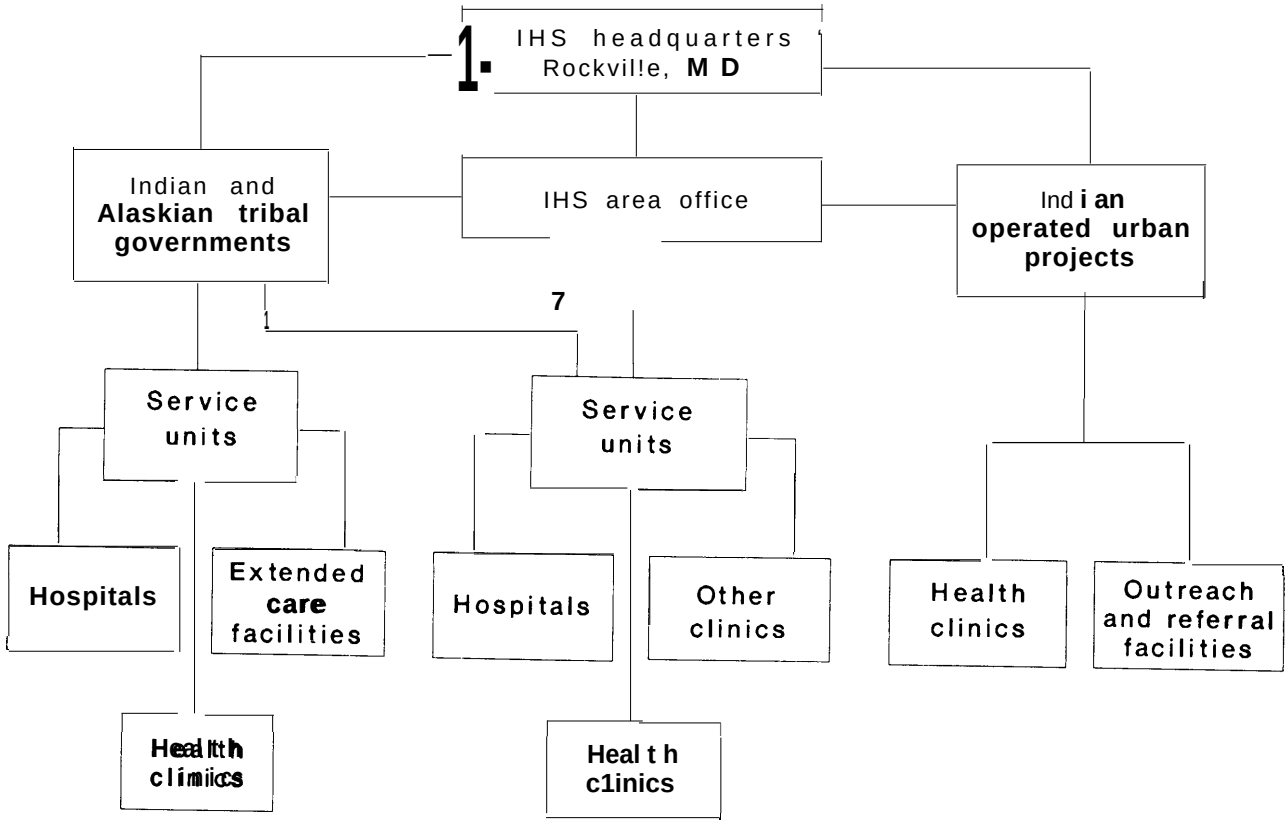
Seven percent of IHS's budget was used for preventive health services (i.e., sanitation, public health nursing, health education, community health representatives, and immunizations) in fiscal year 1988. Of IHS'S total budget, $9.6 million (1.2 percent) was allocated to 35 urban projects. Although it is not shown separately in table C-1, approximately $218 million was used to support Indian self-determination (638) grants and contracts in fiscal year 1988.

Organizationally, IHS comprises 12 regional administrative units called Area Offices (see figure C-1).[5] Currently, the Area Offices oversee 127 basic administrative units called Service Units. Of the 127 service units, 52 are operated by tribes (see figure C-2). IHS operates 43 hospitals, 131 health centers and stations, and 37 other treatment locations (figure C-3), while tribes operate 7 hospitals, 313 health centers and stations, and 11 other treatment locations (figure C-2) (355a). Thirty-five urban health projects are partially supported by IHS (figure C-4). With the partial exception of the urban projects, IHS facilities are concentrated in the Western part of the Nation, where most reservation-based Indians live (figure c-5).

[4]Some contract care funds are used for dental, mental health, and alcoholism services.

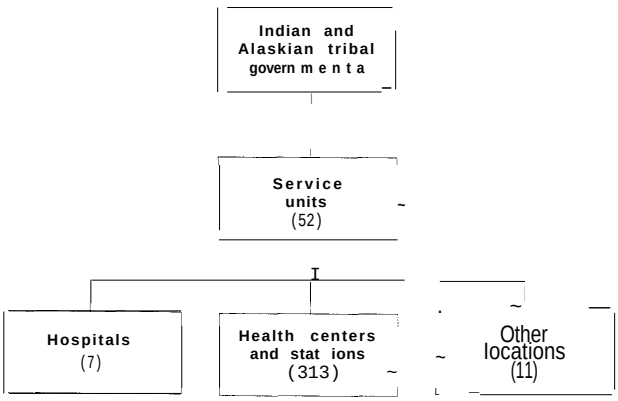
[5]Technically, the IHS office in Tucson is a headquarters office for the Office of Health Program Development, which is responsible for administering health services delivery. For statistical purposes, IHS considers Tucson an Area Office.

Figure C-l-Organization of the Indian Health Service



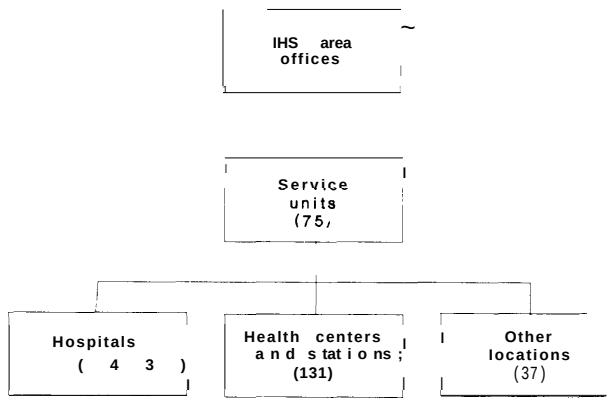
SOURCE: U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation and Legislation, Division of Program Statistics, Trends *in Indian Heath, 1989* (Rockville, MD: 1989).

Figure C-2—Health Services Managed by Indian and Alaskan Tribal Governments



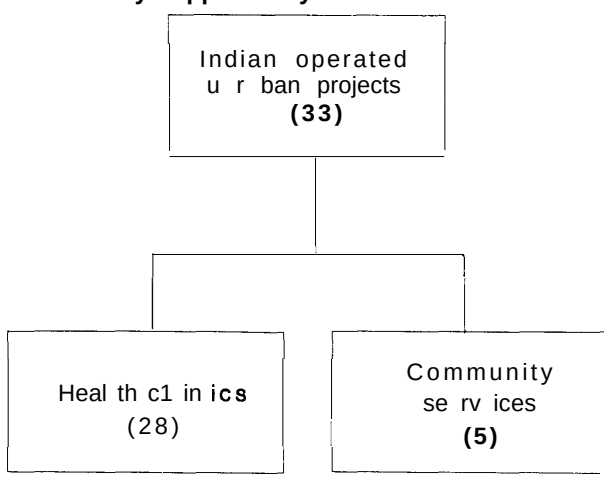
SOURCE: U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation and Legislation, Division of Program Statistics, *Trends in Indian Health, 1989* (Rockville, MD: 1989).

Figure C-3-Service Units, Hospitals, Health Centers and Stations, and Other Treatment Services Operated by Indian Health Service Area Offices



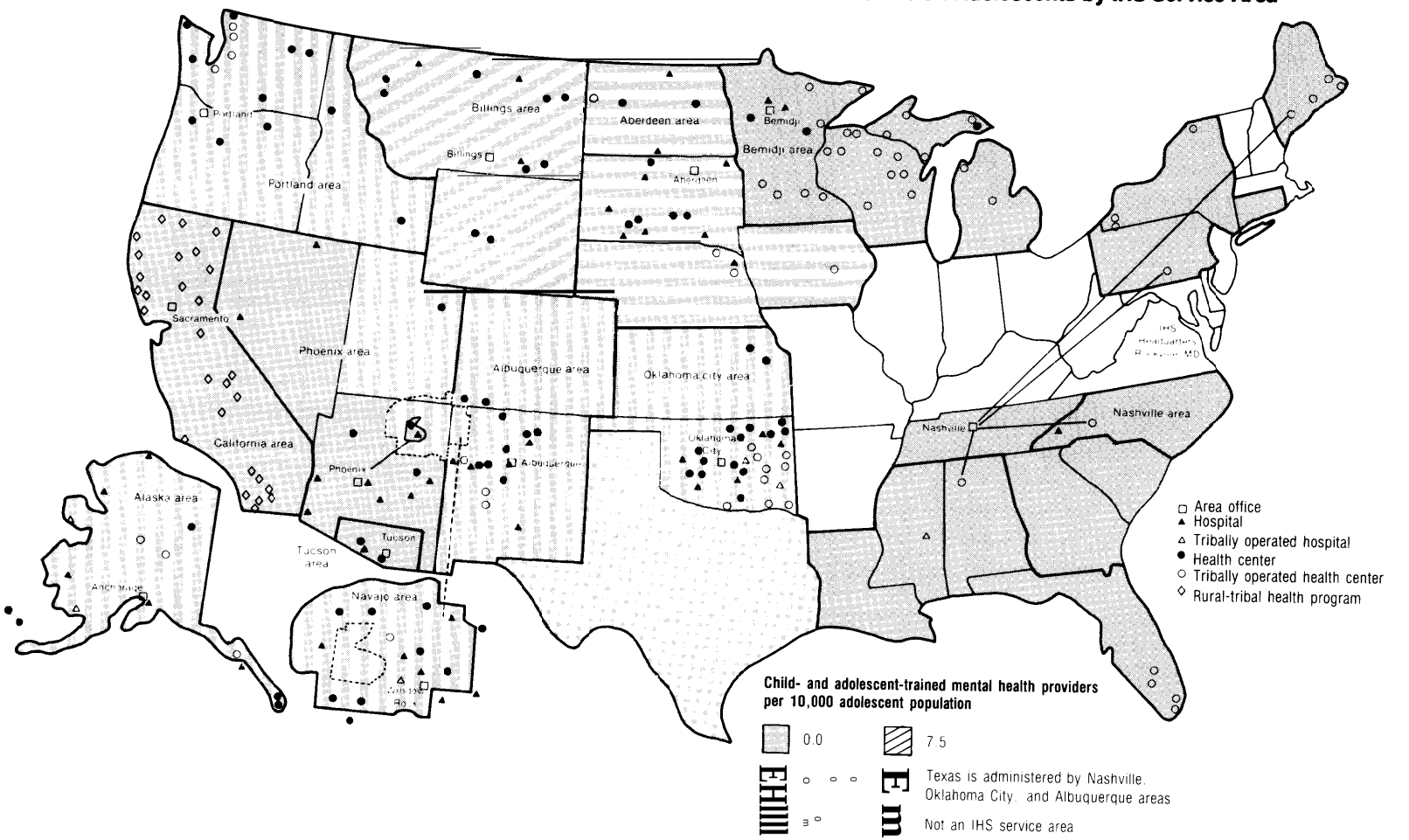
SOURCE: U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation and Legislation, Division of Program Statistics, *Trends in Indian Health, 1989* (Rockville, MD: 1989).

Figure C-4-Indian-Operated Urban Projects Partially Supported by Indian Health Service



SOURCE: U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation and Legislation, Division of Program Statistics, *Trends in Indian Health,* 1989 (Rockville, MD: 1989).

Figure C-5—Child- and Adolescent-Trained Mental Health Care Providers for Indian Adolescents by IHS Service Area



SOURCE: Office of Technology Assessement, 1990.