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ABSTRACT

As reported in this publication, about 410,000 Alaskan Indians, Eskimos, and Aleuts receive a full range of curative, preventive, and rehabilitative health services--including hospitalization, outpatient medical care, public health nursing, maternal and child health care, dental and nutrition services, and health education. The U.S. Public Health Service, through the Indian Health Program, also provides environmental health services, including construction of water-supply and waste-disposal facilities, and the training needed to use and maintain them. In providing these services, geographic and cultural isolation problems such as those related to transportation, communication, and religion are encountered. To meet the needs of the scattered population, the Indian Health Service, which is divided into 8 field areas, not only has contact service but also operates 51 hospitals, 70 health centers, and more than 300 field health clinics. Special health programs are geared to maternal and child care, family planning, trachoma treatment, mental health services, and research. Special educational programs are targeted to training nurses, dental assistants, health records technicians, and community health aides (JB)

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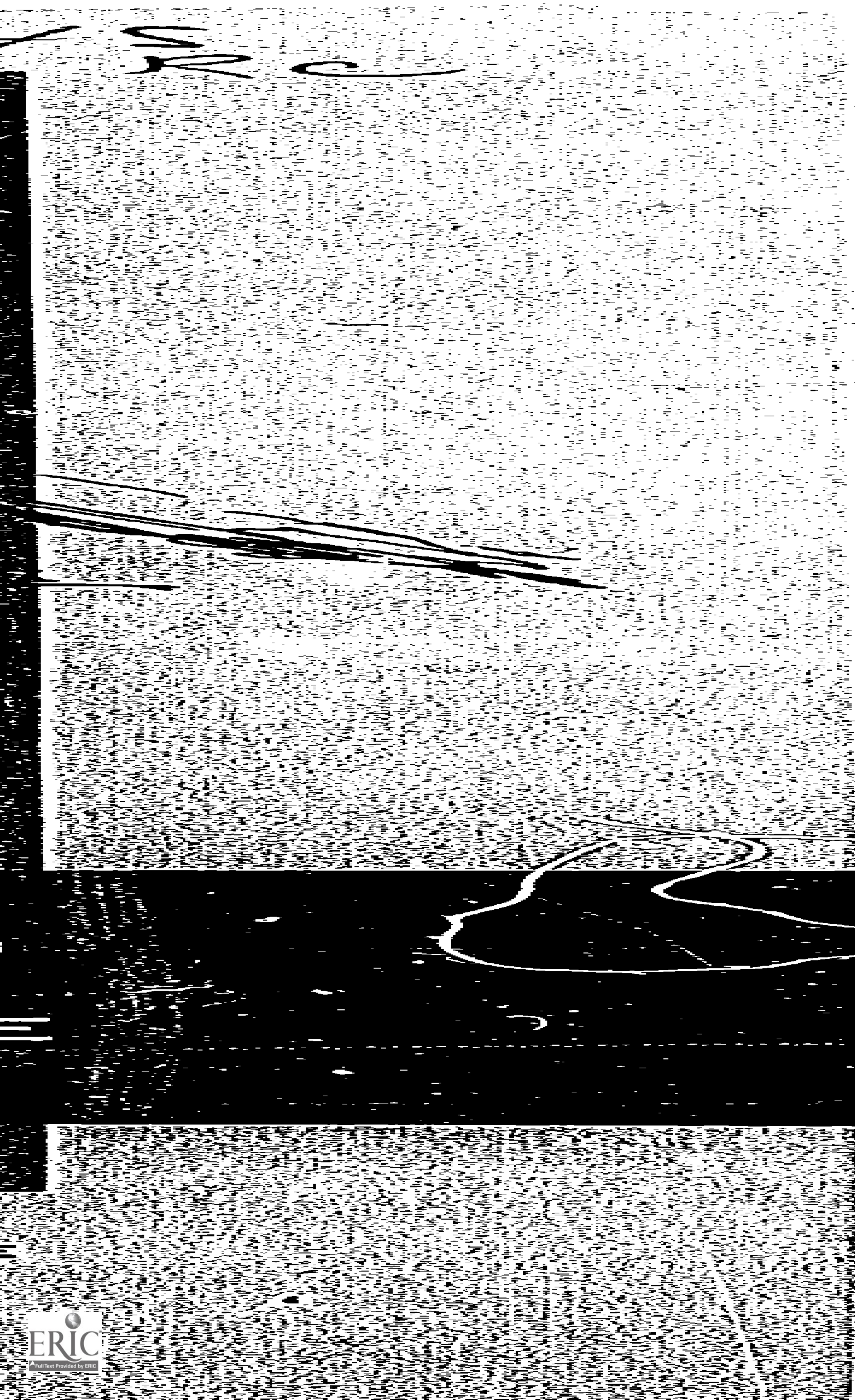

The Indian Health Program

U.S. PUBLIC HEALTH SERVICE

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration

Foreword

No other group of citizens stands in precisely the same relationship to the Federal Government as do American Indians. The unique nature of this relationship is rooted in the treaties and laws which gave the Federal Government responsibility for the protection of Indians and their resources. The many Federal services extended to Indians today, including health, had their origin in this early Indian-Federal relationship and have developed to present day programs. The first organized Federal medical care program for the indigenous peoples of Alaska—the Indian, Eskimo, and Aleut—was established in 1914 in conjunction with the first Territorial schools and services were gradually broadened to include a full range of hospital and health services.

Four public laws have been passed which specifically concern Public Health Service responsibility for the health needs of Indians: Public Law 83–568, effective in 1955, "to transfer the maintenance and operation of hospital and health facilities for Indians to the Public Health Service, and for other purposes"; Public Law 85–151, passed in 1957 "to authorize funds available for construction of Indian health facilities to be used to assist in the construction of community hospitals which will serve Indians and non-Indians"; Public Law 86–121, passed in 1959, which authorized the Surgeon General to provide and maintain essential sanitation facilities for Indian homes, communities, and lands; Public Law 89–702 passed in 1966, which authorized transfer of responsibility for health services for inhabitants of the Pribilof Islands from the Bureau of Commercial Fisheries (Interior) to the Indian Health Service.

It is the endeavor of the Public Health Service to carry out these responsibilities in a way which will most efficiently and quickly help the Indians achieve the highest possible level of health.

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Health Services for the American Indian and Alaska Native

The mission of the Indian Health Service is to raise the health of the American Indian and Alaska Native to the highest possible level. At the present time, the health status of these populations is about that of the rest of the United States 20 to 25 years ago.

Responsibility for the health needs of these first Americans has provided the Public Health Service with the unique opportunity to mutually plan and implement one of the most comprehensive community health care programs in this country.

About 410,000 Indians, Eskimos and Aleuts receive a full range of curative, preventive and rehabilitative health services, including hospitalization, outpatient medical care, public health nursing, maternal and child health, dental and nutrition services and health education.

Environmental health services also are being provided, including construction of water supply and waste disposal facilities, and the training needed to use and maintain them.

PROBLEMS IN PROVIDING SERVICES

Indians and Alaska Natives live in circumstances which differ from those of any other population group in the country. In the majority, they are geographically and culturally isolated on 250 reservations mostly west of the Mississippi, and in hundreds of villages in Alaska. Most of them are removed from the organized community affiliations which meet the physical, social and economic needs of other Americans.

With few exceptions, they live in conditions of poverty. The average family of five or six lives in a one or two-room dwelling without running water or waste disposal facilities and on an income of about $1,900 a year.

In general, Indians and Alaska Natives have maintained their traditional cultures in language, religion, social organization and values. Many are not familiar with modern health concepts and do not understand the scientific bases of illness and medical treatment. Communication is further complicated, in many instances, by the Indians' inability or limited ability to speak English, and interpreters must be used.

Transportation also is a major problem, both for the Indians and Alaska Natives needing health services and for health personnel providing services. Many patients must travel long distances over primitive roads and difficult terrain to reach

hospitals and health centers. The very ill or those needing emergency treatment must be transported by ambulance or airplane, sometimes hundreds of miles.

The topography and extremes of climate in Alaska have necessitated development of a program of medical care by shortwave radio, to augment visits of health teams from Public Health Service hospitals and services of village health aides. Medical officers at field hospitals in Barrow, Bethel, Kotzebue and elsewhere have established daily radio medical clinics to administer to the needs of natives in isolated villages. Also, village health aides, school teachers, traders, missionaries or public health field nurses, can contact Public Health Service hospitals and receive medical guidance and assistance for the sick or injured.

Because of these economic, cultural, environmental and geographical factors, high priority is placed on public health and preventive medicine activities, as well as curative services.

HEALTH FACILITIES

The Indian Health Service operates 51 hospitals, 70 large health centers, and more than 300 field health clinics.

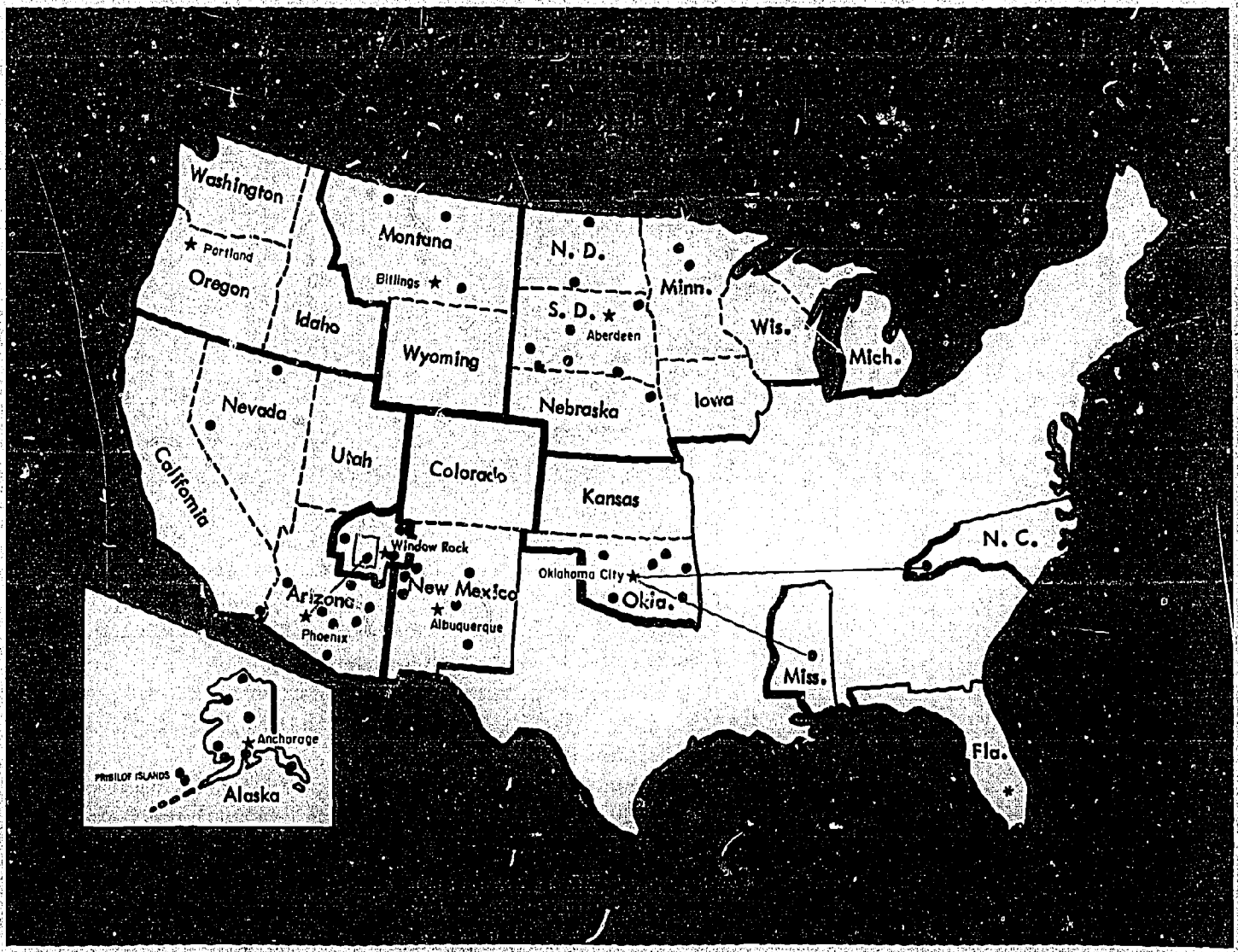
In addition, it has contracts with some 300 private or community hospitals, 18 State and local health departments, and more than 500 physicians, dentists, and other health specialists to

provide specialized diagnostic and therapeutic services to Indians and Alaska Natives. Emergency hospitalization and medical care needed in locations where an Indian hospital or clinic is not readily accessible also are made possible through the contract program.

ORGANIZATION OF THE INDIAN HEALTH SERVICE

The Service is divided administratively into eight field areas with each area responsible for operating the health program for Indians in its respective States.

To facilitate operation of the program, Indian health areas are broken down into service units. These are defined geographic areas, usually centered around a single Federal reservation. A few units cover a number of small reservations; some large reservations are divided into several units. The Navajo Reservation, which covers 24,000 square miles in three States and has a service population of approximately 100,000, is divided into eight service units.



The Health Program

A service unit is the basic health organization in the Indian health program, just as a county or city health department is the basic health organization in a State health program. With few exceptions, each unit has a hospital or a health center, and a number of satellite clinics.

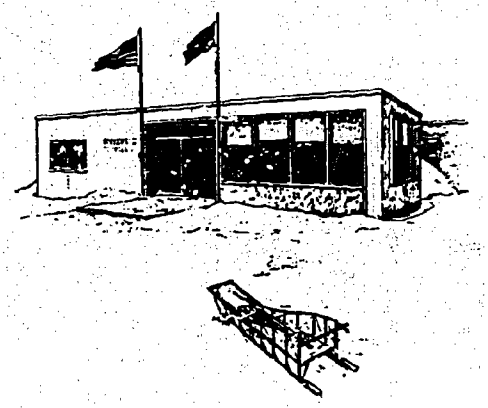
The Public Health Service Indian hospital is the center of activity. Besides providing care for inpatients, it also provides outpatient services through preventive and curative clinics. Additional medical and dental clinics are held at other locations on the reservation on a regular schedule, daily, weekly or monthly; and special clinics, such as prenatal, postnatal, well-baby, diabetes, heart disease, trachoma, tuberculosis and immunization clinics are held at one or more locations intermittently as needed.

Added services are provided by public health nurses, nutritionists, health educators, social workers and sanitarians who are engaged in home visits, in follow-ups on discharged tuberculosis patients, newborns and mothers, in health education conferences and in environmental sanitation.

School health programs are conducted in boarding and day schools operated by the Bureau of Indian Affairs, Department of the Interior.

Dental services are provided at hospitals, health centers and health stations, and in 13 mobile dental units. In some locations where the Public Health Service has no facilities, care is provided under contracts with dentists in private practice. In Alaska, itinerant dental teams travel to remote villages by charter plane taking equipment with them.

Dental care for persons under 17 years of age is given priority, a policy that has begun to pay dividends: for the first time since 1955, the DMF rate (decayed, missing and filled teeth) for Indian children, showed a decline last year. Expanded resources, increased efficiency and the addition of dental assistants, combined with a topical fluoride program over the past few years, have brought about this good result. Reaching all children and providing care for an increasing number of adults are continuing aims.



HOW A HEALTH PROGRAM WORKS

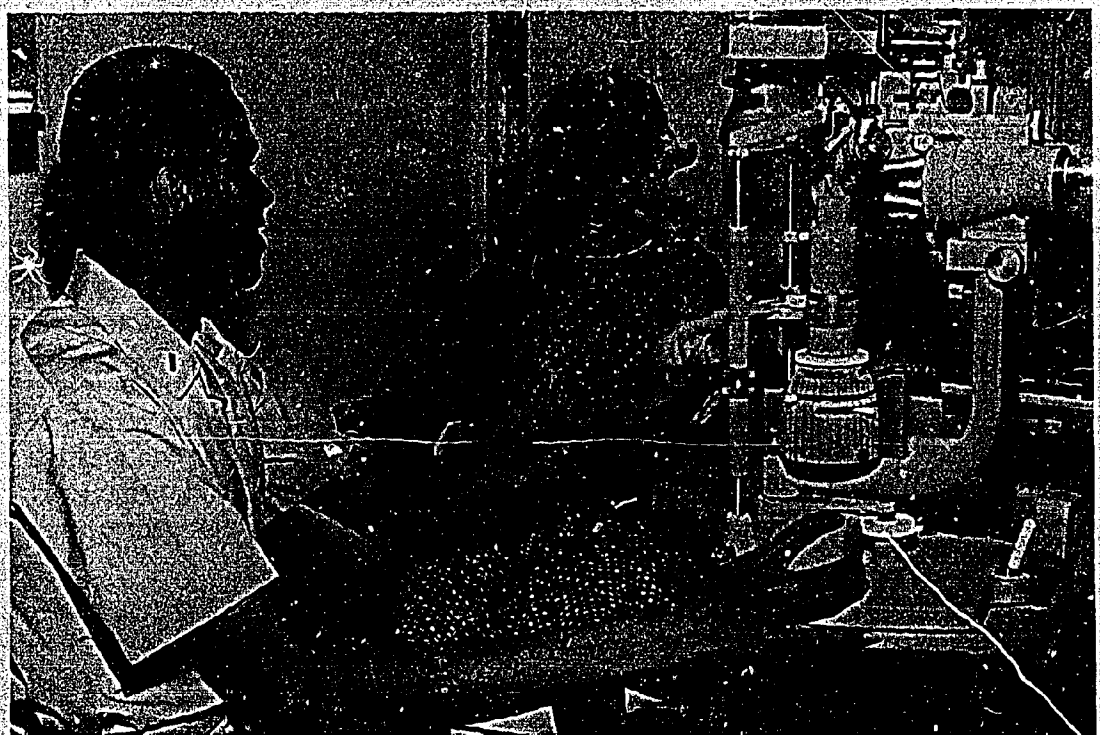
A typical health program is the San Carlos Service Unit in Southwestern Arizona which serves approximately 5,000 members of the Apache Tribe. The San Carlos Reservation covers about 3,000 square miles and the land varies from typical desert topography in the southwest to mountainous wooded areas in the north. The Indian population is concentrated mostly in three communities with some additional persons living in nearby off-reservation communities.

Health services are centered around a 38-bed hospital located in San Carlos with a hospital and field health staff of 61, including four physicians, 12 clinical and administrative nurses, two public health nurses, a dental officer, a pharmacist, a health educator, engineer and sanitarian aide, and supporting staff.

Patients requiring specialty care not available at the hospital are referred to the PHS Indian Medical Center in Phoenix and to contract hospitals. Others living in off-reservation communities who suffer emergencies are cared for at community hospitals in those towns.

Hospital admissions in 1968 numbered 1,239. About 24,000 visits were recorded at the hospital outpatient clinic, and visits to field clinics and home visits numbered almost 10,000.

A staff physician designated as field health officer is responsible for all field health activities, including home visits and



specialty clinics for control of trachoma, diabetes, otitis media, etc., communicable diseases control activities, immunizations, tuberculosis and venereal disease findings, school health programs, health education and environmental health services.

All members of the health team work closely in the field health program to assure coordination of the many efforts needed to improve the health of the Indian.

SPECIAL PROGRAMS

The level of health today among Indians and Alaska Natives is in many respects similar to that of the general population about a generation ago. Diseases seldom seen in a community hospital are often encountered in Indian health facilities, and a greater variety of clinical conditions confront physicians than in other health programs in the country. Special health needs are met in varied ways with activities keyed to removing the source of the problems.

Maternal and Child Care The high rate of illness and death among infants in the first year of life is met with emphasis on early prenatal care for the mother and continuing care after she and the baby leave the hospital. Health education activities are conducted to teach the mother proper ways to feed, bathe and care for her family within the often limited resources of her home, how to recognize illness, and why it is important to observe good health habits and make regular visits to the clinic.

In Alaska, a nurse-midwife program is being introduced to reach mothers living in the extreme isolation of the 49th State.

Family Planning Assistance in family planning as a means of protecting the health of mothers and children, and giving the family freedom to choose the size and spacing of their families, is an element of comprehensive health care. Services are provided at all Indian health facilities. Almost 22,000 Indian and Alaska Native women received family planning services from fiscal year 1965 through 1968, representing 41.5 percent of the potential uses of the services.

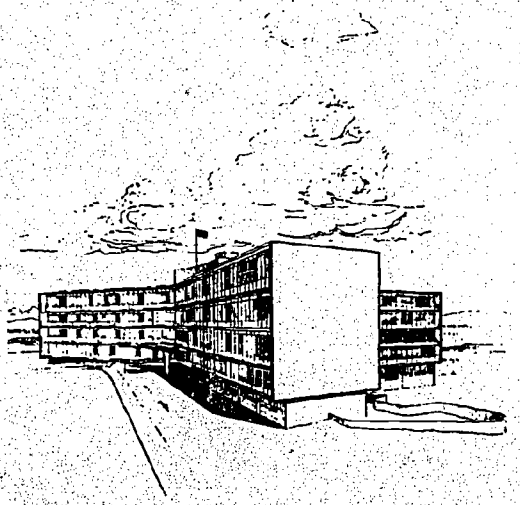
Trachoma Trachoma is a serious eye disease seldom encountered in the general population, but prevalent among Indians in the Southwest. Trachoma medical teams go from PHS Indian hospitals into Indian schools and communities to perform examinations for detection of trachoma and other eye diseases, and to provide treatment and follow-up developed from latest research.

Mental Health Changing cultural patterns and the strain of transition from an old and stable culture into a competitive society are causes of many emotional problems and behavioral disorders among Indians. The percentage of psychotic disorders

is no greater than in the non-Indian population, but the incidence of preventable neurotic disturbances appears to be. Alcoholism and related accidents are problems and on some reservations the suicide rate is high.

To combat these problems, mental health teams are in operation at Pine Ridge, S. Dak., Window Rock and Phoenix, Ariz., Albuquerque, N. Mex., and Anchorage, Alaska. Psychiatric counseling is available in all Indian health facilities including Indian boarding schools.

Research A health program systems center was established at Tucson in 1967 to conduct applied research into all aspects of the delivery of community health services. The major mission of the research program is to develop more effective and efficient ways to meet a community's health needs within the framework of available resources. Findings should be applicable to all Indian health service units.



PROGRESS SINCE 1955

Responsibility for the health care of American Indians and Alaska Natives was transferred to the Public Health Service from the Bureau of Indian Affairs in 1955 through enactment of Public Law 568 by the 83rd Congress. The Surgeon General established the Indian Health Service to administer the program.

Since that time, both staff and responsibilities have expanded. The staff has increased to more than 6,000. The number of physicians is up from 125 to over 400, dentists from 40 to 140, and nurses from 780 to nearly 1,000. Among the new personnel are field health physicians, pharmacists, medical record librarians, public health nurses, practical nurses, dental assistants, maternal and child health specialists, medical social workers, nutritionists, dietitians, health education specialists, environmental sanitarians, and auxiliaries in a number of categories.

At the time of the transfer, one of the most pressing needs was for modern health facilities to serve Indians. Twelve hospitals, 10 health centers, and 38 health stations have been built in the past 12 years, and many other facilities have been improved to meet the requirements of modern-day medicine. Other construction and modernization projects are in the planning or building stages.

Considerable attention has been given to improving the capabilities of the Indian health staff, and numerous education and training activities are conducted to increase efficiency, augment manpower resources and promote career development.

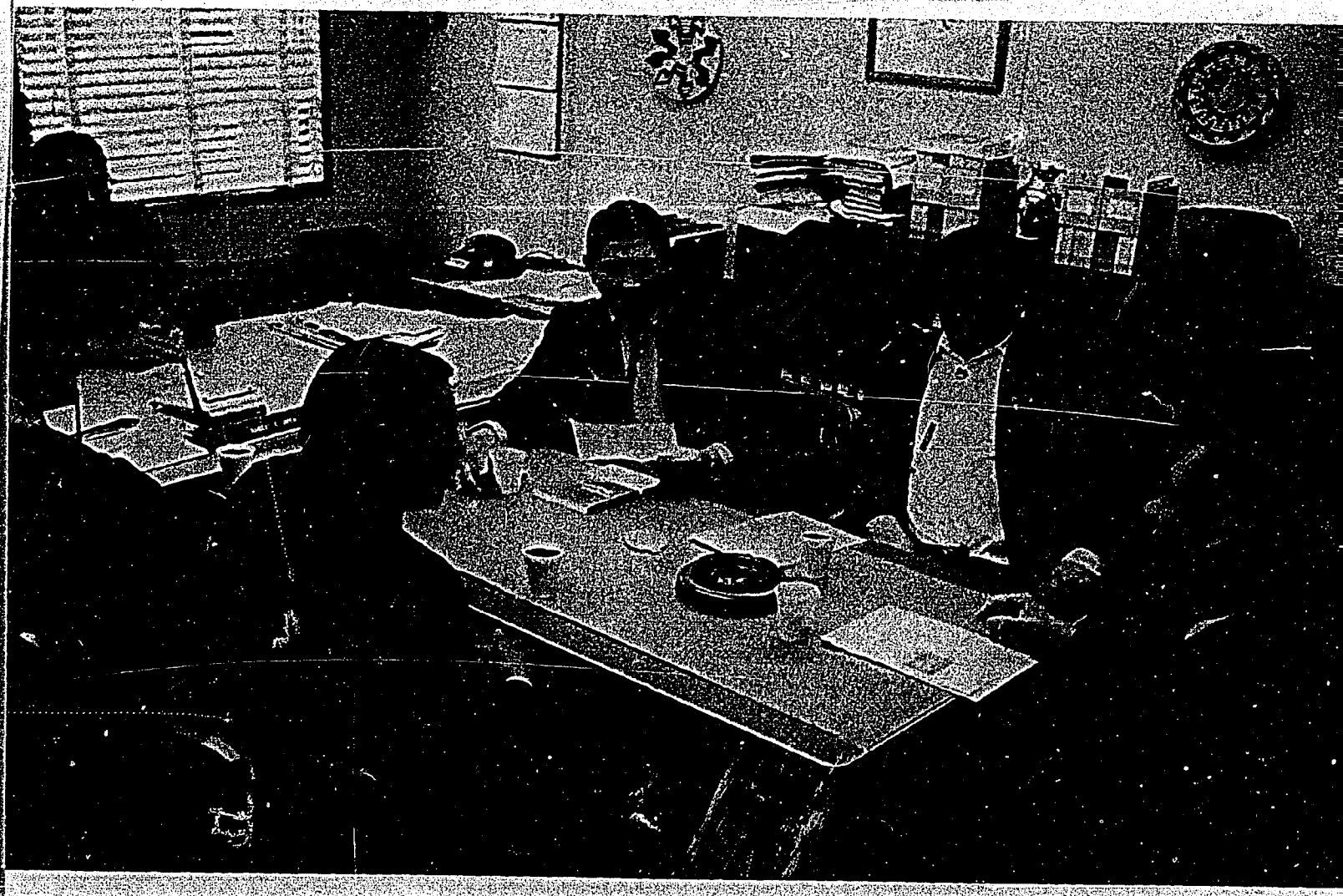
Dramatic increases in the use of services have occurred since 1955. Virtually all Indian births occur in hospitals. Hospital admissions are up 80 percent; outpatient visits have nearly tripled and dental services have more than tripled.

As a result of the understanding and support of the India health program by Congress, the interest and participation of tE Indian people, and the cooperation of other Federal, State, ar local agencies, substantial advances have been made in improvin the health of Indians and Alaska Natives.

Infant death rates have dropped to half the level at tE time of the transfer; tuberculosis death rates are down two-third gastroenteric death rates are down more than half; and influenz and pneumonia death rates are down one-third.

Environmental health accomplishments include the provisic of some type of safe water and waste disposal facilities for mor than 54,000 families. A substantial contribution was made b Indians and Alaska Natives through donated labor, material and funds.

In planning and implementing a comprehensive communit health program for the Indian and Alaska Native, new methoc and procedures have been developed which are having usefu application in solving some health problems in non-Indian com munities of the country as a whole, and in the underdevelope nations around the world.



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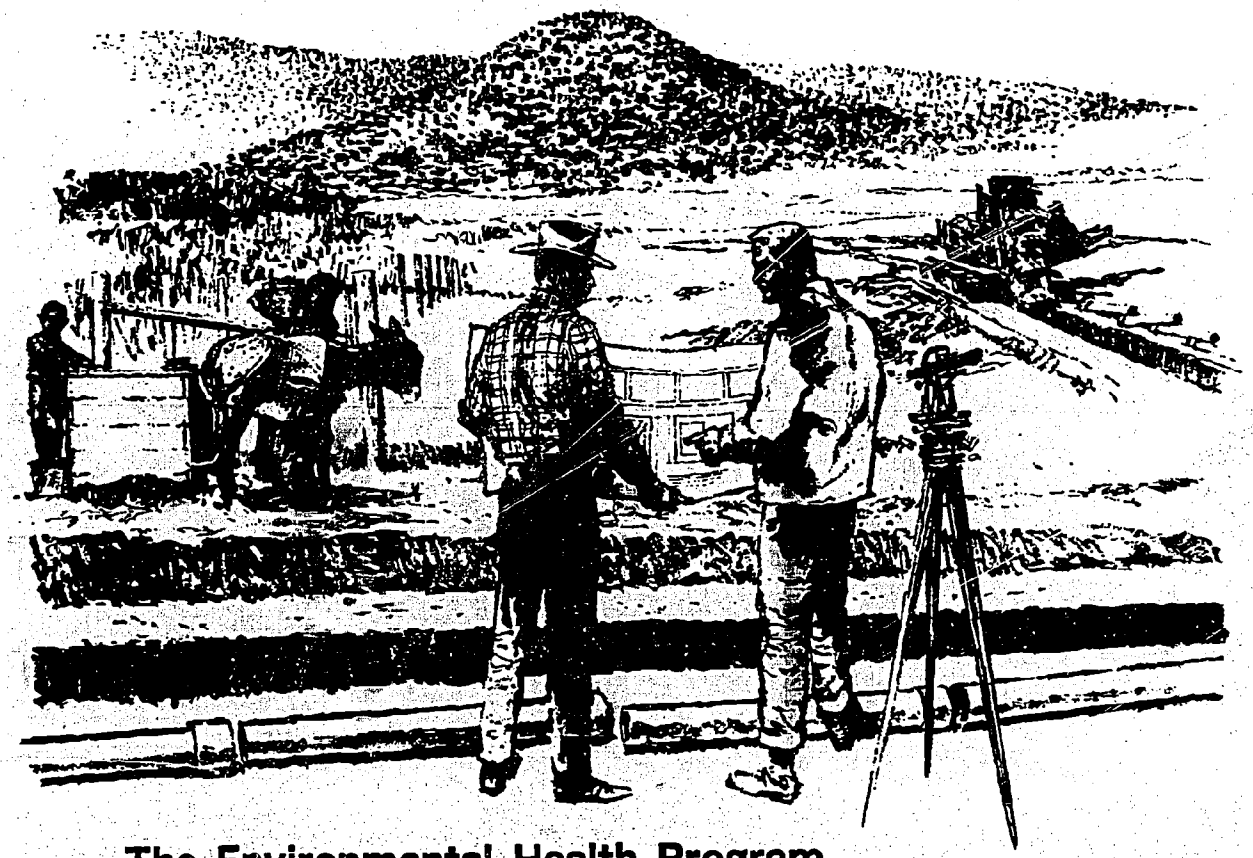


The Environmental Health Program

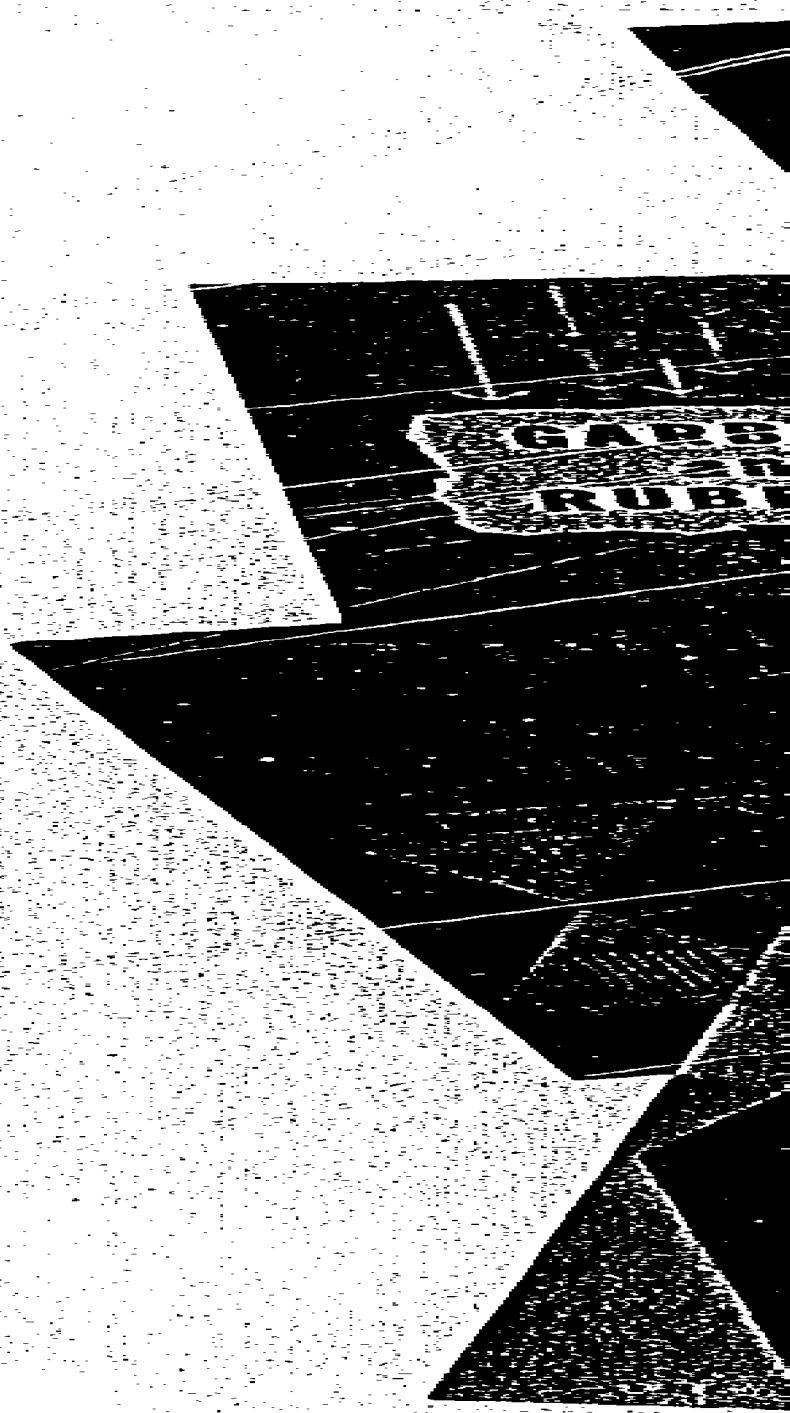
HISTORY OF THE PROGRAM

In 1928 the Public Health Service began to provide engineering services to the Bureau of Indian Affairs on the design of sanitary facilities at Indian schools, hospitals and agencies. For the next 20 years, environmental health activities were limited largely to occasional inspections of sanitation facilities on reservations and to an education program in the schools. In the late forties and early fifties, a few contracts for services to Indian groups were developed between the Federal agency responsible for Indian health and State and local health departments.

In 1950, the first sanitary engineer was assigned by the Public Health Service to the Bureau of Indian Affairs to provide consultation in environmental health matters, and to evaluate sanitary conditions on Indian reservations. Three years later a limited professionally staffed sanitation program was begun.

LEGISLATION AUTHORIZING CONSTRUCTION

Considerable impetus was given to improving the physical environment on Indian reservations when in 1959 Congress passed Public Law 86–121, the Indian Sanitation Facilities Act, giving the Surgeon General authority to make arrangements and agreements with Indians and others regarding contributions toward the construction and responsibilities for the maintenance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of water supply, waste disposal, drainage, and other sanitation facilities for Indian homes, communities, and lands.

Under this legislation, through fiscal year 1968, a total of 764 sanitation projects have been undertaken. These include 613 construction projects (170 of which serve new Federal housing projects) and 151 engineering investigations, emergency works and other special projects. The fiscal year 1969 appropriation authorized 90 additional regular construction projects and an estimated 100 projects to assist housing programs. Upon completion of all work authorized through fiscal year 1969 more than 54,000 Indian and Alaska Native families will have been provided running water and an adequate means of waste disposal.

OTHER ENVIRONMENTAL HEALTH ACTIVITIES

In addition to providing adequate sanitation facilities for Indians and training people in their maintenance and use, other activities are carried out on numerous aspects of the environment. Some of the primary activities are:

- Assist tribes in development and adoption of sanitary ordinances and codes.
- Participate in the investigation of communicable disease outbreaks and initiate corrective environmental control measures.
- Evaluate institutional facilities operated by the Bureau of Indian Affairs and the Public Health Service, and make recommendations to the operators of these facilities so that they may attain a healthful environment for the Indians.

- Conduct home and premise evaluations for the purpose of developing and maintaining a current inventory of environmental health deficiencies.
- Plan jointly with the Indian tribal officials in the development of a comprehensive environmental sanitation activity.

INDIAN SANITATION FACILITIES PROJECTS

Authorized Under Public Law 86-121

Type Project and Fiscal Year	*Federal Funds*	*Number of Projects*			*Approximate Homes[a] to be Served*	*Estimated Population to be Served*
		Construction	*Investigation, Emergency Works and Other*	*Total*		
Regular Sanitation Construction FY 1960-1968	$34,751,354	401	151	552	36,100	181,000
Accelerated Public Works FY 1963-1964	5,170,000	42	—	42	2,500	13,400
Assistance to Federal Housing for Indians FY 1964-1968	6,693,646	170	—	170	5,760	31,680
Sub-Total (60-68)	$46,615,000	613	151	764	44,360	226,180
FY 1969[b]						
Regular	$10,470,000	90	2	92	6,500	35,750
Housing	6,617,000	100	—	100	3,530	19,415
Sub-Total	$17,087,000	190	2	192	10,030	55,165
FY 1960-1969[b]	$63,702,000	803	153	956	54,390	281,345

[a] Not all of these homes served by complete facilities.
[b] Based on current estimates of number of projects, homes, and population to be served.
NOTE: Substautial contributions of labor, money, and material have also been made by the Indian Tribes, communities, and groups toward the completion of these projects. The value of these contributions through FY 1969 is estimated to be more than $17,000,000.

Training and Education Programs

As the Indian health program has expanded and changed to meet the needs of a growing population, education and training programs have also been expanded, and new categories of personnel added. These programs are designed to relieve health manpower shortages, promote career development, and increase participation of Indians and Alaska Natives in the effort to meet their own health needs.

The education and training activities include professional and auxiliary training for Indian Health Service staff; training of Indian people under cooperative efforts with Indian Tribes and training assistance to Government programs in the international field.

PROFESSIONAL EDUCATION AND TRAINING

Education and training and career development opportunities for professional staff include sponsorship of specialty training in public health leading to an MPH degree for physicians, dentists and professional nurses; conduct of physician residency training in pediatrics, general practice and preventive medicine; dental internship programs, and a pharmacy residency program. Training also is provided for professional nurses in specialty fields such as surgery, obstetrics and public health.

Professional staff also has the opportunity at the Indian Health Service Training Center, Tucson, Ariz., to learn principles of epidemiology combined with program planning and managerial practices applicable to the Indian Health Service.

AUXILIARY PERSONNEL TRAINING

Allied and auxiliary personnel training has been greatly expanded as a means of supplementing the work of the professional and of increasing involvement of the Indian people. For the first time college level training is being provided for Indians and Alaska Natives in a program to train medical record technicians.

The role of auxiliary staff has been increased in the categories of licensed practical nurse, dental assistant, sanitarian aide, medical social assistant, food service supervisors and community health representatives, and on-the-job training is provided in such positions as nursing assistants, food service workers, and medical record clerks.

The 50 to 60 percent of Indian health staff who are of Indian descent provide valuable interpretive, educational and motivational services while performing their regular duties.

Practical Nurse Training One of the most successful training programs has been in the field of practical nursing. At the PHS School of Practical Nursing in Albuquerque, some 60 young girls of Indian descent receive training each year as practical nurses. The course provides one year of classroom study and practice as well as clinical experience under supervision in a Public Health Service Indian hospital. The school is accredited by the National Association of Practical Nurse Education and the graduates take State board examinations to qualify as licensed practical nurses. Advanced programs are also available to practical nurses at the PHS Indian Hospital in Rapid City, S. Dak., and at the PHS field health training center at Shiprock, N. Mex. A limited number of qualified licensed practical nurses now also have an opportunity to enroll in professional schools of nursing through a special appropriation for this purpose.

Dental Assistants Training Three dental assistant training programs in Indian schools in Brigham City, Utah, Lawrence, Kans., and Mt. Edgecumbe, Alaska, are operated to train Indians and Alaska Natives who are high school graduates. The programs are one year in length and students are trained in chair-side assisting, record keeping, preventive services and efficient dental practice management. The training programs at Brigham City and Lawrence are certified by the Council on Education of the American Dental Association. Graduating dental assistants are eligible for certification after taking the required examination.

Approximately 30 dental assistants are graduated from these three programs each year and most of them are subsequently employed at various Indian health dental facilities. These Indian and Alaska Native assistants make a significant contribution to the Service's dental program. It is estimated that well-trained dental assistants increase the dental services by approximately 30 percent.

Training in Environmental Health Services To bridge the problem of acceptance of modern sanitary practice by Indian groups, the concept of the Indian sanitarian aide has been developed. Indians are given intensive training in basic elements of communicable disease transmission, sanitary practices and health education techniques, and are then assigned to work on reservations with the Indian people. Basic and advanced courses are given each year with the latter adjusted to provide staff competencies needed for program operations.

Under the direction of staff nutritionists and professional sanitarians at Indian hospitals and at Bureau of Indian Affairs schools, training is given to food service supervisors and workers in all aspects of proper food handling.

Short-term training is provided in radiological health, program management, epidemiology, well drilling and other specialties.

Health Record Technicians Career opportunities for young Indian men and women in the health record field are available through an accredited two-year program of academic study at Phoenix College, Phoenix, Ariz. Sponsored by the Public Health Service, the Bureau of Indian Affairs (Interior) and the College, this open-end training which can lead to a baccalaureate degree, was developed to help meet the shortage of health record librarians in Indian health hospitals. The program will be expanded to other colleges near the areas where Indian students live.

Laboratory and Radiologic Training As part of a laboratory improvement program and to provide laboratory assistants and radiologic technicians the Indian Health Service established a one-year school of certified laboratory assistants and a two-year school of radiologic technology for Indian students at the PHS Indian Hospital in Gallup, N. Mex.

Community Health Aide Training in Alaska To provide a health resource on the scene for people in remote, inaccessible villages in Alaska, a village community health aide program has been developed. Aides are selected by the tribe or village to serve as the link between professional medical staff at Alaska Native hospitals and village residents needing health services, and are used in a variety of clinical, field health, and health education roles. This training program will eventually provide a trained community health aide in 250 native villages.

Community Health Representative Training A program to train community health representatives to work in reservation communities has been undertaken at the request of Indian Tribes. The health representatives who are selected by the Tribe and will be employed by them, are being trained at the Indian Health Service Training Center, Tucson, in groups averaging 35 students. The curriculum which includes 4 weeks of classroom work and 6 weeks of field experience teaches concepts of health and disease and includes basic health skills, home nursing, first aid, nutrition, health education and environmental health. Principles of communication, group organization, and planning and conducting meetings are also taught. This program will improve cross-cultural communication between the Indian community and providers of health services, and increase basic health care and instruction in Indian homes and communities.

CONSULTATIVE AND INTERNATIONAL TRAINING ASSISTANCE

The experience and competency of the Indian Health Service in providing comprehensive health care in isolated areas and cross-cultural settings, and its ability to involve people in the effort to raise their own health status are important assets which have been put to use in a consultative and training capacity to other Government organizations such as the Peace Corps and the Agency for International Development.

The Service is a significant resource for Peace Corps training programs, and has itself conducted training programs for Peace Corps health aides for service in Korea and Malawi. It also is providing administrative, technical and training assistance through an AID/PHS agreement, to the Republic of Liberia to organize and staff a modern medical complex in Monrovia.

Historical Background of the Indian Health Program

THE BEGINNING

Health services for American Indians began in the early 1800's when Army physicians took steps to curb smallpox and other contagious diseases of Indian Tribes living in the vicinity of military posts. Treaties committing the Federal Government to provide health services were introduced in 1832, when a group of Winnebagos was promised physician care as partial payment for rights and property ceded to the Government. Of almost 400 treaties negotiated with Indian Tribes from 1778 to 1871, about two dozen provided for some kind of medical service. Although most treaties imposed time limits of 5 to 20 years for provision of care, the Federal Government adopted a policy of continuing services after the original benefit period expired.

EARLY GROWTH

Transfer of the Bureau of Indian Affairs from the War Department to the Department of the Interior in 1849, stimulated the extension of physicians' services to Indians by emphasizing non-military aspects of Indian administration and by developing a corps of civilian field employees. Within 25 years about half of

the Indian agencies had a physician, and by 1900 the Indian Medical Service employed 83 physicians, including those giving part-time services.

Nurses were added to the staff in the 1890's and grew from 8 in 1895 to 25 in 1900 with practically all of them assigned to Indian boarding schools. Beginning in 1891, field matrons were employed to teach sanitation and hygiene, provide emergency nursing service and prescribe medicine for minor illnesses, activities which were later taken over by public health nurses.

Indian Bureau policy by the late 1880's clearly directed physicians to promote preventive activities, but efforts were limited until well after the turn of the century due to pressure of curative work.

The first Federal hospital built for Indians was constructed in the 1880's in Oklahoma and a concentrated movement was underway before 1900 to establish hospitals and infirmaries on every reservation and at every boarding school. The reasons for construction were the isolation in which Indians lived, the lack of nearby facilities, and home conditions which made prescribing a course of treatment outside a hospital often useless and sometimes dangerous to the patient.

TWENTIETH CENTURY MILESTONES

Professional medical supervision of Indian health activities was begun in 1908 with establishment of the position of chief medical supervisor, and was strengthened in the 1920's by creation of the Health Division and appointment of district medical directors. The first appropriation earmarked specifically for general health services to Indians was made in 1911. In 1926, medical officers of the Public Health Service Commissioned Corps were detailed to certain positions in the program, and in 1955, when the responsibility for the program was transferred by Congress from the Department of the Interior, more than 50 physicians, about a dozen public health nurses, several dentists, sanitary engineers and pharmacists were on detail to the Indian Bureau from the Public Health Service.

Individual disease control programs, such as tuberculosis, were begun early in 1900's and health education activities to support these programs were introduced in 1910.

Dental services were organized in 1913 with assignment of five itinerant dentists to visit reservations and schools.

Pharmacy services were organized in 1953 with PHS pharmacy officers assigned to headquarters, area offices, and hospitals to develop and institute dispensing, packaging, and distribution policies and practices.

Until the late 1920's sanitation services did not extend beyond occasional "clean-up" campaigns and physicians' inspections of homes, schools, and Indian agencies. In 1928, sanitary

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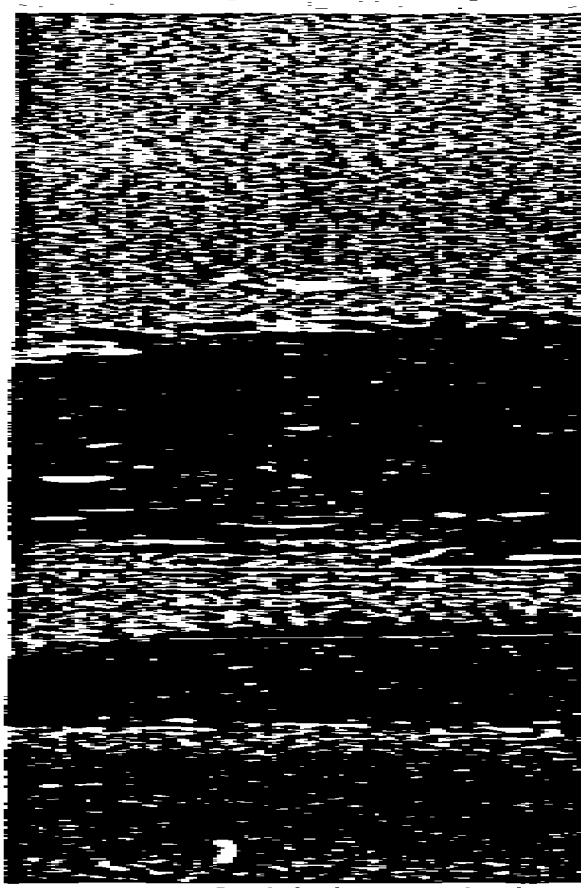

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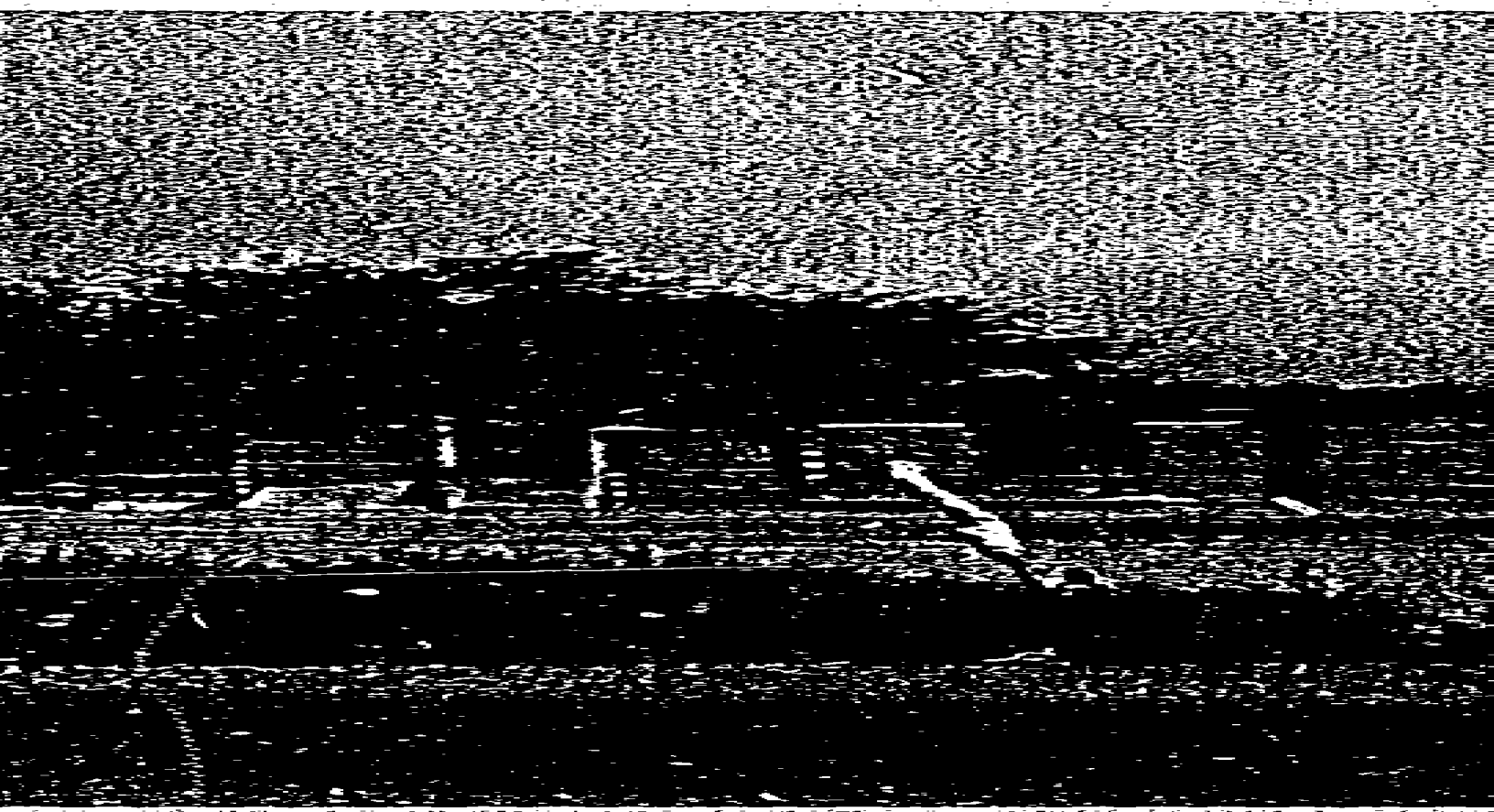


th Service began assistance to the surveying water and sanitation sys- basic sanitary problems, usually ions. An expanded program to im- al homes began in 1950, and in uthorizing the construction of sani- mes and communities.

Statistical Highlights

SERVICE POPULATION

The estimated number of Indians and Alaska Natives eligible for Federal health services is about 410,000. Most of them live on reservations in 23 States and in isolated villages in Alaska. Following are estimated numbers by Indian Health Service administrative areas:

Aberdeen, S. Dak. (S. DAK., N. DAK., NEBR., IOWA, MICH., MINN., WISC.)	58,900
Anchorage, Alaska	49,400
Albuquerque, N . Mex. (N. MEX., PART OF COLO.)	27,900
Billings, Mont. (MONT., WYO.)	25,600
Oklahoma City, Okla. (OKLA., KANS., MISS., N. CAR., FLA.)	74,000
Phoenix, Ariz. (ARIZ., CALIF., NEV., UTAH)	52,700
Portland, Oreg. (IDAHO, OREG., WASH.)	22,500
Window Rock, Ariz. Navajo Reservation (ARIZ., N. MEX., PARTS OF UTAH)	99,000

CHARACTERISTICS OF THE POPULATION

Indians and Alaska Natives differ markedly in their demographic, social and economic characteristics from the general population. They are a younger population on the average, with a median age of about 17 years, compared with a median age of about 28 for the U.S. population as a whole. In terms of educational attainment, data from the National Census of 1960[1], showed the median number of school years completed by Indians 14 years and over to be approximately eight years, compared to 10.6 for the population as a whole. The discrepancy would be greater were comparisons made on the basis of persons 25 years and older; however, comparable data for Indians are not available.

From an economic standpoint, Indians also compare unfavorably with the total population. Most of them reside on land marginal in productivity and in areas of limited employment opportunities. Data from the 1960 Census, though not representing complete coverage indicated a median family income of $1,900. Data for subsequent years, collected by the Bureau of Indian Affairs substantiated this figure.

[1] Nonwhite Report Census Highlights, P.XI

Housing conditions bear similar unfavorable comparisons. Data collected by the Indian Health Service over a period of years on a number of reservations indicate that more than half of the American Indians and Alaska Natives live in one or two-room dwellings, with an average occupancy of 5.4 persons.[2]

VITAL EVENTS

Birth Rates (live births per 1,000 population) 1967 (calendar year)

Indian and Alaska Native	37.4
U. S. All Races	17.8

Indian and Alaska Native birth rates, after steadily increasing from 1954 through 1964, have declined since 1965. The birth rate in 1954 was 37.3 per 1,000 population, reaching its peak in 1964 with a rate of 43.3. In 1966 the Indian and Alaska Native birth rate of 38.7 was more than twice that for All Races.

Life Expectancy 1967 (calendar year)

Indian and Alaska Native	64.0 years
U. S. All Races (prov.)	70.5 years

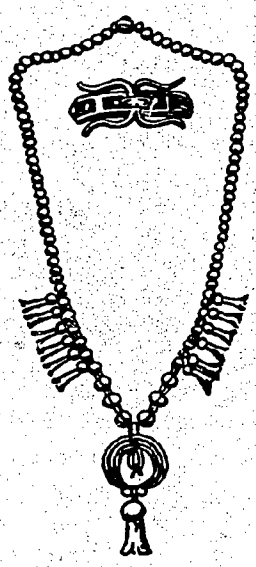
The Indian and Alaska Native estimated expectation of life at birth is below that of the U.S. All Races due largely to the higher infant mortality.

Infant Death Rates Per 1,000 Live Births, 1967 (calendar year)

Indian and Alaska Native	32.2
U. S. All Races	22.4

The Indian and Alaska Native infant death rate has declined about 48 percent since 1955, but is still about 1.4 times as high as that of the general population.

[2] From reprint "Indian Poverty and Indian Health," P.XXVIII



Neonatal Death Rate Per 1,000 Live Births, 1967 (calendar year)

Indian and Alaska Native	15.3
U. S. All Races	16.5

The death rate among Indian and Alaska Native infants under 28 days of age (the neonatal rate) has declined about 33 percent since 1955 and is now about the same as that for the general population. Major causes of neonatal deaths include immaturity, postnatal asphyxia and atelectasis, congenital malformations, birth injuries, and pneumonia of newborn.

Postneonatal Death Rates Per 1,000 Live Births, 1967 (calendar year)

Indian and Alaska Native	16.9
U. S. All Races	5.9

The death rate among Indian and Alaska Native infants 28 days through 11 months of age since 1955 has been reduced by more than 50 percent, but is still almost three times higher than in the general population. The chief causes of postneonatal deaths are respiratory, digestive, infective and parasitic diseases, accidents, and congenital malformations.

Leading Causes of Death, 1967 (calendar year)

Leading causes of death among Indians and Alaska Natives were accidents, diseases of the heart, malignant neoplasms, influenza and pneumonia, and certain diseases of early infancy. These five causes of death which accounted for nearly 60 percent of the total Indian and Alaska Native deaths in 1967, have changed little in order of importance over the years. Accidents continue as the leading cause with a crude death rate of more than three times that of the general population—180.9 deaths per 100,000 to 57.2 for U.S. All Races.

HEALTH FACILITIES AND HEALTH SERVICES

PHS Indian Hospitals and Contract Hospitals

The Indian Health Service operates 51 hospitals—49 general hospitals and 2 tuberculosis sanatoria. Most of the general hospitals are located in Arizona, New Mexico, Oklahoma, South Dakota and Alaska. Tuberculosis sanatoria are located in Albuquerque, N. Mex., and Rapid City, S. Dak., and a tuberculosis unit is an integral part of the general hospital in Anchorage, Alaska.

Available beds in these hospitals number 2,705 (excluding bassinets for newborn).

In addition to the PHS Indian hospitals, about 1,000 beds are available through contractual arrangements with several hundred community general hospitals and State and local government tuberculosis and mental hospitals.

Illnesses Requiring Hospital Services

Illnesses and diseases for which Indian and Alaska Natives are hospitalized provide one of the important indices for identifying health problems.

Leading causes of hospitalization in fiscal year 1968 were:

- Deliveries and complications of pregnancy
- Injuries
- Respiratory system diseases
- Diseases of the digestive system

Pediatric patients accounted for almost a third (31 percent) of the discharges from Public Health Service and contract general hospitals, a much higher percentage than for the general population.

Hospital Inpatient Services

Admissions to all hospitals, including those under contract, increased almost 60 percent between fiscal years 1956 and 1968. Almost 99 percent of all admissions were general medical patients and about 26 percent of the admissions were to contract hospitals.

INPATIENT SERVICES
PHS INDIAN HOSPITALS AND CONTRACT HOSPITALS

Fiscal Years 1956 and 1968

Admissions by Type of Patient	*1968*	*1956*
Total Admissions	92,186	57,975
General Medical	90,957	54,289
PHS Indian Hospitals	67,392	43,773
Contract Hospitals	23,565	10,516
Tuberculosis and Neuropsychiatric	1,229	3,686
TB PHS Indian Hospitals	694	2,445
TB Contract Hospitals	165	1,161
Neuropsychiatric Contract Hospitals	370	80

Outpatient Facilities and Outpatient Services

Each Indian hospital provides outpatient services, and the Service also operates 70 health centers including 29 at Bureau of Indian Affairs (Interior) boarding schools. Each center has at least one full-time health staff member: a physician, a dentist or a clinic nurse, assisted by other auxiliary health staff. The Service also provides itinerant health services at more than 300 health clinics.

Medical and dental services also are provided through contractual arrangements in hundreds of physicians' and dentists' offices, private and community clinics and in other non-Federal settings.

Medical Services 1968 (fiscal year)

Visits to PHS Indian hospital clinics	926,640
Visits to Indian Health Centers, satellite field clinics, schools and other units	648,756
Visits (est.) to contract physician offices	80,000

Medical visits to Service hospital clinics have been rising at an annual average rate of 6 percent since 1960. Preventive and therapeutic medical visits to Service field facilities in 1968 were over 60 percent higher than in 1960.

Dental Services 1968 (fiscal year)

	IHS Dental Clinicians	Contract Dentists
Patients Examined	129,093	13,065
Corrective and Preventive Services	613,084	68,661

Estimated population treated rose to 35.6 from 35 percent in 1968. Corrective and preventive services provided in 1968 (681,745) increased 8.8 percent over 1967.

Public Health Contracts with Health Departments

The Indian Health Service contracts with 18 State and county health departments for public health services, that include public health nursing, sanitation, tuberculosis and other communicable disease control activities.

Budget — July 1, 1968–June 30, 1969

Indian Health Activities	$93,026,000
Construction of Indian Health Facilities	1,499,000
Construction of Sanitation Facilities	16,657,000
Total	$111,182,000

HOSPITALS — INDIAN HEALTH SERVICE

Location	No. of Beds	Outpatient Visits, 1968
Alaska		
Anchorage	*307	44,254
Barrow	14	9,801
Bethel	42	24,792
Kanakanak	31	4,688
Kotzebue	50	15,892
Mt. Edgecumbe	147	11,689
St. George	6	2,184
St. Paul	7	2,620
Tanana	26	2,993
Arizona		
Ft. Defiance	103	55,580
Keams Canyon	39	14,289
Parker	25	11,486
Phoenix	137	36,604
Sacaton	31	22,284
San Carlos	38	25,401
Sells	50	13,622
Tuba City	75	38,190
Whiteriver	40	25,788
Winslow	39	20,433
California		
Winterhaven	20	11,172
Minnesota		
Cass Lake	21	11,763
Red Lake	20	15,544
Mississippi		
Philadelphia	21	9,037
Montana		
Browning	34	24,465
Crow Agency	34	16,023
Harlem	22	8,405
Nebraska		
Winnebago	42	13,555
Nevada		
Owyhee	10	5,719
Schurz	24	6,795
New Mexico		
Albuquerque***	95	1,425
Crownpoint	55	22,168
Gallup	200	57,889
Mescalero	15	7,414
Santa Fe	42	7,898
Shiprock	75	53,282
Zuni	31	12,994
North Carolina		
Cherokee	21	19,722
North Dakota		
Belcourt	50	32,040
Ft. Yates	27	12,879
Oklahoma		
Claremore	48	25,694
Clinton	21	6,123
Lawton	80	27,326
Pawnee	29	11,348
Tahlequah	55	27,386
Talihina	98	16,667
South Dakota		
Eagle Butte	29	13,717
Pine Ridge	53	30,354
Rapid City***	119	**
Rosebud	51	17,688
Sisseton	32	10,505
Wagner	24	7,053
Totals:		
No. of Hospitals		51
No. of Beds		2,705
No. of Outpatient Visits, 1968		926,640

* Includes TB beds
** Reported by Rapid City health center.
*** TB Sanatorium.
Note: Hill-Harris standards used in determining bed capacity.

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HEALTH CENTERS — INDIAN HEALTH SERVICE

Location	*Visits in 1968*
Alaska	
Fairbanks**	
Ft. Yukon	3,425
Juneau	10,473
Ketchikan	15,266
Metlakatla	2,802
Mt. Edgecumbe*	1,711
Nome**	
Wrangell*	1,008
Arizona	
Chinle (2)	29,043
Dilkon*	***
Kaibeto*	116
Kayenta	12,145
Leupp*	***
Lower Greasewood*	247
Many Farms*	***
Peach Springs	4,592
Phoenix*	603
Rough Rock*	***
Santa Rosa	5,388
Shonto*	108
Toyei*	***
Tuba City*	***
Tucson	6,603
California	
Riverside*	863
Colorado	
Ignacio	3,993
Idaho	
Ft. Hall	12,830
Lapwai	***
Kansas	
Lawrence*	2,088
Minnesota	
White Earth	4,975
Montana	
Lame Deer	13,301
Poplar	16,312
Rocky Boy's	8,935
St. Ignatius	***
Nevada	
Stewart*	1,372
New Mexico	
Albuquerque	12,573
Crownpoint*	***
Dulce	7,962
Ft. Wingate*	***
Laguna	11,783
Shiprock*	343
Taos	7,628
Teec Nos Pos*	***
Tohatchi	6,636
North Dakota	
Ft. Totten	9,435
Wahpeton*	296
Oklahoma	
Anadarko	6,266
Chilocco*	766
Concho*	3
Hartshorne*	429
Idabel	***
Jay	***
Okemah	3,577
Shawnee	24,703
Tahlequah*	759
Tishomingo	***
Watonga	3,463
Wyandotte*	67
Oregon	
Chemawa*	3,419
Warm Springs	10,385
South Dakota	
Flandreau	850
McLaughlin	6,139
Pierre*	512
Rapid City	13,733
Wanblee	***
Utah	
Brigham City	11,054
Ft. Duchesne	8,090
Washington	
Nespelem	6,281
Toppenish	14,871
Wyoming	
Ft. Washakie	16,443
Totals:	
No. of visits in 1968	346,665
No. of Health Centers	70

* School health centers. The number reflects patients seen by physicians; does not include those seen by dentists or nurses.
** Medical services provided by contract medical care facilities.
*** Designated health center in 1969.

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PORTLAND, Oregon 97204
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WINDOW ROCK, Arizona 86515
P.O. Box 188

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Health Program Systems Center
TUCSON, Arizona 85706
San Xavier Health Center

TRAINING CENTER

Desert Willow Training Center
TUCSON, Arizona 85700
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