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Tribal Perspectives on Indian Self-Determination and Self-Determination in Health Care Management

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Tribal Perspectives on Self-Determination and Governance in Health Care Management

Volume 1 - Executive Summary
A Report by the National Indian Health Board
NATIONAL INDIAN HEALTH BOARD MEMBERS, ALTERNATES, and DELEGATES DURING THE COMPLETION OF THIS PROJECT

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The National Indian Health Board (NIHB) is a non-profit organization representing all federally-recognized tribes in the United States in advocating for the improvement of health care delivery. NIHB members and alternates represent each of the 12 Indian Health Service Areas, and are generally elected at-large by tribal governmental officials within each Area. NIHB was founded by tribal leaders in 1972 to ensure that the treaty commitments promised to our ancestors are upheld in all matters related to health and human services. The project “Empowering Tribes to Participate in the Development of National Health Policy” was funded by the Department of Health and Human Services Administration for Native Americans grant number 90NA1792/01 and the Indian Health Service Cooperative Agreement number ISU 000694-04-11. The project included the research used to produce this report, as well as evaluation and improvement of NIHB’s performance in its mission and enhancement of NIHB’s ability to communicate with tribes. For additional information or copies contact the National Indian Health Board, 1385 S. Colorado Boulevard, Suite A-707, Denver, CO 80222, (303) 759-3075, fax: (303) 759-3674. Project completed 1998.

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PURPOSE OF PROJECT

It has been 25 years since the federal policy of Indian self-determination was first conceptualized in the form that was ultimately enacted into P.L. 93-638, the Indian Self-Determination and Education Act, in 1975. Since that time, there have been amendments to the law improving contracting and self-governance demonstration projects have begun. Through both self-determination contracting and self-governance compacting, tribes have options to transfer tribal shares of Area Offices and Headquarters Offices of the Indian Health Service (IHS) to local tribally-operated health programs. During this time there have been many other changes in the Indian health care system, including reductions in the growth of the federal budget, re-design of the system under the guidance of the Indian Health Design Team (IHDT), re-organization of the federal government, changes in health care financing, and the addition of newly recognized tribes.

It is difficult to distinguish the impacts of these changes from one another. At least partially for this reason, there has never been a broad national assessment of the impacts of tribal control of health care delivery systems. This project provides such an assessment. While it is admittedly a first step, the assessment this project provides is the result of information gathered on the effects of tribal control from those in the most appropriate position to evaluate the impacts: the tribes themselves.

In the absence of quantitative information, the concerns of those trying, for whatever reason, to protect the status quo have led to assertions that when tribes transfer their shares to the local level, they are hurting other tribes; that the quality of care declines and prevention programs are eliminated when tribes assume control of health care delivery systems; and that health care professionals do not want to work for tribes. Are these myths or reality? Are there “winners” and “losers” among tribes with different types of health care delivery systems?

The purpose of this study is to explore these issues from a tribal perspective and to gather the evidence to confirm or deny these fears and myths. This report includes a financial analysis, as well as an assessment of the changes in services and facilities, management changes and challenges, and the impacts on quality of care. This study also considers the opportunities and barriers to contracting and compacting, the issue of tribal sovereignty, future trends and recommendations from tribal leaders.

The project report is organized into four volumes. Volume 1 is the executive summary. Volume 2 is the narrative report. Volume 3 contains the supporting data. Volume 4 is a compilation of volumes 1, 2 and 3.
For purposes of analysis of most questions, the tribes were grouped into three types as defined here:

**Compacting tribes:** Every tribe that has a negotiated Title III self-governance compact with the IHS, regardless of the types of services included in that compact.

**Contracting tribes:** Tribes that do not have a Title III compact with the IHS and that operate at least one outpatient medical clinic through a Title I contract under P.L. 93-638.

**IHS direct service tribes:** Tribes that do not have a Title III compact with the IHS and do not operate any outpatient medical clinics. These tribes may operate other health services under Title I contracts, such as outreach workers, alcohol and mental health services, and community health nursing. These tribes may receive outpatient medical services from an IHS-operated clinic or they may have services purchased from the private sector.
Within these categories, there is a broad range of management of different types of programs. For 75 percent of the sample, these categories correspond to the tribal leaders' descriptions of how most services are delivered to their tribal members. The tribal leader descriptions are used instead of the study categories defined above to analyze tribal leader responses to questions that evaluate the system. The analysis of quality of care information from the surveys uses the tribal leaders' answers about the primary method of health care rather than the above study classifications.

A total of 210 tribes and tribal organizations participated in this study. This represents 36 percent of the 587 tribes and tribal organizations that received questionnaires. It is about 38 percent of the 554 federally-recognized tribes.

Every IHS administrative Area was represented in the study. The rate of participation by tribes within the Areas ranged from 24 percent to 100 percent.

For the tribal leader survey, 171 questionnaires were received. This is 29 percent of the total 587 mailed and 31 percent of the 554 federally-recognized tribes. Tribal leaders from every Area participated with a response rate ranging from 16 percent to 100 percent by Area. Tribal leaders from every type of tribe participated, with 40 from IHS direct service tribes, 36 from contracting tribes and 95 from compacting tribes.

The health director survey was sent to 256 people in 239 organizations. A total of 71 questionnaires were received representing 30 percent of the organizations. Every Area was represented, with response rates ranging from 15 percent to 100 percent. Health director questionnaires were received from 21 IHS direct service tribes, 31 contracting tribes and 19 compacting tribes.

Overall, the survey sample appears to be representative of the whole. Where responses from an Area are low, they have been combined with those from other Areas to form larger groups for some types of analysis. It should be noted that this survey presents a tribal perspective giving equal weight to every federally-recognized tribe regardless of the number of members enrolled or the amount of the IHS budget allocated to the tribe or the number of facilities serving the tribe.

While this study presents numbers and percentages to describe groups of tribes and trends, no statistical analysis has been done to determine cause and effect.

**FINANCIAL ANALYSIS**

There have been slight increases in Congressional appropriations for the Indian Health Service since 1993 when the Tribal Self-Governance Demonstration Project began.

<table>
<thead>
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<th>Year</th>
<th>Appropriations</th>
<th>Population</th>
<th>Per Capita</th>
<th>Medical</th>
<th>Adjusted</th>
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<td>240</td>
<td>$1,183</td>
</tr>
</tbody>
</table>

*Includes all directly appropriated dollars including construction funds, excludes third party collections from Medicare and Medicaid and Private Insurance*
EXECUTIVE SUMMARY

However, when these amounts are adjusted for population growth and inflation, there has been a decline in the actual purchasing power from $1,442 to $1,183 per person, a decline of 18 percent from FY 1993 to FY 1998.

To cope with the less than adequate levels of Congressional appropriations, both the IHS and tribes that operate health programs have relied increasingly on alternate resources. Only a portion of the tribally-operated revenues from third parties are reported in the DHHS financial data system used in this analysis. However, the figures show that tribes were collecting almost 4 times as much in Medicaid and Medicare revenues in FY97 as they collected in FY93 ($10.5 million compared to $40 million). This is due in large part to a Medicaid rate increase of nearly 50 percent in FY97.

Despite the movement of approximately $48 million in tribal shares from IHS Headquarters and Area Offices to tribal operations, the overall expenditures at IHS Headquarters and Area Offices remained relatively constant over the 5 year period from FY93 to FY97. Within the Areas, however, there has been much variation. For example, among Areas with predominantly IHS direct service, the change in expenditures has ranged from a 44 percent growth in the Aberdeen Area Office cost center to a 29 percent reduction in the Albuquerque Area Office cost center. While it would seem that Areas with a high rate of tribal operations would have been reduced in size, this has only happened sometimes. For example, the Alaska Area Office was reduced by 33 percent, but the Oklahoma Area Office grew by 36 percent.

![Net Gains in Programs By Type of Tribe](image)

Source: Health Director Survey

SURVEY RESULTS

Changes in Services and Facilities

In the past three years there have been more gains than losses in programs in every type of service and in every type of tribe. If one takes the number of new and expanded programs and subtracts the number of programs eliminated or significantly reduced, the net gain is substantial. When the net gain is divided by the number of tribes in the study, the results indicate that among IHS direct service tribes 38 percent have more community-based programs, 86 percent have more clinical services, 19 percent have more auxiliary services, and 66 percent have more prevention programs.

The gains are even more impressive for Tribally-operated health care systems. Of these tribes, 50 percent have more community-based programs, 100 percent have...
at least one new clinical service, 34 percent have more auxiliary services, and 100 percent have at least one new prevention program with 68 percent having more than one additional prevention program.

The contrast between Tribally-operated programs and IHS programs is even more striking when one considers facilities. For contracting and compacting tribes in the study, 49 new facilities were added and 12 facilities were closed for a net gain of 37 facilities. Because some tribes built more than one new facility, the gains actually affected about 44 percent of the tribes in the study.

IHS direct service tribes, on the other hand, did not experience these same gains in facilities. For the IHS direct service tribes in the study, there were 9 new facilities and 8 closed facilities for a net gain of one facility. For the 21 IHS direct service tribes in this study, this indicates only 5 percent of the tribes in this category experienced a gain. There was a net loss of one ambulatory care facility, suggesting that about 5 percent of the IHS direct service tribes experienced a net loss in outpatient facilities.

About 20 percent of the tribes participating in the study reported closing facilities. Less than half the facilities were closed due to funding shortages.
Other reasons were underutilization, staff shortages and lack of support services. About 30 percent of the closed facilities were replaced with newer facilities. Health centers account for 57 percent of the facilities built since 1993 for tribes in this study.

Of course, these are averages and not every tribe fits this profile. Those that close programs for financial reasons may not be adding programs. Clearly, some tribes feel that their services and facilities have suffered due to a combination of problems. Most tribes in the study, even those that have seen dramatic improvements, feel that there are many more health care improvements needed and that this requires greater funding by Congress.

This study suggests that in the era of self-determination and self-governance there are more tribes experiencing improved health care than those with deteriorating health care. Furthermore, there are more winners than losers in every type of tribe: IHS direct service tribes, contracting tribes and compacting tribes. What is most remarkable is that these gains have happened in an era when the federal budget has not kept pace with inflation and there has been governmental downsizing. One can only imagine the possibilities if funding were at least to keep pace with rising costs.

Management Changes and Challenges

As tribes take over management of health programs under P.L. 93-638 contracts, they appear anxious to make changes in management to increase income from third party sources and to create efficiencies by acquiring new computers and re-organizing services. Data from this study suggest that initially tribes are more likely to use a shotgun approach, trying several different strategies to achieve management objectives. However, as they get more experience they learn what works best for them and they keep the most effective approaches and abandon the other strategies. At first, contracting tribes increase their administrative staffing to improve such areas as quality assurance, purchasing and planning. Later they may see a need to streamline their administra-

tion staffing. After 3 years of contracting, when they become eligible for compacting, their management systems are largely in place. Thus, compacting tribes are making fewer management changes and using fewer strategies to achieve their objectives than are the contracting tribes, despite the fact that compacting allows tribes more flexibility in management. Tribes appear to have made most of their innovations and changes by the time they are eligible to compact.

Another pattern that emerges from the information in this study is that tribes are more likely to use income from economic enterprises to support health care services and to build new facilities when tribes are operating the health care programs under contract or compact. It is not clear whether tribes with successful economic enterprises are more likely to be contracting or compacting health programs than tribes with a more limited economic base and less management experience. One of the more surprising findings is that IHS funding for new or expanded facilities appears to benefit compacting tribes more than either IHS direct service tribes or contracting tribes.

![Percentage of Health Care Budget from non-IHS Sources](image)

Tribes report fewer problems recruiting health care professionals than the IHS direct service programs. This may be because tribes have more recruiting strategies available to them than does the federal government. There appears to be little difference in retention of health care professionals between IHS direct service tribes and tribally-operated programs.
Impact on Quality of Care

This is the first large scale study that specifically asks tribal leaders and health directors about their perceptions of the quality of care in the health systems that serve their tribes. Since elected tribal leaders and health directors often make key decisions related to health care services for their tribes, their perspective on the quality of care delivered to their community members is very important, and is often a key factor in the tribe’s decision whether to remain under IHS direct services or to enter into contracts or compacts to manage their own health care services. The quality of care questions were developed to gather information on the overall quality of care from the perspective of tribal leaders and health directors, and to ask for their qualitative comments on a number of indicators of quality. These answers were compared for the different types of health care delivery systems present in Indian country (IHS direct, contracting, and compacting).

From the tribal perspective, the study found that the majority of the tribal leaders and health directors who responded believe that the quality of care is getting “better” in Indian health. Specifically, 57 percent of tribal leaders and 84 percent of tribal health directors thought that the quality of care has gotten “better” over the past 3-4 years.

Tribal leaders and health directors from compacting tribes more commonly responded that the quality of care is getting “better”, compared to tribal leaders and health directors from IHS direct service and contracting tribes. Of the compacting tribal leaders who responded, 92 percent outside...
Alaska and 68 percent in Alaska rated the quality of care as “better” over the past 3-4 years, which exceeds the percentages of contracting tribal leaders (59 and 50 percent, respectively) and IHS direct service tribal leaders (38 to 50 percent, respectively). And while 19 - 22 percent of tribal leaders of IHS direct services tribes and contracting tribes outside of Alaska thought that the quality of care had changed for the worse, none of the compacting tribal leaders had this response. Similarly, in the health director survey, 95 percent of compacting and 93 percent of contracting health directors rated the overall quality of health care as “better”, compared to only 62 percent of IHS direct tribal health directors.

The tribal leaders responded that specific indicators of quality listed in the survey (waiting times, types of services, number of people served, and overall health care system) were “better” over the past 3-4 years. Compacting tribal leaders again rated the quality indicators as “better” more commonly than leaders of other types of tribes. For example, 86 percent of tribal leaders representing compacting tribes rated the indicator waiting time as “better”, compared to only 19 percent of the tribal leaders representing IHS direct service tribes, and 41 percent of the tribal leaders representing contracting tribes.

The tribal leaders and health directors in this sample represented health programs that were well equipped to measure quality, since all of the hospitals and many of the clinics serving these tribes were accredited or in the process of being accredited. The only limitation on accreditation seemed to be a lack of resources as the most common response. In addition, 49 to 79 percent of the facilities represented measured the specific quality indicators listed. About two thirds of the respondents thought that their data was accurate or mostly accurate.

The tribal leaders and health directors in this sample had a high level of involvement in the Quality Assurance (QA) activities of the health facilities serving their tribes. The majority (63 percent) of the tribal leaders were aware of summaries of health care quality from the facilities that serve their tribe, and 60 percent of health directors reported that elected tribal officials were involved in QA activities. Of note, the highest level of awareness of health care summaries was found with tribal leaders from contracting tribes in all areas except Alaska (73 percent), and with tribal leaders from compacting tribes in Alaska (81 percent).

Therefore, from the perspective of tribal leaders and health directors in this survey, the quality of care, as defined overall and by a number of indicators, is getting better in Indian health. And tribal leaders representing tribally managed programs more commonly rated the quality of care as “better.” Very few of the respondents rated the quality of care as “worse”, and they tended to be mostly from IHS direct service tribes. These data contradict the assertions of various authors in the literature who claim that the reorganization and move towards tribally managed health programs has led to a decline in the quality of care.

**Opportunities and Barriers**

Opportunities are the incentives that encourage tribes to move in one direction or another. Barriers are disincentives — they discourage tribes from moving in a direction. Public policies contain a mix of
incentives and disincentives that help to shape tribal decisions about contracting and compacting health services. A driving force in decision-making about health care management, particularly for compacting tribes, is the opportunity to exercise tribal sovereignty and control.

Tribal leaders of tribes in the study with IHS direct services explained the reasons for this choice in terms of barriers to other choices: no other option, historical circumstances, too little funding to contract, staffing limited locally, ineligible to compact. Only 4 of the 69 tribal leaders in this group cited opportunities, including the exercise of tribal sovereignty and federal responsibility. This suggests that if some of the barriers were reduced or eliminated, many of these tribes might make different decisions.

The tribal leaders of compacting tribes sounded much more pro-active in their decision making. These tribes chose compacting to take advantage of opportunities, including flexibility in the management of programs, improving quality of care and maximizing funding. The reason given most often for compacting was the exercise of tribal sovereignty, cited by 53 percent of the tribal leaders of compacting tribes outside Alaska and 31 percent in Alaska.

Contracting appears to be a middle ground, with both opportunities and barriers. Many of the contracting tribal leaders, particularly from California, felt that their choices were limited by historic circumstances and small size. Other contracting tribes felt that contracting provided more tribal control, the opportunity to gain management experience and build tribal capacity. Since federal regulations require tribes to contract for 3 years before compacting, it is likely that many of these tribes will move into compacts after they have gained the requisite experience. But the trend is not always toward compacting: some tribal leaders from Alaska expressed a desire to withdraw from the statewide compact and the regional non-profit health corporations to exercise more control at the local level through contracting.

According to the health director survey, the lack of Indian Self-Determination (ISD) contract support funding was regarded as a barrier to contracting or compacting for 27 percent of the IHS direct service tribes, 28 percent of contracting tribes and 11 percent of compacting tribes.

In general, Area Offices are facilitating the transition to tribal management of health care. Most of the 12 IHS Area Offices were regarded by a majority of tribes in the Area as encouraging or neutral toward contracting and compacting; however, 2 of the Area Offices were perceived as discouraging compacting. In 5 of the 12 Areas, more than half the tribes said they were never consulted prior to the Area Office negotiating with other tribes in the Area. In only 4 Areas did any tribe say it was always consulted prior to negotiations with other tribes, and in those...
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Areas the percentage of tribes with this response was below one-third. Information provided by Area Offices always or sometimes meets the needs of tribes for making decisions regarding health care delivery. In 7 of the 12 Areas, half or more of the tribes participating in the study thought the Area Office was too big. In only one Area was the Area Office regarded as too small.

Future of Contracting and Compacting

About half the tribes expect changes in their health care delivery systems in the next five years. They predict a shift to more contracting and compacting. The projections based on tribal leader responses suggest that the IHS direct service will go from 25 percent of the tribes to 6 percent in the next five years. With about 95 percent of the tribes managing their own health care systems, more than half the tribes will be doing so under annual funding agreements (AFAs).

Tribal Sovereignty: Assessment and Recommendations

Most of the tribal leaders participating in this study are “somewhat” or “mostly” satisfied that the federal government is fulfilling its treaty responsibilities and that the method of health care delivery for their tribe respects their tribal sovereignty. In general, the compacting tribes are more satisfied than other types of tribes, while contracting tribes are the least satisfied.

Tribal leaders make a number of recommendations for changes that are needed at the federal, state and tribal levels to facilitate greater tribal sovereignty in the health care delivery system. Tribal leaders said that the federal government should respect, recognize and support tribal sovereignty. They suggest that a step in the right direction would be if the federal government treated tribes like states for reimbursements under Medicaid, certifications, and eligibility for grants and other sources of funding. They requested more tribal control and more flexibility in regulations and program requirements. Tribal leaders suggested passing laws to protect tribal sovereignty. Stopping block grants to states is another way to protect tribal sovereignty. Tribal leaders also requested broader consultation with the federal government, and they want representation on advisory committees formed by the federal government.

Tribes want Congress to provide adequate funding, increased funding and/or full funding for the IHS. They cited the need for more funding for specific programs, including Contract Health Services and prevention programs. They want funding for facilities construction and contract support costs. Several tribal leaders expressed concerns about equity in funding between tribes.

Tribal leaders also suggested changes in the management and organization of the IHS. They stated that they want to see the recommendations of the Indian Health Design Team implemented at both the Headquarters and the Area levels. The compacting tribes want a more timely distribution of funding under their annual funding agreements (AFAs). Tribes want improved services and increased employment of
Alaska Natives and American Indians. Some of the employment-related changes they recommended include reducing educational requirements for employment and reducing salaries paid to administrators.

Many of the tribal leaders in the study called on states to recognize tribal sovereignty, support tribal rights, and develop a government-to-government relationship with tribes. Tribal leaders felt that states should do a better job of consultation and communication with tribes. They had several suggestions for carrying out this recommendation. Some felt that states that have not already done so should develop a long term process for consultation, such as an Indian Commission. Others stated that treating each tribe as a sovereign nation means determining each tribe’s protocol and using those avenues for communication, policy review, and legislative collaboration. With either method, tribal leaders felt that states should be sharing more information with tribal leaders and working with tribes to develop state laws and regulations.

State budgets were another area where tribal leaders think that changes should be made. They are seeking state funding to supplement federal funding for health care. They want states to give tribes a fair share of federal block grants and other federal funding. They would like to see more contracting with tribes to manage state health programs for tribal members. One change that is needed to facilitate greater tribal participation in state grant programs is the elimination of matching requirements, since tribes may not have the resources necessary to meet the requirements, and thus tribal members are precluded from enjoying benefits available to other citizens.

Another area identified for change is the coordination of services between states and tribes. This includes the coordination between state agencies and tribes to meet the needs of reservation populations that are eligible for state services. Tribal leaders suggested that memoranda of agreement (MOAs) would be useful in this process, as well as devising methods to share services. Several tribal leaders said that states could help tribes to access services at lower costs, for example by letting tribes use the state-negotiated rates for purchasing health care services.

Tribal leaders said that there needs to be education for federal and state officials and employees on trib-
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Tribal sovereignty, Indian health care, Indian issues, cultural differences between tribes, and related topics. They also suggested that there was a need to improve federal/tribal/state communications.

Tribal leaders who participated in this study had many suggestions for changes at the tribal level that would allow tribes to more fully exercise their sovereignty. These responses offer insight as to what the tribes can do locally to improve their situation.

The leading suggestion was to acquire more training and technical assistance for tribal leaders and tribal employees, particularly in the areas of health care management, health care needs, delivery systems and quality assurance. They also saw a need for training in treaties and Indian law, including the Indian Self Determination Act and current changes in laws and regulations. Another area identified for training was the budget process. One tribal leader thought that training on traditional healing and cultural practices for non-Native employees and others was needed.

Tribal leaders recommended changes in tribal planning and evaluation activities. They said that there was a need to analyze and document program effectiveness. There was a need for strategic planning and to assess the costs and benefits of alternatives.

Many tribal leaders identified a need for changes in attitudes and values. They said it was important to assert tribal sovereignty, to insist on being treated as a government. They saw a need for more focus on prevention, empowerment and individual responsibility. Tribal leaders felt they should act as role models. And, they identified the need for more of a customer-service orientation in the delivery of services.

Cooperation among tribes was also suggested. Such cooperation includes, among other ideas, the formation of statewide organizations to provide a strong unified voice at the State level.

CONCLUSIONS

This study has provided the opportunity to survey a broad cross-section of tribal leaders and health directors from every Area of the IHS and every type of health care delivery system. In combination with financial analysis, the information obtained provides a quantitative and qualitative assessment of the impacts of self-determination contracting and self-governance compacting on the system of health care services for American Indians and Alaska Natives. It is significant because it offers a tribal perspective on the changes that have occurred in the past 3-4 years in which tribal self-governance demonstration projects have become part of the landscape of health care in Indian Country. Evidence presented in this study suggests the following conclusions:

1. Population growth and inflation have reduced the purchasing power of Congressional appropriations for Indian health. Despite slight increases in actual Congressional appropriations, there has been an 18 percent decline in the adjusted per capita expenditures, or purchasing power, of IHS dollars from FY 1993 to FY 1998. This reduction is affecting all types of tribes in all Areas of the IHS. A significant increase in Medicaid rates provided some relief during the period of this study.

2. The health of American Indian and Alaska Native people has improved at the same time that there has been a growth in tribal management of programs. Numerous indicators show that the health status of American Indian and Alaska Native people has improved, and there is no direct evidence that tribal management has caused a decline in the health status of American Indians and Alaska Natives. In fact, tribal management has led to many improvements in the health systems...
that serve these communities, and many of these improvements are illustrated in the results of this study.

On average, every type of tribe - IHS direct service, contracting, and compacting - has achieved a higher level of health care since the self-governance demonstration project began. Tribally-managed programs have an even better track record than IHS direct service programs in the addition of new services and facilities. Clearly, some tribes feel that their services and facilities have suffered due to a combination of problems, including population growth, inflation, and unfunded mandatories. Most tribes in the study, even those that have seen dramatic improvements, feel that there are many more health care services needed and that this requires greater funding by Congress.

When tribes assume control of health care, they give a high priority to prevention programs. When tribally-operated programs have had the opportunity to add or expand services, prevention has been the leading area for expansion. When forced to eliminate programs, IHS direct service was more likely than tribally-operated programs to eliminate prevention services.

Tribes more commonly perceive an improvement in the quality of care when they manage their own health care systems. Tribal leaders and tribal health directors in this study more commonly rated the quality of care over the last 3 - 4 years as “better”, especially if they represented compacting tribes. In addition, the tribal leaders and health directors that rated the quality of care as “worse” were more commonly from IHS direct service tribes.

Tribes do not have more difficulty than the IHS in recruiting and retaining health care professionals. Recruitment and retention of health professionals is a problem for all parts of the Indian health system, due in large part to location of health facilities in remote, rural areas. Tribes report fewer problems recruiting health care professionals than the IHS direct service programs. There appears to be little difference in retention of health care professionals between IHS direct service tribes and tribally-operated programs.

The motivation for compacting is not just increased funding. When tribal leaders were asked the reasons they chose their form of health care management, a majority of leaders of compacting tribes cited tribal sovereignty and local control. Other reasons included management flexibility to meet the needs of tribal members and the opportunity to improve the quality of care. Only 7 percent cited maximizing funding.

As the federal system of Indian health care changes, integration of services is occurring through tribally-controlled organizations. While tribes want more local control, many tribes are improving efficiency by entering into multi-tribal agreements for purchasing and delivering services. Multi-tribal agreements are expected to increase in the next five years, according to the tribal leaders.
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- Self-governance compacting is not hurting most other tribes. While many tribes in this study said that they were hurting from lack of adequate federal funding, few reported that they were hurting as a result of other tribes compacting. The direct negative consequences that were reported were the loss of discretionary funds to cover budget shortfalls at the end of the year and the shift of some responsibilities to the Service Unit level. Overall, most of the tribes that were not compacting reported improvements in services, management, and quality of care.

- Resources for IHS direct services have remained constant or grown as tribes assume management of their health care system. In every Area where tribally-operated programs have expanded, direct IHS expenditures have either grown or remained constant, except the Portland and California Areas where almost all services are tribally-operated. The financial analysis in this study does not provide any support for the notion that resources are being moved from IHS direct service tribes (or Areas with mostly IHS direct service) to tribally-operated programs (or Areas with mostly tribally-operated programs).

- The overall expenditures at IHS Headquarters and Area Offices have remained relatively constant from FY93 to FY97. Area Offices have responded in different ways to the pressures to downsize and reallocate resources to field health programs. Some Areas with a large proportion of resources in Title III agreements (like Alaska and Portland) have dramatically reduced the resources expended for the Area Office. So have some Area Offices with no Title III agreements (Tucson and Albuquerque). Several Area Offices with large direct IHS components have increased federal expenditures for the Area Office (Aberdeen and Navajo).

- The federal government could do more to assure tribes that self-determination contracting and self-governance compacting will not lead to termination. Many tribal leaders who participated in this study would feel more comfortable about the future if there were changes at the federal level to protect their sovereignty. They types of changes suggested include laws, funding approaches, flexibility in regulations, increased consultation, and more training in Indian law for Congress and federal employees.

- The federal policy of self-determination contracting and self-governance compacting is working, but it could be improved. Overall, self-determination is working in that tribes that have chosen to manage their health care programs are very successful. However, a significant number of leaders of IHS direct service and contracting tribes felt that they had no choice, or that their choices were more limited than the law provides. Furthermore, the lack of Indian Self-Determination (ISD) contract support funding is preventing some tribes from exercising their options.

- The trend toward increased self-determination contracting and self-governance compacting will make the Indian health system look different in five years. If tribes make the changes they predict in this study, the Indian health system will have 6 percent of tribes receiving IHS direct services, 38 percent of tribes contracting, and...
56 percent compacting. While these projections are based on the definitions used in this study, the indication by tribes is clear that they plan to manage more of their health care delivery systems.

More research is needed on the effects of tribal management on Indian health. Follow up studies are needed to more fully explore some of the issues identified in this report. It is important to continue the work begun by the Baseline Measures Workgroup to further define ways of measuring quality of care indicators so that data may be aggregated nationally, by region and/or by type of tribe for purposes of monitoring trends and comparing performance. While the financial information presented in this report provides a quantitative assessment of the impacts of contracting and compacting, the picture will certainly continue to change and it is necessary to monitor those changes. The changes in the system predicted by the tribal leaders should be monitored in the context of changes in federal policies that affect barriers and opportunities.

If the federal government wants to encourage tribal management, policies could be changed to remove barriers and increase opportunities. According to the findings of this study, these could include:

- More training and technical assistance to help tribes acquire and maintain management expertise; and
- Changing attitudes in those few IHS Area Offices where tribes perceive that compacting is discouraged.

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Abstract

Purpose:
It has been 25 years since the federal policy of Indian self-determination was first conceptualized in the form that was ultimately enacted into Public Law 93-638, the Indian Self-Determination and Education Assistance Act, in 1975. Through both self-determination contracting and self-governance compacting, tribes have options to transfer tribal shares of Area Offices and Headquarters Offices of the Indian Health Service (IHS) to local tribally-operated health programs. This project provides an assessment of the impacts of tribal control of health care delivery systems.

Methods:
This study explores the impacts of tribal control of health care delivery systems from a tribal perspective and gathers evidence to assess the impacts. A survey of tribes was the most critical element of this study, since it provided the tribal perspectives necessary to accomplish the goal of the study: evaluating the impacts of tribal choices in health care. This report includes a financial analysis, as well as an assessment of the changes in the services and facilities, management changes and challenges, and the impacts on quality of care.

Results:
The project report is organized into four volumes. Volume 1 is the executive summary. Volume 2 is the narrative report. Volume 3 contains the supporting data. Volume 4 is a compilation of volumes 1, 2, and 3. The study also looks at the opportunities and barriers to contracting and compacting, the issue of tribal sovereignty, future trends and recommendations from tribal leaders.

Conclusion:
This study has provided the opportunity to survey a broad cross-section of tribal leaders and health directors from every Area of the IHS and every type of health care delivery system. In combination with financial analysis, the information obtained provides a quantitative and qualitative assessment of the impacts of self-determination contracting and self-governance compacting on the system of health care services for American Indians and Alaska Natives. It is significant because it offers a tribal perspective on the changes that have occurred in the past 3-4 years in which tribal self-governance demonstration projects have become part of the landscape of the health care in Indian Country.

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