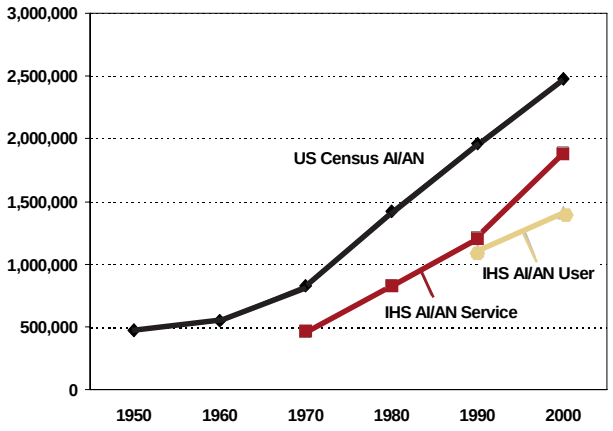
Indian People

American Indians and Alaska Natives (AI/AN) are represented by 562 federally recognized Tribes that are culturally diverse and strong. The Tribes have different population characteristics and a multitude of native languages.

Populations of AI/ANs: U.S. Census, IHS Service, IHS User



In 1955, the Bureau of Indian Affairs (BIA) estimated the American Indian population in the continental United States (excluding Alaska) to be 472,000 persons. The 2000 Census counted almost 2.5 million AI/ANs. More accurate population enumeration methodologies, the addition of Alaska in 1959 with its population of Alaska Natives, and overall population growth contributed to this four-fold increase among AI/ANs. The AI/AN population served by the IHS also grew tremendously during this time period.

The proportion of AI/ANs living in urban locations also changed. In 1950, the estimated number of AI/ANs living in urban settings was 55,909 (16 percent). As of the 2000 Census, the estimate was approximately 1,497,402 (60 percent), a three-fold increase.

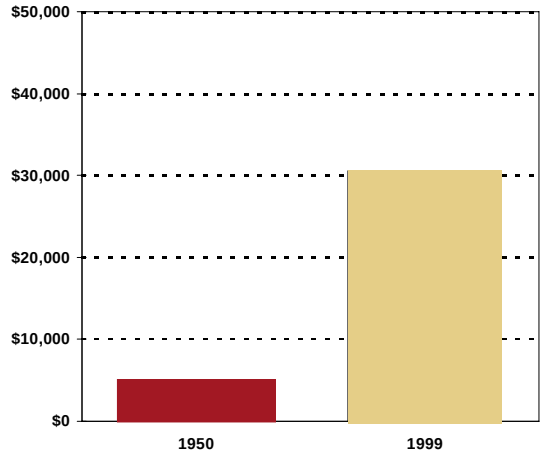
In 1950, American Indians experienced overcrowding and a lack of plumbing, electricity, and adequate sanitation facilities. Some 67 percent of American Indians lived in overcrowded dwellings. As of 2000, 14.8 percent of AI/ANs were living in overcrowded dwellings. While a vast improvement, this figure is still 2.5 times higher than the overall U.S. population.

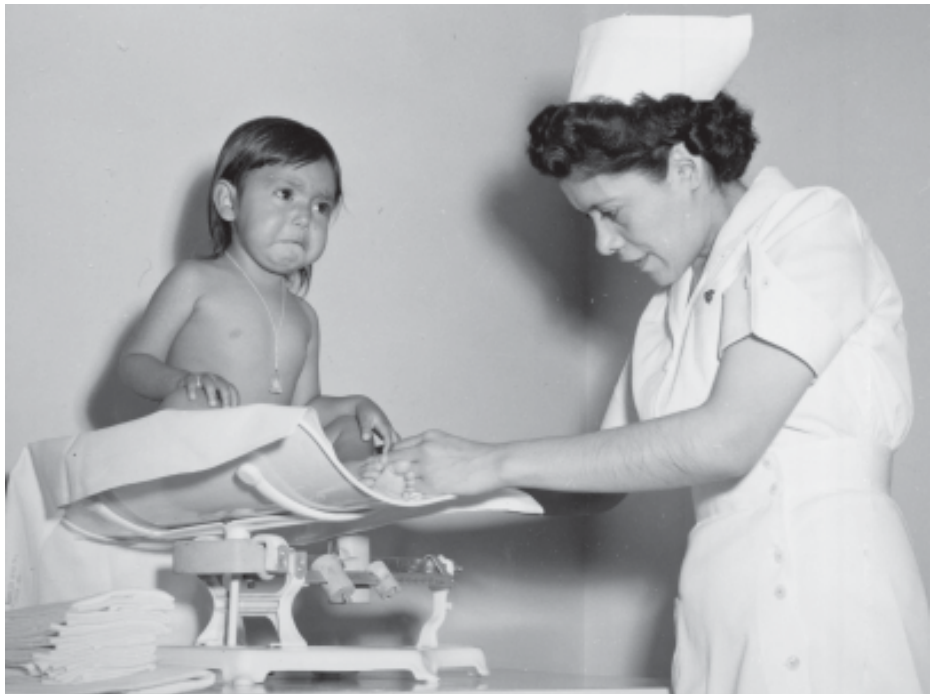
More than 265,000 Indian homes have been provided with sanitation facilities since 1959, when the Indian Sanitation Facilities Act (Public Law 86-121) authorized the construction of essential sanitation facilities. However, some 40,000 Indian homes still lack either a safe water supply or sewage disposal, or both.

According to the 1950 Census, the median income for American Indians was $725. This equates to $5,011 in 1999 dollars. The median income of AI/ANs in the United States in 1999 was $30,599. Poverty still disproportionately affects the AI/AN population, with some 25.7 percent living with an income below the poverty level.

In terms of the educational attainment of American Indians, the median school years completed in 1950 was 7.1 years. By 2000, 70.9 percent of AI/ANs had received a high school diploma (including equivalency) or some college, an associate's degree, a bachelor's degree, or a graduate/professional degree.

Median Household Income 1950 and 2000, in 1999 Dollars.





Health of American Indians and Alaska Natives

Elevating Health Status

The Indian Health Service (IHS) has attained a remarkable record of achievement in improving the health of Indian people. This is one of the few bright spots to emerge from the history of relations between American Indians and the Federal Government. The IHS has raised the health status of the American Indian and Alaska Native (AI/AN) population dramatically over the past 50 years, a striking achievement in the light of the poverty and stark living conditions experienced by this population.

Starting as an emerging Government health care system caring for America's poorest, rural, and most vulnerable populations, the IHS was not anticipated by many to become successful. Such an accomplishment is due to a succession of dedicated IHS leaders, a strongly committed workforce, the support of Tribes and Congress, and an unwavering devotion of all to a singular mission — to raise the physical, mental, social, and spiritual health of AI/AN people to the highest level. Despite imperfections and the lingering health problems that exist among Indian people, the IHS is an example of a Federal program that has worked.

Despite many successes to tell, the story is incomplete. The needs of Indian people have changed enormously in the past half century. Progress in eliminating health disparities has slowed, particularly in the last 15 years. New health gaps and disparities have emerged; diabetes among Indians is at crisis proportions, as an example. The IHS mission is not yet fully accomplished.

1950s

In the first decades of the IHS, emphasis was placed on children's health and the control of communicable diseases. Priority problems among American Indians included complications of childbirth, vaccine-preventable diseases, malnutrition, basic sanitation, treatment of dysentery, acute care for injuries, and tuberculosis (TB). In 1956, fully half of all hospital beds in IHS and contract hospitals were occupied by TB patients. Heart disease was the leading cause of death, with a rate per 100,000 population of 170 deaths, half of which were due to coronary artery disease. Unintentional injury was the second leading cause of death, with half of these deaths due to motor vehicles. Enteric diseases were very common due to the 80 percent of AI/AN homes that lacked indoor plumbing and a safe water supply.

21st Century

As the IHS advances in the 21st century, immunization rates are high, infant mortality rates are low, TB has been largely controlled, and most communities are experiencing access to a

The 10 Leading Causes of Death in the AI/AN Population

1951-1952	1996-1998
1. Heart disease	1. Heart disease
2. Accidents	2. Cancer
3. Influenza and pneumonia	3. Accidents
4. Tuberculosis	4. Diabetes
5. Certain diseases of early infancy	5. Chronic liver disease
6. Cancer	6. Stroke
7. Intestinal disease (dysentery, enteritis)	7. Pneumonia and influenza
8. Stroke	8. Suicide
9. Congenital malformations	9. Chronic obstructive pulmonary disease
10. Homicide	10. Homicide

safe water supply. The immunization rate among AI/AN children was 83 percent in 2001. The rate of new TB cases in the IHS in 2001 was 13.2 per 100,000 population. By 2000, infant mortality was reduced to 9.0 deaths per 1,000 live births, almost one-tenth of the AI infant-mortality rate of 1955. The number of AI/AN homes with indoor plumbing increased over four-fold from 1950 to 2004.

The average life expectancy of AI/ANs has increased by 10 years since 1955, leading to a rapid increase in the number of elders and an increasing need for facilities to care for them. Several factors have contributed to a shift in the pattern of disease for AI/ANs, most notably the control of infectious diseases; access to abundant fast foods and foods high in sugar and fat; commercial tobacco products; and the overall transition to a more Western lifestyle. Chronic diseases now account for 6 of the top 10 leading causes of death, with an epidemic of obesity and diabetes affecting every community.

At the time the IHS was established, diabetes was not among the 10 leading causes of death. In the last 50 years, there has been a four-fold increase in the death rate due to diabetes, and this significant increase has made it the fourth leading cause of death among AI/ANs. Complications of diabetes, such as heart disease, kidney failure, vision loss, and amputations have increased enormously since 1955. While the IHS has become a world leader in treating diabetes, the challenge for the future will be working at the local level to change eating and exercise behaviors and ultimately reducing the prevalence of this devastating and costly disease.

Fifty years ago, cancer was a rare disease among AI/ANs. Cancer death rates have steadily increased since that time, although they are still lower than the U.S. rate for all races. The increase is due to many factors, including increased smoking, sedentary lifestyle, changes in diet, fewer pregnancies, an aging population, and, possibly, an increase in exposure to environmental pollution.

From 1954 to 1998, the total injury rate among AI/ANs decreased approximately 36 percent. Important strides are being made in the area of injury prevention, but injuries still account for 41 percent of the years of potential life lost, and unintentional injuries are the leading cause of death for

AI/AN Unintentional Injury Deaths

	1954	1996-1998	
Total injury deaths	136.0	52.4	
Motor vehicle related deaths	68.9	51.2	
Deaths due to other injuries	67.1	36.4	*rate per 100,000 population*

AI/ANs under age 44. Community-based injury-prevention work must continue to improve safety and reduce dangers that lead to illness and death among the AI/AN people.

Findings from IHS patient-based surveys indicate a higher prevalence of oral diseases for American Indians. Most oral diseases result from limited access to community and personal preventive measures, such as fluoridated water and toothpaste, as well as lack of oral hygiene. More recent surveys done IHS-wide in 1984, 1991, and 1999 show a general decrease in the mean number of decayed, missing, and filled permanent teeth for children.

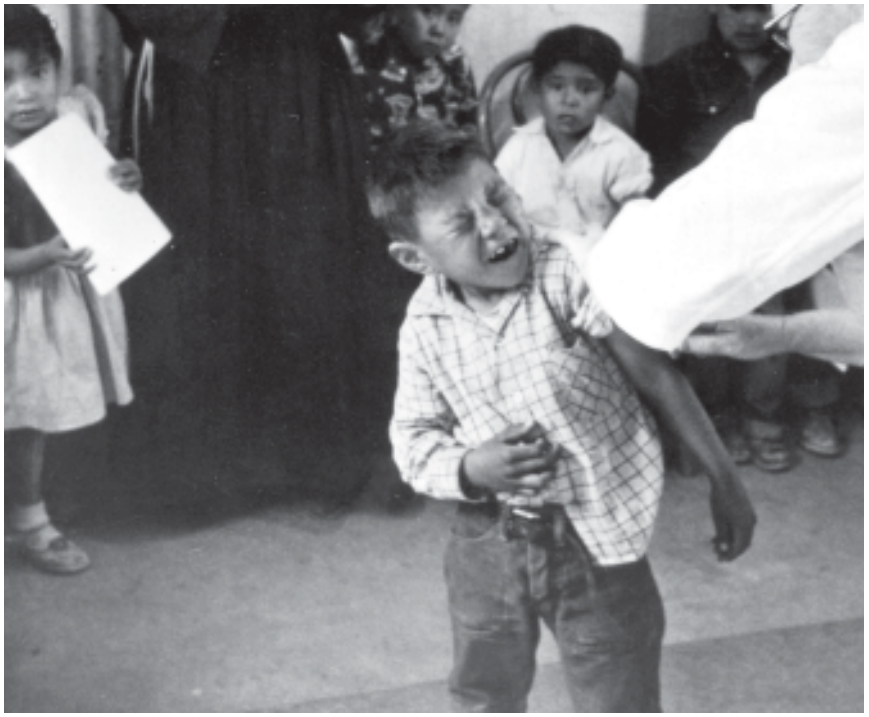
Oral health has evolved from the days in 1913 when five dentists were employed to by the Bureau of Indian Affairs to provide services to various reservations. Presently, a community-oriented primary care model is used for dental services, with oral health organized into levels of care with special emphasis on community prevention programs. These advancements in the treatment and prevention of oral disease have improved the health and well-being of AI/ANs, with more work underway to bring the level of oral health up to par with other U.S. populations.

The overall state of AI/AN behavioral health is one of great need and guarded hope. The great need is seen in the external demands upon individuals, families, and communities that are many and powerful. Long histories of subjugation and the continued resulting challenges of changing cultures, poor economics, and lack of opportunities mean most of these demands are negative and destructive. Behavioral health disparities are significant and vexing, and range across a spectrum of emotional pain and physical suffering. Alcoholism rates are over seven times the national average, suicide rates are almost double, and homicide rates are one-and-a-half times the national average for all races.

The guarded hope rests in the fact that Tribes and Tribal communities have, in the past 20 years, increasingly chosen to take responsibility for behavioral health care delivery. The IHS Division of Behavioral Health (DBH) was established in 1995 as a response to Tribal self-determination and a national movement that viewed alcoholism/substance abuse and mental health/social services as integrated, not separate. To that end, the original Alcoholism and Substance Abuse and the Mental Health and Social Services program branches established in the mid-to late-1970s were combined in a single division to improve coordination and programming. Today, the DBH supports the AI/ANs' delivery of behavioral health care by providing national services and infrastructure. As care transitioned from the IHS to Tribal and Urban Indian health programs, the need to support Tribes in behavioral health care delivery became critical. The primary areas of support include national programs and programming, advocacy, education, traditional practice, and health information systems. The DBH has become the primary policy and legislative office and a national data repository to support congressional funding of all BH services nationally.

Clearly, a need for the services provided by the IHS continues. But in the face of the chronic diseases that now plague AI/ANpeople, our approaches must expand and represent a true partnership with individuals, families, and communities. The recent past has shown that our progress in reducing the overall mortality rate of AI/AN people has slowed down; it has been a challenge to simply maintain access to critical services by the continually growing AI/AN population. As a result, the disparity between the health status of AI/ANs and the overall U.S. population is actually widening at the present time. Thus, we must continue to seek more efficient and effective approaches to address these health problems as well as advocate for the resources that are essential to close the disparity gap.

As with all organizations, time will bring new challenges and new ways for the Indian health system to serve. The story to be told at the 100th anniversary will be different from the one told in 1955 or today. One constant that will remain is the resolve and deep commitment of the IHS and its stakeholders to do all that is in our power to accomplish our vital mission.



The Indian Health Service Program

Comparison of IHS: 1950s-Present

A milestone was reached in 1954 when Congress transferred the responsibility for American Indian and Alaska Native (AI/AN) health care from the Department of the Interior's Bureau of Indian Affairs (BIA) to the United States Public Health Service (USPHS) within what is now the Department of Health and Human Services. It is instructional to compare and contrast some key attributes of the Indian health care system THEN and NOW.

Then – 1955	Now – 2005

IHS Beneficiaries

In 1955, fewer than 500,000 Indians were identified in the U.S. Census count. Of this number, the USPHS reported serving 335,000 Indians primarily located in and around reservation lands. The IHS services available outside of reservation areas were extremely limited or non-existent.

In 2005, the IHS provided personal health care services to more than 1.4 million AI/ANs, 442 percent more than in 1955. Additionally, more than 200,000 Indians not personally receiving medical care from the IHS or Tribal programs live in or near Indian communities that benefit from IHS environmental, sanitation, and community public health programs. Among urban areas, where more than 600,000 Indians reside, 34 Urban programs provide limited health care services to approximately 100,000 urban Indians.

Budget

In 1955, the USPHS administered Indian health services at an annual cost of $35 million, about $24 million of which was for the lower 48 States and $11 million for Alaska. None of the funding came from third-party collections. The IHS spending per person averaged about $71.

In 2005, the IHS appropriation was $3.77 billion, a 108-fold increase in 50 years. Of the total 2005 funding, $639 million (17 percent) was collected from Medicare, Medicaid, and private insurance. Counting both appropriations and collections, the IHS spending per person is estimated at $2,100 for personal health care services plus $500 for public health programs.

1955 - $35 Million **2005** - $3.77 Billion

Personnel

In 1956, the IHS employed about 2,900 employees: 350 at Area Offices, 100 at Headquarters, and 2,450 at hospitals and other field locations. There was a wide variety of professional and sub-professional groups, including physician, nurse, and field health categories.

In 2004, more than 15,000 full-time equivalents (FTE) were employed by the IHS (more than 1,000 assigned to Tribes). The broad mix of medical and field health staff continues, but the percentage of the workforce in hospital settings is substantially lower. There also is an unknown number (assumed to be in the thousands) of non-Federal health care staff working directly for Tribes.