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Perspective

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Toward a New Era for the Indian Health System

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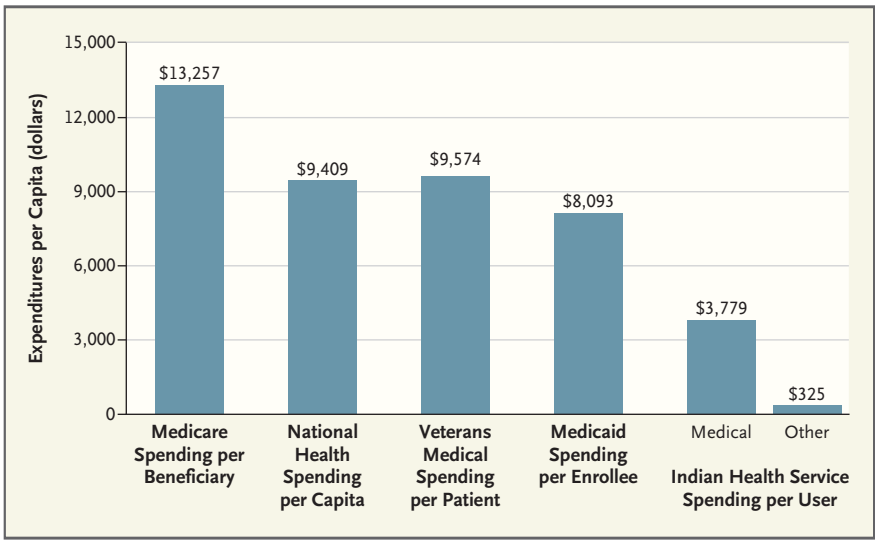
There are institutional failures, and there are institutions that have been set up to fail. Imagine a health care system that spends less than half as much per person as the national average, delivers care in outdated clinics and hospitals, and has chronically high staff vacancy rates. How would such a system be expected to perform? These features reflect the reality of the U.S. Indian Health Service (IHS), the small federal agency tasked with providing health care to tribal nations throughout the United States. The IHS is composed of federal, tribal, and urban Indian Health facilities, collectively known as the Indian Health System, that serve 2.6 million American Indian and Alaska Native people in more than 30 states. Indian Health System facilities are often located in remote settings. Some locations, such as Fort Belknap in Montana and Fort Duchesne in Utah, reflect the era of colonization and conflict that continues to define the boundaries of Indian lands.

The Indian Health System is unlike any other health care system. The basis for the federal government's provision of health care to American Indians and Alaska Natives is the cession of most of the lands of the United States by tribes in hundreds of codified treaties, many of which identified health services as part of ongoing payment for the land. These trust and treaty obligations are part of the fabric of the United States; they are based on Article 1 of the Constitution and have been upheld by federal law and Supreme Court rulings.

Former Supreme Court Chief Justice John Marshall once noted that the federal government has a habit of rescinding its treaty obligations to tribes and forcing new terms of agreement. Each revision has contained a "solemn guarantee of the residue." The modern federal policy of tolerating a barely-good-enough health care system for American Indians echoes this long tradition of broken promises.

The IHS budget permits annual health care expenditures of about $4,000 per patient, as compared with the national average of $9,409 (see graph). Facilities can also bill Medicare, Medicaid, and private insurers for the care they provide. Although the revenue that facilities receive is critical to their viability, it is insufficient to put them on even ground with the rest of the U.S. health care system. The average IHS hospital is 40 years old, as compared with the national average of 10.6 years, which translates into episodes such as a sewage leak in an operating room and risks to patients



Federal Health Expenditures per Capita by Category, 2018.

Adapted from the National Indian Health Board.[1] Payments by other sources of medical services provided to American Indians and Alaska Natives outside the Indian Health System are unknown.

from vintage medical equipment.[1,2] At current funding levels, a newly built IHS or tribal facility would not be replaced for another 400 years.

The Indian Health System is also understaffed, which leaves it ill equipped to fulfill its duty. The Department of Veterans Affairs (VA) health system serves about 3.5 times as many patients as the Indian Health System, but has about 15 times as many physicians. Vacancies and turnover — among professionals at all levels, from clinicians to administrators to support staff — compound the problem. A 2018 government report found that 25% of provider positions were vacant, in part because the IHS is unable to match market salaries and hiring can take more than a year.[3]

In addition, the IHS is weighed down by a critically important digital divide. The ability to deliver high-quality care depends on having adequate health information technology infrastructure. The IHS has highlighted this need in budget plans for multiple years, but it has nowhere near the funds necessary to either modernize its own system or follow the VA's path and adopt a private-sector platform. A health care system with an antiquated health informatics infrastructure will struggle to attract staff and to deliver care that meets current standards.

There is broad agreement that the Indian Health System is poorly resourced, but policymakers use the system's deficiencies as cover. Former Senator Al Franken (D-MN) once quipped in a hearing before the Committee on Indian Affairs that the IHS is dysfunctional because it is underfunded, but it is underfunded because it is dysfunctional. Although the IHS must be held accountable for the care it provides, withholding equitable funding harms patients and perpetuates rather than solves the problems that plague the health system. Adequate funding may not be a sufficient step to fix the Indian Health System, but it is a necessary one.

The IHS has endured scandals of abuse, mismanagement, and lethal lapses in care. Corrective action has focused on establishing additional safeguards and enhanced reporting systems. But so long as the agency's foundations remain cracked, similar episodes will be hard to avoid. At a more fundamental level, this patchwork system is a key contributor to poor health in tribal nations. It underpins the well-documented health inequities affecting American Indian and Alaska Native people,[4] which have become even more important during the SARS-CoV-2 pandemic.[5]

There is no defensible reason for the Indian Health System to lag behind the rest of the country on nearly every fiscal, staffing, and infrastructure metric. Although Covid-19 brought the system a historic one-time appropriation of more than $6 billion, annual funding will need to be transformed for inequities to be addressed. A recent proposal by the Biden administration includes a 23% budget increase for the IHS, which would bring its total budget to $8.5 billion. This additional funding is important, but it would still be well below the $48 billion per year that tribal leaders are seeking to fully fund the IHS.[1] The Biden administration also proposed implementing advance appropriations for the health system, which would fulfill a long-time request by tribal leaders, prevent funding lapses, and better ensure continuity of care.

The Biden administration's budget proposals are grounds for cautious optimism. If his policies are enacted, they could widen the path for programs to successfully address the complex health challenges facing tribal nations. Already, several tribal health pro-

grams have implemented innovative solutions that illustrate what a properly resourced health system can deliver, even in times of crisis.

Facing high mortality from Covid-19, many tribal nations have led successful emergency responses. Local programs implemented community-specific contact tracing and expanded telehealth services. Federal and state governments worked with tribal governments and followed through on their promises, including by providing important supplies, logistic support, and information. Tribes exercised their sovereignty to set and execute vaccination policies adapted for their contexts and provided consistent messaging, in line with national health recommendations.

Similarly, established tribal health programs may inform new and scalable ways of delivering integrated care. For example, the Swinomish Indian Tribal Community's didgʷálič Wellness Center, located in Washington State, is a multispecialty community health organization that provides comprehensive substance use disorder, medical, and social services to Native and non-Native patients. This system has been effective and is now being expanded to other tribes. The Community Health Aide Program, developed by the Alaska Native Tribal Health Consortium, brought health care to the state's most remote areas by training community members to be frontline practitioners. This model is also being expanded to other parts of the country. The first medical school to be affiliated with a tribe, the Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation, which opened in 2020, will increase the number of Native clinicians and is expected to produce doctors who will stay in the community.

An audio interview with Ms. Leston is available at NEJM.org

We believe a new era for the Indian Health System is within reach. As the United States reexamines its social contract and definitions of racial equity, it is a promising time to reflect on big solutions for fostering a transformative, rather than transactional, relationship between the federal government and tribal nations. The collaborations wrought by the necessities of the Covid-19 response and the reforms proposed by the new administration could be catalysts for renewed relationships based on respect, tribal sovereignty, and equitable resources. There are painful lessons to learn from the past and present, but there will also be vast opportunities in the future.

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Marking the 40th Anniversary of the AIDS Epidemic — American Physicians Look Back

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June 5, 2021, will mark the 40th anniversary of the first report of cases that would signal the onset of the U.S. AIDS epidemic. On that date in 1981, the *Morbidity and Mortality Weekly Report* from the Centers for Disease Control (CDC; now the Centers for Disease Control and Prevention) noted that between October 1980 and May 1981, five young men, "all active homosexuals," were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia (PCP) at three hospitals in Los Angeles. Two had already died. On the basis of those cases, the CDC hypothesized that there was