James R. Shaw, M.D., was assigned as a public health advisor to the BIA in 1952. He became the first IHS Director with the transfer in 1955 and served until 1962. He focused initial efforts on: 1) improving the quality of clinical care, 2) expanding prevention programs, and 3) bridging the gap between the Tribal members who needed care and the health facilities to provide it. Dr. Shaw recognized the importance of health statistics and built on the 1957 IHS Gold Book baseline to measure progress. He established a professional unit to provide reports on Indian health (e.g., morbidity statistics and hospital and clinic data use). The first priority was to establish competent and high-quality medical care. Extensive recruitment of health professionals; the remodeling of health facilities; and the establishment of clinical laboratories, radiological services, and surgical teams were undertaken. Funds were made available to buy services from private physicians and hospitals that provided the needed care for Indian people. Preventive services including immunizations, prenatal and well-baby care, and environmental sanitation were provided. The passage of the 1959 Indian Sanitation Facilities Act (Public Law 86-121) enabled the IHS to build facilities for the provision of safe water and sanitary waste disposal. This program was critical in improving living conditions and reducing water- and waste-borne communicable diseases.

The 1960s

With progress being made in establishing basic health services during the 1950s, the IHS shifted its emphasis to health program management, health planning, health professional and health occupations training for Indians, and health management training for IHS administrators. Carruth J. Wagner, M.D., the second director of the IHS, served from 1962 to 1965 and focused on building management skills and training personnel at all levels to lead the program. Medical and dental residencies were established as well as training programs for nursing, nutrition, and environmental health.

Under the 1966-1969 leadership of Erwin S. (Stu) Rabeau, M.D., the third IHS director, an innovative training center was started (Desert Willow, near Tucson, Arizona) to train Indian community members as community health representatives (CHR). The CHR program was established in 1965 to bridge the existing gap between patients in the community who needed care and health clinics and hospitals to provide it. In 1968, the CHR program became the first formal assumption by an Indian Tribe of an IHS-supported program.

Dr. Rabeau believed strongly in the use of scientific data to sell programs. Health services research (the Health Programs Systems Center (HPSC)) was established on the San Xavier Reservation near Tucson in 1967. In 1971, HPSC became a component of a new organizational unit of the IHS, the Office of Research and Development (ORD). The basic mission of the ORD was to increase the efficiency and effectiveness of IHS service units and to expand the participation of the Indian community in managing its health affairs.

The 1970s

The decade of the 1970s was one of the most revolutionary in the history of Indian health services. President Richard M. Nixon's Indian Policy Statement of July 8, 1970, had the most significant effect on Federal-Indian relations since the end of the treaty-making era. The President noted that Federal-Indian relations were based on the U.S. Constitution and on treaties between the U.S. Government and the Governments of Indian Tribes – a Government-to-Government relationship. He advanced the concept of Tribal "self-determination," proposing that Federal programs provided to Tribes be "taken over" and managed by Tribal Governments. These new Federal policies led to landmark legislation to support self-determination and improve Indian health care.

Emery A. Johnson, M.D., the fourth IHS director, served from 1969 to 1981 and is known to have had superior and legendary political skills. He immediately recognized that the remarkable change in Federal Indian policies had tremendous potential for improving Indian health services. He worked the political channels to expand health care programs, fostering Indian leadership to obtain funding for new programs.

During this period, Congress established President Nixon's Government-to-Government relationship policy in law through the passage of the Indian Self-Determination and Education Assistance Act (ISDEAA) (Public Law 93-638) in 1975. The law provided that any Indian Tribal Government could, on request, take over the operation of any BIA or IHS function.

Congress also established two major national goals in the Indian Health Care Improvement Act (IHCIA) enacted in 1976: 1) to ensure the health status of Indian people is elevated to the highest possible level, and 2) to achieve the maximum participation of Indian people in the Indian health programs. Additional innovations included the establishment of a scholarship program to support preparatory and graduate education for AI/ANs, the construction of Indian health facilities and sanitation systems for Indian homes and communities, and authority to receive reimbursement through Medicare and Medicaid programs for care rendered to Indians eligible for services under these programs.

In the legislation, Congress gave the IHS a clear mandate not only to provide medical care but also to eliminate the existing health disparities between Indian people and the general U.S. population. The IHS efforts were directed toward developing an efficient and effective health-care delivery system while promoting AI/AN participation in and management of their own health-care systems.

Health committees formed by individual Tribes or intertribal organizations evolved into more formal Area-wide boards. In 1972, the Area Health Boards formed the National Indian Health Board (NIHB). The NIHB and the American Indian Health Care Association (AIHCA), formed by the Urban Indian Health programs, were the first national Indian-controlled organizations directed toward their own health-care programs. Another strategy to assist Indian participation and acceptance was the promotion of collaboration between "Western" (e.g., IHS) and American Indian medicine. Collaboration had begun earlier with Dr. Shaw, the founding director of the IHS, who considered native healers to be important participants in improving their communities' health.

The 1980s

The 1980s were marked by great increases in funding for Indian health programs, special emphasis on professional excellence, construction of modern health facilities, and movement towards greater Tribal involvement. In 1981, Everett R. Rhoades, M.D. (Kiowa) (1981-1993), became the first American Indian Director of the IHS – a leadership landmark for the Agency. His profound sense of service to Indian people led him to leave a successful academic career to lead the IHS.

The IHS was elevated to Agency status within the United States Public Health Service (USPHS) in 1988. It had formerly been a Bureau within the Health Resources and Services Administration under the Department of Health and Human Services. For the first time, a formal consultation process between the IHS and Tribes was begun in the "Tulsa

One" meeting in the mid-1980s. Tribal Governments were involved in establishing and designing allocation methodologies to be used in annual appropriations.

Attention was focused on disparities in the level of funding for individual Tribal and community programs, and the concept of equity in the allocation of resources was given major attention. Further refinement of IHS mechanisms for measuring both the "level of need funded" and a "resource requirement methodology" was useful not only in the formulation of the IHS budget but also in its execution.

The 1990s

The 1990s were characterized by the continued evolution of the self-determination process and the conversion of the IHS Director position from career public health officer to political appointee. Michael H. Trujillo, M.D. (Laguna), IHS Director from 1994 to 2002 and the first political appointee, was known for his strong support of self-determination.

With the passage of the ISDEAA in 1975, legislation was in place to support the process for Tribes to contract or assume the responsibility for programs formerly managed by the IHS. As experience was gained in the 1980s, the process evolved from "self-determination" into "self-governance." In 1994, Congress passed legislation to extend Tribal self-governance on a demonstration basis to allow Tribes to contract for the programs, services, functions, and activities within the IHS and BIA. The success of the demonstration period resulted in permanent authority in 2000.

With the continued evolution of the process, the total Indian health system became identifiable by distinct sectors. These sectors include those managed by the IHS, those managed by Tribes, and those categorized as Urban Indian health programs, with the total system described as "I/T/U." With the transfer of IHS programs to Tribal entities, IHS Headquarters and Area Offices decreased dramatically in size.

The Current Status of the IHS

Providing services in the community has always been a hallmark of the IHS program. Charles W. Grim, D.D.S., M.H.S.A. (Cherokee) (2002-present), the current IHS Director, has advocated for and enhanced the two major and fundamental achievements of the present system of health care for AI/ANs: 1) the development of comprehensive, community-oriented care, with the consolidation of preventive, curative, environmental, and local management within a single national program; and 2) the transition from a directly operated Federal program to one under the control and direction of the local Indian community. Fundamental changes in Indian health services continue and are supported by Dr. Grim.

Emphasis is on decentralized operations that are integrated through 12 regions, identified as Area Offices, and IHS Headquarters, located in Rockville, Maryland. The basic organizational element in the IHS health care program is the service unit, which serves the local community. It often is a hospital-based program with outlying clinics, but many service units are made up of one or more ambulatory-care facilities. The unique mission, goal, and emphasis on comprehensive community-based care makes the IHS one of the most complex organizations of any type for delivering health care to the sovereign Indian Nations.

Presently, 34 Urban programs, generally operated by local non-governmental and non-Tribal organizations, provide various clinical services as well as active outreach programs to assist urban Indians in gaining access to other programs. The Urban programs are partially supported through contracts with the IHS.

The IHS Headquarters integrates the vast and myriad programs operating under very different circumstances across the Nation into a coherent, unified program meeting the various mandates set by Congress. Area Offices provide valuable support services on a regional basis to the service units within their jurisdiction.

Federal Indian Policy

Federal Paternalism

Since its beginning as an independent nation, the United States has assumed responsibility for dealing with the indigenous peoples of this country. Article 1, section 8, clause 3 of the U.S. Constitution regulates commerce "with foreign Nations and among the several States, and with Indian Tribes." Article II, section 2, clause 2, the treaty clause, grants the Federal Government the exclusive authority to make treaties on behalf of the United States. These two clauses establish the cornerstone of Federal Indian policy.

> *"The Government's long-range goal for our Indian citizens -- economic self-sufficiency, with access to good health services, good schools and good housing, and participation on a basis of equality in the life of the country and community."*
>
> *- 1957 IHS Gold Book*

The Federal Government has a special relationship with the Tribal Governments it has recognized. It considers them "dependent" Nations within the United States and, in turn, assumes a trust responsibility to these Indian Nations based on treaties, court determinations, and Federal laws. The Federal Government has provided services to Indians for more than 200 years. The earliest Federal services provided to Indians were based on treaties and were intended to compensate Indians for the land cessions and other benefits granted to the United States. This relationship continues to carry immense legal and moral obligations.

Transfer of the Indian Health Service to the Public Health Service

In the early 1800s, the provision of Federal health services to Indians was part of the U.S. Army's responsibility to control the spread of infectious diseases and, in particular, to protect soldiers and other non-Indians living nearby. It was not until 1832 that Congress first appropriated funds for health care to Indian people specifically for the purpose of purchasing quantities of the smallpox vaccine to immunize the Indians. While the responsibility for Indian health care began with the War Department, that responsibility was transferred to the newly created Department of the Interior in 1849.

It was not until 1908 that the Bureau of Indian Affairs (BIA) within the Department of the Interior began to develop health services for Indians. By 1910, Congress began appropriations for health care services administered by the BIA. In 1921, Congress enacted the Snyder Act, authorizing funding for Federal Indian health programs for the relief of distress, conservation of health, and employment of physicians for Indian Tribes as well as directing the BIA to administer programs "for the benefit, care, and assistance for the Indians throughout the United States."

In 1926, commissioned corps officers of the United States Public Health Service (USPHS) began to be assigned directly to Indian health programs. During the period that responsibility for Indian health remained with the BIA, Indian advocacy organizations and public officials felt that health care could better be served by the USPHS under the Department of Health, Education, and Welfare (HEW), now the Department of Health and Human Services (HHS).

In 1954, Congress enacted the Transfer Act to move the responsibility for Indian health care to HEW. In 1955, the Indian Health Service (IHS) became an agency within the USPHS. Since the Transfer Act, health care to AI/ANs has improved significantly. In 1959, the Indian Sanitation Facilities Act enabled sanitation to become an integral part of the national IHS public health program. The provision of safe water and sanitation has dramatically contributed to improving the health status of AI/ANs.

1950s and 1960s: Termination of Federal Trusteeship Over Indians

In the 1950s, the termination policy of the Federal Government was intended to assimilate Tribes into the broader society by the rapid termination of the Tribal/Federal Trust relationship, elimination of the reservations, and relocation of Indians to urban areas of the country. It was believed that if Indian people were relocated from their reservations to urban and non-reservation areas, they would assimilate into the general society more rapidly, move away from their traditional ways of living, ultimately become part of the larger culture and society, and be free from Government control and oversight. It was also anticipated that Indian people would become more economically successful and, thereby, be released from the poverty and unemployment that existed on many of the Indian reservations.

The result of the termination policy was the sale of Tribal lands, assumption of judicial authority by State governments over the terminated Indian lands, and the right of States to tax those terminated Indian lands. It also devastated Tribal communities and, in turn, Tribal customs, languages, and cultures. During the "termination period," Congress enacted

legislation that terminated the Tribal/Federal Trust relationship with 109 Tribes and Bands. The effect was the termination of Tribal sovereignty for these 109 Tribes and Bands. Fortunately, Congress has not terminated a Tribe since 1966.

1960s and 1970s: Acculturation and Integration

Acculturation and integration of Indians into the larger U.S. culture and society were always goals of the U.S. Government since it was believed that the most appropriate way to improve their educational, social, and economic status would be if they were to learn English and the skills of the larger culture of the country. Unfortunately, this meant that Indians would lose their individual languages and cultural and Tribal identities.

Government boarding schools were established in the mid-19th century with the specific agenda of stripping Indians of their languages and cultures as a way to assimilate them into the larger society and culture of the country. Throughout the mid-19th and the 20th centuries, Congress, Tribes, Indian advocacy groups, governmental studies, social policy makers, and scholars debated over the appropriate manner to diminish, destroy, or conserve Indian culture.

By the 1960s, Indians began to advocate for their own civil rights and self-determination. By the early 1970s, the period of "relocation" ended. The social and political movements of the 1960s and 1970s were not missed by AI/ANs. It was during this period that the era of "self-determination" as a Federal policy began to emerge. Self-determination meant that Tribes could determine their own destiny and manage their own Federal programs in a manner that was appropriate to their individual Tribal communities. During this era, Indian activist groups and Tribal and Urban Indian leaders questioned and challenged Federal policies towards AI/ANs while asserting their rights under hundreds of treaties that promised rights, benefits, and services based on their relinquishment of millions of acres of Indian lands and other benefits to the United States.

Evolution of Tribal Self-Determination: Where We Are Today

During the Administration of President Richard M. Nixon Indian self-determination progressed quickly. In 1970, President Nixon's Special Message to Congress called for "self-determination without termination." In 1975, Congress enacted the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (P.L.) 93-638. This Act heralded a new era in Indian policy, which Tribes promptly embraced. During this period, Congress passed legislation to restore individual Tribes that had been terminated.

In 1976, Congress passed the Indian Health Care Improvement Act, P.L. 94-437, which provided authority for specific directives, programs, and activities. With the passage of these key statutes, Tribes began to contract under the ISDEAA programs authorized by the Indian Health Care Improvement Act.

> "Self-determination without termination"
>
> *- President Richard Nixon*
> Special Message on Indian Affairs

In 1994, Congress passed legislation to extend Tribal self-governance on a demonstration basis to allow Tribes to contract for the programs, services, functions, and activities at the BIA and the IHS. The demonstration program was so successful that Congress passed legislation in 2000 to make self-governance a permanent authority for the IHS and the BIA.

A key factor in the success of the policy of Indian self-determination is that it authorizes Tribes to plan and deliver services appropriate to their diverse demographic, economic, and institutional needs. There are 562 federally recognized Tribes, and more than 50 percent of the IHS budget is contracted to Tribes though the ISDEAA.

How To Choose Cold Germs-
KEEP OUT FLIES