

Spirit of
Community
Health

Policy Brief

Funding Gaps in Tribal Public Health Systems and
Services

2015

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The U.S. government has a trust responsibility to provide for the health of tribes in exchange for land and natural resources ceded in treaties. However, Native American people experience poorer health outcomes and have shorter average life expectancy than the overall US population. Through a case study of tribal public health system organization and performance we found that a relatively well-resourced tribe with a strong and visible health program had an inadequate and unsustainable funding structure for public health systems and services, resulting in gaps and instability in their public health workforce, programming, and service delivery. Additionally, the types of funding received by the tribe placed limitations on their ability to culturally tailor programs and services to best meet the needs of the community.

INTRODUCTION

There are 567 federally recognized tribes in the U.S. Tribes are sovereign nations with a nation-to-nation relationship with the U.S. government. The federal government has a unique trust responsibility with tribes, originating with treaties, to provide for education, health care, and other services in exchange for Tribal land and natural resources.

The Snyder Act of 1921 authorized the expenditure of federal funds for the “relief of distress and conservation of health of Indians” (Pevar, 1992), and, in 1955, the Indian Health Service (IHS) was established to provide both medical care and public health services to tribes. However, the IHS has been grossly underfunded. The annual per person expenditure on health care is far lower than any other federal health program, and the federal estimate of unmet need is around 50% (Sequist, Cullen, & Acton, 2014).

IHS has a sustained influence on the organization, structure, and goals of tribal public health systems and plays a large role in the financing of public health for tribes. In 1975, the Passage of Public Law 93-638, the Indian Self-Determination and Educational Assistance Act of 1975, provided tribes the authority

to directly administer health programs within their own communities by entering into contracts and compacts with IHS. Tribes may choose to contract with the IHS to administer specific IHS funded programs, services, functions, and activities (PSFAs). Tribes may also choose to compact with IHS and assume control over PSFAs.

While IHS is the most common source of funding for tribal health organizations, it is not the only source of public health funding for tribes (NIHB, 2010). For tribal health departments, in particular, the most common sources of funding included IHS, state funding, federal grants (e.g., Centers for Disease Control and Prevention, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration), tribal funding, and private grants.

APPROACH

This research used a case study design in order to develop a deep understanding of the complexities of a single tribal public health system. The case study Tribe was in the Bemidji Area, and it was federally recognized in 1975. At the time of the study, the Tribe had ~14,000 members and operated in a 7 county service area (180,000 sq. mi.), which was mostly rural or very rural. The Tribe operated under a 12 member elected Board of Directors and a Tribal Chairperson. The case study site was a 638 Compact Tribe with a Health Division that operated 4 clinics and 4 community health centers, and administered a comprehensive set of PSFAs.

Study participants included key informants and tribal community members. Data were gathered through key informant interviews (n=50), seven focus groups (n=54), a Tribal public health system capacity assessment questionnaire, and secondary data such as the Tribe’s IHS Multi-Year Funding Agreement. Analysis involved thematic analysis of interviews and focus groups, abstracted quantitative and qualitative information from capacity questionnaire about funding, and content analysis of IHS multi-year funding agreement.

FINDINGS

Funding for public health and healthcare was insufficient to meet the needs of the community.

The case study site's Tribal Health Division operated on an annual budget of approximately \$32 million for health care and public health services. This per capita expenditure of ~\$2,288 is 25% of the per capita expenditure on health reported by the World Bank for the United States in 2013 (\$9,146). The agency received its funding through IHS (59%), third party revenue (25%), federal grants (15%), and other small state or private grants (<1%). However, funding was not sufficient to meet the needs of the community. Participants noted that there was a documented unmet health care need of approximately 50%, which resulted in the Tribe allocating much of its IHS funding to health care services. As such, funding for many public health activities had to come from other sources.

"That whole component of prevention services has to be made up somewhere else with the limited funding we have because we don't receive a lot of Indian Health Service funding. You would receive a little bit for prevention."

The public health services that have been supported by IHS and its predecessors were reflected in this Tribe's public health services and infrastructure. The public health activities delivered by the case study Tribe reflected the legacy of the IHS health delivery system. The predecessor of IHS focused preventive health care services on reducing infectious disease and environmental health hazards through improved sanitation, facilities, and water supply. The influence of this program was apparent in the Tribe's legal codes, which did not include a public health code or authority but did authorize a Tribal Environmental Protection Authority. Following the Snyder Act, the federal program for tribes added services such as health education and personal health services delivered in the home by public health nurses and later, health aides. These were also consistent with

the focus of the case study Tribe's current public health service system.

Federal investments in public health that went to the State did not consistently or significantly benefit the Tribe. The Tribal Health Division received \$86,000 through the State, primarily for emergency preparedness, which amounted to about .3% of the Division's budget. As such, federal investments in public health programs and services directed toward the State did not substantially contribute to the Tribe's public health infrastructure. Additionally, in areas where funds were provided, such as emergency preparedness, there was a lack of clarity around the nature of the relationship between the state and the tribe. For example, participants noted that when the H1N1 vaccine was distributed to states by the CDC, it was not provided to the tribes in a timely manner due to confusion regarding how and to whom this resource should be distributed.

Competitive federal grant funding was used to fill gaps in the Tribes' public health services and infrastructure. In order to fill gaps in funding for essential public health services and address disparities, the Tribe sought competitive grants. The tribe selected for this case study was unique in that they had been particularly successful in obtaining competitive federal funding from Centers for Disease Control and Prevention and other sources. According to the NIHB Profile (2012) only 40% of tribes surveyed and 50% of tribal health departments received any federal grants.

Key informants emphasized that competitive grant funding was a key driver of many activities of the Tribe's public health system. Although the Tribe was largely successful in bringing a variety of grants to the community that addressed important needs, participants noted several limitations of relying on competitive federal funding to build core public health infrastructure.

Competitive funding resulted in discontinuous public health programs and services that did not reflect the full spectrum of the community's most pressing needs or culturally tailored solutions. Grant

funding provided the resources and impetus for the Tribe to build capacity in core public health services such as mobilizing partnerships, assessing community health status, and developing policies and plans to improve community health. However, because these activities were associated with a particular grant, they tended to be isolated to partners involved with the grant and limited in scope based on funding restrictions. This sometimes created tension in the planning process between being responsive to community needs and meeting funding requirements.

Additionally, many of the Tribe's grants were focused on tobacco, nutrition, and physical activity. While these were important health issues for the Tribe, being tied to the narrow funding requirements of a competitive grant sometimes felt in conflict with the desire to address a broader spectrum of community priorities, be informed by community wisdom, or follow professional expertise. Also, when grant funding ended, oftentimes that meant the services supported by that grant ended. Interview participants felt that there was no conclusion to the programs when funding ended and worried that people felt like they had been abandoned. Focus group participants raised similar concerns, noting that grant programs sometimes ended abruptly without notice. Some organizations were able to secure funds to continue programs after grants ended, but often the funding level was lower so they were not able to reach as many people. Also, when grants ended, staff capacity was often lost, which was problematic in an environment where public health professionals were scarce.

"It seems like with every grant there's a new focus. Or not always new, you know, but maybe it's the same but it's done in a different way. So you start these programs, you know, and things are to be done a certain way. And then when that grant's finished it's kind of like everything just stops and the focus is lost and it seems like to me, you know, a lot of times you feel like you're leaving people in the dust, you know,

because they don't know—like you don't even know when there's an end to something."

Some focus group participants felt that because of how short grants were, and what was required by federal grants in particular, staff were unable to implement programs in a way that honored the Tribe's culture. Others felt that the differing requirements of so many grants pulled programs in different directions, rather than focusing on one area or having a cohesive program.

CONCLUSIONS

The financing structure of the case study Tribe's public health system placed limitations on the breadth and depth of public health services provided by this Tribe. IHS funding was insufficient to assure the Tribe had the capacity and infrastructure to deliver core public health services. Competitive federal funding resulted in discontinuous services that were not always reflective of the tribe's cultural context. Additionally, federal public health funding passed through the state was minimal and not reflective of the many federal funding streams that support public health activities at the state and local level.

"I mean we're not there yet, you know, obviously...because right now we're still like, the disparity is still there. The health disparities are still there. The funding's not here and that has been trusted to us from the federal government."

IMPLICATIONS

The U.S. government has a trust responsibility to provide for the health and wellbeing of tribes. In fact, the Indian Health Care Improvement Act of 1976 states:

*“The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal to **provide the highest possible health status to Indians**, and to provide existing Indian health services with **all resources necessary to effect that policy**. (25 U.S.C Sec. 1602 as cited in Pevar, 1992, p. 275)”*

A strong public health infrastructure is a core component of a comprehensive strategy for achieving health equity. Consistent and reliable funding for core public health at the tribal level would help to assure tribes have the necessary capacity to deliver essential

public health services that are sustainable and culturally tailored.

RECOMMENDATIONS

Federal investments in tribal public health are insufficient to meet the needs of tribes or achieve health equity. We recommend that additional, sustainable, federal public health funding be made available to tribal public health agencies. This could take the form of directing block grants and other formula-based federal funding available to states to tribes. It could also take the form of adequately funding IHS to support tribes in delivering a comprehensive set of programs, services, functions, and activities that prioritize essential public health services.