

A Brief History of California Indian Health

In California, Indian Country is more than 4.5 times larger than the Navajo Nation, encompassing 123,000 square miles. Yet California Indians have been short-changed adequate funding for health care since the late 1950s. This shortage totals \$56,000,000, according to a recent report to Congress by the Advisory Council on California Indian Policy.

History

The State of California has the largest American Indian population with 104 federally recognized tribes- not including the many tribes who were terminated or are seeking federal recognition. During the Termination Era from 1958 to 1961, the federal government withdrew Indian health care programs in California.

In 1969, this led nine California tribes to form a consortium that lobbied for a special line item of the Indian Health Service (IHS) budget for Indian health. The consortium marked the inception of the California Rural Indian Health Board, Inc. (CRIHB), a tribally sanctioned entity, established by California Indians to meet the health needs of California Indian tribes.

Landmark legislation passed during the Nixon Administration gave all Indian tribes the right to self-determination (Public Law 93-638). Then in 1980, in the historic case of Rincon Band of Mission Indians v. Harris, (618 F.2d 569, 9th Cir.) the U.S. Court of Appeals ordered IHS to comply with a legal obligation to provide equitable funding levels to California tribes. They responded to IHS by exercising their right to self-determine within the "638" process. Today, tribes contract tribal shares from the California Area Office and are presently pursuing tribal shares for IHS Headquarters functions.

Obstacles

California tribes continue to seek funding that will enable them to meet their own health needs despite these obstacles:

- Equitable funding does not exist.
- Facility funding does not exist.
- An accurate health data collection system does not exist.

Appropriated funds due California Indians are still outstanding. Although Congress appropriated additional funds to IHS for California tribes, they have yet to receive equitable funding.

Under the IHS system California tribal programs are not budgeted for facilities, staff or equipment. California tribes do not have access to Indian hospitals and must rely on Contract Health Services (CHS) funding for inpatient and specialty care. One major illness or surgery could wipe out a clinic's CHS funding for one year. The CHS funding shortfall for California is approximately \$8 million.

A lack of accurate health data effects California tribes' ability to obtain appropriate funding. Even in instances in which health problems are well documented—a high infant mortality rate and a high rate of diabetes, cancer, heart disease and alcohol-related deaths—the Indian Health Service fails to address funding shortfalls.

CRIHB

The California Rural Indian Health Board is a focal point for the development of IHS funded services for 12 tribal health programs. These programs-and their resolutions-represent 36 tribal governments and their constituents. Through a unique system of subcontracting CRIHB provides contract negotiation, fiscal oversight and technical assistance. In this way, CRIHB participates in the development of tribal health programs, enabling the organization to effectively address health care funding on behalf of California Indians.

Level of Need Funded

In response to a request from Congress in Fiscal Year (FY) 1998, Dr. Michael Trujillo, director of the IHS, established a Level of Need Funded (LNF) Work Group. The LNF will measure the health care needs of American Indians and Alaska Natives (AI/AN) and the costs of providing the needed health services.

Over the years, IHS, Indian Tribes, and Indian organizations have used different forecasting tools to measure the health status and health care needs of its constituents, which produced inconsistent data that adversely affected policymaking and resulted in inequity in funding allocations. Consequently, Congress directed IHS to determine standard measurement tools.

Comprised of tribal official and health professionals from each of the 12 IHS geographic areas, plus at-large representatives, the LNF Work Group provided input and perspectives from Indian country. The Group measured needs benchmarked with a comprehensive medical benefits package comparable to contemporary health plans. The LNF determined health funding needed as if comparing health care benefits comparable to comprehensive employer-based health plans were assured to Indian people.