

systems are not designed with vision loss in mind; they tend to be visually based through computer and camera systems, provide little audio feedback, and depend on availability of a sighted caregiver (Charness, 2006). These are, however, problems that can be overcome. Services for older adults with vision loss could be augmented through appropriate use of technology and research. This is an area in which the complementary knowledge bases of the vision rehabilitation and public health fields can be tapped in order to find ways to increase accessibility through Internet-based video camera technology, improved synthetic speech, enlarged screens with large print and good contrast, braille output, and "Smart Homes" that can interact with a consumer's computer. A *Smart Home* is defined as a highly automated home that uses a common electronic network infrastructure for lights, appliances, and other electronic devices. A security system and camera monitors in a smart house are designed to allow someone other than the home owner, such as a family member or health care provider, to monitor the older person's well being and safety. Automated products, such as those featured in Smart Homes, are designed to allow the older person to remain at home rather than moving to a higher level of care such as an assisted living facility.

SUMMARY

Vision loss is an issue for both the fields of aging and public health. It must be recognized as such and receive the attention it deserves, as well as being given a commitment from the public health arena to address it. The vision rehabilitation field stands ready to join forces with the aging and public health systems to enhance the ability of older adults with vision loss to continue to live independent lives.

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Indian Health Services: Creating a Balance Between Federal Legislation and the Vision Care Needs of Sovereign Nations

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In her recent book on life in the Navaho territories, Moore (2004) recounted attempts in the 1960s by the Indian Health Service (IHS)—an agency of the U.S. Public Health Service, Department of Health and Human Services—to improve sanitary conditions in traditional Navajo homes. Free pesticides were offered by sanitary engineers who were dispatched from Washington, DC, by IHS to rid the homes of lice and bedbugs. A man in Lukachukai, Arizona, stood up at a community meeting and commented to the sanitary engineers:

Many years ago, Waashindoon came here to our land and told us it was important for our families and our land to give up some of our sheep. They killed our sheep in front of our eyes, and now Waashindoon is back to take away our bedbugs. I do not want any spray.

Moore maintained that the tribe had the right to uphold the culture that it wanted to preserve rather than abide by the health system of the U.S. government. Despite prior issues related to sovereignty of the Navajo nation, in the 1970s the U.S. government attempted through legislation to give the Navajo and other Native American nations complete sovereignty. The Indian Self-Determination and Education Assistance Act, Public Law 93-638 was passed in 1975 to give Native American people self-determination by assuring "maximum Indian participation in the direction of educational as well as other federal services to Indian communities so as to render such services responsive to the needs and desires of those communities." This law has shaped the way Native American tribes throughout the United States have offered health services to its members.

This article will explore the effect of PL 93-638 on the ability of IHS to provide vision loss care to the native peoples of all tribes; describe the current IHS system as it exists today in the 12 regions that comprise IHS and suggest ways to increase vision services to native peoples, including children, a group that is often overlooked by the service-delivery system.

IHS INFRASTRUCTURE

Members of federally recognized Indian tribes and their descendants are eligible for services provided by IHS, which operates a comprehensive health service delivery system across 12 regions for approximately 1.5 million of the two million American Indians and Alaska Natives in the United States. Its annual appropriation is about \$2.2 billion. IHS strives for maximum tribal involvement in meeting the needs of its service population. There are more than 550 federally recognized tribes in the United States, and their members live mainly on reservations and in rural communities in 34 states, mostly in the western United States and Alaska. IHS has its

12 regional administrative offices in Aberdeen, South Dakota; Albuquerque, New Mexico; Anchorage, Alaska; Bemidji, Minnesota; Billings, Montana; Nashville, Tennessee; Oklahoma City, Oklahoma; Phoenix, Tucson, and Window Rock, Arizona; Portland, Oregon; and Sacramento, California.

THE EFFECTS OF PL 93-628 ON IHS

The tribal involvement with IHS in serving the needs of the native population has its roots in PL 93-638, which states that:

Congress is committed to having individual Indian tribes and people plan, conduct and administer programs and services to their own people. The United States is committed to supporting and assisting Indian tribes in the development of strong and stable tribal governments, capable of administering quality programs and developing economics of their respective communities.

This federal legislation was interpreted by IHS agencies serving tribes in the 12 different regions in a variety of ways, leading to a potpourri of health services that was unevenly distributed throughout the regions. Funding for eye care to prevent vision loss and for services to individuals with visual impairments varies considerably from region to region. One reason for this might be that general eye health care and low vision care are not included in the Government Performance Results Act (GPRA) indicators. The GPRA indicators are the priority areas that the government asks IHS to address within their budgeted allocations for all health services. The 16 indicators cover a diverse list of services, but only one item on the list relates to eye health care among the Native American people.

In February 2005, an IHS report was published detailing the performance of the 12 regions for each of the 16 GPRA indicators:

poor glycemic control among diabetic patients, good glycemic control among diabetic patients, blood pressure control for diabetic patients, dyslipidemia (cholesterol) screening for diabetic patients, kidney disease screening for diabetic patients, retinal examinations for diabetic patients, annual dental visit for diabetic patients, influenza vaccines, pneumococcal vaccines, cervical cancer screenings, breast cancer screenings, access to dental care, fetal alcohol syndrome prevention, domestic violence or intimate partner violence screenings, body mass index measurements, and use of tobacco assessments (IHS, 2005).

An examination of these GPRA indicators makes it apparent that, other than retinal exams for diabetic patients, eye health care and vision loss services for those already identified as having low vision are not included. No age is specified for the retinal exams, and the person screened would need to already be diagnosed with diabetes. It should also be noted that a retinal exam is included as one of the performance indicators, but only as the condition relates to diabetes.

According to Dr. Charles Jaworski, clinic chief in the Interior Alaska Service Unit in Fairbanks, Alaska (personal communication, March 6, 2006), variable levels of eye health care are offered throughout the regions, depending on local needs and decision-making as well as geographic and environmental obstacles. Fairbanks, Alaska, for example, offers a variety of services, including referrals to a low vision clinic in Anchorage, whereas other IHS units may offer fewer services. The Chinle Hospital Eye Clinic in Arizona, for example, offers eye exams to all Navajos and free glasses to anyone needing them. Programs providing glasses are unique, and are not offered in all IHS regions. Low vision services are limited or nonexistent, although they are greatly needed.

A high prevalence rate of an indigenous type of retinitis pigmentosa has been documented

in many of the natives in the Navajo nation. Several years ago, a high incidence of retinitis pigmentosa was reported in Kayenta, Arizona. According to Dr. Davis, Indian Health Service optometrist on the reservation, (personal communication, October 2001) it is estimated that there are 1 in 1,040–1,400 individuals under the age of 18 with retinitis pigmentosa living on the Navajo reservation in Northern Arizona and New Mexico, an incidence that is two times the national rate. This figure is also confirmed by John R. Heckenlively at the Jules Stein Eye Institute in Los Angeles, California (personal communication, September 12, 2001). Despite these acknowledged circumstances, IHS will not fund prosthetics, optical devices, or video magnifiers. According to Dr. Jaworski (personal communication, March 6, 2006), the low vision devices program is spotty, and is generally offered only if the administration of a particular region made it a priority. IHS monies may also be designated for local hospital and clinic budgets, to be dispersed as the hospital administrators see fit. Finally, IHS clinics are not set up in a uniform manner, and may vary depending on the population of Native Americans they serve. The Alaska clinic, for example, operates IHS quite differently than does the one in Arizona. In Alaska, many natives are employed so health care is run like a business in which health care costs are reimbursable. IHS can bill an individual's insurance company to help cover the cost of care. In Arizona, IHS is itself the primary provider of health insurance for many of the Navajo people, since so many are unemployed.

Retention, training, and attrition of qualified eye health care staff is another issue affecting the provision and quality of IHS eye care and vision loss services. Allocation of doctors is highly inconsistent; the ratio may be one eye doctor to 40,000 patients in one area and one doctor to 500 patients in another. However, according to Dr. Jaworski (personal communication, March 6, 2006), the current situation is an improvement compared to 40 years ago, when there was only one eye

doctor for 96,000 people. One reason for the lack of medical personnel may be the fact that medical students have to graduate and begin the loan repayment program after they accept their first medical assignment (for example, as an optometrist in training) with no guarantee that they will receive a job. In addition, few IHS scholarships are available for training eye health care staff members, and these scarce monies usually go to Native Americans.

CONCLUSION AND RECOMMENDATIONS

Whereas the cost of health care in the United States is rising 14%–15% each year, IHS receives an increase in funds of about 1%–2% annually (Dr. Jaworski, personal communication, March 6, 2006). Currently, there is no line item for vision care (which is not a GPRA indicator) in the IHS budget. The implications are unfortunate: The funding needed to establish exemplary IHS eye health care and vision loss services is likely to be even more difficult to obtain when the monies available for all health services are spread ever thinner.

Even now, the inconsistent spending on eye health care likely means that early identification of children who have amblyopia and refractive errors is too often missed. In certain areas of the United States, there may not be a comprehensive program to identify and provide services for children with uncorrectable vision loss. Given that federal legislation mandates that each sovereign nation determine how its health dollars are spent, positive

change can only be brought about through a sustained effort by groups dedicated to the provision of eye care and vision loss services, working collaboratively to offer ongoing education to the tribes about the importance of including eye health care in IHS budgets within the 12 regions. The eye doctors of IHS have been attempting to spread the message of the importance of eye care for years, but there is a need for other groups to add their voices. It is time for all of us in the fields of ophthalmology, optometry, and low vision, and for the educators of students with visual impairments who work with Native American populations to come together, to plan and to strategize about how we can best effect changes to benefit native peoples in the areas of eye care and vision loss. There has been progress in the last 40 years, but there is much work still to be done.

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