UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

OGLALA SIOUX TRIBE	)	
	)	
PLAINTIFF,	)	
	)	Civil Action No. 15-_____
v.	)	
	)	
SYLVIA BURWELL, et. al.	)	
	)	
	)	
	)	
DEFENDANTS.	)	

PLAINTIFF'S EXHIBIT A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

MAY 22 2015

Dear Tribal Leader:

I am writing to inform you of a settlement that the Indian Health Service (IHS) has reached with employee unions. The settlement resolves claims by IHS employees for overtime compensation for work that they performed in or for only Federally operated IHS hospitals, clinics, or facilities and for which they were not adequately paid.

The claims largely arise from IHS employees who have covered shifts at health care facilities that would not otherwise have been covered or stayed beyond their scheduled work time to serve additional patients. While we recognize that there are other important needs for which these funds could be used, it is important that IHS employees are properly compensated for the work that they have performed in delivering health services or in support of direct health care. The majority of the settlement will be used to compensate these IHS employees.

We believe that settling these claims now is right, the appropriate step, and the most fiscally responsible action. This settlement allows us to avoid future litigation costs and the possibility of future awards totaling hundreds of millions of dollars. It will allow us to continue to focus our attentions going forward on the important task of serving Indian Country health needs.

A combination of current-year funds that have been obligated but not spent, and prior year funds that would have been available to pay salary obligations at the time that the work was performed, will be used to resolve the claims. The total settlement costs will be borne by the Service Units based upon salary obligations where the claims arose.

Beginning in 2008, the unions representing employees among various IHS locations and facilities across the country filed grievances alleging unpaid overtime. After initial attempts to negotiate a settlement failed, IHS and the unions entered arbitration on 21 claims. Sixteen of those claims were adjudicated or resolved in favor of the employee unions and adjudicated or resolved at a valuation of $685,000. The average award per claim totaled nearly $33,000. With approximately 20,000 employees potentially eligible for this settlement, if all claims were litigated separately, total awards could run to several hundred million dollars.

A portion of the settlement will be paid from current, fiscal year 2015 funds. IHS intends to reallocate $20 million from the new staffing funding increase in the fiscal year 2015 appropriation, originally identified for the Kayenta Health Center in Kayenta, Arizona. The construction schedule for this facility has experienced delays and, as a result, only $4 million of the $24 million obligated will be needed for staffing funding. IHS has notified Congress of its intent to reallocate the remaining $20 million on a one-time, non-recurring basis for the purpose of this settlement.

The remaining portion of the settlement must be charged to the fiscal year in which the overtime was earned. IHS will use prior year funding that remains available to the extent legally permissible (up to $9 million). The remaining amount (approximately $50 - $51 million) will come from prior year third-party health insurance collections that would have been available to pay these overtime salary costs at the time that the costs were incurred.

IHS is also working to address the management of overtime work performed by IHS employees.

I trust this information is helpful and wish to assure you of our commitment to providing the highest level of health care possible to your communities. Should you have any questions, please don't hesitate to contact me.

Sincerely,

/Robert G. McSwain/

Robert G. McSwain
Acting Director

UNITED STATES DISTRICT COURT
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	)	
DEFENDANTS.	)	

PLAINTIFF'S EXHIBIT B

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JUL 29 2015

Dear Tribal Leader:

I am writing to provide an update on my May 22 letter to you regarding a settlement that Indian Health Service (IHS) reached with employee unions. Specifically, I want to address three questions about the settlement that have been raised frequently in various forums since then.

The first question that is often asked is why the settlement payment is not being paid through the Judgment Fund? Because the settlement was reached through an administrative settlement of a Union grievance in arbitration, the Judgment Fund is not available to pay the costs of settlement. The authorizing statute for the Judgment Fund makes clear that it is only available for the payment of claims brought through a judicial (as opposed to Union grievance/arbitral) proceeding, or which are settled under the authority of specifically identified statutes (e.g., the Federal Tort Claims Act). The Fair Labor Standards Act is not one of the statutes identified in the Judgment Fund's authorizing legislation.

The second question I hear a lot is, if IHS must pay the settlement, why are service unit third party collections funds being used for the payment? The answer to this question is tied to the type of costs associated with the settlement. The $80 million settlement is comprised of two categories of costs: 1) $60 million for back pay and back pay-related costs (e.g., payroll taxes); and 2) $20 million for administrative costs and attorney's fees.

The claimants in this settlement are largely service unit employees, consistent with IHS's organizational structure in which approximately 90 percent of its workforce is at the service unit level. Therefore, the settlement payment is borne largely by the service units. In addition, the settlement covers Fiscal Years (FY) 2005 through 2014. Under requirements of Federal appropriations laws, the agency must charge back pay owed to an employee to the fiscal year in which the pay was earned. Past year appropriated funds for FY 2005-2009 that could have been used to pay the overtime are no longer available (as past year unspent appropriations are cancelled after five fiscal years). Consequently, the only funds which could be used to pay the overtime for those years, and which are available now, are third party collections. The agency has identified roughly $10 million in expired appropriated (but not yet cancelled) funds that may be used for the back pay from the FY 2010-2014. These funds will decrease the amount of third party collections needed to meet the settlement obligations. Therefore, the settlement will be paid from third party collections ($50 million) and expired appropriations ($10 million). Third party collections are only collected and spent at the service unit level so these funds must come from the service units. IHS has made an initial estimate of the amounts that would be owed by each service unit, for purposes of making the payment of the $60 million to the union. The union will provide quarterly reports to IHS of actual payments to claimants, which will then be used to adjust the initial estimated amounts contributed by each service unit to ensure each IHS service unit, Area Office, and Headquarters is charged as appropriate. From a legal perspective, these are not new obligations. Rather these are obligations that should have been recorded and paid in the appropriate Fiscal Year. Also, IHS is paying the $20 million in administrative costs and attorney's fees from current FY 2015 appropriations.

The third most asked question about the settlement is why Tribes were not consulted about the payment ahead of time? The settlement arose from a group grievance filed by the union. Information about employee grievances is generally an internal agency matter, and the agency does not disclose such information without consent of the aggrieved party. IHS communicated with Tribes and offered an opportunity to comment and ask questions as soon as it was practicable to do so.

Finally, I understand you are keenly interested in knowing how your service unit funding is impacted by this settlement. I have asked the Area Directors to ensure this information is available by August 14, 2015, when IHS must make the payment to the union. However, as described above, the initial amounts paid by each service unit will be reconciled as the union makes payments to individual employees. Area Directors will provide updated information once a final reconciliation has been completed.

I trust this update is helpful. Please do not hesitate to contact me with any additional questions.

Sincerely,

/Robert G. McSwain/

Robert G. McSwain
Deputy Director

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DEFENDANTS.	)	

PLAINTIFF'S EXHIBIT C

Michael L. Roy

From: Jennifer P. Hughes
Sent: Monday, August 10, 2015 7:38 PM
To: Michael L. Roy
Subject: FW: Headquarters Setllement with the Union - $1,655,658 taken from the Service Unit

Jennifer P. Hughes, ***Partner***
T 202.822.8282 | F 202.296.8834

HOBBS STRAUS DEAN & WALKER, LLP
2120 L Street NW, Suite 700, Washington, DC 20037

HOBBSSTRAUS.COM

From: Donna Solomon [mailto:DonnaS@oglala.org]
Sent: Monday, August 10, 2015 6:38 PM
To: Jennifer P. Hughes
Subject: FW: Headquarters Setllement with the Union - $1,655,658 taken from the Service Unit

From: Conroy, Sophia (IHS/ABR/PRH) [mailto:Sophia.Conroy@ihs.gov]
Sent: Friday, July 31, 2015 12:22 PM
To: Weston, Sonia (Oglala Sioux Tribe) <soniaw@gwtc.net>; supertap_46@yahoo.com; Donna Solomon <DonnaS@oglala.org>; Kevin Steele <Kevin@oglala.org>; John Yellow Bird Steele <JohnS@oglala.org>; ABR/PRH Leadership <ABR_PRHLeadership@ihs.gov>; Cournoyer, Earl (IHS/ABR/PRH) <Earl.Cournoyer@ihs.gov>
Subject: FW: Headquarters Setllement with the Union - $1,655,658 taken from the Service Unit

FYI

Sophia Conroy, MSAS
Acting CEO
Pine Ridge Hospital
PO Box 1201
Pine Ridge, SD 57770
Phone: 605-867-3021
Fax: 605-867-3271
cell: 605-441-0414
email: sophia.conroy@ihs.gov

From: Conroy, Sophia (IHS/ABR/PRH)
Sent: Friday, July 31, 2015 1:21 PM
To: Cornelius, Ron (IHS/ABR/AO); Weber, Patrick (IHS/ABR/PRH); Davis, Allen (IHS/ABR/RBH)
Cc: Huff, Richard (IHS/ABR/AO)
Subject: RE: Headquarters Setllement with the Union - $1,655,658 taken from the Service Unit

Thank you Ron...

Sophia Conroy, MSAS
Acting CEO

Pine Ridge Hospital
PO Box 1201
Pine Ridge, SD 57770
Phone: 605-867-3021
Fax: 605-867-3271
cell: 605-441-0414
email: sophia.conroy@ihs.gov

From: Cornelius, Ron (IHS/ABR/AO)
Sent: Friday, July 31, 2015 12:54 PM
To: Weber, Patrick (IHS/ABR/PRH); Conroy, Sophia (IHS/ABR/PRH); Davis, Allen (IHS/ABR/RBH)
Cc: Huff, Richard (IHS/ABR/AO)
Subject: RE: Headquarters Setllement with the Union - $1,655,658 taken from the Service Unit

I am engaging with Headquarters on an alternate plan to reduce this amount. Will let you know as soon as I can.

From: Weber, Patrick (IHS/ABR/PRH)
Sent: Thursday, July 30, 2015 3:28 PM
To: Conroy, Sophia (IHS/ABR/PRH); Cornelius, Ron (IHS/ABR/AO)
Cc: Steele, John; donnas@oglala.org; Weston, Sonia (Oglala Sioux Tribe); supertap_46@yahoo.com; kevin@oglala.org; ABR/PRH Leadership; Cournoyer, Earl (IHS/ABR/PRH); Jackson, Mark (IHS/ABR/AO); Tatum, Alma (IHS/ABR)
Subject: RE: Headquarters Setllement with the Union - $1,655,658 taken from the Service Unit

If this action actually stands, it will have a devastating results on our Service Unit. We are ALREADY having a very difficult time maintaining our clinical services. The suicide epidemic and our new clinic in Martin our taking their toll financially. We have no additional funding for these added services and so far no reimbursement for Martin yet due to that clinic not being Medicaid certified. We will have to discuss either reducing services as soon as next month. The added reduction in our budget from this settlement could start a chain reaction that could affect our readiness to maintain CMS accreditation.

I am not sure what can be done about this situation but I trust we can work with the Aberdeen and Tribal administrations to come up with a viable solution without having to reduce services which will adversely affect patient care.

Dr. Weber
Acting Clinical Director
Pine Ridge I.H.S. Hospital
Pine Ridge, SD 57770

From: Conroy, Sophia (IHS/ABR/PRH)
Sent: Thursday, July 30, 2015 11:25 AM
To: Cornelius, Ron (IHS/ABR/AO)
Cc: Steele, John; donnas@oglala.org; Weston, Sonia (Oglala Sioux Tribe); supertap_46@yahoo.com; kevin@oglala.org; ABR/PRH Leadership; Cournoyer, Earl (IHS/ABR/PRH)
Subject: Headquarters Setllement with the Union - $1,655,658 taken from the Service Unit

Ron,

We just received a phone call from the Finance Office in Area that the following will be taken out of our Funding:

Pine Ridge: $1,346,976

Kyle: $210,465
Wanblee: $98,217
A total of $1,655,658 taken from the Service Unit

This will affect direct patient care dramatically as it will take all our current funding!

I was told the Settlement was by Headquarters with the Union regarding Fair Labor Standards (overtime for the Employees).

I would like to stress that the Pine Ridge Service Unit has addressed and litigated all of the Union Complaints and we should be excluded.

I was also informed by one of the participants that attended the Spearfish Meeting with the Tribes that Mr. McSwain informed the Tribes that Headquarters has funding in their prior year accounts for this settlement and no funding will be taken away from the Great Plains Service Units???

Thank you,

Sophia Conroy, MSAS
Acting CEO
Pine Ridge Hospital
PO Box 1201
Pine Ridge, SD 57770
Phone: 605-867-3021
Fax: 605-867-3271
cell: 605-441-0414
email: sophia.conroy@ihs.gov

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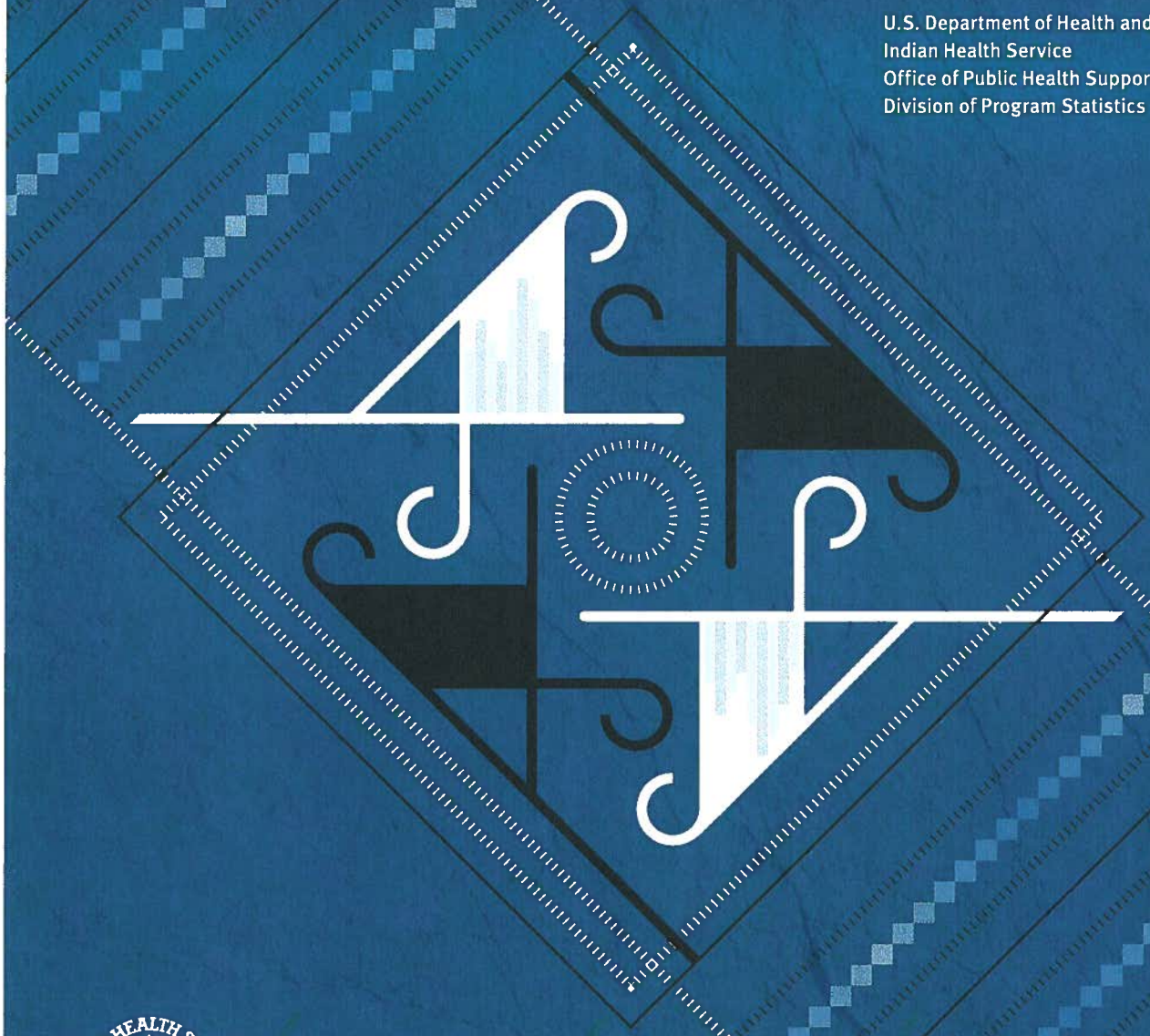
DEFENDANTS.	)	

PLAINTIFF'S EXHIBIT D

TRENDS IN INDIAN HEALTH

2014 EDITION

U.S. Department of Health and Human Services
Indian Health Service
Office of Public Health Support
Division of Program Statistics



INDIAN HEALTH SERVICE
TRENDS IN INDIAN HEALTH
2014 EDITION

Department of Health and Human Services
Sylvia Burwell
Secretary

Indian Health Service
Robert G. McSwain
Acting Director

Office of Public Health Support
CAPT Francis Frazier
Acting Director

Division of Program Statistics
Kirk Greenway, M.A., M.P.H.
Director

The AI/AN age-adjusted death rates for all causes of death for years 2007-2009 is 1.2 times the rate for U.S. all races (2008); tuberculosis (5.5 times), chronic liver disease and cirrhosis (4.7 times), diabetes (3.1 times), unintentional injuries (2.4) and homicide (1.9). AI/AN rates were below those of the U.S. all races for Alzheimer's disease (0.5 times), HIV infection (0.9 times), and major cardiovascular disease (0.9 times). These AI/AN rates have been adjusted to compensate for misreporting of AI/AN race on the state death certificates.

Chart 4.11 Selected Age-Adjusted Death Rates

Ratio of American Indians and Alaska Natives (2007-2009) to U.S. All Races (2008)

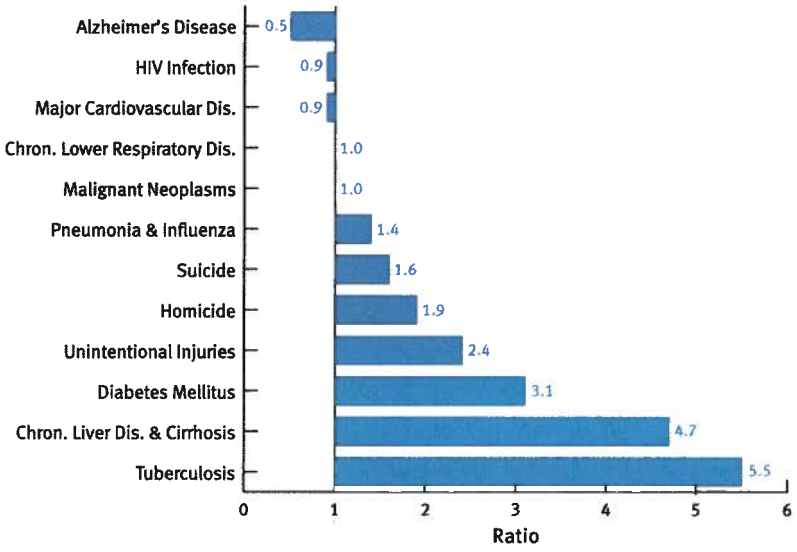


Table 4.11 Age-Adjusted Death Rates

American Indians and Alaska Natives, IHS Service Area, 2007-2009, and U.S. All Races and White Populations, 2008 (Rate per 100,000 Population)

Cause of Death	American Indian and Alaska Native Rate		U.S. All Races	U.S. White	Ratio of American Indian and Alaska Native[1] to:	
	Unadjusted	Adjusted[1]	Rate	Rate	U.S. All Races	U.S. White
All Causes	***818.0***	***943.0***	***774.9***	***767.2***	***1.2***	***1.2***
Major cardiovascular diseases	204.1	235.9	250.9	298.9	0.9	0.8
Diseases of the heart	156.9	182.4	192.1	189.3	0.9	1.0
Cerebrovascular diseases	33.8	39.1	42.1	40.4	0.9	1.0
Atherosclerosis	2.0	2.4	2.4	2.5	1.0	1.0
Hypertension	8.1	9.0	10.0	8.6	0.9	1.0
Malignant neoplasms	148.7	170.8	176.4	175.9	1.0	1.0
Unintentional injuries	79.5	94.5	38.8	40.7	2.4	2.3
Motor vehicle	32.0	39.3	12.9	13.3	3.0	3.0
Other unintentional injuries	47.5	55.2	25.9	27.4	2.1	2.0
Diabetes mellitus	51.0	61.0	20.0	20.2	3.1	3.0
Chronic lower respiratory diseases	36.5	43.2	44.7	47.1	1.0	0.9
Chronic liver disease and cirrhosis	37.4	43.1	9.2	9.6	4.7	4.5
Pneumonia and influenza	22.1	24.1	16.9	16.7	1.4	1.4
Suicide	16.2	18.5	11.6	12.9	1.6	1.4
Alzheimer's disease	13.1	11.6	24.4	26.7	0.5	0.4
Homicide	9.6	11.0	5.9	3.7	1.9	3.0
Human immunodeficiency virus (HIV) infection	2.8	3.0	3.3	1.7	0.9	1.8
Tuberculosis, all forms	1.1	1.1	0.2	0.1	5.5	11.0

[1] Adjusted to compensate for misreporting of AI/AN race on state death certificates.

SOURCE: Rates for U.S. All Races and U.S. White: Centers for Disease Control and Prevention. CDC Wonder. *http://wonder.cdc.gov/*

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DEFENDANTS.	)	

PLAINTIFF'S EXHIBIT E

U.S. Department of Health and Human Services

Indian Health Service

Disparities

Members of 566 federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS is an agency within the Department of Health and Human Services that provides a comprehensive health service delivery system for approximately 2.2 million of the nation's estimated 3.7 million American Indians and Alaska Natives. The IHS strives for maximum tribal involvement in meeting the health needs of its service population, who live mainly on or near reservations and in rural communities, mostly in the western United States and Alaska.

The American Indian and Alaska Nativepeople have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

Diseases of the heart, malignant neoplasm, unintentional injuries, and chronic lower respiratory diseases are leading causes of American Indian and Alaska Native deaths (2006-2008).

American Indians and Alaska Natives born today have a life expectancy that is 4.2 years less than the U.S. all races population (73.7 years to 78.17 years, respectively).

American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.

Given the higher health status enjoyed by most Americans, the lingering health disparities of American Indians and Alaska Natives are troubling. In trying to account for the disparities, health care experts, policymakers, and tribal leaders are looking at many factors that impact upon the health of Indian people, including the adequacy of funding for the Indian health care delivery system.

Additional information on the IHS is available at ihs.gov.

MORTALITY DISPARITY RATES

American Indians and Alaska Natives (AI/AN) in the IHS Service Area
2007-2009 and U.S. All Races 2008
(Age-adjusted mortality rates per 100,000 population)

	AI/AN Rate 2007-2009	U.S. All Races Rate - 2008	Ratio: AI/AN to U.S. All Races
ALL CAUSES	943.0	774.9	1.2
Diseases of the heart	182.4	192.1	0.9

Malignant neoplasm	169.4	178.4	0.9
Alzheimer's	170.8	176.4	1.0
Unintentional injuries*	94.5	39.2	2.4
Chronic lower respiratory diseases	43.2	44.7	1.0
Diabetes mellitus	61.0	22.0	2.8
Chronic liver disease and cirrhosis	43.1	9.2	4.7
Cerebrovascular diseases	39.1	42.1	0.9
Influenza and pneumonia	24.1	17.8	1.4
Nephritis, nephrotic syndrome	22.1	15.1	1.5
Intentional self-harm (suicide)	18.5	11.6	1.6
Septicemia	16.5	11.3	1.5
Alzheimer's disease	14.6	24.4	0.6
Assault (homicide)	11.0	5.9	1.9
Essential hypertension and hypertensive renal disease	12.8	13.9	0.9
Parkinson's disease	5.1	6.6	0.8

* Unintentional injuries include motor vehicle crashes.

NOTE: Rates are adjusted to compensate for misreporting of American Indian and Alaska Native race on state death certificates. American Indian and Alaska Native age-adjusted death rate columns present data for the 3-year period specified. U.S. All Races columns present data for a one-year period. ICD-10 codes were introduced in 1999; therefore, comparability ratios were applied to deaths for years prior to 1999. Rates are based on American Indian and Alaska Native alone; 2000 census with bridged-race categories.

January 2015

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DEFENDANTS.	)	

PLAINTIFF'S EXHIBIT F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

ROBERT G. MCSWAIN

ACTING DIRECTOR, INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

OVERSIGHT HEARING ON

DEMANDING RESULTS TO END NATIVE YOUTH SUICIDE

JUNE 24, 2015

Chairman and Members of the Committee:

Good afternoon, I am Robert G. McSwain, Acting Director of the Indian Health Service (IHS). Today, I appreciate the opportunity to testify on "Demanding Results to End Native Youth Suicide."

Thank you for the invitation to talk about this very serious issue of Native youth suicide. It is with a heavy heart that we discuss an issue that continues to plague American Indian and Alaska Native (AI/AN) communities. Most recently, the Oglala Sioux Tribe has faced the same tragedy of a suicide cluster that too many other AI/AN communities have experienced. Our thoughts go out to the Oglala Sioux Tribe and the families and friends who are grieving the loss of their young people. Today, I will highlight our key programs, initiatives, and investments to end Native youth suicide and we look forward to continuing to work with the Committee to address this devastating problem.

As you know, the Indian Health Service (IHS) plays a unique role in the Department of Health and Human Services because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The IHS has the responsibility for the delivery of health services to an estimated 2.2 million American Indians and Alaska Natives who belong to 566 Federally-recognized Tribes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The agency goal is to assure that comprehensive, culturally appropriate personal and public health services are available and accessible to the AI/AN population. Our duty is to uphold the Federal Government's obligation to promote healthy AI/AN people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major pieces of legislation are at the core of the Federal Government's responsibility for meeting the health needs of American Indians and Alaska Natives: The Snyder Act of 1921, 25 U.S.C § 13, and the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §§ 1601-1683. The Snyder Act authorized appropriations for "the relief of distress and conservation of health" of

American Indians and Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the provision of programs, services, functions, and activities to address the health needs of American Indians and Alaska Natives. The IHCIA also includes authorities for the recruitment and retention of health professionals serving Indian communities, health services for people, and the construction, replacement, and repair of healthcare facilities.

Introduction

We share your deep concern about the tragedy of suicide among Native youth. Suicide is a complicated public health challenge with many contributing factors in AI/AN communities. Although suicide contagion is not unique to AI/AN populations, too frequently, AI/AN communities experience suicide that takes on a particularly worrying and seemingly contagious form, often referred to as suicide clusters. In these communities, the suicidal act becomes a regular and transmittable form of expression of the despair and hopelessness experienced by some Native youth. While most vividly and painfully expressed in close knit AI/AN communities, suicide and suicidal behavior and their consequences send shockwaves through the community. We at IHS – and at HHS more broadly – try to prevent these suicide clusters from beginning and to halt them once they begin occurring.

However, all too many AI/AN communities are affected by high rates of suicide. The recently published IHS *"Trends in Indian Health, 2014"* reports:

- The age adjusted suicide rate (18.5 per 100,000 population) for the three year period (2007-2009) in the IHS service areas was 1.6 times that of the U.S. all races rate (11.6) for 2008.
- Suicide is the second leading cause of death (behind unintentional injuries) for Indian youth ages 15-24 residing in IHS service areas and the suicide death rate for this cohort is four times higher than the national average.
- Suicide is the sixth leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide.

- AI/AN young people ages 15-34 make up 64 percent of all suicides in Indian country.

Responding to Suicide Crises

Tribal leaders will often request IHS to provide additional support and funding to help prevent any further suicides during a cluster. Since no two suicide clusters are the same, the IHS response is tailored to the needs of the community in crisis. In general, our Area Office typically takes the first steps to organize and implement a response to a suicide crisis. In particular, the IHS Area Office reaches out to tribal leadership to ensure IHS and key Federal partners, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), are aware of the Tribe's level of need and the specific requests for a response. We take steps to work hand-in-hand with the tribe, in organizing our response. IHS and SAMHSA coordinate to ensure Federal resources are readily available.

SAMHSA's resources may include existing grants awarded to the tribe under the new Tribal Behavioral Health Grant (TBHG) program that is focused on preventing suicidal behavior and substance abuse and promoting mental health in AI/AN youth or the Garrett Lee Smith State/Tribal Youth Suicide Prevention program that supports youth suicide prevention and early intervention strategies and collaborations among youth-serving institutions and systems (i.e., schools, juvenile justice, foster care, substance abuse, mental health, and other child and youth supporting organizations). Other SAMHSA resources include specialized technical assistance centers such as the Suicide Prevention Resource Center, National Native Children's Trauma Center, and National AI/AN Addiction Technology Transfer Center.

If the Tribe requests a deployment of healthcare providers, IHS takes the lead with the Division of Commissioned Corps Personnel and Readiness (DCCPR) to assess and plan for the deployment. A deployment team can be on the ground in a matter of days. These short term deployment teams are intended to deal with the immediate crisis until mid- and long-term solutions can be set in place.

Zero Suicide

In 2015, IHS will launch the Zero Suicide Initiative, a key concept of the 2012 National Strategy for Suicide Prevention. In our current system, suicide care has traditionally been provided by individual local champions and clinical providers. IHS is moving toward a more programmatic system-wide approach by implementing Zero Suicide. IHS' commitment to create a leadership-driven, safety-oriented culture committed to reducing suicide among people under our care will drive the improved patient outcomes we need to see as a result of a collective Agency effort. Moving forward, IHS is making the commitment to set big goals and improve our approach to inform system changes to provide better care for AI/AN individuals at risk for suicide.

Zero Suicide represents a bold goal for IHS. It is the foundational belief that suicide deaths for individuals under our care within our health and behavioral health systems are preventable. IHS is committed to creating a leadership-driven, safety-oriented culture focused on reducing suicide. The approach represents a commitment from IHS to set in place an organizational structure where suicidal individuals and individuals at-risk will receive coordinated care from a competent workforce. The fundamentals of Zero Suicide implementation include: leadership's commitment to reduce suicide deaths; training a competent, confident, caring workforce; identifying and assessing patients for suicide risk; engaging patients at risk for suicide in a care plan; treating suicidal thoughts and behaviors directly; following patients through every transition in care; and applying data-driven quality improvement. To accomplish our commitment, IHS has begun a virtual training series through the Tele-Behavioral Health Center of Excellence (TBHCE). IHS is also partnering with SAMHSA and the Suicide Prevention Resource Center to bring a tailored Zero Suicide Training Academy for IHS and Tribal healthcare facilities in 2015. In addition, as discussed below, the Fiscal Year (FY) 2016 Budget requests an additional $25 million to hire additional behavioral health providers through the Methamphetamine and Suicide Prevention Initiative (MSPI).

Methamphetamine and Suicide Prevention Initiative

The MSPI is an IHS nationally-coordinated demonstration project, focusing on providing much-needed methamphetamine and suicide prevention and intervention resources for AI/AN communities. It is a key resource for IHS as we work to prevent youth suicides. It promotes the

use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches from a community-driven context.

The MSPI supports 130 programs across the country. The goals of the MSPI are to:

- Prevent, reduce, or delay the use and/or spread of methamphetamine use;
- Build on the foundation of prior methamphetamine and suicide prevention and treatment efforts, in order to support the IHS, Tribes, and Urban Indian health organizations in developing and implementing culturally appropriate methamphetamine and suicide prevention and early intervention strategies;
- Increase access to methamphetamine and suicide prevention services;
- Improve services for behavioral health issues associated with methamphetamine use and suicide prevention;
- Promote the development of new and promising services that are culturally and community relevant; and
- Demonstrate efficacy and impact.

MSPI projects provide multiple services related to suicide and methamphetamine use. The most common focus of funded projects is suicide prevention (94%), methamphetamine prevention (69%), and suicide treatment and intervention (55%). The MSPI projects are in the sixth and final year of the demonstration program. From 2009-2014, the MSPI resulted in over 9,400 individuals entering treatment for methamphetamine use; more than 12,000 encounters via tele-health for substance abuse and mental health disorders; over 13,150 professionals and community members trained in suicide crisis response; and more than 528,000 encounters with youth provided as part of evidence-based and practice-based prevention activities.

MSPI projects offer a multitude of evidence-based practices and treatments. The most common types of evidence-based practices utilized among MSPI programs to prevent suicide are Question, Persuade, Refer (QPR); Applied Suicide Intervention Skills Training (ASIST); Safe Tell, Ask, Listen, Keepsafe (safeTALK); Mental Health First Aid; and Gathering of Native Americans. Evidence-based treatments to prevent suicide re-attempts utilized among MSPI programs include Motivational Interviewing, Cognitive Behavior Therapy (CBT), and Dialectical Behavior Therapy, to name a few. For instance, the White Earth MSPI project, called

Native Alive, stations mental health professionals at reservations schools and maintains a support hotline staffed by health professionals trained in ASIST.

MSPI projects often incorporate cultural elements into their programs and activities such as by teaching traditional beliefs, smudging, ceremonies, or sweat lodges in collaboration with traditional healers. The Absentee Shawnee MSPI project, Following in Our Footsteps, utilizes cultural activities such as Native American storytelling, arts and crafts, dancing, sweat lodge ceremonies, and positive youth activities to promote healthy life choices and positive decision-making skills.

Building on the associations between social connections and lower suicide risk, MSPI projects enlist partners to build community-based suicide prevention. Partnerships with local schools are key in the MSPI for school-based interventions to develop skills to protect against suicidal thoughts and behaviors, raise awareness, encourage help-seeking, and teach positive life and coping skills. Examples of such activities at work in MSPI communities include American Indian Life Skills, Native Hope, and Project Venture. Youth may not want or may not always be able to ask appropriate adults for help and may reach out to their peers for assistance. MSPI projects offer training to youth to build their intervention skills for such situations. The MSPI funds allow projects to expand community-based mental health care into youth-based settings, increasing access to care for mental health and substance use disorders for our Native youth. The funding for MSPI funding is not enough to go to every Tribe. Therefore, IHS awards the funds on a competitive basis. In FY 2015, IHS will open a new funding announcement for a project period to run from September 30, 2015 to September 29, 2020, contingent on appropriations.

Domestic Violence Prevention Initiative

Since the Institutes of Medicine (2002) report[1] on suicide research, there has been much learned about the role of child abuse in later suicide risk. According to the Center on the Developing Child at Harvard University, a toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity, such as physical or emotional abuse, chronic neglect,

[1] See: http://www.iom.edu/Reports/2002/Reducing-Suicide-A-National-Imperative.aspx

caregiver substance use and mental health disorders, exposure to violence, and/or the accumulated burdens of family economic hardship. These adverse childhood experiences can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years.

IHS' primary response to children exposed to violence is through the Domestic Violence Prevention Initiative (DVPI). The IHS began the DVPI in 2010 with the purpose of better addressing domestic violence (DV) and sexual assault (SA), including the pediatric and adolescent population, within AI/AN communities. The program has awarded funding to a total of 65 projects that include IHS/Tribal/Urban operated programs. This initiative promotes the development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to DV and SA from a community-driven context. Types of evidence-based treatment practices provided by DVPI projects include CBT, Trauma Focused CBT, Beyond Trauma: Traumatic Incident Reduction, and Strengthening Families, a program to improve parenting and family relationships. Practice-based practices utilized by DVPI projects include elders teaching traditions, talking circles, or smudging ceremonies. For instance, Santa Clara Pueblo provides more community education activities; in-school services for young witnesses of family violence; violence prevention education in schools; and counseling for young victims of DV.

The DVPI expands outreach and increases awareness by funding projects that provide victim advocacy, intervention, case coordination, policy development, community response teams, and community and school education programs. The funding is also used for the purchase of forensic equipment, medical personnel training, and the coordination of Sexual Assault Examiner (SAE) and Sexual Assault Response Team activities. From 2010-2014, the DVPI resulted in over 50,500 direct service encounters including crisis intervention, victim advocacy, case management, and counseling services. More than 38,000 referrals were made for domestic violence services, culturally-based services, and clinical behavioral health services. In addition, a total of 600 forensic evidence collection kits from eight SAE programs were submitted to Federal, state, and tribal law enforcement. In the last year, DVPI projects referred over 2,000 children and youth to behavioral health, cultural services, DV or SA services, shelter services, specialized medical care, or to victim advocates.

Prioritizing Behavioral Health Services for Native Youth

The Administration's 2016 Budget proposes key investments to launch Generation Indigenous (Gen-I), an initiative addressing barriers to success for Native American youth. This integrative, comprehensive, and culturally appropriate approach across the Federal Government will help improve lives and opportunities for Native American youth. The HHS Budget Request includes a new Tribal Behavioral Health Initiative for Native Youth with a total of $50 million in funding for IHS and the SAMHSA. Within IHS, the request includes $25 million to expand the successful MSPI to increase the number of child and adolescent behavioral health professionals who will provide direct services and implement youth-based programming at IHS, tribal, and urban Indian health programs, school-based health centers, or youth-based programs. SAMHSA will expand the Tribal Behavioral Health Grant program to support mental health promotion and substance use prevention activities for high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment. These activities will both fill gaps in services and fulfill requests from tribal leaders to support Native youth.

IHS' Gen-I activities include youth engagement through the development of youth steering committees at the local level to inform IHS on planning, implementation, and evaluation of its youth health programs and services. The information from the local youth steering committees will feed into regional and national recommendations to operationalize the input received from Native youth. Secondly, IHS will provide opportunities through its Pathways Internship Program. Pathways is a streamlined program designed to attract students enrolled in a wide variety of educational institutions (high school, home-school programs, vocational and technical, undergraduate and graduate) with paid opportunities to work in agencies and explore Federal careers while still in school. This program exposes students to jobs in the Federal civil service by providing meaningful "developmental work" at the beginning of their career, before their "career paths" are fully established. The flexible nature of the program is to accommodate the need to hire students to complete temporary work or projects, perform labor intensive tasks not requiring subject matter expertise, or to work traditional "summer jobs." The program provides agencies with the opportunity to hire interns who successfully complete the program and

academic requirements into any competitive service position for which the Intern is qualified. The IHS Gen-I Pathways Internship Program offers Native youth an opportunity to apply for paid summer positions at IHS Service Units in their local community. The initiative kicked off in May 2015, and we have posted job advertisements at all the IHS Areas and have over 80 summer internship positions allocated IHS-wide.

IHS will also provide more funding opportunities geared toward Native youth for early intervention and positive youth development through its three largest initiatives. In the Special Diabetes Program for Indians, grantees will have the option to elect to use FY 2016 funding to implement the Family Spirit Program, an early intervention home visiting program. Family Spirit is an evidence-based and culturally tailored in-home parent training and support program. Parents gain knowledge and skills to achieve optimum development for their preschool aged children across the domains of physical, cognitive, social-emotional, language learning, and self-help. The program is currently the largest, most rigorous, and only evidence-based home visiting program ever designed specifically for American Indian families. Family Spirit now has randomized controlled trial evidence demonstrating that it reduces risk factors associated with a number of adverse outcomes, including obesity and substance use.

The MSPI program will also provide FY 2015 funding for local programs to support their Gen-I activities through evidence-based and practice-based programming. Examples of such activities include implementation of American Indian Life Skills, Model Adolescent Suicide Prevention Program, Project Venture, Native HOPE (Helping Our People Endure), ASIST (Applied Suicide Intervention Skills Training), and cultural activities like Native American storytelling, traditional teachings, ceremonies, and other local relevant practices.

Behavioral Health Integration with Primary Care

The current system of services for treating mental health problems of American Indians and Alaska Natives is a complex and often fragmented system of tribal, Federal, state, local, and community-based services. The availability and adequacy of mental health programs for American Indians and Alaska Natives varies considerably across communities. The future of AI/AN health depends largely upon how effectively behavioral health is addressed by

individuals, families, and communities and how well it is integrated into community health systems. We know that successful and sustained behavioral change will require cultural reconnection, community participation, increased resources, leadership capacity, and the ability of systems to be responsive to emerging issues and changing needs. In 2014, IHS began a small pilot project of six sites, the Behavioral Health Integration Initiative (BH2I). The goal of the funding was for sites to develop rapid cycle improvements of behavioral health integration with primary care using the Improving Patient Care (IPC) model. BH2I will continue into FY 2016. IHS will host a National Behavioral Health Integration with Primary Care Conference in Phoenix, Arizona to disseminate integration best practices and lessons learned from BH2I.

The IPC Program is an outpatient primary care quality improvement program designed to assist IHS/Tribal/Urban Indian clinics with improving their care delivery and achieving Patient Centered Medical Home (PCMH) recognition. The PCMH is a model of care that aims to transform the delivery of comprehensive primary care to children, adolescents, and adults. The PCMH is best described as a model that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. The medical home is focused on the needs of patients, and when appropriate, their families and caregivers. A significant element of the PCMH is integration of behavioral health services into primary care patient visits. This can include screening for behavioral health conditions, addressing beliefs about diseases and treatments, identifying disorders and initiating treatment, and collaboration with behavioral health professionals as part of the integrated primary care team.

Training and Tele-Behavioral Health Services

IHS recognizes the need to support access to services and to create a broader range of services linked into a larger network of support and care. IHS piloted the use of tele-behavioral health to increase access to specialty behavioral health services in the MSPI demonstration pilot phase. MSPI projects provided over 6,000 tele-behavioral health encounters in the fifth year alone.

The TBHCE was developed in 2009 to promote and develop tele-behavioral health services. Working in partnership with the University of New Mexico, the TBHCE provides services in a number of settings including school clinics, youth residential treatment centers, and health

centers. The TBHCE has leveraged their ability to use federal service providers and provides technical and program support nationally for programs attempting to implement tele-health services. IHS programs are increasingly adopting and using these technologies with more than 8,000 encounters provided via tele-behavioral health in FY 2014.

IHS benefits from the use of telemedicine for the prevention and treatment of youth suicide by connecting widely separated and often isolated programs of varying sizes together into a network of support. For example, small clinics would need to develop separate contracts for services such as child and adult psychiatric support, but the TBHCE is able to provide more cost-effective specialty care conveniently located within the clinic patients utilize for services. Such a system could provide 24/7 access to emergency and routine behavioral health service in any setting with adequate telecommunications service and appropriately trained staff.

The TBHCE also provides opportunities for mutual provider support. For example, currently when psychiatric providers are on leave or are attending a training conference there are often no direct services available during that time period. Sufficient services could be provided via tele-health connections to improve continuity of care with providers who are familiar with treating AI/AN patients. IHS also encourages families to participate in care through tele-health in circumstances when their youth may be transitioning from a treatment facility or residential program.

Providers with particular specialty interests can also share their skills and knowledge across a broad area even if they themselves are located in an isolated location by videoconferencing, providing clinical supervision and working with multidisciplinary teams. Universities providing distance-based learning opportunities have demonstrated for years that educational activities can be facilitated by this technology and reduce burn out due to professional isolation. Recruitment also becomes less problematic because providers can readily live and practice out of larger urban or suburban areas and are thus more likely to continue providing service over time.

The TBHCE also provides virtual training to primary care providers, nurses, and behavioral health providers on current and pressing behavioral health topics in an effort to increase the Indian health system's capacity to provide integrated behavioral health care with primary care. In

FY 2014, over 8,000 providers received training.

Recruitment and Retention

The rural and remote geographical locations of AI/AN communities present challenges with recruitment and retention of qualified behavioral health providers. Many of the facilities that serve AI/AN populations are in what the Health Resources and Services Administration (HRSA) has designated as health professional shortage areas.[2] The IHS offers financial incentive programs to recruit and retain behavioral health providers. The IHS Loan Repayment Program offers financial support in exchange for a service obligation in IHS-designated facilities upon completion of training and licensure. The IHS Indian Health Professions Scholarship Program is designed for AI/AN recipients entering the healthcare field. The recipients receive full or partial tuition support and a monthly stipend in exchange for a service obligation upon completion of training and appropriate licensure for placement within IHS-designated facilities located in designated shortage areas. The Indians into Psychology grant provides funding to colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs to encourage AI/AN students to enter the behavioral or mental health field. Recipients of the program receive tuition, fees, and a monthly stipend. Upon graduation with a Ph.D., these professionals are placed within IHS-designated facilities.

The National Health Service Corps (NHSC), administered by HRSA, has both a scholarship program and a loan repayment program. The NHSC adds another source of service-obligated providers to IHS, Tribal, and Urban Indian health programs, including behavioral health professionals. IHS and HRSA collaborated to increase the numbers of IHS, Tribal, and Urban Indian health program sites that are eligible for assignment of NHSC personnel. The NHSC Loan Repayment Program is another opportunity for behavioral health providers to serve in communities with limited access to care and have their student loans repaid.

Conclusion

Suicide prevention needs to be addressed in the comprehensive, coordinated way outlined in the

[2] See: Health Resources and Services Administration Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations. Available at: www.hrsa.gov/shortage/find

National Strategy for Suicide Prevention. No one agency or one approach will solve the tragedy of suicide in AI/AN communities. Suicide is complex and thus has many factors that must be considered. Reducing the number of suicides requires the engagement and commitment of people in many sectors in and outside government. IHS is committed to being a partner in the response to end Native youth suicides. As a central provider of health care for American Indians and Alaska Natives, we must do better in reaching youth with behavioral health and other help they need. We want to work with you to get us closer to the Zero Suicide goal. We all recognize that the challenges faced by Native youth run deep – we must all work together in offering them hope for a better future.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

OGLALA SIOUX TRIBE	)	
	)	
PLAINTIFF,	)	
	)	Civil Action No. 15-_____
v.	)	
	)	
SYLVIA BURWELL, et. al.	)	
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DEFENDANTS.	)	

PLAINTIFF'S EXHIBIT G

LAKOTA HEALTH CARE ACCESS AND THE PERPETUATION OF POVERTY ON PINE RIDGE

Kathleen Pickering and Bethany Mizushima

ABSTRACT

Poor health conditions are a major factor in perpetuating poverty on the Pine Ridge Indian Reservation. This chapter explores the ways in which market-based health care delivery systems shirk health care costs of Lakota households on the periphery of the market economy. Furthermore, the economic value of health care services provided by these same marginal households is understated because market-based health care privileges commodified biomedicine. Examining economic activity beyond formal market integration reveals how households least able to bear the costs of health care subsidize the market economy at the expense of their own efforts to move out of poverty.

Lakota people living on the Pine Ridge Indian Reservation in South Dakota face some of the worst health conditions in the U.S., including extremely low life expectancy and alarmingly high rates of heart disease, cancer, and diabetes. Additionally, Pine Ridge is one of the most impoverished areas in the U.S., struggling as many other American Indian reservations do to generate economic development on the narrowest margins of the world

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economy. Synergies between ill health and poverty spiral downward, as individuals' health problems not only reduce their abilities to pursue education, wage work, or self-employment, but also divert household resources as family members shift from generating household support to providing uncompensated home-based health care.

Based on primary data gathered from 300 Lakota households on the Pine Ridge Indian Reservation over the last six years, this chapter argues that household activities beyond market-based transactions are critical to understanding Lakota responses not only to poverty but also to inadequate health care access as well.

1. SOCIALLY EMBEDDED ECONOMIES AND SOCIALLY EMBODIED HEALTH

Health care access is an economic development issue. In Eurocentric economic and medical practice, the individual is elevated as the central actor. Access to health care services is an act of individual exchange on a free market, just like entering an employment contract or buying groceries. However, for communities with a strong history of collective consciousness and weak ties to market economics, individuals act in socially embedded spheres of exchange, where the health of an individual is fully integrated into the dynamics of household production. By looking at the household as the unit of analysis, it becomes apparent that health problems pose a significant demand on the time and limited financial resources of households. Health problems also impact the economic vitality of a much larger portion of the population than is apparent when individual disease prevalence is used as the unit of analysis. Furthermore, experiences with biomedicine are in fact interpreted collectively, not through the individualized market model, so that group experience informs health care perceptions and ultimately affects health care access.

However, the activities of marginalized, impoverished communities within the structures of capitalism continue to be overlooked and under-theorized. Typically, social scientists conceive of economic activity as being from one of two distinct worlds. The world associated with the prosperity of the U.S. is an orderly, formal, structured, industrialized, market-based economy with associative relations and cash-based, materialistic consumption. The world associated with poverty, indigenous peoples, and societies in need of economic development is theorized in contrast to the idealized capitalist

world to be amorphous and unstructured, with non-market forms of exchange, kin-based relations, and non-monetarized, uncommodified forms of consumption (Evers, 1991; Haynes & Bosworth, 1996; Sacks, 1995, p. 250).

In practice, however, poor people are moving fluidly between these two worlds, allocating time, consuming, and socially interacting across this theoretically constructed divide (Halperin, 1990; Nash, 1994; Peterson, 1989; Stack, 1974). Within the U.S., the area of overlap between these two worlds is potentially greater than the areas of separation. For households in poor communities, their economic practice is a dynamic combination of formal and informal, arms length and social, regulated and unregulated, and market-based and reciprocal activities.

As Karl Polanyi observed, the "human economy is embedded and enmeshed in institutions, economic and non-economic" (Polanyi, 1957, p. 250). Polanyi postulated four modes of economic integration, all of which are present to some degree in every society, but vary across societies and over time in terms of which mode is dominant or subordinated (Polanyi, 1944; Polanyi, 1957, p. 253; Halperin, 1994; Halperin, 1991). Since the economy is an instituted process embedded within society, the economies within different societies may be instituted in significantly different ways (Hopkins, 1957, p. 295). Redistribution, which occurs when goods are accumulated through familial or political relationships and then redistributed to establish social ties and support throughout the community, is common among tribal societies where the social structure is based on the collective interests of kinship groups. Reciprocity is most often defined by gift giving, with some acknowledged obligation to make a return gift at some time in the future (Mauss, 1990; Sahlins, 1968). Forms of barter that take into account the social relationship between the parties to the exchange also constitute reciprocity. Householding refers to the movement of goods and services within and among household members, also referred to as resource pooling by some authors (Halperin, 1991; Peterson, 1989). These three modes of integration are all explicitly based on the social relationship between the parties to the exchange. There is no sense of faceless, alienated participants in these exchanges, or of invisible forces defining what is fair or equitable. The imbalance in the value of gifts exchanged between mother and child is explained and accepted by their social relationship, as is the redistribution of meat to a family whose primary hunter suffered a severe injury.

Market exchange, in contrast, is where prices are determined at arms length, and has been the dominant mode of integration accompanying the

global spread of capitalism over the past five centuries. And, while markets do in fact depend on people acting within the obligations and constraints of society, the ideology of the market economy stresses the independence and freedom of individuals to make choices and accumulate wealth without obligation to anyone in particular or to society in general (Mingione, 1994). In the current world economy, the market is often assumed to be not only the dominant but also the universal and exclusive mode of integration for all societies, as it is in most industrialized societies.

However, as the global economy evolves, areas which were almost exclusively dedicated to market practice but have become redundant to the global system now exhibit renewed and expanded efforts in reciprocal and redistributive domains. Similarly, areas which have only had weak ties to the global market economy may continue to demonstrate strengths in other forms of economic integration, often centered around kinship systems and the importance placed upon familial obligations, while market exchange remains subordinate (Annis, 1987; Halperin, 1991). In such settings where market exchange is not the dominant mode of integration, analyses that are limited to formal market transactions and relationships run the risk of missing the full array of activities involved in meeting household needs, and misrepresenting significant areas of economic life as inactivity, leisure, or inefficiency (Pickering, 2000; Pickering, 2004; Pickering et al., 2006).

In relation to health care access, the biomedical model of health delivery systems is embedded in the mode of market exchange. Projections of health care coverage are based on the costs of fully commodified goods and services dedicated to health and medical treatment. As a result, health care practices governed by other modes of economic integration and their social costs are often left out of biomedical models, which focus rather on formal hospital or clinic settings with services provided by fully compensated wage workers. Furthermore, the market-driven biomedicine of the U.S. implies that only those participating in market-based economic activities deserve health care coverage. Virtually every other industrialized nation has created a redistributive government health care system in which the contributions of those currently working offset the health care costs of those unable to engage in market-based economic practices.

For places in the U.S. like Pine Ridge, where formal markets continue to be weak, the real costs of preventative, acute and long-term health care fall back onto reciprocal and householding modes of integration through the uncompensated labor of household and extended family members. This shift of health care costs onto households with the most limited resources works

to perpetuate poverty in two ways. First, short-term, seasonal, and regional employers are able to avoid these health care costs by imposing them onto the reservation households of their employees (see Meillassoux, 1981). As a result, uncompensated, home-based health care provided by peripheral households ends up subsidizing the market economy at the expense of their own efforts to move out of poverty. Second, the uncompensated labor of households providing health care is left out of formal market equations governing the productivity and human capital potential of the community. As a result, a distorted portrait of economic inactivity is constructed by businesses to further marginalize and undercapitalize these communities, perpetuating poverty once again.

2. UNCOVERING REAL HOUSEHOLD ECONOMIC PRACTICE

To understand how the processes of health care access and economic marginalization intersect, primary data was drawn from longitudinal economic and health data gathered on the Pine Ridge Indian Reservation in South Dakota from 300 Lakota households over the last six years. The objective of the overall research, funded in part by the National Science Foundation, is to analyze the relationship between time allocation, household consumption, and social networks in structuring household economic opportunities and decision making. By using the household as the unit of analysis for longitudinal research, it becomes possible to move away from the static and atomistic picture of individuals engaged in fixed relationships and activities, and move toward a more accurate understanding of how household membership and economic resources are dynamic and contested strategies that change, in some cases radically, over time (Knack, 2001; Pickering, 2004). The data-gathering portion of the project began in the summer of 2001 and was concluded in the summer of 2006.

To randomly select the 300 household participants for this study, every housing unit on the reservation was identified, marked, and numbered from aerial photographs of the reservation taken in 1994 by the USDA-FSA Aerial Photography Field Office's National Agriculture Imagery Program (NAIP). These photographs were updated with ground level observations, and with aerial photos from 2004 that were made available also by NAIP. A set of random numbers was then generated by computer and used to

identify participant households. Each year, beginning in 2001, 60 new households were added to the sample, and follow-up interviews were conducted with households that had been selected and surveyed in prior years. In 2005, the final 60 randomly selected households were added to the sample. The random sample was stratified to be proportionate to the percent of housing units in each of the eight reservation political districts, so that variations and conditions within a given district could be compared and contrasted to the conditions for the reservation as a whole (Bernard, 2006, pp. 154–155).

Each randomly selected household was approached in person and the residents were asked to respond to a standard form questionnaire eliciting a mixture of qualitative and quantitative responses. New questions were added each year in response to suggestions and concerns offered by Lakota households and organizations. For example, while the initial survey did not address health issues directly, this area of inquiry was added and expanded after Lakota people expressed the enormity of the burden of poor health on households and the tremendous loss to the community from premature deaths and disabilities. The longitudinal aspect of this study helped enhance the accuracy of the data because each follow-up interview was devoted in part to confirming information from prior years concerning household membership, income, and expenses. Trust and familiarity also developed over the years with the residents of the participant households in the process of conducting follow-up interviews each year.

3. THE HEALTH OF THE ECONOMY AND THE ECONOMICS OF HEALTH ON THE RESERVATION

Pine Ridge has presented a special challenge to economic development. The reservation is an area of persistent poverty, ranking in the top five counties for the highest rates of poverty over the last 30 years (Pickering et al., 2006). It suffers from persistently high levels of unemployment, well in excess of those experienced across the U.S. during The Great Depression. The largest source of employment is a combination of federal, state, and tribal government jobs. There is virtually no private sector. With one or two exceptions, no local business employs more than 20 people, with a more likely number of two or three employees outside of immediate family members. In all total, there are no more than 50 small businesses on the reservation. There are virtually no banking services on the reservation, an

area the size of Connecticut, and only one bank operates a mobile banking unit that drives to the reservation to provide certain banking services on a weekly basis (Adamson, 1997). Furthermore, household economic composition is dynamic, as members shift fluidly from wage work, often sporadic and temporary, to other forms of productive activity, such as subsistence hunting, gathering, or home-based enterprise, and government programs. Most households participate in a dynamic mixture of temporary or part-time wage work, microenterprise for cash sales, and intra-community gifts and barter of goods and services (Sherman, 1988; Pickering, 2000). A good deal of wage and microenterprise activity is undertaken to meet a specific cash need, and therefore tends to be short term and sporadic. Social networks also work to redistribute goods, food, and cash through ceremonial and community events (Pickering, 2004). Otherwise, household income supplements include retirement pensions, Social Security and Supplemental Security Income (SSI) benefits, Food Stamps or Commodities, and Temporary Assistance to Needy Families (TANF) (Pickering, 2000; Pickering et al., 2006).

Household composition is dynamic and fluid, with the concept of family comprising many different relationships and individuals. The boundary between extended and immediate families is obscured by the fluidity and size of household composition, as well as the close interaction that family members have on a daily basis. Families living under the same roof are often multigenerational, including grandparents, aunts, uncles, cousins, nieces, nephews, as well as parents and siblings. Family members may help raise children from their extended family for short or long periods of time depending on the situation and the needs of the people involved. Finally, adult family members may come and go. As individuals fluidly enter and exit the households because of work, education, or interpersonal relationships, they bring with them different skill sets and abilities to promote a diversified livelihood strategy which draws upon all individuals within the household. Understanding the economy on Pine Ridge through the lens of household dynamics provides insights into how market exchange, redistribution, reciprocity, and householding are all drawn upon and integrated into everyday life, especially in relation to the health needs of the Lakota.

Ill health greatly influences the ability of individuals to keep their employment. As the Lakota emphasize respect and responsibility to their family and loved ones, and appreciate the tenuous nature of purely market exchange in comparison to more socially embedded forms of economic life, social relationships become more important than wage labor employment. Therefore, if a family member becomes ill, it is most likely that one of their

loved ones will reduce their other responsibilities and obligations to become a caregiver. The prohibitive costs associated with long-term, institutional forms of health care also weigh in favor of intra-family caregiving.

Like the larger American Indian population, the Lakota people of Pine Ridge are faced with some of the worst health disparities in the U.S., including extremely low life expectancies. Many households are affected by chronic ill health such as heart disease, diabetes, cancer, alcoholism, chronic respiratory illness, weight problems, automobile accidents, and other accidents and injuries (Associated Press, 2007). Although the health of American Indians has improved since 1955 and infectious disease rates have gone down, in part by the creation of the Indian Health Service (IHS), chronic illnesses, such as diabetes, heart disease, and cancer, have skyrocketed (Bergman, Grossman, & Erdrich, 1999, p. 571; Dixon & Roubideaux, 2001, p. xx; Sandefur, Rindfuss, & Cohen, 1996, pp. 9–10; Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004, p. 53). As the Lakota on Pine Ridge are one of the poorest nations in the U.S., their socioeconomic status prevents Lakota people from purchasing health insurance plans or affording out of pocket health expenses. Even basic needs that could be considered aspects of preventative health care, such as healthy foods, clean housing, running water, heat, and electricity, are often difficult to consistently obtain. Additionally, access to health care services is geographically, logistically, and economically difficult.

Because of the peripheral position of Pine Ridge to the market economy, most adults have some wage work experience, but that experience either is part-time, temporary, or seasonal work that does not provide health care benefits, or is from periods of time spent away from the reservation and does not extend health care after returning to the reservation. As a result, only 7% of households reported having medical insurance coverage. The IHS is required by law to provide health care for tribal members, derived from treaty rights established under the Fort Laramie Treaty of 1868 whereby the U.S. government pledged to provide food support, education, and health care for the Lakota in exchange for large land cessions from the Lakota. U.S. federal court decisions have determined, however, that while the U.S. government has the obligation to provide health care to tribal members, it is not required to provide adequate health care. Consequently, the health care provided through this delivery system is avowedly inadequate, under-funded, and focused on triage rather than preventative care. Lakota households express the perspective that this inadequate health care is the product of institutional discrimination, and that ethnicity is a risk factor in disease incidence, treatment, and outcomes for Native Americans.

These factors therefore increase the reliance of the Lakota on the limited and often inadequate health care provided by the IHS. The IHS is a public health facility that provides health care delivery to reservations like Pine Ridge. Historically, IHS was founded through the federal Indian trust relationship to raise the health status of American Indians and Alaska Natives, and still today the relationship and obligation of the federal government remains in place. Currently, it is estimated that IHS is operating with less than 60% of the funding it needs (U.S. Commission on Civil Rights, 2003, p. 43). In 2005, IHS spent approximately $2,100 per person per year for health care, in contrast to the estimated expenditures for the average American of $5,298, a difference of more than $3,000 per person per year (Indian Health Service, 2005a). This under-funding of IHS results in the provision of universal but rationed health care to tribally enrolled members (Joe, 2003, p. 532). Within IHS hospitals and clinics, almost two-thirds of the biomedical care needed cannot be provided within the facilities.

4. THE DYNAMICS OF POVERTY ON PINE RIDGE: MARGINALIZED BY AND SUBSIDIZING THE MARKET

4.1. Fluid Economic Integration

While the market has been a component of reservation economy for a century, it is difficult to argue that it is the dominant form of economic integration for most Lakota households. Householding, reciprocity, and redistribution continue to represent significant arenas of economic life on Pine Ridge. Based on our data, only 35% of the Lakota population on Pine Ridge over age 16 is employed, while nearly 43% are unemployed (see Table 1).

In contrast, exchanges that would be characteristic of reciprocal, redistributive, and householding or self-provisioning modes of integration are prevalent across Lakota households. For example, 78% of households continue to eat wild resources, such as deer meat, antelope, berries, and wild turnips. Often these wild resources are gathered and consumed directly by the household. Even if no member of a household hunts, fishes or gathers, wild game and plants may still be important to the household and be provided by an extended family member that is a part of the householding network. Wild resources are also part of a larger amount of food that is

Table 1. Employment Status for Individuals Living on Pine Ridge Over Age 16, Comparing Results with U.S. Census Figures.

N=655	Total Employed (%)	Full-Time (%)	Part-Time (%)	Total Not Working (%)	Over 63 (%)	Disabled (%)	Full-Time Student (%)	Select Not to be in the Labor Force (%)	Unemployed (Looking or Discouraged) (%)
Pickering study (2005)	35.42	30.23	5.19	64.58	7.95	4.28	3.21	6.4	42.74
2004 US Census	34.3				5.0	24.9		Not in the Labor force 48.8	16.9

shared between different households of extended families, or distributed by a central member of the tiyospaye or large extended family through ceremonies, public dinners, and gifts. A tiyospaye, composed of many subgroups of immediate families, will host a giveaway or public meal, and family members connected to the tiyospaye will donate material items and food, so that the entire community can receive the goods. These social events always include a meal, which the family who is hosting the event provides, and those attending the event usually bring containers to take food home. At these events there is food that would be considered traditional by most Lakota, like wojape (a chokecherry pudding) or buffalo stew, and non-traditional food such as fried chicken, macaroni salad, and ham. Instead of monetizing the amount of goods it takes to host a social event, usually individuals discuss it in the amount of time. For example, individuals generally estimate that it takes about two years to accumulate the supplies to host a giveaway (Pickering, 2000, pp. 57–58). These social events redistribute an incredible amount of food and goods throughout the community.

Microenterprise is another economic activity that cuts across several modes of integration. Examples of different types of microenterprises include carpentry services, babysitting, car repair, rummage sales, and Lakota traditional goods such as beadwork, star quilts, the production of Indian dancing outfits, or food items such as Indian tacos and fry bread. Although these different microenterprises may appear at first to be driven toward cash exchange, on the Reservation, they are often not. Services, goods, and food are commonly traded or provided in reciprocity. Additionally, people on the Reservation may allow trade or reciprocity with certain community members or family members while expecting cash payments from others. Furthermore, when there is a cash exchange for these goods, prices may be differentially set according to who is purchasing the good. For example, those providing the service or good will sometimes ask how much the purchaser can afford to pay, or set the price according to how much they assume the person can pay based on their perceived socio-economic status (Pickering, 2000, p. 55). Therefore, the individuals involved and the context define the mode of integration for microenterprise activities.

Furthermore, household economic composition is dynamic, as members shift fluidly from wage work, often sporadic and temporary, to other forms of productive work, such as subsistence hunting, gathering, or home-based enterprise, and government programs. The Lakota economy relies on social networks that include participants in cash income generation, although the particular individuals with cash access change constantly. Of the participant

Table 2. Percent of Households that Receive Various Types of Income.

Type of Income Source	Percentage of Homes from Sample with At Least One Member of Their Household Receiving Income from the Specified Source (%)
Wage work	49.6
Home-based enterprise	50.6
SSI	24.2
TANF/GA	22.1
Social security, VA, or any other pension	29.6
Unemployment	3.3
Food stamps	40.8

households, 49.5% had some wage income among the household members (see Table 2). However, this does not imply that these households have stable access to wage income. For example, of those households who had wage income in 2004, 25% of them did not have wage income in 2003. Similarly, of those households who had wage income in 2003, 12% of them did not have wage income in 2004. In total, that means 37% of households had a change related to access to wage income in the household in only a two-year period. Only 23% of households never had wages over the last four years. Furthermore, while 23% of households had only wage income between 2003 and 2004, 61% of households had 2 or more sources of income, reducing the risk associated with the loss of any one source of income.

These dynamics are consistent across all the potential sources of income for households. The only constant is change. There is no guarantee of security for anyone in this extremely peripheral economic margin. As a result, programs or policies based on stable households with stable access to resources are completely irrelevant. These dynamics must be the foundation of any health care or development planning.

4.2. Households, Ill Health and Poverty

Unfortunately, the prevalence of chronic poor health conditions has a negative impact on the economic productivity of households in Pine Ridge. Individuals regularly report acute and chronic health care concerns, such as

diabetes, cancer, heart disease, and physical injuries. When asked "how do you rate your overall health," nearly 40% responded fair or poor.

By looking at health problems on a household, rather than individual, basis, it becomes apparent that health problems are a drain on limited household resources. The illness of a household member demands dedication of some or all of the time allocation and financial resources of the household to the care of members with chronic, life-threatening disabilities. For example, 40% of the households had at least one person in the household with diabetes, and 10% had a least one person in the household with cancer.

When ill health decreases one's ability to engage in activities, other activities, family members, and modes of integration must accommodate this loss. Without this flexibility and expansive amount of economic diversity, the ill health of one individual could be devastating. However, it is important to understand that these economic shifts are not always easy for households to endure. A family member becoming ill can create large amounts of stress, anxiety, and difficulty making ends meet. For example, one participant lives on $601 of Food Stamps each month, which feeds her and her four children, and presently has no other form of income because she and her infant are ill. When she received a health care bill from the Mayo clinic of $107,000, no amount of shifting between activities and modes of integration would have been enough to cover the expense.

4.3. Wage Labor and Health Care Access: Subsidizing Employers

In a context of prevalent and severe health problems, access to quality health care delivery systems would seem essential. However, access to adequate health care is limited to those households with a member engaged in long-term, permanent wage work. Because of the peripheral position of Pine Ridge to the market economy, however, the number of permanent wage labor jobs is extremely limited.

A full 92% of adults on Pine Ridge report having some wage work experience. However, the vast majority of the wage work individuals have had is part-time, temporary, or seasonal jobs that are not eligible for benefits such as health care insurance. For example, one participant works a seasonal job at Cedar Pass Lodge, a private concession facility for tourists in the North unit of Badlands National Park, and pays payroll taxes for four months a year. This is not long enough to become covered by the concession company's health care plan, even though she works there seasonally year

after year. Therefore, the full cost of her labor contribution to the market system is not born by her employer. Another major category of wage work experience comes from short or longer periods of time living away from the reservation. Even if health care benefits were a part of the off-reservation work, that job and therefore that health care coverage terminates when the worker returns to the reservation.

As a result, despite the fact that 92% contributed their labor as a commodity through some wage work history, only 7% of households reported currently having private medical insurance. This figure highlights the extreme peripheral position of Pine Ridge in relation to the market economy. While only 28% of American Indians nationally have health insurance, with 55% relying solely on the IHS for their health needs (U.S. Commission on Civil Rights, 2003, p. 35), this percentage seems large in comparison to the health insurance access on Pine Ridge. More than 90% of the Lakota households on Pine Ridge responded that the IHS represented their only access to health care, with a few also reporting eligibility for Medicaid or Medicare coverage, or access to Veterans Administration health facilities.

The IHS hospital on the reservation provides care free of charge to tribally enrolled members, but the care provided is avowedly inadequate. The inability of the IHS to provide adequate care largely stems from the lack of funding allocated by the federal government to the IHS. The IHS hospital on Pine Ridge, a 46 bed facility that is staffed by 16 physicians to provide 24-hour medical, obstetrical, pediatric, surgical, and dental services, provides services to more than 28,000 tribal members living within the reservation boundaries, and another 15,000 members living in border towns or regional cities who come to Pine Ridge for health services. There are also four satellite clinics, which are open to see patients once a week in a village, and two health centers on the reservation (Indian Health Service, 2005a).

Although the hospital and the clinics are available locally, they do not have the ability to provide all the services needed by the population. IHS does have some limited Contract Health Services (CHS) funding to refer patients to contract care providers with the facilities or specialized training to handle conditions beyond the capacity of IHS. For example, victims of serious physical traumas, such as car accidents, in need of emergency care must be flown 120 miles away to Rapid City Regional hospital for treatment. The local IHS hospital is also strained by the increasing demands from chronic illnesses such as diabetes, chronic heart disease, or cancer, and ends up referring many of these patients to Rapid City Regional as well. IHS, therefore, directly subsidizes health care services through contracts

with private providers, particularly for specialized services and other services not available in IHS direct care facilities (Cunningham, 1996, p. 289).

However, because IHS is severely under-funded, funds for CHS are not always available. Often patients are denied the services they desperately need. Nationally, the denial rates of CHS have drastically increased over the last 10 years, so that 23,368 American Indian patients were denied contract services in 2004 (Indian Health Service, 2005b). Even those who have been sent out from IHS to a different hospital or service provider off the Reservation may still receive a bill if CHS denies payment. For example, a Lakota man in his forties went to IHS twice complaining about the pain in his foot. Each time he went in for an examination, they told him that it was a sprain and they sent him home with aspirin. It turned out that he had a broken bone in his foot, not just a sprain, and it had become infected, thus needing to be amputated. IHS referred him to Rapid City Regional to have the amputation because the Pine Ridge IHS could not perform the surgery. Afterwards, he was billed $40,000 even though CHS had approved his surgery. Stories like this are not uncommon. Our research found that 27% of households have been denied CHS care. Those who have had care provided to them from other hospitals have often come home to find bills they did not expect.

Lakota people who receive care at IHS clinics and hospitals voice their concerns about the treatment they receive. People express at least annoyance, and often anger, fear, and resentment stemming from negative experiences at IHS. Although it is most often individuals who experience negative interactions or situations, individuals share those occurrences with their family and friends. These individual accounts then become shared collective community memories and beliefs, which reinforce the perceived inadequacies of IHS. For example, one participant went into the IHS hospital after injuring her knee. She waited in the emergency room lobby for three hours, watching two people die, one an elderly woman and the other a young man bleeding from a gun shot wound. She finally left the hospital without having her injury treated. She continues to tell friends and family her story, and vows she will never go to the IHS hospital again. Another participant stated, "I do not go to the IHS anymore, not since my sister almost died there." Horrific experiences are shared with friends and family and, in turn, a loss of faith in the health care delivery system is amplified throughout the community.

Our research indicates a strong presence of perceptions of racial and ethnic discrimination in the health care delivery system. When the

Table 3. Lakota Perceptions of Discrimination at IHS.

A	B	C	D	E	F	G	Scale	Responses
17.19%	20.34%	11.96%	7.10%	6.32%	17.03%	23.12%	5	Strongly disagree
47.40%	44.63%	43.48%	29.51%	17.89%	41.21%	40.32%	4	Disagree
10.94%	14.69%	13.59%	15.85%	11.58%	6.59%	5.91%	3	Neutral
15.63%	11.30%	16.30%	31.15%	36.32%	26.92%	22.58%	2	Agree
8.85%	9.04%	14.67%	16.39%	27.89%	8.24%	8.06%	1	Strongly agree
1	1	1	1	1	1	1	Total	

A: I experience discrimination when I go to IHS facilities.
B: I experience discrimination when I go to Contract Health Facilities.
C: My access to diagnostic technologies and therapies has been limited because I am Indian.
D: Racial/ethnic discrimination is a risk factor in disease incidence, treatment, and outcomes for Native Americans.
E: Institutional Racism is prevalent in health care delivery systems or policies toward Native Americans.
F: I have trouble communicating with the IHS doctors and staff who are not Native Americans.
G: It is difficult to always follow doctor's orders.

affirmative responses of agree and strongly disagree are combined, nearly a quarter of the respondents agreed with the statement "I experience discrimination when I go to IHS facilities" (see Table 3). Nearly, a third of the respondents felt that "My access to diagnostic technologies and therapies have been limited because I am Indian," and nearly half agreed that "Racial/ethnic discrimination is a risk factor in disease incidence, treatment, and outcomes for Native Americans." Finally, an incredible 64% agreed that "Institutional Racism is prevalent in health care delivery systems or policies toward Native Americans." These perceptions and experiences of racism further undercut the quality of health care received through IHS.

4.4. The Tribe and Households Pick Up the Slack

Given that reservation health care access overall is inadequate, Lakota households end up providing for the health care needs of family members. Wage workers who are not currently employed have no access to the market-based health care delivery system. It is the family members of the ill person providing care for them at home, and not in hospitals or nursing

homes, who bear the brunt of providing care, not the system itself. For example, one-fifth of the household participants reported personal or family health conditions as the reason why their last job ended. In addition, 42% reported having to quit work for family reasons. Not only do they lose the opportunity to apply their labor to other economic pursuits, either within market exchange or some other aspect of the reservation economy, but also the labor they contribute in health care services for their family member is not compensated by the market interests which initially consumed that ill person's labor. As a result, individuals who are already marginalized by the global market economy end up subsidizing the system.

Some support is provided by the Oglala Sioux Tribe for health care. Revenues from a modest casino operation are distributed through the local districts to help families with transportation costs to visit relatives who are hospitalized. The Community Health Representatives (CHRs) for each district will give patients a ride to the hospital or clinic for doctor appointments or to pick up medications, and will visit the homes of people with chronic conditions like cancer or advanced diabetes. The Tribe's Oyate Blihelya program conducts diabetes screenings for household members through door-to-door campaigns across the reservation and for children through the school system. These programs have the potential of supporting alternative health care delivery systems that are decentralized, household-based, and flexible to meet the lived social context of individuals with chronic illnesses.

4.5. Community Solutions to Poor Health Care

When designing and implementing health care programs, community ideas, perspectives, culture, and the dynamics of the economy all affect whether a health care program is appropriate and effective. Involving the ideas and perspectives of community members in both the creation and the evaluation of health care programs integrates the abstract theories of health care delivery with the collective practice of accessing that health care system. For example, Potvin, Cargo, McComber, Delormier, and Macaulay (2003) discuss a diabetes intervention and research project in the Kahnawake schools in Canada that focused on community partnership. The concept of having the community as an equal partner helped to ensure that the community's interests were being addressed and that the intervention aspects of the project were culturally appropriate and community driven. This research followed the philosophy emphasized by the World Health

Organization, that health promotion and health programs should incorporate community participation in both decision making and action processes, so that the community can define what the results of health programs should be, and how the program should operate (World Health Organization, 2002, p. 1).

Through a community-based approach, the perspectives of community members are integral to the development of a health care delivery system. On Pine Ridge, individual experiences with IHS hospitals and clinics have become collective memories and beliefs about the inadequate, dangerous, and discriminatory services provided at these facilities, rendering the facilities themselves ineffective in improving health for this community. Similar findings were made in research on the interpretations of local Pima women about what it means to be at risk for diabetes. Pima women interpreted the risk of diabetes from large "collective banks of memory and experience that may or may not support biomedical accounts of disease" (Smith-Morris, 2005, p. 160). Arguably, abstract ideas of what it means to have a borderline diagnosis, contradicting the idea that either you have diabetes or you don't, become even more complicated when the collective memories and experiences of the community describe diabetes as physically destructive and irreversible. Without taking local perceptions into account, diabetes programs directed at educating individuals about their borderline diagnosis were destined to fail. Community experience, perspectives, culture, and economics all need to be incorporated to inform the development, implementation, and evaluation of successful health care programs.

Another tension in the design of health care programs exists between population health statistics and the political, economic, historical, and cultural context of that population. For example, a majority of the diseases on the reservation, such as diabetes, are increasing now not only among American Indians but also for other marginalized populations around the globe. The concept of what it means to be at risk, or an at risk population, goes beyond the choices of individuals within that population, and implicates structural conditions of poverty, oppression, and socioeconomic displacement. As Rock argues, political, economic, cultural, and historic forces contribute to mental health issues, like stress, duress, and social suffering from marginalization, that compound ill health among native peoples (Rock, 2003; see Gravlee, Dressler, & Bernard, 2005). Individuals and their health status cannot be separated from their collective marginalization. Without health programs that resonate with local perceptions, beliefs, and knowledge, poor health will continue to increase (Rock, 2003, p. 173).

The integration of community perspectives into health care delivery systems is still controversial, however. In a recent review of a proposal to National Institutes of Health (NIH) whose "objective is to solicit ideas from Native Americans themselves regarding ways of changing the IHS to reduce perceptions and experiences of racism," a reviewer asserted that "Improving health care systems requires economic and personnel resources as well as a tremendous amount of highly specialized technical knowledge. Native American users of the IHS are unlikely to have practical, workable ideas that can be easily or feasibly implemented" (Summary Statement for Application No. 1R03CA 129901-01, 3/08/2007). From the point of view of this reviewer, the biomedical model of health care delivery can remain oblivious to the devastating critiques of collective memory and experience, and nevertheless will be able to improve the health of people who believe these facilities are places where you go to die.

Alternatively, if the biomedical model were to bend to the realities of reservation economic life, households might be supported in the strategies they engage in to navigate the current health care system. For example, IHS funds could be allocated to households as home health care providers. With expanded reliance on tribal programs like the CHRs and Oyate Blihelya, specialized medical services and professional monitoring could be brought into households, not only reducing the costs of transportation needed to bring patients and their families into centralized hospital facilities, but also reducing the operating costs of those facilities as well. State TANF programs could recognize home health care as a qualifying work activity so that the care provider would be eligible for welfare benefits. Federal Earned Income Tax Credits could be extended to individuals providing home health care to family members as a form of home-based enterprise. Through each of these initiatives, not only would the true economic contributions of home health care providers be recognized, but also the quality and consistency of both preventative and acute health care would improve.

5. CONCLUSION

We conclude that health care access is an economic development issue, and that viewing households solely through the lens of the market economy occludes not only the full extent of their economic activities, but also the ways in which market-based health care delivery systems result in the accumulation of substantial resources from households in poverty to the private sector. As Pine Ridge faces devastating ill health, it is important

to understand not only how ill health affects the economy on the reservation, but also how the economy affects ill health. Four key factors highlight the relationship between economics and health for Pine Ridge residents.

First, the market is not the dominant form of economic integration for most Lakota households. As Polanyi theorized, social relationships encompass and define economic practice. The myth of market individualism is thinly veiled in the deep economic periphery of Pine Ridge (Mingione, 1994). Rather, social relationships define the dynamic adaptations of Lakota households to all aspects of economic life. Householding, reciprocity, and redistribution continue to represent significant arenas of economic life on Pine Ridge.

Second, the prevalence of chronic poor health conditions has a negative impact on the economic productivity of households. An ill family member reduces the number of wage workers in the household, as is true in mainstream society. However, since the market system is relatively weak on the reservation, it becomes apparent that individuals who are ill not only lose potential market productivity, but also lose productivity within redistributive and reciprocal economic activities and reduce their ability to participate in and contribute to the householding economic patterns of the household. Furthermore, as kinship responsibilities are important to the Lakota, family members will reduce their economic productivity to help care for the ill family member. Subsistence, barter, and other non-market activities of the household are impeded as other household members must reallocate their labor and resources toward the health care needs of their ill family member. Therefore, other individuals and other modes of integration within the household economy must act as safety nets and pick up the slack.

Third, access to adequate health care is limited to the small percentage of households with a member engaged in long-term, permanent wage work. Most households must rely on limited access to grossly under-funded services from the IHS. With the increasing prevalence of chronic illness, the future economic prospect for the reservation looks dim without interventions that improve the health status of the Lakota, which in part requires the ability to utilize quality health care.

Finally, employers who use Lakota labor on a short-term, part-time, or regional basis do not bear the health care costs of these workers. These employers, therefore, are subsidized by Lakota households who must divert their limited resources to the health care needs of family members. Viewing households solely through the lens of the market economy occludes not only the full extent of the economic activities of Lakota households, but also the ways in which households in poverty must expend their limited resources to provide health care shirked by the private sector.

When analyzing the economy and developing health intervention programs, ideological pitfalls of perceiving health and economics solely in the realm of the market economy may blind us to the real practices of communities with other dominant modes of integration. As this case study of the Pine Ridge Indian Reservation reveals, increasing the health status of marginalized peoples is a crucial step in any approach to economic development, but health programs should focus their attention on economic activities and modes of integration other than the market economy. Although we cannot remove biomedicine from the market economy, we can redirect its focus and funds to support the actual providers of health care operating outside of the formal market economy.

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