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Choctaw Health Center Mississippi Band of Choctaw Indians

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In the 1960s, members of the Mississippi Band of Choctaw subsisted in miserable economic and health conditions. Nearly all tribal housing was substandard (90 percent of tribal members lived in units with no plumbing and 30 percent had no electricity), life expectancy was less than 50 years of age, and the Tribe's infant mortality rate was among the highest in the United States.

At that time, the Indian Health Services (IHS) was the primary provider of reservation health care services and spent approximately \$1,000 per tribal member per year on physical, mental, and dental health care. But by the early 1970s, the Choctaw tribal government determined that it would be better for the Tribe to work on its own to find solutions to its citizens' health problems. Over the next decade, the Tribe worked consistently to contract with the IHS to take over management control of reservation health programs. It obtained IHS funds to build a new hospital (the 58,800 square foot Choctaw Health Center in Philadelphia, MS opened in 1975) and had contracted all of the IHS's public health programs, some critical support services, and a few direct medical care activities. Still, it was not until the mid-1980s that the Tribe was able to take over the management of all health services: On January 1, 1984, the Mississippi Band of Choctaw became one of the first Indian nations to assume responsibility for the management of a complete tribal health care system.

Despite this high degree of management control, health conditions among the Choctaw had improved only marginally since the 1960s. Health system managers pointed to funding as one of their main problems. For example, even though the Tribe had contracted for control of the hospital, IHS funding covered only 38 percent of the community's established need. At a deeper level, the problem lay in the stipulations of Public Law 93-638, the act that allows tribes to contract with the federal government to take over management of service programs. Under the law, an existing program's budget defines the parameters of a "638" contract. This restriction made it difficult for the Choctaw to create new programs and to move funds between programs in response to need or according to tribal priorities – and left many vital programs underfunded.

Therefore, in 1994, the Tribe took the final step in breaking away from the restraints of federal government control: It entered into a self-governance compact for all health care services and funds designated for the Choctaw. Essentially, self-governance compacts are block grants to tribes. They transfer all of the federal government's budget in a particular service area to a tribe without stipulating the specific programs in which the money must be used. Under a compact, a tribe can set its own priorities, develop its own programs, and create a truly

indigenous system of service provision. Ideally, compacts free Indian nations' program planners from thinking in the same boxes that federal program developers do. While there are drawbacks to compacts (in particular, the negotiation phase can be more difficult), the Choctaw felt that having tried self-management, self-governance of health care would be an even better option.

Indeed, the Choctaw's five years of self-governance over health care have built successfully on the previous two decades of self-management. Since compacting, the Tribe has achieved tremendous strides against the health problems that have plagued community members, and it has put in place a health system specifically designed to meet members' needs. For example, the Choctaw Health Center's programs have helped to improve the Tribe's immunization rate for children (from 70 percent in 1990 to 95 percent in 1999) and to increase the average life span for tribal citizens (which reach 68 years in 1999). With seven full time physicians and over 240 employees, the Health Center's services now include a 18-bed inpatient acute care unit, a 24-hour emergency medical services department, outpatient and dental clinics, a mental health center, a diabetes clinic, a disability clinic, a women's wellness center, and a variety of preventative programs.

In addition to these improved and expanded service offerings, the Tribe has implemented an efficient billing and records system and reduced the red tape typically associated with third party billing.

The Mississippi Band of Choctaw's methodical take over of federally funded health care programs and its systematic development of the Choctaw Health Center are a model of the opportunities presented by the U.S. government's self-determination and self-governance legislation. Today, the Tribe – not the Indian Health Service or other federal agencies – “calls the shots” in its health care delivery system. The Tribe hires the providers it chooses. It contracts with off-reservation providers for specialized care. Choctaw children are born in state-of-the-art local facilities instead of low-income patient wards in urban hospitals, and the Tribe has developed many other preventative and direct-care health programs that are specifically suited to member needs. Because the Mississippi Band of Choctaw Indians sets its own priorities in health care, it has been able to significantly improve health conditions among its citizens – a remarkable example of the effective exercise of sovereignty.

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