

Most states and jurisdictions have numerous ethnic minorities and racial minorities. Notably, American Indian/Alaska Natives are also political minorities that have a specific legal status. The federal government recognizes 566 tribes, ranging from large nations in the contiguous states to remote villages located in rural Alaska.¹ All together, there are 5.2 million American Indian/Alaska Natives living in this country.² In the 2011 ASTHO profile of state and territorial health agencies, 36 out of 51 states (70%) reported that they were working with American Indian/Alaska Native populations. Of those states, 35 had a primary contact person that works on minority health, health disparities, and health equity issues and 32 had an organizational unit that has primary responsibility on all minority health issues.³

Through treaty rights, statutes, executive orders, presidential memoranda, court decisions, and the Constitution of the United States, the federal government recognizes tribes as sovereign nations. This unique **government-to-government relationship** affords the tribes the ability to deal directly with the federal government.⁴ This identity as sovereign nations has its origins in the beginning of our country, as specifically identified in the Constitution.

The Indian Commerce Clause

“The Congress shall have power to regulate commerce with foreign nations, and among the several states and with Indian Tribes.” — *United States Constitution, Article I, Section 8, Clause 3*

Treaties and Laws

Since the formation of the United States, hundreds of treaties have been signed between the federal government and tribes, and a number of laws related to American Indian/Alaska Native populations have been established. Some of the most important health related federal laws from the last 100 years include:

- The Snyder Act (1921), which states that American Indian/Alaska Native health services are not an entitlement.
- The Indian Reorganization Act (1934), which established population definitions. This was informed by the Merriam Report (1928).

¹ “Indian Entities Registered and Eligible to Receive Services from the United States Bureau of Indian Affairs.” *Federal Register* 75:190 (Oct. 1, 2010), pp. 60810-60814.

² U.S. Census Data, American Indian and Alaska Native, American Community Survey. Available at www.census.gov/acs/www/about_the_survey/resources/aian.php. Accessed Aug. 20, 2012.

³ *ASTHO Profile of State Public Health, Volume 2*. Washington, DC: ASTHO, 2011.

⁴ U.S. Dept of Health and Human Services 12th Annual National HHS Tribal Budget & Policy Consultation Session, March 4-5, 2010. Available at www.nihb.org/docs/04122010/DHHS%20Tribal%20Consultation%20Testimony_NIHB_3.2010.pdf. Accessed Aug. 20, 2012.

- The Transfer Act (1955), which established the Indian Health Service (IHS) as part of the United States Public Health Service (USPHS), transferring responsibility for Indian health from the Bureau of Indian Affairs (BIA) to the Department of Health, Education, and Welfare (now the Department of Health and Human Services).
- The Indian Self-Determination and Education Assistance Act (1975), which states that any Indian tribal government can, on request, take over the operation of any BIA or IHS function.
- The Indian Health Care Improvement Act (1976), the key legal authority for the provision of health care to American Indians and Alaska Natives.
- The Patient Protection and Affordable Care Act (2010), which includes a permanent reauthorization of the Indian Health Care Improvement Act.

Building Trust

“It’s so important to me that there are strong relationships between our agency and reservations in Montana. The best example I can provide is our work with our Healthy Montana Kids (HMK) program, which provides low-cost or free health coverage for children. We initially began with developing and improving our relationships, explaining why it benefits Indian children to be enrolled in HMK. We had to gain that trust and relationship with our Indian counterparts. That work then carried over into the entire public health system, improving immunization rates and increasing participation in WIC.” —**Anna Whiting Sorrell, MPA**, Director, Montana Department of Public Health and Human Services and Enrolled Member of the Confederated Salish and Kootenai Tribes

The ongoing need for legislation in recognition of the autonomy of the American Indian/Alaska Native population points to the sensitivities between states/territories and tribes. It is important to recognize that tribal entities are independent sovereign nations and should be identified as both a political minority and a racial minority. They exist within state jurisdictions against a significant historical and political backdrop. They are both citizens of their tribe and citizens of United States, with the full rights and responsibilities of any citizen. Tribes are separate governmental entities and are as underfunded as the jurisdictions in which they exist, often with few revenue streams. Sometimes funding to improve American Indians/Alaska Natives’ health goes directly to states, and other times it goes to tribes. Most importantly, data on the poor health outcomes of American Indians/Alaska Natives may be used to secure funding without any reassurance that such funding will directly impact American Indian/Alaska Native health.

- evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;
- assist Indian tribes, tribal organizations, and urban Indian organizations in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;
- make recommendations for the targeting of services needed by the populations served;
- make recommendations to improve health care delivery systems for Indians and urban Indians;
- provide requested technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community;
- provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian communities to promote public health.” (source: <http://www.law.cornell.edu/uscode/text/25/1621m>)

Q: Why TECs?

A: American Indians/Alaska Natives (AI/AN) have a unique historic and legal relationship with the US federal government that entitles certain AI/ANs to health benefits unlike other US citizens. Federally recognized Tribes have a government-to-government relationship with the US. This unique relationship has been given substance through numerous Supreme Court decisions, treaties, legislation, and Executive Orders. The provision of health services grew out of this government-to-government relationship. The federal trust responsibility was transferred to the Indian Health Service (IHS) in 1955. This responsibility includes the provision of medical care and maintenance of public health functions.



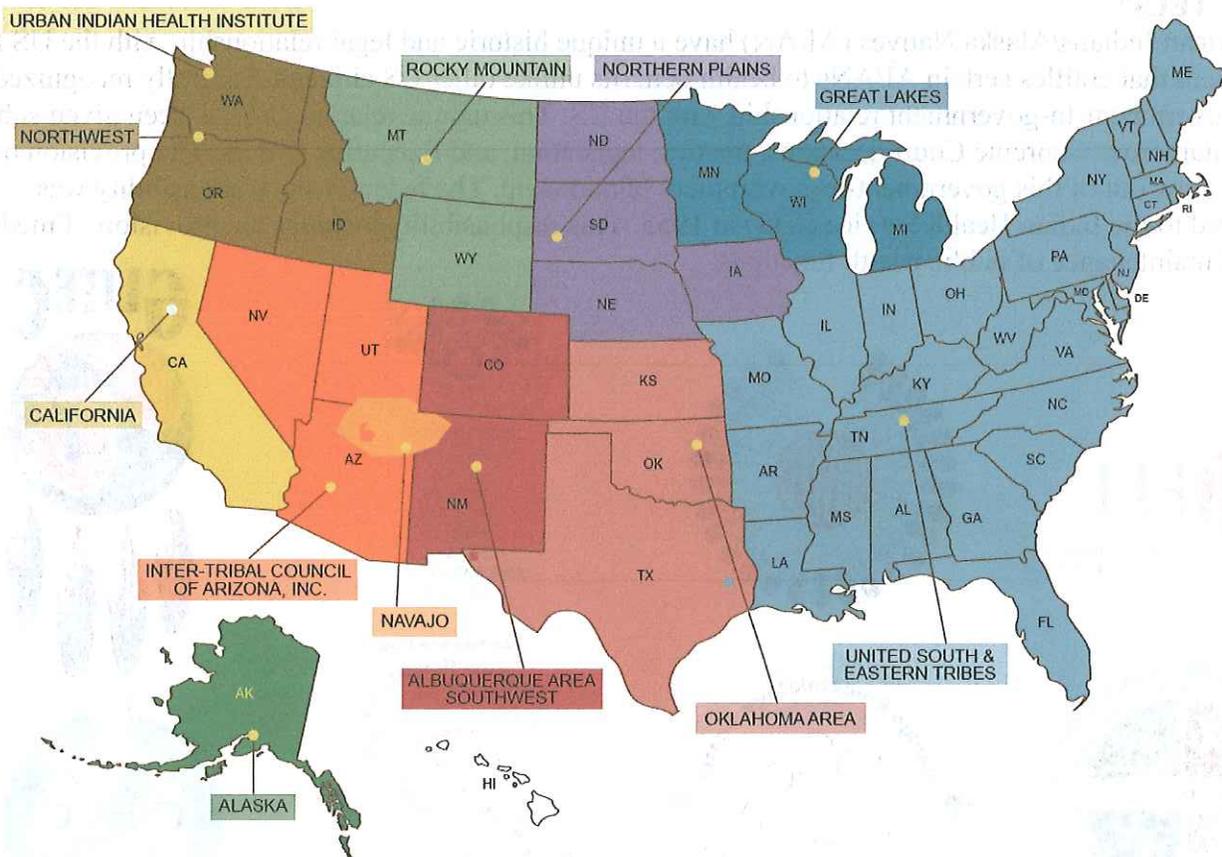
Tribal Epidemiology Centers FAQs

Q: What are Tribal Epidemiology Centers (TECs)?

A: "Tribal Epidemiology Centers are Indian Health Service, division funded organizations who serve American Indian/Alaska Native Tribal and urban communities by managing public health information systems, investigating diseases of concern, managing disease prevention and control programs, responding to public health emergencies, and coordinating these activities with other public health authorities."

(Source: http://www.ihs.gov/Epi/index.cfm?module=epi_tec_main)

There are 12 TECs in the United States. Each TEC is designated to serve the federally recognized Tribes within one of the 12 Indian Health Service (IHS) administrative areas, although one TEC serves two IHS areas and another TEC serves UIHOs throughout the nation. (See map below) TECs are located at Tribes or Tribal organizations which are authorized under the Indian Self Determination Act to act on behalf of AI/AN Tribes.



Q: What authority do TECs have?

A: TECs have the authority to conduct public health activities on behalf of AI/AN Tribes and people. TECs are expressly designated as public health authorities. TECs add one more layer to the United States public health infrastructure: Federal, state, local... And now Tribal!

Q: What do TECs do?

A: "Functions of TECs: In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area—

- collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian tribes, tribal organizations, and urban Indian organizations in the Service area;

TRIBAL EPIDEMIOLOGY CENTERS

