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Health Engagement Challenges and Strategic Perspectives for the 2023 Health Financing Transition in the Federated States of Micronesia and the Republic of the Marshall Islands

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Health Engagement Challenges and Strategic Perspectives for the 2023 Health Financing Transition in the Federated States of Micronesia and the Republic of the Marshall Islands

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Abbreviations

AI/AN: American Indian/Alaska Native

COFA: Compacts of Free Association

CNMI: Commonwealth of the Northern Mariana Islands

DOI/OIA: Department of the Interior's Office of Insular Affairs

FAS: Freely Associated States

FSM: Federated States of Micronesia

HHS: Department of Health and Human Services

IHS: Indian Health Service

JEMCO: FSM's Joint Economic Management Committee

JEMFAC: RMI's Joint Economic Management and Financial Accountability Committee

PHS: Public Health Service (PHS) Act

RMI: Republic of the Marshall Islands

SSA: Social Security Act

T/THO: Tribes and Tribal Health Organizations

TTPI: Trust Territory of the Pacific Islands

USG: U.S. Government

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Introduction

The Federated States of Micronesia (FSM) and the Republic of the Marshall Islands (RMI) are situated 7,000 miles west of Washington, D.C. in the Pacific Ocean. Along with the Republic of Palau, these independent nations are referred to within the U.S. Government (USG) as the Freely Associated States (FAS). They are grouped under the label US-Affiliated Pacific Islands, alongside the US territories Guam, American Samoa, and the Northern Mariana Islands (CNMI).¹

FSM and RMI together constitute a land area of roughly 350 square miles spread over nearly two million square miles of ocean. The Federated States of Micronesia has 65 occupied islands divided into four states: Yap, Chuuk, Pohnpei, and Kosrae. In 2018, the FSM population was reported as 104,937. In 2018, RMI had 24 occupied islands and a total population of 53,066, with the majority of the population located on two islands, Majuro and Ebeye. For context, these nations' total populations would be the equivalent of less than 1% of Texas' 2018 population spread out over an area of sea roughly seven times the land area of Texas. Population growth and economic development in FSM and RMI are stagnant (1).

FSM-RMI Health Context

These island nations struggle with health burdens associated with developing and developed countries. The management and treatment of infectious diseases, poverty-related maladies, and chronic diseases are significant challenges in these islands. FSM and RMI have high rates of tuberculosis, similar to other countries in the region.² These nations also have high rates of obesity and diabetes. RMI reported the highest prevalence of diabetes in the world in 2017, with 53% of its population obese and 33% of its population aged 20-79 (an estimated 12,550 people) suffering from the disease (2,3). Maternal mortality is significantly higher in FSM and RMI than in the US: 100 per 100,000 mothers die in childbirth in FSM compared to only 14 per 100,000 in the US (4,5). Life expectancies in FSM/RMI are 73.5 years, significantly shorter than the US national average of 80 years (6–8). Fewer children in FSM and RMI are fully immunized, with 95%, 80% and 73% of children fully-immunized in the US, RMI, and FSM (9).

Other health-related concerns include climate change—notably its potential to impact crops/food security, delay shipments of food or medical supplies, and increase the frequency of natural disasters— and organizational issues— including concerns around shortages of human resources and trained staff, complicated financial processes on island, and information technology issues.

FSM, RMI and the US: A Historical Perspective

¹ There are 24 populated small island countries and territories in the Pacific; 14 are independent countries and 10 are territories. French Polynesia (population 285,000), New Caledonia (280,000), and Wallis and Futuna (11,680) are associated with France; Norfolk Island (2,170) is an Australian territory; Tokelau (1,380) is a territory of New Zealand; Easter Island (5,600) is a Chilean territory; and Pitcairn Island (48) is a British territory. The Cook Islands (17,500) and Niue (1,600) are freely associated with New Zealand. (1)

² In 2017, the incidence of TB in the US was 3 per 100,000 population per year while the incidence of TB in FSM and RMI was 165 and 480 cases per 100,000 population per year, respectively (14).

Broadly speaking, these island nations occupy a region of the Pacific important for US geopolitical and military interests. The US Army Garrison at Kwajalein Atoll in RMI is home to the Ronald Reagan Ballistic Missile Defense Test Site. Securing the immense amount of Asian trade that flows through the East and South China Seas around the FAS is an important driver for US engagement in the region (10). Current political discourse suggests that China's growing influence in the region may influence US commitments to Pacific partners in the coming years. Recent administrations' emphasis on the Indo-Pacific region indicate significant foreign policy efforts will continue. Despite their physical distance, the FAS are not entirely isolated from the broader US, as there is significant outmigration from these islands to Guam, CNMI, Hawaii, and the US mainland.

These islands were first tied to the US in the wake of World War II. Japanese colonies before the war, the islands were grouped into the Trust Territory of the Pacific Islands (TTPI) and administered by the USG on behalf of the United Nations after the war. In the 1980s, FSM, RMI, and Palau chose to become independent nations and implemented significant development efforts from this point forward. The 1986 Compact of Free Association (COFA) was the product and binding agreement of US-FSM-RMI negotiations (11). Under this public law, the USG agreed to provide economic and technical assistance, ensure US military defense support, and allow unrestricted travel to/from the US for these non-resident FAS citizens. In return, these FAS agreed to give the USG unlimited and exclusive use of their land and waterways for strategic purposes. This strategic denial has remained a crucial element of COFA as China's influence and concerns around North Korea have grown. Between 2003 and 2023, USG economic assistance to FSM and RMI through COFA will total roughly \$3.6 billion (12).

The Department of the Interior's Office of Insular Affairs (DOI/OIA) is responsible for the administration of COFA funds. Health and education services are prioritized, typically receiving more than half of annual economic and technical sector grant assistance. Amendments to COFA in 2003 preserved this direct assistance through 2023 and established trust funds to replace direct USG economic assistance post-2023. In this way, 2023 represents a planned shift in the modality of USG health financing in FSM-RMI: in this year, the majority of DOI/OIA direct economic assistance to FSM-RMI will end and the amount of annual funding will be replaced by revenues from these separate trust funds.³ Other components of COFA described above will continue in perpetuity. However, after seventy-five years of direct financial assistance for FSM-RMI, 2023 represents a shift away from this engagement structure (Fig. 1). This research assesses current health engagement structures between FSM, RMI, and the USG, and

³ Compact sector grants—which make up the majority of compact health financing— will end in 2023. However, not all forms of economic assistance referenced in the Compacts will end in 2023. Kwajalein-related grants for RMI, for example, will continue for as long as the Military Use and Operating Rights Agreement is in effect. Other programs identified in the amended Compacts' implementing legislation or the Compacts' programs and services agreement may continue because the countries' eligibility for programs now provided under Compact legislation will continue under current US law or could continue under other legal authorities; further information on these programs can be found in GAO 18-415. For the purposes of this report, it is sufficient to state that the vast majority health-related economic assistance through the Compacts will end in 2023.

highlights alternative engagement models that may benefit FSM and RMI health systems beyond 2023.

[Figure 1: Nature of USG-FSM-RMI relations and financial assistance]

Materials and methods

An initial literature review began in February 2018. This review included academic, government, and private-sector documents concerning FAS' and other Pacific Islands' health status, geopolitical history, culture, and governance structures. It also considered the history of USG engagement in the region, developmental strategies for small island economics, and multilateral organizations' efforts in the region. Research considered alternative health support models including foreign appropriations models (US Agency for International Development and the President's Emergency Plan for AIDS Relief) and a domestic compacting model (USG support for American Indian populations). Data on Pacific,⁴ FAS, US, and Tribal health indicators and health system strength were primarily gathered from the World Health Organization's Global Health Observatory Data Repository, Pacific and Virgin Islands Training Initiatives, and the World Bank database.

More than 115 people were engaged in this project through interviews, briefings, email consultations, and online surveys. Interviews were conducted in person or over the phone with representatives from the USG, FAS governments, and non-governmental organizations present in the region. In total, the author completed 45 discrete interviews with a total of 58 people, yielding more than 40 hours of conversation and an average interview length of 53 minutes (range: 30 minutes to 90 minutes). Where interviews were not possible, the author collected 28 online surveys or email questionnaires.

Additional information was collected at the Pacific Island Health Officers Association Executive Board Meetings in American Samoa and Hawaii in March and September of 2018.⁵

Results

USG Health Support in States and in FSM-RMI

The mission of the Department of Health and Human Services (HHS) is to protect the health and well-being of all Americans. The Department's primary relationship with a typical state is to support its local health efforts. HHS support for states often includes data collection and research, supplementary grant funding, and programmatic technical assistance. These provisions are catered to states' mature health infrastructures and are meant to supplement local financial

⁴ Pacific, in this case, refers to: American Samoa, Australia, Cook Islands, Fiji, FSM, Kiribati, Nauru, New Zealand, Niue, Palau, Papua New Guinea, RMI, Samoa, Solomon Islands, Tonga, Tokelau, Tuvalu, and Vanuatu

⁵ PIHOA is a US NGO based in Honolulu, Hawaii that promotes advocacy, offers technical assistance, and helps to build the capacity of Pacific Island health systems.

resources. Within this relationship, advocacy to improve federal health support is directed at Congress, which regulates and funds HHS' activities.

Formally, HHS engagement in FSM-RMI is offered for purposes consistent with the COFA and its authorizing legislation, with grants awarded pursuant to the Public Health Service (PHS) Act and the Social Security Act (SSA) (13). However, as with states, HHS does not define the health or developmental priorities that would ultimately guide FSM-RMI to apply to a cross-section of grants that might support a holistic approach to health system strengthening. USG support for FSM-RMI health systems is most frequently given as technical assistance; disaster relief, mitigation and reconstruction; and financial assistance.

FSM-RMI depend on USG health financing. As shown in Table 1, DOI/OIA and HHS provided a combined \$35 million and \$19 million in economic assistance for FSM and RMI health systems in 2016 (14). DOI/OIA financing was distributed through COFA health sector grants, trust fund contributions, and related grants. Barring a change in legislation, it is assumed that HHS will remain engaged in the region post-2023 (11,12).

[Table 1: USG Healthcare Financing in FSM and RMI, FY 2016]

Fig. 2 illustrates the scale of recent USG assistance to FSM-RMI relative to local investments into FSM-RMI health systems. In FY 2019, COFA and federal grants were predicted to support 57-95% of total health expenditures in FSM-RMI (15,16). Of this external financing, HHS grants were expected to support roughly one-quarter of each nation's health expenditures. Local revenue was expected to support 5% and 41% of FSM's and RMI's respective health expenditures in 2019. Note that in 2018, just 15% of RMI health expenditures came from local revenue.

[Figure 2: Sources of health financing: FSM, RMI, and US state average]

Fig. 2 also presents the distribution of healthcare financing sources in an average state. Roughly 42% of a state's healthcare financing comes from local sources, including state funds, fees, fines, and taxes (which are not a significant source of revenue in FSM-RMI). A state's remaining health revenue comes from federal social and human services grants for which FSM-RMI are not eligible (32%), federal social and human services grants for which FSM-RMI are eligible (16%), and a variety of other sources (10%).

Limited local expenditures in health do not appear to be driven by a lack of available revenue: FSM and RMI national governments have maintained a budget surplus each of the last four fiscal years (12).⁶ Growing revenue from the Parties of the Nauru Agreement (tuna revenue) is largely to credit for these surpluses.

⁶ In FY 2016, the RMI government recorded a surplus of \$8 million, equal to 4% of GDP. In FY 2016, the FSM national government recorded a surplus of \$26.6 million, equal to 8% of the FY 2016 FSM GDP, while the four states had a combined deficit of roughly 2.5 million.

Different Types of USG Health Support: DOI/OIA and HHS

Because DOI/OIA COFA support and HHS grant support in FSM-RMI have traditionally been complementary, the 2023 shift in DOI/OIA COFA assistance may affect HHS program efficiency and utility. Efforts to plan for health system financing beyond 2023 will benefit from an understanding of these agencies' complementary support structures.

DOI/OIA COFA financial assistance primarily supports recurrent operational expenses for hospitals (personnel, medical equipment, electricity, etc.). HHS grants complement DOI/OIA financing by targeting public health, preparedness, surveillance, prevention, data capacity, and workforce development. For the most part, HHS appropriations for discretionary grants do not authorize construction nor hospital care.

DOI/OIA COFA financing derives its authorities from FSM's Joint Economic Management Committee (JEMCO) and RMI's Joint Economic Management and Financial Accountability Committee (JEMFAC). JEMCO and JEMFAC allocate and attach terms and conditions to grant awards at annual meetings with FSM-RMI leadership (17). In contrast, HHS financing derives its authorities from Congress, in which FSM-RMI leadership are not represented. Compact authorizing language ties awarded Compact funds to FSM and RMI medium-term budgets and investment frameworks (§211); Congressional authorizing language ties awarded HHS funds to US national health priorities and a nationally-standardized set of requirements. HHS' national priorities and requirements may not match the needs and capacities of FSM-RMI populations, and without representation in Congress, FSM's and RMI's health concerns may lack visibility and incentive for legislative solutions.

Lastly, DOI financial assistance allows for advance funding whereas HHS grants are awarded under a reimbursement model. In the advance funding model, FSM-RMI are awarded a portion of funds and can obtain additional funds after submitting financial status reports on previously awarded funds. In the HHS reimbursement model, grantees incur expenses for program implementation and then submit requests to HHS to access grant funds. FSM-RMI have not organized with HHS to implement the capital advance reimbursement method.⁷ Without these capital advances, HHS' reimbursement model can cause significant program implementation delays for HHS programs in FSM and RMI, as these nations may not have sufficient local revenue (in FY 2016, \$9-14 million dollars) to upfront HHS grant amounts. Additionally, limited human and administrative capacity contribute to slow project implementation. In comparison, US states are able to obtain appropriated, dedicated health funding from their respective treasuries and implement these programs with large skilled workforces.

Efforts to re-strategize around HHS engagement post-2023 should consider two alternative USG health engagement models: a foreign appropriations approach and a domestic

⁷ The option to elect a capital advance is available through the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2CFR200)

compacting approach. USAID engagement and USG support for Alaska Native populations are used here as examples of these models.

Foreign Appropriations Approach: USAID in the Pacific Islands

USAID leads the USG's international development and disaster assistance efforts. HHS, rather than USAID, leads USG health assistance efforts in FSM-RMI because USG assistance began in the domestic sphere. Despite the nations' sovereign status today, most USG support still draws from domestic appropriations.

USAID's health assistance model is distinct from that of HHS for its multisectoral, development-focused portfolio. Health is not the primary focus of USAID's work in a country but rather one of many components within development programming. The agency's efforts to reduce health burdens and improve a health system's human, physical, and technological capacity are a function of USAID's broader development schema. In this way, USAID engagement brings a uniquely holistic perspective to health and is well suited to address challenges that lay outside of the traditional health realm but can stymie a community's health and health system, such as financial management (18). HHS does not share this mission.

USAID currently operates no health programs in the FSM and RMI, though USAID/OFDA is identified within the amended COFA as the lead agency for disaster mitigation, relief, and reconstruction in the countries (19). The USAID mission that covers the Pacific Islands, including FSM and RMI, is based in Fiji.

Domestic Compacting Approach: USG Support for Alaska Native Populations

With similar population attributes but different funding mechanisms, elements of the Alaska Tribal model could inspire strategies for local ownership of federal funds, best practices for engagement with federal partners, workforce development programs, and health system strengthening strategies more generally. Detailed information on the similarities between FSM-RMI and Alaska Native populations can be found in Appendix A.

The Indian Health Service (IHS) is authorized and appropriated by the US Congress to meet the federal government's trust responsibility to provide health services to American Indian/Alaska Native (AI/AN) persons. IHS' role in Alaska today is significantly smaller than is IHS' role in other regions of the US: Alaska Native Tribes and Tribal Health Organizations (T/THOs) manage and implement 99% of Alaska Tribal health programs, functions, services, and activities. The ability of Alaska Native Tribes to build a robust and successful health system through IHS compacting and contracting mechanisms was credited to political savvy developed through Alaska Natives' historical involvement in for-profit organizations created in place of reservations, as well as the transfer of federal staff to Tribally-operated organizations (20).

While conceptually similar, the practical application of IHS compacting and contracting in FSM-RMI settings would pose significant challenges. The courts require HHS, through IHS, to care for the health and wellbeing of AI/AN people; HHS has no such requirement for FSM-RMI populations. As such, these populations may not be able to demand the same degree of care from the USG. Additionally, the IHS model leverages Medicaid/Medicare financing for the

provision of clinical and hospital services. As foreign countries, FSM-RMI are not eligible for Medicaid/Medicare programs (21). Lastly, financing streams to AI/AN communities are significantly larger than those to FSM-RMI communities; annual IHS per capita expenditures for health services are roughly \$3,850, whereas annual HHS per capita expenditures in FSM-RMI are less than \$200 (14,22).

Discussion

Prompted by the potential shift in USG involvement in FSM and RMI in 2023, this paper seeks to highlight challenges inherent in the current HHS-FSM-RMI engagement structures. It suggests potential strategies and opportunities through which FSM-RMI leadership and partners can contribute to sustainable health system development and improved health outcomes moving forward.

HHS engagement stems from a domestic appropriations/authorizations model that targets specific health issues; the style of engagement is not structured to promote development, but rather to provide tools to help state governments achieve their health goals. HHS engagement without direction from a funded, actionable strategic action plan may not contribute to sustained health for development. DOI/OIA COFA assistance has facilitated varying levels of health system growth over the last forty years, but USG engagement through 2023 will not see FSM-RMI achieve the financial self-sufficiency and independence set out by COFA in 1986. In FSM-RMI, a reliance on external financing and strategic plans driven more by available resources than by health priorities have contributed to a sense of perpetual grant-chasing in which local priorities are sometimes overshadowed in the search for additional resources.

Crucial to improved HHS-FSM-RMI engagement is an understanding that FSM and RMI are significantly different from states. Discordant operating environments, differing health priorities, and varying levels of local health infrastructure challenge the efficacy of the traditional grant-based HHS domestic model in FSM and RMI. FSM and RMI's demography and geography are distinct from the mainland US, and their economic development levels are more similar to Senegal or Cameroon than to the broader US (23). Clinically, these barriers make it difficult to access care and increase the cost of care per capita. Epidemiologically, FSM-RMI experience high burdens of health issues more associated with developing worlds. Financially, these small, less-developed nations maintain smaller treasuries; this lack of liquidity influences FSM and RMI grantees' ability to function within HHS' reimbursement model and contributes to these nations' comparatively low financial absorptive capacity. FSM-RMI also lack a large population and strong education system through which to develop and recruit skilled professionals for clinical, laboratory, and healthcare management roles. Politically, FSM and RMI do not have a voice in the US Congress. FSM-RMI health systems also lack the health-related safety nets found in most impoverished mainland communities: FSM-RMI health systems receive no revenue from Medicaid and communities may lack basic communication and sanitation infrastructure. These capacities, structures, and priorities coalesce into FSM-RMI health systems that are substantially different from mainland health systems.

By including FSM-RMI in domestic authorizations and appropriations structures—thereby making these sovereign nations eligible grant recipients in the same way that states are eligible grant recipients—current HHS engagement implies an expectation that these sovereign nations can implement health programs as states can. This is not a realistic expectation nor the ideal engagement strategy. A framework catered to mature state health systems will not efficiently build capacity in the developing health systems of FSM and RMI (see Fig. 3).

[Figure 3: Discordant operating environments: HHS support by design (state) versus in practice (FSM-RMI)]

Looking to and past 2023, more productive engagement will require changes from both FSM-RMI health leaders and their partners within and outside of the federal government. If FSM and RMI choose to continue to engage with the USG for health system support, leaders must actively consider how to best leverage the resources and relationships available from HHS. Relative to their familiarity with a traditional donor aid process, FSM and RMI may be less aware of the role that the US Congress—not HHS nor the operating and staff divisions within it—plays in determining much of the availability and flexibility of financing that reaches FSM-RMI. Lacking a voice in Congress, FSM-RMI would benefit from (1) stronger lobbying efforts around Congress to push for island-centric concerns, (2) continued advocacy within states to improve health situations for Micronesian and Marshallese citizens who have emigrated to the US, and (3) louder and more frequent advocacy for the strategic use of funds on island rather than simply additional funds to the islands. Embassies in DC can play a central role in this advocacy. This advocacy must capitalize on FSM-RMI's expanding data capacities, which will craft stronger narratives and justify financial support for FSM-RMI causes.

Additionally, FSM and RMI health systems would benefit from financial shifts on island. FSM-RMI leaders must increase local revenues for health. Self-financed systems can address local health priorities and invest in long-term growth better than can systems reliant external financing. At present, FSM and RMI may contribute proportionally fewer local funds to their health systems because substantial funds have always been available from the USG. It is unclear to what extent FSM-RMI governments have allocated tuna revenues toward sustaining core health services or supporting additional/expanded services. Facing uncertain financing levels post-2023, political leadership should begin to set aside more local financing for health.

A shift toward local financing will enable a second necessary shift: an adherence to the costed strategic actions plans that reflect island priorities and enable FSM-RMI to solicit assistance from other health financiers in support of these goals. Costed strategic action plans define, guide, and hold leaders accountable to a comprehensive health systems approach driven by local health priorities rather than by readily available financing. Coordination with the Ministry of Foreign Affairs or Embassy may help to leverage these costed strategic action plans within health-focused international relationships and to coordinate health financing to achieve goals set forth within these plans.

If FSM-RMI seek a foreign appropriations style of economic assistance, USAID has the federal mandate to support health system strengthening within a developing world operating context.

To the extent that components of the Alaskan Tribal Health System can be replicated in isolation from its financing mechanisms, the Alaska model may present opportunities for FSM-RMI. This isolated, sovereign health system has embraced traditional HHS support as one component of a multifaceted, locally driven health system to produce significant and sustainable growth over the last two decades. Appendix A reviews several components of the Alaska Tribal system that may translate to an FSM-RMI context, including workforce development strategies, local financial management structures, and a tradition of strong advocacy.

FSM and RMI's strategic importance to the US will grow as US foreign policy continues to orient toward the Pacific. Without significant and sustainable health system development, the pace of health-related outmigration of Marshallese and Micronesian populations to other territories and states will continue to grow. This will strain already under-reimbursed territorial health systems, as well as heavily impact Hawaii's healthcare system and the healthcare systems of other states with large Micronesian or Marshallese populations (such as Arkansas and Washington). The 2023 financing shift from Compact to trust fund revenue provides an opportunity to re-strategize around health system development in FSM and RMI. Island leaders and their partners and advocates within the US should capitalize on the "systems improvement" headspace that may accompany this transition to spark innovative solutions for the next chapter of FSM-RMI development.

Future Directions

This report is a resource for upcoming 2023-focused discussions across FSM-RMI and partners. Future research should consider how the models presented here may align with cross-sectional issues important to the islands or USG, such as climate change and global health security.

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Conflict of Interest:

The authors declare that this study was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Figures and Tables

Nature of USG-FSM-RMI health relations and financial assistance

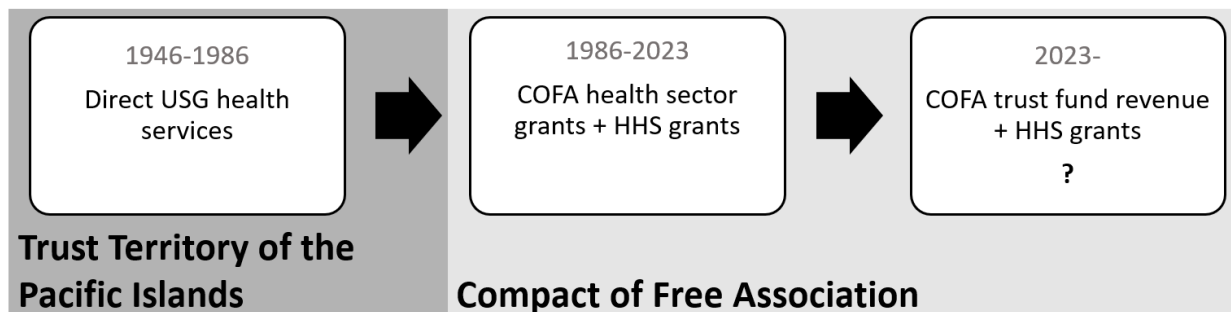


Figure 4: Nature of USG-FSM-RMI relations and financial assistance

Table 1: USG Healthcare Financing in FSM and RMI, FY 2016

	FSM	RMI
DOI/OIA COFA health-related funding	\$20,725,187	\$9,266,142
HHS grant funding	\$14,785,967	\$9,901,601
<i>Sum healthcare financing from USG</i>	<i>\$35,511,154</i>	<i>\$19,167,743</i>

Source: Banerji, S. and Ottley, B. (2016) *FY2016 Report on Federal Financial Assistance to the US Pacific and Caribbean Islands*.

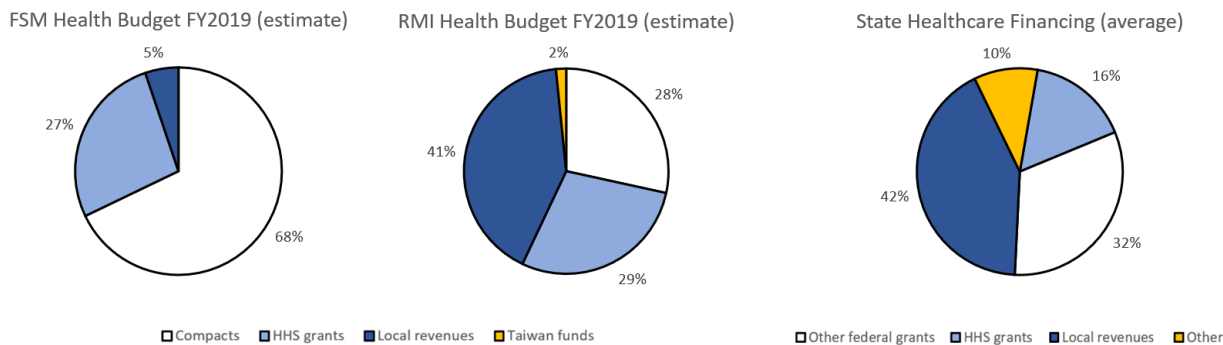


Figure 5: Sources of health financing: FSM, RMI, and an average US state

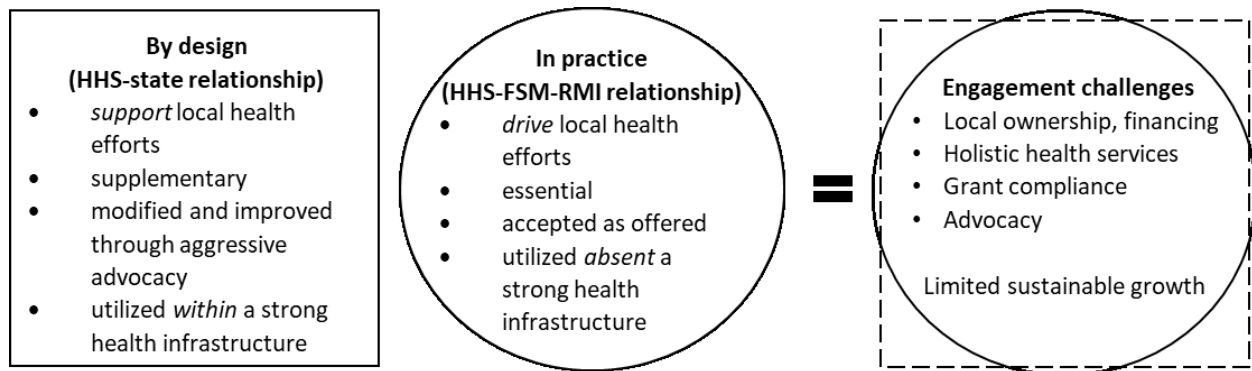


Figure 6: Discordant operating environments: HHS support by design (state) versus in practice (FSM-RMI)

Appendix A

The Alaska Native population is roughly the same size, similarly geographically isolated, and shares epidemiological and historical challenges with FSM-RMI populations.

The Alaska Native population maintains infant mortality, maternal mortality, and obesity rates higher than other US populations. The population has a life expectancy roughly 8 years shorter than the national average (FSM-RMI life expectancies are 7-9 years shorter than the national average). Both Alaska Native and FSM-RMI populations have also borne historical challenges with TB and alcohol. The Alaska system has evolved from an operating context similar to FSM/RMI:

- Alaska's 175,000 Alaska Native peoples are culturally distinct from the broader US,
- more frequently dependent on lifestyles ill-suited for a cash economy,
- weary of federal involvement given a colonial history,
- and often based in villages that are geographically isolated across Alaska's 660,000 square miles (2.5 Texases)

Like FSM-RMI populations, they're distinct from the mainland but not a homogenous group; there are 229 federally recognized Tribes in Alaska. The table below reviews strategies utilized in an Alaska Native context that may be applicable for FSM-RMI health systems development:

Lessons from an AI/AN context
Program and workforce development: paraprofessional programs like the Community Health Aide Program increase access to primary care in isolated, rural communities and contribute to workforce development over the long term.
Federal engagement: Tribes collectively negotiate health compacts and contracts with IHS. Legal advocates in DC and the states push for Tribal concerns in the courts and in Congress.
Advocacy structures for health: the Alaska Native Health Board includes representatives from each of Alaska's Tribal Health Organizations and provides policy analysis and technical assistance to Alaska Native Tribes and the public at large. It is recognized as the statewide voice on Alaska Native health issues. It also facilitates engagement between Tribes and IHS, including support for and management of Negotiations.
Braiding financing mechanisms: Alaska Native Tribes apply for grants from CDC, HRSA, and other agencies alongside broader compact financing from IHS.
Accountability structures: IHS compacting requires three years of financial stability and financial management capability before a Tribe is eligible to enter into a compact with IHS. Federal certification boards staffed by Tribal health employees oversee the Community Health Aide paraprofessional program.
Comprehensive data and research: data collection and research are locally conducted by a Tribal health data center (the Alaska Native Tribal Health Consortium's EpiCenter), supported by CDC grants and technical expertise. Used to support advocacy efforts and monitor the health of Alaska Native people in pursuit of the ANTHC vision: "Alaska Native people are the healthiest people in the world".
Local and sustainable ownership of federally funded programs: compacting structures include mechanisms to transfer federal employees and technical assistance. T/THOs negotiate

the Continuing Services Agreements that match Tribal priorities with federal funding. Alaska Native people express pride and ownership of the Alaska Tribal Health System.