Guide to Equity in the Indian Health Service

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ABOUT THIS GUIDE

This guide equips advocates with key information about the Indian Health Service, including an overview of inequities, and highlights the policy and accountability levers that can advance equity.

This guide is part of a larger project on inequities and policy levers in the US health care system. For the complete guide, visit urbn.is/4054rNQ.

The other topics covered include the following:

- behavioral health care system
- Children's Health Insurance Program
- health care for the uninsured
- Marketplace insurance
- Medicaid
- Medicaid-Medicare
- Medicare
- pharmacy services
- Veterans' Affairs

OVERVIEW

The Indian Health Service (IHS) was established in 1955 to fulfill the US federal government's obligation to provide comprehensive health care services to members of federally recognized tribes. This obligation grew out of terms first established in 1784 treaties between the federal government and tribal governments and was reaffirmed through numerous US Supreme Court rulings, executive orders, and federal laws. In these treaties, tribes agreed to give up their lands in exchange for the federal government's protection and benefits, including housing, education, and health care.

The IHS is a federal agency responsible for providing health care services to American Indian and Alaska Native (AI/AN) populations, but it is not a health insurance entitlement program such as Medicare or Medicaid. However, the US Congress has repeatedly failed to fulfill its responsibilities, as demonstrated by the chronic underfunding of the IHS. This persistent underfunding negatively affects access to, quality, and outcomes of health care services and contributes to significant health inequities among AI/AN people compared with the US general population.

Furthermore, historical trauma, which is defined as the multigenerational and cumulative collective experience of injustice, has deeply affected Native communities. Systemic racist policies aiming to undermine AI/AN communities, such as forced relocation to reservations and acculturation through abduction of AI/AN children into government boarding schools, have caused much suffering and trauma and have lasting impacts on the overall health and well-being of AI/AN people to present day.

For More Information

- **History of the IHS:** "The First 50 Years of the Indian Health Service: Caring and Curing," IHS.gov, accessed March 6, 2024.
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POPULATION

In the 2020 Census, about 1 percent of the US population, an estimated 3.7 million people, identified as AI/AN alone. An additional 5.9 million people identified as multiple races, including AI/AN. Altogether, about 9.7 million people (or 2.9 percent of the US population) identify as AI/AN alone or in combination with other races.

Three-quarters (75 percent) of AI/AN people live in the Southern and Western US, with significant populations concentrated in California, Oklahoma, Texas, Arizona, and New Mexico. Nearly half (49 percent) of people identifying as AI/AN alone live in Oklahoma, Arizona, and New Mexico. Over half (about 60 percent) of AI/AN people live in metropolitan areas, and of those living in rural areas, only 13 percent live on reservations or land trusts.

There are 574 federally recognized sovereign tribes in 37 states, which means members of these tribes are entitled to health care provided by the federal government through the IHS. In January 2020, the IHS provided health care to 2.56 million AI/AN people.

There are also over 200 tribes in the US that do not have federal recognition and do not have the same rights or access to federal resources, including health care, as recognized tribes.

For More Information

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- **IHS factsheet:** "IHS Profile," IHS.gov, accessed March 6, 2024.
- **Federally unrecognized tribes:** Eilis O'Neill, "Unrecognized Tribes Struggle Without Federal Aid During Pandemic," *National Public Radio*, April 2021.

PROVIDERS AND SERVICE DELIVERY

The IHS is organized into 12 regional offices, each responsible for providing culturally effective health outreach, education, and direct health care services to unique tribes in their respective physical areas. The Urban Indian Programs under the IHS serve AI/AN people who live in urban areas and are not near a reservation.

The IHS provides health care services directly, operating its own facilities and employing providers. The IHS facilities are comprised mostly of small clinics and hospitals located on reservations, and services are often limited to primary care and some specialty and ancillary services (such as laboratory tests). The IHS Division of Behavioral Health oversees and administers behavioral health programs, including mental health and substance use services.

In addition to clinical services, the IHS provides various programming and interventions to promote the health and wellness of AI/AN people, such as environmental health services, health promotion, and nutrition education.

For More Information

- **IHS regional offices:** "Locations," IHS.gov, accessed March 6, 2024.
- **Urban Indian Health Programs:** "Office of Urban Indian Health Programs," IHS.gov, accessed March 6, 2024.
- **IHS characteristics**: "Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs," GAO.gov, December 10, 2018.

- **IHS community health services**: "Community Health" IHS.gov, accessed March 6, 2024.

FINANCING

The federal government is responsible for financing health care services for members of the federally recognized tribes as agreed to in treaties. The largest source of the IHS funding is congressional appropriations, requiring the IHS to submit an annual budget proposal and justification for review and approval by US Congress. This means the funding levels vary each year and may not be sufficient to cover all needed services, and the uncertainty makes it difficult to effectively plan for improvements, such as medical equipment upgrades. Compared with other federally funded health programs, the IHS is estimated to be underfunded by as much as 50 percent. In 2017, the IHS spending per person was $4,078 compared with per-person spending of $8,109 in Medicaid, $10,692 in the Veterans Health Administration, and $13,185 in Medicare, respectively.

Another important source of financing for health care delivered to AI/AN populations is health insurance programs, including Medicare, Medicaid, the State Children's Health Insurance Program, the US Department of Veterans Affairs, and private insurance. The IHS is a payer of last resort, meaning that IHS clinics seek reimbursement from other insurers when available. The IHS is not a health insurance program; however, the federal government does encourage members of federally recognized tribes to enroll in health insurance when eligible.

For More Information

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BARRIERS TO HEALTH CARE ACCESS AND QUALITY

The chronic underfunding of the IHS poses many challenges to meeting health care needs of AI/AN people. The key barriers to high-quality, comprehensive health care services include the following:

Staff shortages and lack of culturally effective care

Because of inadequate funding, health care provider salaries are lower, and IHS clinics have challenges recruiting an adequate workforce. In addition, many IHS facilities in remote rural areas lack adequate housing, posing additional barriers to attracting a health care workforce. Furthermore, there is a general lack of AI/AN clinicians, affecting culturally effective care availability. Historically, traditional healing practices have been discouraged and may not be widely available in IHS clinics.

Challenges to maintaining continuity and quality care

Staff shortages often lead to long wait times for basic health care services and contribute to provider burnout and turnover, negatively affecting patient outcomes. To address provider shortages, the IHS sometimes contracts with temporary providers and employs nonresidency-trained physicians (medical school graduates who did not complete medical residency) in the areas of highest need. Both these strategies can undermine continuity and quality of care. Aging IHS infrastructure, including crumbling health care facilities and outdated medical equipment, further compromises the quality and timeliness of patient care. AI/AN people living in urban areas may have challenges accessing health care services from Urban Indian Programs due to limited funding for these programs.

Limited access to behavioral health and other specialty care

Access to specialist care, including mental health and substance use services, is further constrained by provider shortages. The IHS can arrange for patients to access health care services that are unavailable within IHS clinics through the IHS Purchased/Referred Care program. However, due to limited funding, services provided through the Purchased/Referred Care program are often reserved for those with the most severe or urgent medical needs.

Racism and discrimination

About a quarter of AI/AN people report experiencing bias and discrimination in health care settings. These experiences fuel entrenched mistrust of federal government and Western medicine, borne out of historical trauma from oppression and exploitation, such as when first settlers purposefully exposed Native populations to smallpox and other infectious diseases they didn't have immunity against or forced sterilization of AI/AN women.

High rates of uninsurance

On average, 16 percent of AI/AN people are uninsured compared with 7 percent of white Americans. Because IHS provides limited services, enrolling in health insurance coverage could improve access to services unavailable in IHS facilities. However, many AI/AN people may not be aware of available coverage options or have challenges enrolling and navigating insurance coverage. In addition, many AI/AN people prefer the IHS because they believe it's the responsibility of the federal government to provide free health care to them. Furthermore, public or private health insurance options may offer limited to no access to culturally and linguistically effective services.

Structural barriers

The long history of mistreatment and disinvestment by the federal government, such as forcible removal of tribes from their Native lands to remote rural areas, is manifested in high poverty rates among tribal populations, severe housing shortages, inferior education systems, limited economic opportunities, and substandard community infrastructure (including basics such as paved roads, running water, and grocery stores on reservations), which pose additional barriers to accessing health care and promoting optimal health.

Getting Health Care on the Reservation

"Cody Pedersen and his wife, Inyan, know that in an emergency they will have to wait for help to arrive. Cody, 29, and his family live in Cherry Creek, a Native American settlement within the Cheyenne River Indian Reservation in north central South Dakota. The reservation is bigger than Delaware and Rhode Island combined. But Cherry Creek has no general store, no gas station and few jobs. When Inyan, 34, was preparing to give birth to her two youngest children, doctors scheduled her to have cesarean sections in a hospital rather than having her wait until she was in labor to come in. In January, Cody was stabbed in the neck. It took an ambulance two hours to arrive. A 17-mile gravel road in Chery Creek connects to a better road that eventually leads to Eagle Butte, the largest town on the reservation and home to just over 1,300 people. That's where the closest doctors are. When Cody runs out of gas money, he has to pay $40 to a neighbor to take him to the health center in Eagle Butte. But he can't do that before lucking out and securing an appointment, calling at 7 a.m. on the day he wants to see a doctor.

Clinics like the one Cody goes to don't allow patients to schedule appointments in advance."

—Excerpted from Misha Friedman, "For Native Americans, Health Care is A Long, Hard Road Away," National Public Radio, April 13, 2016.

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DISPARITIES

In addition to the lasting effects of historical trauma, the barriers described above, such as ongoing racism and disinvestment in the Native communities, are the root causes of deep disparities in the health status of AI/AN people when compared with white Americans. Examples of these disparities include the following:

- AI/AN women are two times more likely to die from pregnancy-related conditions than white women.
- AI/AN infants are almost twice as likely to die within their first year of life than infants born to white mothers.
- AI/AN report worse mental health and higher rates of substance use than white people and are more likely than white people to die from drug overdose and suicide.
- Because of higher rates of underlying chronic health conditions, AI/AN people were nearly three times more likely to get infected, be hospitalized, and die from COVID-19 than white people during the first year of the pandemic.
- AI/ANs lifespan is, on average, 5.5 years shorter than that of white people and AI/ANs have the shortest life expectancy across all racial and ethnic groups in the US.

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- **Racial and ethnic health inequities**: Riis L. Williams, "Native American Deaths form COVID-19 Highest Among Racial Groups," Princeton, NJ: Princeton School of Public and International Affairs, December 2, 2021; and "Disparities," IHS.gov, accessed March 6, 2024.

OVERSIGHT AND ACCOUNTABILITY

The US Congress is responsible for upholding its obligations toward tribal nations established through treaties and other binding agreements and court or executive orders, which includes adequate funding for comprehensive health care services and other federal programs. The responsibility for providing and ensuring quality health care services is delegated to the IHS, which is an agency within the US Department of Health and Human Services.

Other entities, programs, and tools that support IHS' oversight, accountability, and transparency functions include the following:

- **National Accountability Dashboard for Quality**, hosted by IHS, tracks important performance indicators, compliance with policy requirements, accreditation standards, and/or regulations at its hospitals and health centers. The IHS asks for feedback from tribal leaders and other partners to help with continuous quality improvement.
- Dubbed "the investigative arm of Congress" and "the congressional watchdog," the **Government Accountability Office** aids Congress in improving the performance of federal programs, including the IHS, by conducting independent research and providing recommendations.
- **The US Commission on Civil Rights** is an independent federal agency responsible for informing the development and enhancing enforcement of national civil rights laws through investigations and reporting, including protecting AI/AN from racism and discrimination.
- **Advocacy organizations** led by and for AI/AN people work to preserve cultural traditions and advocate for health and social justice for tribal nations, including the Association of American Indian Affairs, National Alaska Native American Indian Nurses Association, Native American Disability Law Center, and many others.

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POLICIES AND ACTIONS THAT COULD LESSEN BARRIERS AND DISPARITIES

Reducing disparities and improving the health of the AI/AN population requires multi-prong, large-scale policy reforms, including investments to advance the social and economic conditions of the tribal population. In addition, the US government can take meaningful steps toward improving the availability, access to, and quality of health care services provided by the IHS. Key considerations for federal policymakers include the following:

Stabilizing and increasing IHS funding

- The bulk of IHS funding comes through annual congressional appropriations, which leads to uncertainty, poses administrative burdens and costs on IHS and tribal health care programs, and can disrupt services. Congress could consider granting the IHS advance appropriation authority to address funding uncertainty and improve IHS operations.
- In addition, increased IHS funding levels are needed to bring IHS funding on par with other federal health care programs, improve aging medical infrastructure, expand health care facilities, and recruit and retain a sufficient health care workforce.

Addressing IHS workforce shortages

- Federal policymakers could consider expanding various initiatives to increase entry and retention of AI/AN people in health care professions and incentivize service in tribal communities, including improving the quality of K-12 education, creating and expanding STEM initiatives and health profession pathway programs, expanding physician loan repayment programs and residency opportunities in AI/AN communities, developing AI/AN health profession schools, and other workforce initiatives. Furthermore, medical and nursing education programs should prepare all clinicians to provide culturally effective care, such as training on cultural awareness, implicit bias, and unique health care needs of AI/AN people.

Promoting partnerships with and self-governance of tribal communities

In recognition of tribal sovereignty, federal policymakers should continue to promote and support effective partnerships with tribal governments and tribal decisionmaking. This could include:

- meaningfully partnering with and listening to tribal leadership and consumers on an ongoing basis to understand (1) what federal policies, practices, and programs are effective; (2) how to improve or eliminate ineffective practices; and (3) how to improve capacity and infrastructure to collect, disaggregate, share, analyze and act on AI/AN data to continuously assess for equitable effects of federal policies;
- sustaining and expanding the Tribal Self Governance Program to develop culturally effective programming and initiatives addressing the unique needs of AI/AN communities while improving training and policies within the regional IHS office to address complaints, misconduct, and harm against IHS patients; and
- increasing the exchange of information and coordination between HHS agencies and Urban Indian Organizations to effectively meet the health care needs of urban AI/AN people.

For More Information

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GLOSSARY

Appropriations are decisions made by Congress about how to allocate federal funds.

Accountability is an assurance that an individual or organization is evaluated on its performance or behavior related to something for which it is responsible.

Culturally effective health care is the ability of providers and organizations to effectively deliver health care services that meet patients' social, cultural, and linguistic needs.

Forced sterilization is the involuntary or coerced removal of a person's ability to reproduce, often through a surgical procedure. Forced sterilization is a human rights violation and can be considered genocide.

Disparities are preventable differences in disease, health status, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

Federal Indian reservation is an area of land reserved for a tribe or tribes under a treaty or other agreement with the United States government.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Indian treaties were established between 1778 and 1871 between the United States and individual American Indian nations indigenous to what is now the United States. These "contracts among nations" recognized and established unique rights, benefits, and conditions for the treaty-making tribes, who agreed to give their lands in exchange for the federal government's protection.

Provider burnout is caused by long-term stress and can include emotional exhaustion, lack of empathy for or negative attitudes toward patients, and feelings of decreased personal achievement.

Science, Technology, Engineering, and Mathematics (STEM) initiatives are educational programs that help prepare students for college and careers in these fields.

Tribal sovereignty refers to the concept of the authority of AI/AN tribes to govern themselves.

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