
Commentary

Health Care For Native Americans: Who Will Pay?

by Ellen M. Smith

The Federal Indian Health Service (IHS), in the Department of Health and Human Services, provides comprehensive inpatient and ambulatory care services at no charge to Native Americans who are eligible on the basis of Indian descent, but IHS does not serve all Indians. Of the 1.4 million Native Americans and nearly 7 million persons with some degree of Indian ancestry in 1980, IHS recognized about 830,000 as eligible to use its health care system. Today, the IHS eligible service population is estimated at nearly 1 million.

Historically, federal services to Indians have centered on the reservations, and IHS continues to direct its health services to Indians who live on or near federal reservations. This effectively excludes approximately half of all Indians (54 percent in 1980), those who live in metropolitan areas. In seeking to eliminate the small IHS budget for urban Indian health projects (\$9 to \$10 million annually), the Reagan administration has argued that urban Indians do not need IHS services because they have adequate access to other health resources. Given their generally lower socioeconomic status, it is likely that many urban Indians turn to Medicaid and other state and local programs for the medically indigent, but it is not known how adequately they are served.

The reservation-based IHS delivery system relies on Medicaid (and Medicare) to pay for an increasing share of the services it provides because IHS is the "residual payer," or payer of last resort. When IHS-eligible Indians who also are eligible for Medicaid or Medicare are treated in IHS facilities, IHS can seek reimbursement for those services. And when IHS refers patients to private providers under its contract care program, IHS pays only the remainder of the bill not covered by other sources.

The IHS service delivery appropriation for fiscal year 1987 is \$858 million, including \$16 million in new funding for drug abuse programs.

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IHS receives a separate appropriation for facilities construction and renovation, usually in the range of \$50 to \$60 million a year. Data from the Health Care Financing Administration indicate that nearly 178,000 American Indians and Alaska Natives received Medicaid services in fiscal year 1985, at a cost of \$197.5 million. Of this total, \$15.6 million was paid to IHS for services rendered in IHS facilities (IHS collected an additional \$17.3 million in Medicare reimbursements). On this basis, it appears that over 90 percent of Medicaid payments for Indians were for services delivered by private providers either as IHS-authorized contract care, or to Indians outside the IHS system.

Thus, Medicaid already provides a significant amount of health care for Native Americans. A situation is developing, however, that could increase the role of state Medicaid programs substantially: IHS soon may experience staffing shortages, because it depends on the National Health Service Corps (NHSC) for physicians to staff its facilities and programs. The number of service-obligated physicians who will be available from the NHSC will diminish rapidly after 1988.

American Indian And Alaska Native Populations

In April 1986, the congressional Office of Technology Assessment (OTA) published a major review of Indian health status, services delivery, and other issues related to Indian health care (Indian Health care, OTA-H-290, April 1986). Sadly, the findings of the OTA assessment were much the same as those of earlier studies: the health status of Native Americans is poorer than the general population, and the services provided to meet Indian health needs are limited.

Considerable progress has been made in improving Indian health since IHS was organized in 1955. Mortality due to infectious diseases has been greatly reduced, as has infant mortality, which now is only slightly higher than the infant mortality rate for all races in the U.S. Little is known about the health problems of urban Indians, but the OTA analysis found that the age-adjusted overall death rate for IHS's eligible service population was 1.4 times that of the general population in 1981. Indians do not live as long as other U.S. populations: from 1980 to 1982, 37 percent of Indian deaths occurred in Indians younger than age forty five, compared with only 12 percent of all U.S. deaths in that age group. The Indian death rate due to accidents was 3.4 times the U.S. rate, and deaths due to liver disease and cirrhosis were 4.2 times the U.S. rate. The high rates of alcohol abuse, homicide, and suicide among Indian populations are well known.

IHS service utilization data, weak as they are, do not correlate with the health problems identified by mortality rates. Some diagnoses for which death rates were relatively high were associated with lower-than-ex-

pected hospitalization rates, suggesting limited access to needed services. Environmental and socioeconomic factors contribute to Indian health problems. In 1980, for example, 27.5 percent of all Indians lived on incomes below the poverty level among reservation Indians, the core of IHS's service population, the rate was 44.8 percent—compared with 12.4 percent of the U.S. general population. Housing, water quality, and sanitation problems are common on reservations.

Eligibility for IHS services is a controversial subject. Underlying conflicts about who is and who is not Indian, for purposes of receiving IHS benefits, were brought to the surface in 1986 by proposed new IHS eligibility regulations that included sensitive “blood quantum” requirements, as well as geographic Limitations. IHS argued that it needed to define its service population to deliver services effectively and plan for the future, but most tribes saw it as a threat to tribal sovereignty and an attempt to reduce the service population. IHS is not an entitlement program, as are Medicare and the Veterans Administration, Although the federal government recognizes a legal and moral responsibility for the well-being of Native Americans, neither funding levels nor minimum benefits packages are guaranteed. The range of services IHS provides is determined within the broad authorization of the Snyder Act of 1921 and delivered with “such moneys as Congress may from time to time appropriate.”

The IHS Health Care System

As long as eligibility for IHS services is not clearly defined, it will remain the central equity issue. In the battle for limited IHS resources, eligibility pits the reservation-based tribes that have services against the urban Indians and newly recognized tribes, the have-nots. Resources traditionally have been allocated among the twelve IHS service areas on a “program continuity” basis (that is, status quo), not on the basis of population size or service needs. Because of their government-to-government political relationship with the United States, each tribe believes it has a treaty right to its own comprehensive, free health care system (including as it does important employment opportunities for local Indians). Add to these expectations the enormous practical difficulties of delivering health services to small populations spread over the most isolated parts of thirty-two states, including the entire state of Alaska, and it is not surprising that IHS is not a perfectly rational and equitable health care system.

IHS is the largest direct provider of health care remaining in the U.S. Public Health Service. The IHS system consists of fifty-one hospitals, 124 comprehensive ambulatory centers, and nearly 300 smaller health stations. In 1985, the total IHS workforce was composed of about 10,400

individuals, including some 750 physicians, 2,800 nurses, 300 pharmacists, and 275 dentists. Nearly 60 percent of all IHS employees are American Indians and Alaska Natives, but only 3 percent of the physicians and dentists are Indian. Services not available or accessible from IHS facilities may be purchased from private providers under the IHS contract care program, but budget constraints have resulted in rather severe rationing of contract services.

IHS hospitals differ from the typical U.S. community hospital in that IHS hospitals are older (average thirty-five years old), smaller in bed size (average forty beds), and more limited in the range of inpatient services they provide. Five of the fifty-one IHS hospitals operate fourteen or fifteen beds; only five have more than 100 beds. The largest referral Indian medical center operates 170 beds, while the average U.S. community hospital has 177 beds (1984). IHS hospitals offer a relatively wide range of health-related and social support services, but fewer high-technology services. Only thirteen IHS hospitals maintain staffed general surgery services; a few more offer limited surgery using part-time contract surgeons.

Specialized services, such as cardiac intensive care, radiation therapy, organ transplants, burn care, neonatal intensive care, and others are available to IHS beneficiaries only through contract care, which is rationed on the basis of medical urgency. As a result, contract services for conditions that are not life-threatening may be deferred or denied. The severity of contract care rationing varies by IHS area, depending on the availability of IHS direct services and on the area's contract care budget. In two areas that have no IHS hospitals (California and the Pacific Northwest), all inpatient services must be purchased with contract care funds, unless Medicaid and other resources can be tapped. It is virtually essential in all IHS areas, for example, for Indians to be enrolled in the Medicare End-Stage Renal Disease Program or Medicaid to receive renal dialysis services.

An Immediate Problem: The Loss Of NHSC Physicians

The NHSC, in the Public Health Service, provides medical scholarships in exchange for one to four years of obligated service in areas with a shortage of health personnel, which include IHS sites. The future of the NHSC is critically important to IHS, because it has been the main source of physicians for IHS in the 1980s. From 1984 through 1986, IHS recruited 130 to 150 of the 200 new physicians it needs each year from the NHSC. During this same period, IHS recruited no more than fifty voluntary physicians a year. At least 60 percent of new physician recruits and 45 percent of all physicians now employed in IHS are paying back service obligations to the NHSC.

The number of physicians who will be available to IHS from the NHSC will be sharply reduced after 1988, and there will be none after 1991, because new scholarship awards have been practically eliminated since 1980. The Reagan administration justifies this policy by arguing that the national surplus of physicians will motivate new physicians to establish practices in increasingly rural locations, thus providing services to the underserved and eliminating the need for the NHSC.

While there is evidence of a growing surplus of physicians, and of physicians locating in less densely populated areas, these trends are not likely to solve staffing problems for IHS in the near future. Physicians in private practice are accessible to IHS beneficiaries only through the IHS contract care program. IHS will have to compete with other community organizations in recruiting physicians for rural group practices, and it often will be competing at a disadvantage. Not only are IHS facilities among the most isolated in the United States, with the associated problems of inadequate housing and community services, but IHS salaries and benefits frequently are not competitive. IHS can offer a new, three-year resident family physician about \$45,000 a year; even in rural areas, many communities can offer \$60,000 and up.

IHS is aware of the imminent loss of NHSC physicians and is taking steps to increase physician recruiting on a voluntary basis. Voluntary recruiting alone, however, is not likely to fill 200 physician vacancies a year in IHS. The consensus in IHS and the NHSC seems to be that a loan repayment program would be a more practical source of obligated physicians than the NHSC scholarship program. Renewed scholarship awards would provide no immediate relief to IHS, because medical students supported now would not be available until 1994 or 1995, long after IHS staffing needs would have become critical. A loan repayment program administered by the NHSC could recruit health professionals quickly to help fill IHS vacancies in 1988 and thereafter. A reduced default rate (now estimated in the range of 10 to 15 percent in the NHSC scholarship program) is seen as a major advantage of loan repayment. For a first-year cost of \$6 to \$8 million, the NHSC would contract with second- and third-year medical residents to assume \$15,000 of their educational debts for each year of obligated service (in addition to salary). Although the Reagan administration's 1988 budget proposal does not include a loan repayment program, if it were considered separately from the NHSC scholarship issue it might win support.

What May Happen?

At present, the IHS system probably is operating with a 10 to 20 percent shortage of clinical staff. If it loses its recruits from the NHSC and cannot replace them with voluntary physicians, IHS could be forced

to reduce or eliminate services, close facilities, rely more heavily on contract care, and refer eligible Indians to other payers, such as Medicaid, Medicare, and state and local programs for the medically indigent. In areas where IHS traditionally has served most Indians, this would be disruptive to the state and local programs, and unacceptable to IHS-eligible Indians.

Because of the potentially negative effects on Medicaid programs in many states (especially in states with large Indian populations, such as California, Arizona, Oklahoma, and Alaska), it is not likely that Congress would allow major reductions in IHS services to occur. The outcry would be too great, state governments and Indian tribes would besiege their representatives in Congress, and a variety of solutions such as the NHSC loan repayment program would be applied. Congress could encourage more demonstration programs, such as those to enroll Indian populations in health maintenance organizations, where they are available. Contracting out large parts of the IHS system to the private sector probably is not a feasible solution, because tribes would oppose it and private providers are not accessible to many IHS locations. Based on the assumptions that IHS will never be able to provide all services to all Indians, and that its service delivery capabilities may be reduced in the near future by physician shortages, it is reasonable to conclude that state Medicaid programs will continue to play an important role in caring for Native Americans.