Addressing the Health Care Needs of American Indians and Alaska Natives

Although the public health community is generally aware that American Indians and Alaska Natives have a higher burden of illness, injury, and premature mortality than non-Hispanic Whites,[1] the health care needs of this population are often excluded from policy discussions. This exclusion reflects, at least in part, an absence of data, a misperception that the Indian Health Service (IHS) is an adequate source of care for most American Indians/Alaska Natives, and a failure to recognize pervasive disparities. In this issue of the Journal, Zuckerman and colleagues plant the seeds of a long overdue national dialogue on the health care challenges facing American Indians/Alaska Natives.

UNMET NEEDS

Zuckerman et al. demonstrate that American Indians/Alaska Natives are more likely than non-Hispanic Whites to be uninsured and that troubling gaps exist in access to health care and rates of service utilization, particularly for low-income American Indians/Alaska Natives.[2] Almost half (48%) of low-income American Indians/Alaska Natives are uninsured. Given that more than half (55%) of American Indians/Alaska Natives have incomes below 200% of the federal poverty level ($28 256 for a family of 3 in 2001), compared with 25% of Whites, the impact on the community is widespread.

Included among the uninsured are American Indians/Alaska Natives who report receiving health care from the IHS. Slightly fewer than half of low-income American Indians/Alaska Natives with no other form of insurance have access to the IHS, making it important to understand the role and limitations of the IHS.

On the basis of treaties and federal statutes, the US government has a trust responsibility to provide health care to members of federally recognized tribes, a responsibility filled since 1955 by the IHS. In fiscal year 2003, the IHS received $2.5 billion in federal appropriations for its services. According to the IHS Federal Disparity Index, an additional $1.8 billion would be needed to provide active IHS users with services at the same level as services provided by the Federal Employees Heath Benefits program.[3] Despite serious resource shortfalls, however, the IHS has improved the health of American Indians/Alaska Natives.[4] Zuckerman et al. found that low-income American Indians/Alaska Natives with only IHS coverage fare better on several measures of health care access and utilization than uninsured American Indians/Alaska Natives without such coverage.[2]

Moreover, they do approximately as well as low-income insured non-Hispanic Whites on most measures of access and utilization, although they do less well on receipt of preventive health services, including breast examinations.

The IHS, however, has a limited reach. In the 2000 US census, 4.1 million people, representing 1.5% of the population, identified themselves as either Native American or Native American in combination with another racial group.[5] The IHS provides care to approximately 1.5 million of these people. Some of the remainder are ineligible for services because they are not members of federally recognized tribes. Many others are geographically distant from IHS sites. When the IHS was created, the vast majority of American Indians/Alaska Natives lived on or near reservations, and IHS health care facilities were nearby. Today, with the majority of American Indians/Alaska Natives living in cities, the location of most IHS sites has become a major barrier.[6]

OPPORTUNITIES FOR THE PUBLIC HEALTH COMMUNITY

The findings of Zuckerman and colleagues challenge us to improve access to culturally competent care for all American Indians/Alaska Natives. The Institute of Medicine points the way forward in the recommendations that emerged from its assessment of racial and ethnic disparities in health care.[7]

The Institute of Medicine deemed an emphasis on data collection "critically important" in the effort to understand and eliminate these disparities.[7(p21)] Collecting and analyzing local, state, and national health care data pertaining to American Indians/Alaska Natives ensures that their unique issues are not lost in aggregated figures. For example, when the US Census Bureau releases its annual reports on the number of uninsured Americans, information on American Indians/Alaska Natives should be provided. We should also be able to draw on the major national health care data sources, including the Medical Expenditure Panel Survey and the Medicare Current Beneficiary Survey.[8,9] In addition, the regional data collection and analysis efforts of the 6 epidemiology centers run by the tribes themselves, with IHS funding, deserve support. We also need to understand how the dramatic increase in tribal management of IHS facilities under the 1975 Indian Self-Determination Act (Pub L No. 93-638) has affected health care disparities.

Strategies that have improved access to health care for other underserved populations need to be identified and studied. Medicaid is one possible mechanism for reaching low-income American Indians/Alaska Natives, but the community itself will have to decide whether to pursue this approach. Relying on a state-administered, means-tested entitlement program, as well as on appropriations, may provide greater financial stability. On the other hand, Medicaid itself is under stress, and such a shift could inadvertently weaken the federal government's obligation, contained in treaties and case law, to provide health care to American Indians/Alaska Natives. Other options to explore might include conducting an assessment of how the IHS deploys its limited resources or proposing federal legislation, accompanied by adequate appropriations, to redefine the scope of IHS services or expand eligibility criteria.

In its report on educating public health professionals, the Institute of Medicine emphasizes cultural competency "as an essential element in teaching, research and practice."[10(p84)] Public health professionals in academic and practice settings can increase their own awareness of American Indian/Alaska Native health care issues and can educate others. Assessing the extent to which American Indian/Alaska Native health issues are integrated into the curriculum at schools of public health is another important step. Given the data that demonstrate an association between racial concordance of patient and provider and greater patient participation in care,[11] it may be appropriate to use outreach and academic scholarships to encourage American Indians/Alaska Natives to enter the health professions.

Zuckerman et al. have performed an important service in highlighting the health care disparities faced by American Indians/Alaska Natives. With American Indians/Alaska Natives taking the lead, public health professionals can promote a dialogue about how best to meet the needs of members of this population without health insurance coverage or access to IHS facilities. A wide range of stakeholders, including federal and state policymakers, the business community, and health professionals, should be part of that dialogue. ■

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