American Indian and Alaskan Native (AI/AN) Health and Indian Health Care Improvement Act

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Policy Brief Overview

There are currently an estimated 5.6 million American Indian and Alaska Natives (AI/AN) that reside in United States.[4] Of the 1.7 percent of the US population that are made up of AI/AN, the US federal government provides health services through the Indian Health Services (IHS) for approximately 2.6 million AI/AN.[4]

The Indian Health Care Improvement Act is the cornerstone legal authority for the provision of health care to American Indian and Alaska Natives in the United States. The goal of this piece of legislation is to increase access to health care services for AI/AN populations. This policy brief will also outline the biggest inequities and disparities in health AI/AN women face. This policy brief will assess and analyze the IHCIA and its impact on AI/AN health. Lastly, this policy brief will outline the gaps and benefits of the IHCIA and draw conclusions and recommendations for reform from stakeholders in the field.

Key Issues among AI/AN Women

AI/AN suffer from some of the worst health disparities including maternal mortality, depression, and cardiovascular disease.[5] American Indian and Alaska Native Women have the highest rate of maternal mortality in the country. AI/AN women have a two times higher rate of maternal mortality than non-Hispanic white women.[1] Furthermore, AI/AN women are 2 to 3 times as likely to die from a pregnancy-related cause than white women with the PRPMs rate being 32.8 and 32.5, respectively.[1] This disparity increases with age and studies show that even with higher education, disparities persist proving that this is a major national issue.[1] Approximately 3 in 5 of pregnancy related deaths are preventable.[1]

Mental health disorders rank in the top 10 leading causes of hospitalization and outpatient treatment within the Indian Health Services (IHS).[5] As mentioned, the IHS only services less than half of the entire AI/AN population in the US. Mental health disorders are under tracked and recorded in the American health system and remains a major burden of health on AI/AN women. There are many factors that contribute to mental health of AI/AN women including genocide, uprooting from homelands and tribal communities, bans on cultural practice and limited economic opportunity.[5] Furthermore, mental health and interpersonal and domestic violence are correlated when it comes to AI/AN women's health. AIAN women report more violent victimization than any other racial background.[1] In a study done by the Centers for Disease Control and Prevention, AI/AN women were significantly more likely than white women to report they were raped. Additionally, AI/AN women were more likely to report they were stalked.[1] This shows that AI/AN women are experiencing more trauma and violence which puts them at a higher risk for mental health disorders because of the violence they experience.

Furthermore, AI/AN women face huge barriers when it comes to accessing health care. Some of the major barriers for accessing care are distance and lack of transportation, poor coordination among clinical staff, scarce tribal

and IHS programs, and historical distrust of programs. One study shows 68 percent of a Western tribe stated they had no transportation to get to their appointments.[3]

Indian Health Care Improvement Act

The Indian Health Care Improvement Act (IHCIA) is the cornerstone legal authority for the provision of health care for American Indians and Alaska Natives. The IHCIA was reauthorized permanently under the Patient Protection and Affordable Care Act. Under the IHCIA, IHS and tribal programs are allowed to bill Medicare and Medicaid and receive reimbursements for services provided to AI/AN from Medicare, Medicaid and Children's Health Insurance Program (CHIP).[6] This expanded access to health services quite significantly and changed the amount of funds states pay for medical health services for AI/AN. Nonetheless, the underfunding of IHS remains a prominent issue and has lead to significant challenges in providing the services AI/AN need which will be discussed herein. In a study done by the National Tribal Budget Formulation Workgroup, IHS is the least federal health expenditure in the United States when compared to Medicaid, veterans, Medicare, and Federal Employee Health Benefits. This shows that although the IHCIA has allowed IHS programs and facilities to bill for their health services, underfunding of IHS remains a clear and prominent issue that leads to increased inequities and disparities in health.

Key Findings

In a survey implemented by the American College of Obstetricians and Gynecologists, we wanted to understand the opinions of clinicians when it comes to issues affecting AI/AN women. We surveyed nearly 100 clinicians that serve AI/AN women and asked them to rank maternal mortality, mental illness and interpersonal and domestic violence from least important to most important. 44 percent of survey responses said that mental health was the number one most important health topic that must be addressed. 48 percent of survey responses said that interpersonal and domestic violence is the second most important topic that must be addressed within AI/AN women. Lastly, 59 percent of survey responses said that maternal mortality is the third most important issue that needs to be addressed among AI/AN women.

This shows that there are still existing disparities when it comes to maternal mortality, mental health and interpersonal and domestic violence and AI/AN women. Particularly when it comes to mental health, clinicians believe that AI/AN women are impacted the most. The IHCIA must allocate additional funds to IHS to address these issues and bring relief to AI/AN women.

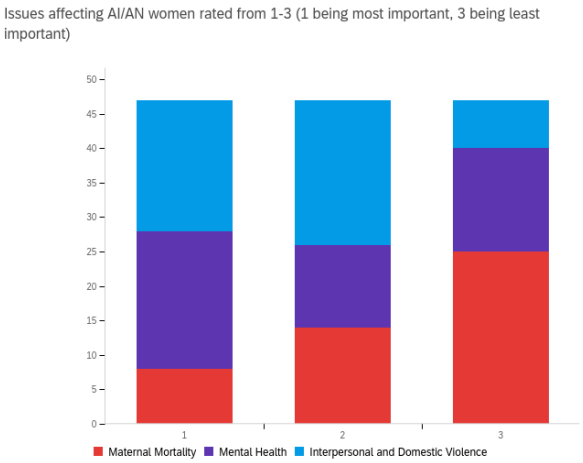

Figure 1.0

In figure 2.0 you will see a pie chart that shows data about the biggest barriers AI/AN women face. Clinicians were asked which of the major barriers to health care were the biggest barriers AI/AN women face. Approximately 41 percent of survey participants selected that distance and lack of transportation is the biggest barrier to accessing health care services. 23 percent of survey participants selected scarce tribal and IHS programs. Poor coordination among clinical staff and historical distrust in programs came next with 13 percent of survey participants selecting poor coordination among clinical staff and 13 percent selecting historical distrust in programs. Historical distrust is caused by a long history mixed with conflict, warfare, cooperation and partnership.[5] Events in history have caused AI/AN individuals to be reluctant when receiving care from a federally funded program of health institution. Lastly, approximately 8 percent of survey responses said that cultural barriers is the biggest barriers AI/AN women face when accessing health care services. Many programs implemented by the IHS do not implement culturally sensitive and appropriate interventions which further leads to disparities and inequities in health.

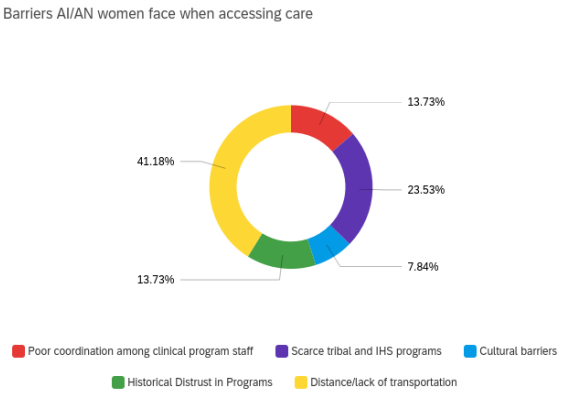

Figure 2.0

In Figure 3.0 you will see a bar graph that will show data on the familiarity of the Indian Health Care Improvement Act among Clinicians who serve AI/AN. This question showed that the majority of clinicians, over 40 percent, were not familiar with this act. This shows that not only is there a gap within the health care system about the knowledge that will improve health of AI/AN, but clinicians aren't playing an active role in knowing what resources are available to their AI/AN patients. The familiarity of the Act is directly correlated with the ability to improve health and availability of services to individuals.

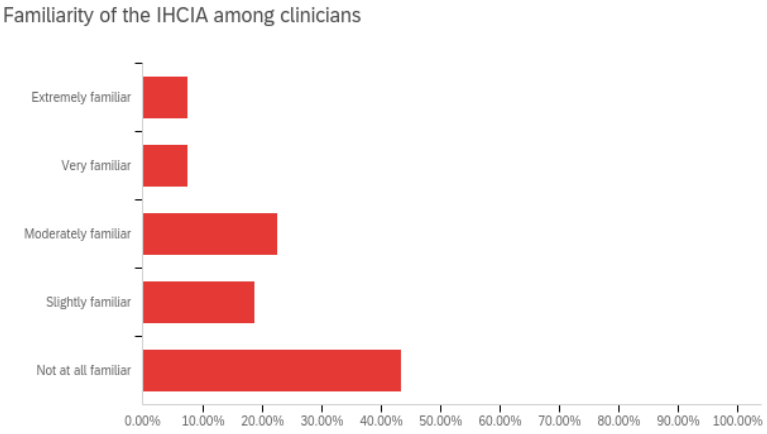

Figure 3.0

Clinicians were asked how well-known they believe the Indian Health Care Improvement Act is within the AI/AN population. Clinicians responded that 32 percent of AI/AN are slightly aware of the Indian Health Care Improvement Act. 26 percent are moderately well aware, 16 percent extremely well aware and 16 percent not well aware at all.

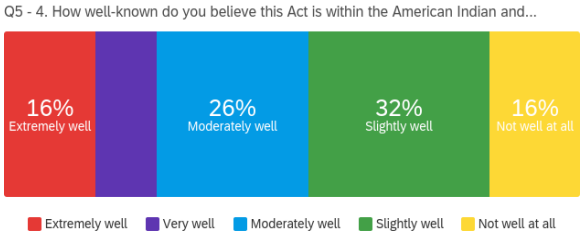

Figure 4.0

Clinicians were asked what the biggest benefits of the IHCIA are for AI/AN populations. The number one answer was increased access to preventive health services. Preventive services are the leading benefit of the IHCIA, however a referrals such as a colonoscopy could be denied by the IHS as the IHS does not act as a insurance to AI/AN. Although the screening would be covered, the expenses and referrals following that visit would not. As a result, disparities and inequities increase and AI/AN are unable to receive the services they need. Furthermore, only 28 percent said availability of tools for women's health. Approximately 24 percent said increased access to women's health services and 17 percent said increased support of health care delivery. Furthermore, those who are not aware of the IHCIA are unable to reap the benefits of the act as listed below. Many clinicians may not be billing Medicare and Medicaid if they are unaware of the covered services that are available for their patients.

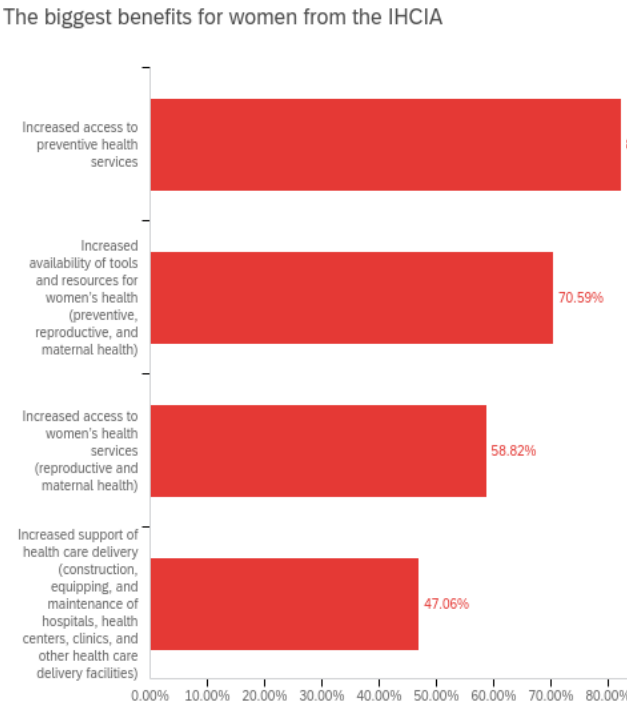

Figure 5.0

#	Field	Percentage
1	Additional Funds	5.26%
2	Expansion of programs for mental and behavioral treatment and prevention	15.79%
3	Expansion of authorities for long-term care services, including home health care, assisted living and community based care.	5.26%
4	Improvement of third party reimbursements to IHS facilities	0.00%
5	All of the above	78.95%
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Showing rows 1 - 6 of 6

Figure 6.0

Clinicians were asked how could the IHCIA be improved. 65 percent of clinicians responded that all of the above are ways the IHCIA can be improved. The list is as follows: expansion of programs for mental and behavioral health, additional funds, expansion for long-term care services, including home health care assisted living and community based care and improvement of third party reimbursements to IHS facilities.

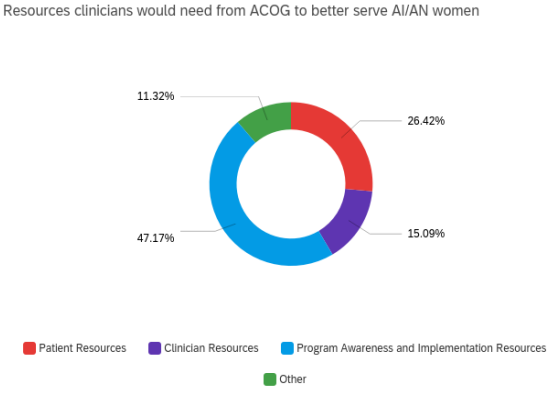

Figure 7.0

Clinicians were asked what resources they need from ACOG to serve AI/AN women. 47 percent of clinicians responded that they need program awareness and implementation resources. Approximately 26 percent of clinicians responded that they need patient resources.

Approximately 15 percent of clinicians responded that they are in need of clinicians resources. Finally, approximately 11 percent of clinicians responded other. In the policy implications and conclusions, stakeholders from the field will identify what other resources may be useful as this time.

Policy Implications and Conclusions

Below are conclusions and policy implications and recommendations from stakeholders in the field.

- The IHCIA must include reimbursements and additional funds for transportation of AI/AN to health and medical visits.
- Specialized care must be expanded into the IHCIA to improve AI/AN health.
- The IHS remains underfunded and is need of additional funds for program implementation and awareness. Congress must approve additional funds. Issues affecting AI/AN women go beyond the health care system.
- The IHCIA must include funds to improve COVID-19 relief and resources to AI/AN populations.
- Guidance is needed from ACOG on COVID-19 in AI/AN populated areas in the United States.
- Quality and evaluation measures should be created and incorporated into the IHCIA for improvement of health of AI/AN across AI/AN programs and facilities.
- A next step to increase resources from ACOG would be to engage with clinicians from different specialties and not only those who are OBGYNs.

Sources

[1]Centers for Disease Control and Prevention. (2000). *Full report of the prevalence, incidence, and consequences of violence against women.* Retrieved from: https://stacks.cdc.gov/view/cdc/21948

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[6]Warne, D., Frizzell, L. (2014). *American Indian Health Policy: Historical Trends and Contemporary Issues.* Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035886/