Introduction to Indian Health Services Federal Health Program

Indian Health Services (IHS), established in 1955, is an agency within the Department of Health and Human Services initiated as a means to provide federally funded health care to the American Indian (AI) population. The IHS mission is to provide this population with the highest possible level of medical care to 1.9 million American Indians in 566 federally acknowledged tribes across 35 states (IHS, 2013). This federal health program is meant to adequately assist in the care of this vulnerable population however, the current laws cause this promised health coverage to fall far below the standard of helping American Indians and their medical needs. One in three American Indians, 65 years and younger, rely solely on IHS for health care. Of these documented American Indians, 27.6% still lack the access to medical assistance despite the IHS government aided health coverage (US Census, 2012). Even though 32% of these AI population fall at or below the poverty line (national average at 13%) many still do not qualify for any supplemental health programs such as Medicaid and Children’s Health Insurance Program (Warne, 2006).
Despite the intended services provided by IHS not all reservations have access to the necessary services to provide comprehensive care. According to multiple studies, the health program run by the IHS has improved acute disease outcomes in the AI population nonetheless due to underfunding, have been unable to manage chronic illness leaving many American Indians vulnerable to health disparities compared to the majority of United States citizens. As an advanced practice nurse functioning within the IHS system, it is critical to have an understanding of how this type of medical program is run and where there is a deficit so an attempt can be made to better assist this population in receiving the highest possible overall care.

**Background Information**

Beginning early in our American history, a relationship was established between the United States government and the American Indians with the negotiation of land in the form of verbal treaties promising federal health care and other services to the AI people. For many years, the verbal agreements were empty and not upheld. Legislation eventually appeared when it was determined by the Supreme Court, in the case of Cherokee Nation vs Georgia in 1831, that the United States has a legal obligation to “raise the standard of living and social well being of the Indian people to a level comparable to the non-indian society” (Westmoreland, 2006). However, it wasn’t until the 19th century when smallpox devastated many American Indian tribes that the ruling of the 1831 court case was upheld and action was taken to raise the AI’s living standards. The Snyder Act of 1921 was the first legal authorization to federally fund the government’s verbal promises of the past. This bill was the key to establish legislative authority to allocate funds for the overall medical care of the American Indian
Indian Health Services (IHS) itself was not established until 1955 and was created to finally disentangle the government’s obligation to provide health services to the American Indians. Unfortunately, minimal funding was provided for the promised health care regulations and the mid-1970’s brought disparities with the initiation of the Congressional Act of 1974. This act placed the medical needs of American Indians in the discretionary spending instead of mandatory spending category of congress yearly funding causing further deficits in financing the overall IHS health care system. In 1976, Congress passed the Indian Health Care Improvement Act (IHCIA) with the intent to provide American Indians with the necessary resources for Indian Health Services to provide legitimate medical care. Goals for IHCIA were instituted at the release of this Act by Congress in the hopes to provide quality care for this minority population. However the IHCIA Act expired in 2001 and was not reinstated by Congress.

Over the years, many legislation were enacted in an attempt to address and implement concerns to create the current IHS health system, however, many did not provide betterment but rather negatively impacted the overall IHS health system of care.

**Program Overview and Eligibility**

The Indian Health Services (IHS) was enacted by the US government to provide healthcare to the American Indians. The IHS is divided into twelve separate regions with 161 clinics and hospitals each being managed separately by IHS staff, all addressing different issues depending on tribe and location. Many times, IHS is the sole provider of medical care to many of the 1.9 million AI in this
In order to be eligible for health insurance through the Indian health services an individual must meet specific criteria. According to the IHS manual, an individual must be able to prove they are American Indian descent by: the reservation acknowledging the person as a member, the community regarding him/her as an AI, he/she resides within the tribal territory, and/or is a participant in affairs of the tribe. Some exceptions lie within the stipulations of service, which include: an Indian of Canadian or Mexican origin regarded as a tribal member, a non-Indian woman pregnant with an AI’s child that carries baby to term, or a non Indian member living within an established Indians residence that is in need of care that would otherwise impact the overall public health of the community (IHS, 2013).

IHS provides a list of potential programs varying from acute (ambulatory and inpatient care), to ancillary (lab, pharmacy, radiology) to preventative services (clinics, education programs, immunization, and rehab) (IHS, 2013). However depending on region and funding, many reservations access to these programs is usually very limited. According to the IHS website, there are no guarantees that all services will be provided in all regions. Regardless of the potential gaps in health care, AI tribe members may qualify for the Contract Health Services program allowing for extend care outside the limits of the designated Indian clinics/hospitals.

Contract Health Services or CHS is a program funded by the IHS that provides health services outside the boundaries of the basic Indian community. If qualified, an individual will be provided with financial coverage or reimbursement for services provided outside the system. Potential services that CHS may cover include medical emergencies, a consult/ visitation by a specialist, inpatient hospitalization, medical supplies, travel reimbursement, dental, pharmacy, or optometry care (Indian Health Services, 2013). CHS funding is based on medical needs and is regulated by a federal code of
regulations. The priority of the CHS program is based on levels of care ranging from Level I (most critical) to V (non life threatening). The reality of this program is most tribes only have been allocated annual funding that barely covers Level I or critical needs. According to a 2005 study by the General Accountability Office (GAO), the majority of health funding is directed to emergency services leaving some reservations without access to any non-urgent care. According to the study, of the 13 facilities reviewed, 7 had no or limited access to cancer screening and 11 facilities had no or limited access to address chronic pain issues (GAO, 2005). These statistics demonstrate that overall preventative care of chronic illnesses on Indian reservations is much to be desired. In some cases the GAO study found that some facilities had no funding available for such referrals to be subcontracted. The CHS overall lacks appropriate funding to effectively give any extra recommended care.

**Pros and Cons of Indian Health Service Federal Health Program**

Even though the Indian Health Service federal health program is a free program to qualified American Indians, one can still constructively evaluate for both the pros and cons within the system. One advantage of the Indian Health Services health program is that it relinquishes an already vulnerable population some access to healthcare. Due to high poverty levels and isolated Indian reservations, many AI would otherwise be without any health care.

When evaluating individually initiated programs there has been a substantial advancement made in the management of Diabetes within the AI tribes. Diabetes has highly impacted a large percentage of the AI’s population. Statistics have demonstrated AI are 2.4 to 6 times more likely to develop Diabetes than the average American (Stang, 2009). The study also suggests a significantly higher rate of diabetic
complications (cerebrovascular disease, hypertension, amputations, kidney and liver disease) compared to an insured American outside the IHS system. This results in diabetes being the fourth leading cause of death for American Indians, exceeding the average US Diabetic American by 50% (O’Connell, 2010). Because such disparities exist between diabetes in American Indians and the rest of the US population, the government initiated time and funding in an effort to improve the disproportionate gap amongst American Indians and the general population. With the initiation of legislation passed in 1997 to provide more federal funding to AI diabetes care, IHS has witnessed marked improvement in the management of diabetes. Along with continued diabetic prevention education led by the American Indian community, initiation of continued monitoring and management by health care providers was imperative to the program’s success. An evaluation of these funded programs in 2001, showed improvement not only in the diabetic markers (HbA1C, blood glucose levels) but also marked advances in blood pressure and cholesterol levels as well in those American Indians with diabetes involved in these community led programs (Wilson, 2005). Using this data one can deduce that with the right funding and appropriate tribal staff, the American Indian healthcare has the potential to succeed. Although there is hope within the system, much of the IHS program is still lacking for the majority of American Indians on the government’s health plan. Overall, when evaluating the pros and cons of the IHS program, there is by far more deficits than positive advancements for the AI population medical care.

According to a study completed by the Epidemiology and Health Service Research, American Indians IHS medical care significantly lags behind the average American with traditional health insurance. Statistics have shown American Indian adults have the highest rate of diabetes, obesity, and cardiovascular disease than any other ethnic group (Stang, 2009). Not only do American Indians have the highest rate of these diseases compared to all other ethnicities in the United States, studies have
shown that American Indians have the shortest life expectancy of any other race (Warne, 2006). This being said, one must ask how it is that there is such a stark contrast in results from AI’s health and that of the rest of the country.

One major reason for the difficulties in providing healthcare is the inability to appropriately fund the IHS program. As previously mentioned, the health care funding is allocated by the yearly government budget in the discretionary spending category. A study conducted in 1999 by the Level of Funded Workgroup (LNF) suggested that the IHS is only funded at 54% of what is needed to efficiently run the insurance plan (Westmoreland, 2006). In comparison to mandatory spending programs like Medicare and Medicaid, IHS funding (through discretionary spending) has caused a huge gap difference in the amount of money allocated. In an analysis completed from 1980-2002, overall Medicare grew 7.8% per year while IHS only increased 4.8% yearly. This equates to a growth of $5200 per person for medicare and only $1121 per person for IHS individuals, a huge gap that continues to grow with each passing year (Westmoreland, 2006). Given the government’s inability to adjust funding for AI’s medical needs based on inflation, this has potential to further jeopardize an already lacking American Indian insurance healthcare system.

Another major funding component that causes the IHS health program to lack is its inability to care for the chronically ill AI patients within these communities. As the General Accountability Offices study of 2005 suggests, not enough emphasis is being placed on long term care of chronic diseases which in turn results in the overall health disparity of the average AI under the IHS plan. As suggested in much of the literature, lack of funding has created much of the discrepancy seen across the IHS system. An example of how the lack of funding impacts care of the chronically ill on the most fundamental level, one can inspect the allocation of medications to IHS patients. Because of the limited access to certain
expensive diabetic pharmaceuticals medications, one with diabetes is limited to what medications are
distributed on the reservations. Due to cost of the long acting medication, once a day dosing diabetic
medications is unavailable leaving only twice to three times a day dosing of medication to be offered.
This limited access to convenient medication decreases the likelihood of compliance and leads to poor
overall diabetic management (Warne, 2006).

Other than financing disparities, lack of access has presented a problem to meet the basic
necessities of medical services. This means overcoming even the most simple barrier of lacking
transportation to secure basic health care at reservation clinics or facilities. In a study conducted
amongst 60 year old American Indians and non-Hispanic whites (NHW), American Indians were
extremely limited on access to health care compared their counterparts resulting in poorer health
outcomes (Kim, 2012).

Among other important limitations of the IHS system found were lack of ancillary services being
available, lack of equipment, and even staffing deficits were common at clinics available to American
Indians. Due to staffing issues, something as simple as making an appointments can be difficult and may
result in long time lapses between the request for services and the actual date of being seen by a
healthcare provider (GAO, 2005). Overall, many of the components to make this IHS health system an
effective medical vessel are lacking, making it impossible to provide overall comprehensive medical care
to the AI population.
Recommendations and Conclusions

Although the Indian Health Services intent was to service the Indian communities overall health, it has proven to be ineffective overall. The staggering statistics have shown not only the system is lacking in the currently provided services, but also the overall health of American Indians has been declining—not improving over the years the IHS federal health program has been in place.

Some programs like the diabetic initiatives of 1997 have proven to be a positive glimmer of hope and deemed that the system is not a full loss. It appears that those tribes that take control and manage their own health systems have largely been more effective than those tribes that allow IHS management to lead. It is in these tribes that successfully lead the direction of their own health care that provide more wellness programs, build more healthcare facilities including fitness centers, and find more financing from third party sources (Roubindeaux, 2002). Like in the case of diabetic patients, tribes that have taken control and become involved have seen an influx of positive changes in their fellow AI’s overall health.

The current system may be lacking but further changes appear to be on the horizon. As the Affordable Care Act unfolds we should be witnessing more improvement in the Indian Health Services health system. As part of the new Obamacare, the Indian Health Care Improvement Act (IHCIA) of 1976 will be improved and made permanent as part of the new reform. Some of the specifics of the IHCIA include improvements of Contract Health Services, funding for more health care professionals, patient travel cost coverage, and expansion of community programs. With the promise of improvement and change, there is hope that practicing healthcare professionals such as advanced practice nurses, will
have the needed resources to provide quality care.

However as of today, healthcare professional involved in the Indian Health Service system are fully aware of the current limitations to create a quality centered health care system for the American Indian population. At this point and time it will fall on medical personnel to be aware that success hinders on pressure being placed on program planning and community involvement in order to really make a difference for the American Indians health in this country.
References


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