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POLICY BRIEF

Increasing Funding for the Indian Health Service to Improve Native American Health Outcomes

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For many decades, Native Americans have experienced higher rates of health problems than the general American population and other racial minority groups.[1] Today, the average Native American dies five and a half years sooner than the average American.[2] In the recent past, Native Americans have suffered disproportionately from the COVID-19 pandemic. During the first year of the COVID-19 pandemic, Native Americans faced the highest rates of infection, hospitalization, and death due to COVID-19 when compared with any other race or ethnicity in the United States.[3]

At least two important causes are behind the poorer health outcomes that Native Americans experience. First, the Indian Health Service (IHS), a healthcare system funded and managed by the federal government, has struggled chronically with underfunding and bureaucratic shortcomings. Second, the pervasive poverty that many Native Americans experience has contributed to poor health outcomes. Institutions that raise transaction costs of economic development and innovation perpetuate poverty, contributing to worse health outcomes.

Improving Native American health will require both immediate, small-scale policy changes and long-term, large-scale institutional reforms. In terms of small-scale policy changes, Congress could increase funding for the IHS, which is an immediate and practical solution for delivering more healthcare to more individuals. However, increasing IHS funding will not solve the underlying management problems in the IHS or the institutional problems contributing to widespread poverty. This brief focuses on the shortest-term solution—increasing IHS funding. Other briefs in this series tackle larger, longer-term changes to IHS management and reforms to broader governance institutions on reservations.

UNDERFUNDING IN THE IHS

The roughly 70-year history of the IHS has been characterized by significant resource constraints. Many scholars have argued that the IHS is severely underfunded, and some believe that the IHS receives only half of what it needs to provide adequate service.[4] Since the federal government became involved in Native American healthcare, it has allocated smaller proportions of money per capita to the IHS than any other federally funded healthcare program.[5] Medicare, Medicaid, the Veterans Health Administration (VHA), and federal prisons receive two to three times as much federal funding per person. The Government Accountability Office (GAO) finds that in 2017, IHS per capita spending was $4,078, as compared with $8,109 for Medicaid, $10,692 for the VHA, $13,185 for Medicare, and $8,600 for federal prisoners.[6]

Compared with other federal direct providers (e.g., the VHA) or public insurers (e.g., Medicare and Medicaid), the IHS spends much less annually and serves a much smaller number of individuals. In 2017, the IHS spent a total of $6.68 billion, which represents less than 10 percent of the VHA's spending and roughly 1 percent of spending by either Medicare or Medicaid. Also in 2017, the IHS served about 1.6 million individuals, which is about one-quarter of the number of individuals that the VHA serves and less than 3 percent of the number served by Medicare or Medicaid.[7]

However, it is important to note that the IHS, the VHA, Medicare, and Medicaid significantly differ in many ways, including their design, structure, funding, population needs, and services provided. Thus, such differences make it difficult to do an accurate apples-to-apples comparison of these federal programs. Despite the difficulty in making interprogram comparisons, the widespread scholarly consensus is that the IHS is underfunded, and the continued poor health outcomes for IHS recipients support this consensus.

The IHS receives the bulk of its funding through congressional appropriations (mainly discretionary), as well as collections from reimbursement, including Medicare, Medicaid, the State Children's Health Insurance Program, the US Department of Veterans Affairs, and private insurance.[8] The IHS Division of Budget Formulation prepares and manages the annual IHS budget justification to Congress, in which it makes the case to Congress for certain budgetary allocations. For fiscal year (FY) 2021, the IHS requested $6.4 billion for all its operations.[9] Congressional appropriations to the IHS have been growing incrementally over the past few years, from $4.8 billion in FY 2016 to $6.0 billion in FY 2020.[10] IHS funds are directed to many different programs, such as facility maintenance, clinical services, and preventive health measures.[11] The IHS is the only major federal healthcare provider whose funding comes solely through regular, annual congressional appropriations.[12]

The IHS is a payer of last resort, and its facilities seek reimbursement from third-party insurers when applicable, including Medicare and Medicaid, meaning that the actual government spending per capita is somewhat higher than just IHS spending per capita. For example, roughly 23 per-

cent of Native Americans using Medicare also list the IHS as a source of coverage.[13] Calculating a straightforward number of healthcare-related government spending per Native American is difficult because multiple factors and funding sources need to be considered, but each of those factors and funding sources does not necessarily apply to all Native Americans. Despite this difficulty, IHS funding levels are especially important for the segment of the Native American population that relies solely or largely on the IHS for its healthcare.

EFFECTS OF INSUFFICIENT FUNDING

In the IHS system, less immediate health issues are often neglected due to funding shortages or the lack of staff or equipment for on-site services, leading to relatively long wait times for routine healthcare services and gaps in ancillary services. The IHS has chronically struggled to provide adequate services in a timely manner, especially in poor, rural areas. Additionally, staffing vacancies and aging infrastructure and equipment have increased the wait times in many IHS facilities. In a 2005 GAO study of 13 randomly selected IHS facilities, four facilities reported that patients routinely had to wait more than a month for some types of primary care. In some cases, wait times in the IHS ranged from two to six months, especially for women's healthcare, general physicals, and dental care. Such long wait times exceed the standards of other federally operated healthcare systems. For example, policies in the US Department of Veterans Affairs dictate that nonurgent outpatient appointments should be completed within 30 days for eligible veterans with high priority. Within the US Department of Defense's managed care program, routine appointments should be completed in 7 days and routine specialty care appointments in 30 days.[14]

More than a decade after that 2005 study, a 2016 GAO investigation found that wait times were still long. This study found that the IHS "has not conducted any systematic, agency-wide oversight of the timeliness of primary care provided in its federally operated facilities and, as a result, cannot ensure that patients have access to timely primary care," which does not comply with federal internal control standards.[15] Despite ongoing problems, IHS officials in various area offices have been attempting to solve the problems. In the Great Plains Area, some facilities have expanded their daily hours to 7 a.m. through 11 p.m. to better serve IHS patients. In the Phoenix Area, some IHS facilities now schedule "nursing only" visits where a doctor is not required, such as vaccinations.[16]

Mental healthcare is also in short supply. The GAO has reported that roughly one-quarter of IHS outpatient mental healthcare services do not have the capacity to meet the demand for mental healthcare. For example, managers at one facility stated that two to three times the amount of psychiatric care was needed.[17]

The GAO has also found frequent gaps in diagnosing and treating nonemergency medical conditions that cause pain or some degree of disability.[18] Thus, the agency's funding constraints have made it difficult to respond to the fluctuating needs of the population in a given year.[19]

Federal agencies, such as the Centers for Medicare and Medicaid Services, have suggested that individual Native Americans should consider getting health insurance because the IHS's funding limitations generally prohibit Native Americans from receiving all the healthcare they may need or want.[20] Like other Americans, Native Americans may purchase their own private health insurance to cover healthcare expenses that the IHS does not or cannot fund. However, owing to the combination of no-cost IHS services, high rates of poverty, and low employment rates, Native Americans lack health insurance at rates higher than national averages.[21] Approximately 36 percent of Native Americans have private health insurance coverage. Because of high rates of poverty, Medicaid covers roughly 34 percent of nonelderly Native Americans, leaving the remaining 30 percent of Native Americans to rely completely on IHS services or to pay out of pocket. For comparison, 62 percent of the overall nonelderly population in the United States has private health insurance.[22] Health insurance could provide more access to healthcare that Native Americans do not receive under the status quo in the IHS. However, the realities of poverty and unemployment cause Native Americans to face, on average, some of the largest barriers to accessing health insurance.

Similarly, financial constraints have meant that IHS facilities can provide and pay for only a limited range of services. The IHS often runs out of funding for specialty services that are contracted out within their fiscal year, leaving many patients to pay fully out of pocket, use health insurance, or go without care.[23] The IHS provides services to eligible patients at no direct out-of-pocket costs, but it is not an entitlement program, like Medicare or Medicaid, or an insurance program. When congressional funds are exhausted in a given fiscal year, the IHS must limit the services it directly provides or the services it pays for through Purchased/Referred Care (PRC) at non-IHS facilities.

If a Native American patient receives services at a non-IHS facility, there is no guarantee that the IHS will pay for any services through the PRC program. Patients must meet several requirements to have the IHS pay for PRC services, including residency requirements, notification requirements, medical priority, and use of alternate resources. Additionally, authorization to use PRC funds is allowed only when an IHS beneficiary has exhausted all other healthcare resources available, such as private insurance, state health programs, and Medicaid. Thus, many Native Americans are left with unmet healthcare needs, especially those with limited access to private insurance, Medicare, or Medicaid.[24]

The IHS must engage in healthcare rationing because it does not have enough funding to pay for all the medical needs of eligible Native Americans, meaning that IHS officials have no choice but to prioritize who receives care and what kind of treatments they will receive. Regulations and guidance for making rationing decisions can be found in the *Code of Federal Regulations*, especially title 42, sections 136.23, 136.24, and 136.61, as well as Indian Health Manual, part 2, chapter 3: manual exhibit 2-3-B. Depending on resources and local demands for care, imaging for preventable cancers such as colon, breast, and cervical cancers are not always available. Similarly, diabetic eye

exams to prevent loss of vision are rare, despite many Native American populations having some of the highest rates of type II diabetes in the world.[25]

Related to the problem of underfunding is a problem of understaffing. Across the IHS system, hospitals and health centers are having trouble retaining staff members. A 2019 *New York Times* analysis and a 2018 GAO report have found that roughly one-quarter of all medical positions within the IHS are vacant. In some locations, the vacancy rate is roughly 50 percent.[26] In recent years, IHS hospital administrators have expressed concerns about the inability to recruit and retain staff members, which leads to a dependence on temporary personnel, acting personnel, and contracted providers.

The GAO has found that IHS facilities lack enough permanent doctors or nurses to provide quality and timely healthcare. Although the IHS has taken steps to recruit and retain providers, such as offering financial incentives and housing, vacancies remain a problem. The GAO has found that the IHS cannot usually match local market salaries and does not have enough housing to meet its demand for IHS healthcare providers. Thus, the IHS has become reliant on hiring temporary providers, which can be problematic because (a) it may be more costly on some margins, and (b) it may result in lower quality patient care over time.[27]

THE BIGGER PICTURE OF REFORM

Increased funding will not solve the IHS's underlying institutional problems or other socioeconomic factors that contribute to the generally poorer health of many Native Americans. However, increased funding will likely solve some of the problems that the IHS faces, such as healthcare rationing, deteriorating physical facilities, aging medical equipment, and a shortage of trained medical staff. The question of how much funding Congress should appropriate to the IHS is difficult because policymakers must find the margin of funding that (a) reasonably allows the IHS to fulfil its legal obligations without being wasteful and (b) is democratically acceptable.

Because IHS funding comes through Congress's annual fiscal year appropriations cycle, delays in the appropriations process lead to uncertainty and disruption for the IHS's operations. To partially resolve this problem, Congress could grant the IHS advance appropriation authority. This appropriation system has already been implemented in the VHA, which is currently the only federal agency that receives advance appropriations for its healthcare program. Congress granted the VHA advance appropriation authority for specified medical care accounts in 2009.[28] If Congress were to consider granting the IHS advance appropriation authority, it could use the VHA system as a template and modify the details as necessary to fit the IHS's unique context.

Increasing the IHS's funding or changing the system of appropriations are only small steps in improving Native American health outcomes. Policymakers can set the stage for Native Americans

to flourish by increasing IHS funding, reforming IHS policies, and removing barriers to entrepreneurship and innovation.

Ultimately, policymakers can and should develop a more ideally constituted set of institutions for Native Americans that both improve the IHS and help resolve the underlying causes of poverty. The relatively low levels of funding limit preventive care for many Native Americans, who outpace other minority groups in deaths from preventable diseases. Increasing IHS funding is a practical, short-term way to deliver more healthcare to individuals. However, this recommendation should not be construed as providing an excuse to neglect tackling deeper institutional issues in the IHS or the roots of poverty.

The IHS is a highly imperfect healthcare system, and long-term solutions must focus on institutional reforms. For example, Congress and IHS policymakers could institute better mechanisms of internal accountability and communications within the IHS. Congress and IHS policymakers could also consider reducing barriers to healthcare-related innovations, such as telemedicine. Such reforms could increase the supply of healthcare to Native Americans.

At the largest scale, institutional reforms must remove barriers to innovation and entrepreneurship. Because poverty and poorer health are interrelated, improving health outcomes for Native Americans will require addressing the underlying causes of poverty, including the formal institutions on reservations that impose high costs on potential entrepreneurs.

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NOTES

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