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POLICY BRIEF

Increasing the Supply of Healthcare for Native Americans

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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] 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. Increasing IHS funding will likely help improve health outcomes to a degree, but more funding will not solve the larger underlying causes of health problems, such as management problems in the IHS or the institutional problems contributing to widespread poverty.

Perhaps one of the most effective ways to improve Native American health outcomes is to increase the supply of healthcare. In both the IHS and the wider sector of healthcare, policymakers could relax the policies that limit the supply of healthcare services, which would allow innovators to find new and imaginative ways to improve people's health. A more innovative, productive path forward for the IHS necessitates an acceptance of experimentation and competition.[4] For example,

the supply of healthcare could be increased through telemedicine and removal of barriers to willing healthcare providers.

TELEMEDICINE

Telemedicine is an important innovation that will likely become increasingly important for Native Americans who live on reservations or in rural areas. Telemedicine includes various forms of communication, including video conferencing, remote monitoring, online prescribing, asynchronous consultation, email, or telephone conversation. Innovations around telemedicine could dramatically improve the healthcare provision to Native Americans, and it has already shown some promise.[5] Previous research has shown that doctors and nonphysician providers can deliver high-quality healthcare remotely.[6]

Telemedicine benefits patients because it allows those who live in rural and underserved areas, such as reservations, to receive high-quality medical care promptly and conveniently, which has the potential to reduce costs and improve healthcare access significantly.[7] In the IHS system, where retention of medical staff is difficult and vacancies are especially high, expanding telehealth could be an important innovation that helps solve the severe staffing shortage. Additionally, telemedicine can facilitate many aspects of healthcare, including consultations and diagnoses. In the future, innovations in telemedicine could even allow for remotely performed surgeries.

Evidence from non–Native American situations suggests that telemedicine has significant benefits for mothers in rural areas, which could be vitally important for Native Americans who have high rates of complications with labor and delivery.[8] The University of Arkansas developed a successful telemedicine program that helped reduce deliveries of very-low-birth-weight infants from 13.1 percent to 7.0 percent in nine participating hospitals, contributing to a drop in infant mortality. This improvement is significant because those nine hospitals were not equipped with neonatal intensive care units.[9]

Despite the demonstrated and potential benefits of telemedicine, federal, state, and tribal policies impose institutional barriers. Reforming telemedicine's regulatory and bureaucratic environment could offer patients higher quality and more efficient healthcare.

Some states have required and continue to require a telepresenter—a medical assistant who is physically present with the patient when the patient engages with a doctor via telemedicine. Such requirements subvert the benefits of convenience, spontaneity, and cost reduction that telemedicine can potentially provide.[10] However, in recent years, several states, including Alaska and Hawaii, have reformed their laws and regulations so that telepresenters are no longer necessary for patients and doctors to engage in telemedicine. Texas is now the only state to require a telepresenter.[11] Texas policymakers could consider cost-reducing reforms, such as eliminating the need

for telepresenters, which will help expand the use of telemedicine. States should avoid implementing telepresenter requirements in the future; those requirements would make patients' access to telemedicine more difficult and costly.

Requirements that physicians doing telemedicine must be licensed in the state where the patient is located can be problematic if qualified and willing healthcare professionals are located far from their patients.[12] Only 15.5 percent of physicians are licensed in more than one state.[13] Such requirements artificially restrict the supply of willing and qualified healthcare providers. One reform is to specify that the location of the doctor is the location of consequence for telemedicine. Alternatively, states could enter into interstate compacts to make medical licensing easily transferable between states.[14] Lower regulatory barriers could improve Native Americans' access to preventive medicine for many chronic illnesses. If regulatory barriers are low enough, innovations can emerge that allow doctors to remotely perform rare and difficult surgeries through robotics and the internet.[15]

REMOVAL OF LEGAL BARRIERS TO WILLING AND QUALIFIED HEALTHCARE PROVIDERS

The supply of willing and qualified healthcare professionals is artificially restricted because of current policies. Federal, state, and tribal policymakers could help reduce this artificial scarcity in at least two ways: allow nonphysician healthcare providers to practice and allow international medical school graduates to be employed in the IHS system.

One potential reform to increase the supply of healthcare professionals is to allow nonphysician healthcare providers to practice up to their qualification level without physician supervision. Because the IHS system has such high rates of vacancy and turnover of healthcare providers, increasing the supply of healthcare providers, even if they are not physicians, is important.

Owing to current regulations, many medical services require a licensed physician's attention, but those same services can be done safely and effectively by nonphysician professionals. Reforms could allow nurse practitioners, physician assistants, nurse anesthetists, psychologists, and pharmacists to deliver a wider range of primary care services without the need for a physician. Such reforms would grant physicians increased time to look after the more difficult cases that require additional specialized training, thus lowering costs and expanding access to more routine forms of healthcare.[16]

Another potential reform to increase the supply of healthcare professionals is to allow international medical school graduates to be employed in the IHS system. Under current IHS policies, a medical provider must be a US citizen, have a current medical license from any state, and have board certification or board eligibility in a medical specialty.[17] However, the IHS system, like many

other parts of the healthcare system in the United States, faces a shortage of providers. Thus, the IHS could decrease turnover and the number of vacancies by allowing noncitizens or international medical school graduates to work in the IHS system. Additionally, states could lower the regulatory barriers that noncitizens face to practicing medicine in the United States.[18]

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NOTES

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