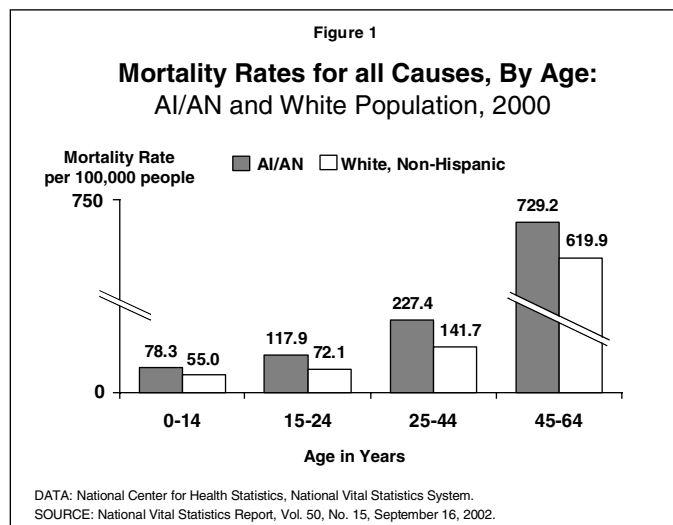


American Indians and Alaska Natives: Health Coverage and Access to Care

In the 2000 U.S. Census, 4.1 million people (about 1.5% of the U.S. population) identified themselves as of American Indian or Alaska Native (AI/AN) ancestry. Of this group, 2.5 million people identified themselves solely as AI/AN, and an additional 1.6 million identified as AI/AN in combination with one or more racial groups.

AI/AN people (also referred to as Native Americans) have higher mortality rates than whites at each stage of the life span (Figure 1). Some chronic conditions are also particularly high among Native Americans—for example, the highest prevalence of diabetes in the world is found among the Pima Indians of Arizona. AI/AN's poorer health indices are related, in part, to their higher poverty rates than whites. However, limited access to high quality health care is also a factor.



The Indian Health Service

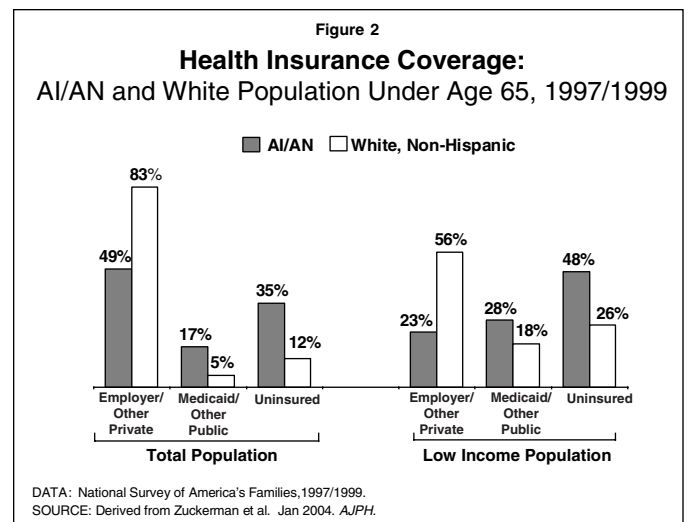
The U.S. government has a trust responsibility based on treaty obligations and federal statutes to provide health care to members of federally recognized tribes.¹ The Indian Health Service (IHS), within the Department of Health and Human Services, has fulfilled that trust responsibility since 1955.² IHS provides or pays for care for a service population of approximately 1.5 million AI/ANs. Eligibility for IHS is defined by federal law. In 2003, IHS had an operating budget of \$2.8 billion.

IHS providers are located predominantly on or near tribal reservations that are in rural areas of the U.S. Since over half (about 56%) of the AI/AN population now live in urban areas, many IHS providers are not geographically accessible to urban Indians.³

The AI/AN health care system has evolved in response to AI/AN demographic shifts and changes in federal legislation. The system now consists of three major types of programs often called the I/T/U system.⁴ The “I” refers to IHS health centers and hospitals managed by the federal government. Tribally managed services, the “T” of the system, now represent nearly half of the IHS budget. Urban Indian health programs, the “U” of the system, represent about 1% of the IHS budget.

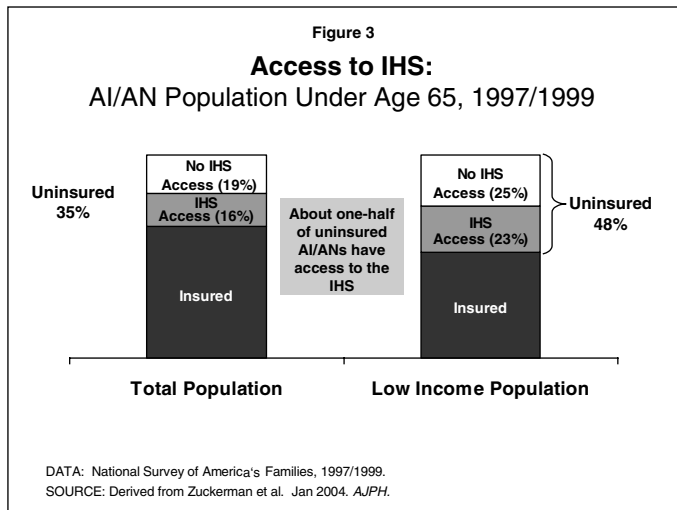
Health Insurance Coverage

While IHS is the hub of the AI/AN health system, AI/AN people also may qualify for private and other public sources of health financing or services. About half (49%) of AI/AN people have job-based or other private coverage, compared to 83% of whites (Figure 2).



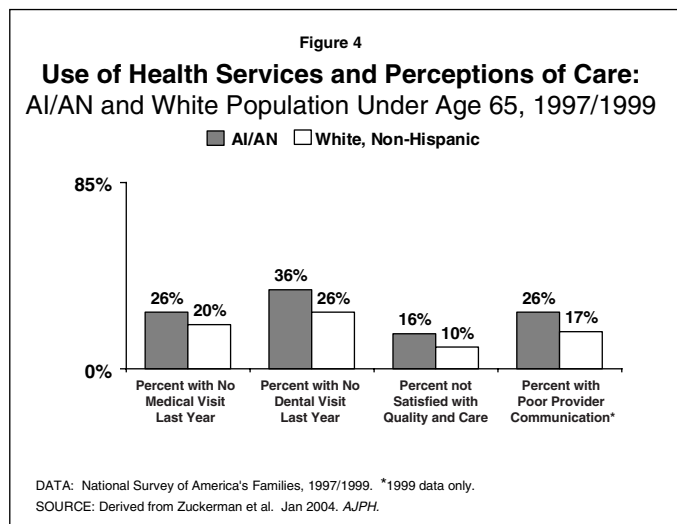
Medicaid helps to offset the relatively low rates of private coverage, especially among the low-income population. Nearly 1 in 5 (17%) AI/ANs, compared to 5% of whites, report coverage through Medicaid and other public programs. Medicaid is playing an increasingly larger role in financing AI/AN care and as a revenue source for IHS providers.⁵ Still, more than one-third (35%) of AI/ANs are uninsured and the problem is worse among low-income AI/AN people.⁶

Almost half (48%) of low-income AI/ANs are uninsured, largely reflecting the low rates of job-based coverage in this income group. Although IHS is a resource for some of the AI/AN population, its reach is limited. Just under half of uninsured AI/ANs identify IHS as a source of coverage and care (Figure 3).



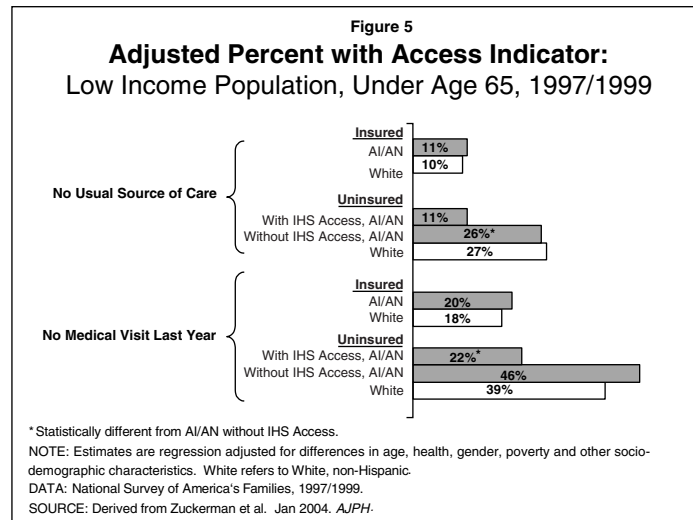
Access to Health Care

In general, AI/ANs compared to whites are more likely to be without a medical or dental visit in a year and to be dissatisfied with their care (Figure 4). Adjusting for differences in the characteristics of AI/ANs and whites eliminated the disparity in health services use, but not in satisfaction with quality or communication.



Since health insurance is such a key factor in obtaining access to health care for the general population, it is helpful to know whether it plays the same role for the AI/AN population. Consistent with prior research, the insured (both AI/ANs and whites) generally fare better than the uninsured on measures of access.

However, among the low-income population, AI/ANs covered only through IHS report measures of access similar to the insured, except in the use of preventive services.⁷ For example, about 22% of uninsured AI/ANs with IHS access and 20% of insured AI/ANs report not making a medical visit in the past year. In contrast, almost half (46%) of uninsured AI/ANs without IHS access did not make a medical visit in a year (Figure 5).



Issues and Challenges

Data on current patterns of health coverage and access among AI/ANs is limited, in part, because of their small numbers and wide geographic dispersion in the U.S. The limited data contributes to misunderstandings about the extent to which Native Americans' health needs are being addressed.

Disparities in health coverage and care show that AI/ANs continue to be at a disadvantage in the U.S. health system. AI/ANs are nearly three times as likely as whites to be uninsured, and almost half of the low-income AI/AN population is uninsured. Moreover, the uninsured without IHS access experience troubling gaps in obtaining care.

Many people assume that IHS providers are available to most, if not all AI/ANs. This analysis, however, shows otherwise, even when considering the component parts of the IHS system as they have evolved. The most vulnerable AI/ANs are those who are uninsured, only half of whom IHS reaches. The choice facing federal policymakers is whether to expand the I/T/U system to meet these needs or to address them through other measures.

- IHS reports that there are currently over 560 federally recognized tribes. However, other tribes are recognized by their home states but not the federal government and their members are ineligible for IHS.
- See www.ihs.gov.
- Forquera, R. 2001. "Urban Indian Health." Kaiser Family Foundation (Pub. #6006).
- Roubideaux Y. 2001. "Current Issues In Indian Health Policy." University of Arizona Udall Center for Studies in Public Policy.
- Schneider A and Martinez J. 1997. "Native Americans and Medicaid: Coverage and Financing Issues." Kaiser Family Foundation (Pub. #2101).
- Low-income persons are defined as those with family incomes less than 200% of the federal poverty threshold (income less than \$30,500 for a family of three in 2003).
- For the findings on preventive services, see Zuckerman et al. 2004 below.

For more detailed information see Zuckerman S, Haley J, Roubideaux Y, and Lillie-Blanton M. Jan 2004. *AJPH*, the article from which much of this fact sheet was drawn.

The Henry J. Kaiser Family Foundation is a non-profit, private operating foundation focusing on the major health care issues facing the nation. The Foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public. Additional copies of this fact sheet (#7020) are available on the Kaiser Family Foundation's website at www.kff.org.