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INDIAN HEALTH SERVICE

Health Care Services Are Not Always Available to Native Americans

GAO Accountability·Integrity·Reliability

Highlights

Highlights of GAO-05-789, a report to the Committee on Indian Affairs, U.S. Senate

Why GAO Did This Study

The Indian Health Service (IHS), located within the Department of Health and Human Services, is responsible for arranging health care services for Native Americans (American Indians and Alaska Natives). IHS services include primary care (medical, dental, and vision); ancillary services, such as laboratory and pharmacy; and specialty care, including services provided by physician specialists. IHS provides some services through direct care at hospitals, health centers, and health stations, which may be federally or tribally operated. When services are not available—that is, both offered and accessible—on site, IHS offers them, as funds permit, through contract care furnished by outside providers. Concerns persist that some Native Americans are experiencing gaps in necessary health care.

GAO was asked to examine the availability of (1) primary care services and (2) ancillary and specialty services for Native Americans. Additionally, GAO examined the underlying factors associated with variations in the availability of services and strategies used by facilities to increase service availability. GAO conducted site visits to 13 facilities and interviewed IHS officials from all 12 IHS areas, which cover all or part of 35 states.

GAO received written comments from IHS. IHS substantially agreed with the findings and conclusions of this report.

www.gao.gov/cgi-bin/getrpt?GAO-05-789.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie Aronovitz at (312) 220-7600 or aronovitzl@gao.gov.

What GAO Found

The availability of primary care—medical, dental, and vision—services was largely dependent on the extent to which Native Americans living in IHS areas were able to gain access to the services offered at IHS-funded facilities. All of the 13 facilities GAO visited offered medical services, such as physical examinations, while 12 facilities offered dental and 12 facilities offered vision services. However, access to these services was not always assured because of factors such as the amount of waiting time between the call to make an appointment and the delivery of a service, travel distances to facilities, or a lack of transportation.

Certain ancillary and specialty services were not always available to the Native Americans served by the 13 facilities, primarily because of gaps in the services offered by the facilities. While some ancillary and specialty services were offered to all patients, GAO also identified gaps in other services, including services to diagnose and treat nonurgent conditions—such as arthritis and knee injuries—specialty dental care, and behavioral health care. Most facilities lacked the staff or equipment to offer these services on site and thus had to purchase them with contract care funds, which were rationed on the basis of relative medical need at 12 of the 13 facilities. Five of the 12 facilities were unable to pay for any contract care services that were not deemed emergent or acutely urgent.

GAO identified three distinct factors that were associated with variations in the availability of services, namely a facility's structure, location, and funding from sources other than IHS. A facility's structure was associated with the overall amount and range of services available. For example, hospitals offered a broader array of services on site for more hours per week compared with other facilities. Location was a factor in recruiting and retaining staff for geographically remote facilities and in the cost of certain types of services, most notably transportation. Finally, a facility's funding from two types of sources—reimbursements from private and federal health insurance programs for care offered on site and any tribal contributions made—affected the extent to which the facility was able to offer services. The amount of these funds varied across facilities.

Facilities reported using at least one of six strategies to increase the availability of services. These strategies included bringing specialists on site and negotiating discounts for contract care. According to officials, the strategies were not available to, or effective for, every facility. For example, four facilities reported that while hospitals generally offered discounted rates for contract care, physicians were not always willing to do so.