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WOMEN'S HEALTH CARE PHYSICIANS

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Committee on American Indian/Alaska Native Women's Health
Committee on Health Care for Underserved Women

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Health Care for Urban American Indian and Alaska Native Women

ABSTRACT: Sixty percent of American Indian and Alaska Native women live in metropolitan areas. Most are not eligible for health care provided by the federal Indian Health Service (IHS). The IHS partly funds 34 Urban Indian Health Organizations, which vary in size and services. Some are small informational and referral sites that are limited even in the scope of outpatient services provided. Compared with other urban populations, urban American Indian and Alaska Native women have higher rates of teenaged pregnancy, late or no prenatal care, and alcohol and tobacco use in pregnancy. Their infants have higher rates of preterm birth, mortality, and sudden infant death syndrome than infants in the general population. Barriers to care experienced by American Indian and Alaska Native women should be addressed. The American College of Obstetricians and Gynecologists encourages Fellows to be aware of the risk profile of their urban American Indian and Alaska Native patients and understand that they often are not eligible for IHS coverage and may need assistance in gaining access to other forms of coverage. The American College of Obstetricians and Gynecologists also recommends that Fellows encourage their federal legislators to support adequate funding for the Indian Health Care Improvement Act, permanently authorized as part of the Patient Protection and Affordable Care Act.

Of the more than 4.3 million individuals who identified themselves as either partly or solely American Indian or Alaska Native in the 2000 U.S. Census, 61% do not live on reservations or Native lands (1). Forty-three percent do not reside in geographic areas where the federal Indian Health Service (IHS) provides care (eg, reservations and adjacent counties) (2). The number of American Indian and Alaska Native women who live in metropolitan areas is increasing (3–5). American Indian and Alaska Native women lag behind the majority population in many health indicators, and it is important for obstetrician–gynecologists to be aware of their unique social and economic needs. The American College of Obstetricians and Gynecologists' Committee on American Indian/Alaska Native Women's Health includes Urban Indian Health Organizations in its annual site visits and program reviews to address issues faced by American Indian and Alaska Native women, provide guidance, and advocate for improvements in health care for these women and children.

Although many who self-identify as solely American Indian or Alaska Native live in rural western states, most

live in metropolitan areas (6). According to the 2000 U.S. Census, more than 87,000 individuals who identify as American Indian or Alaska Native alone or in combination with another race live in New York City, 53,000 live in Los Angeles, 35,000 live in Phoenix, and 20,600 live in Chicago (1). Many American Indian and Alaska Native women live in cities because of educational and employment opportunities or for access to services other than health care; others were forced to relocate because of past government policies. Many of these women have lived in cities for generations and move back and forth between cities and reservations in order to take advantage of IHS or tribal health care on or near their reservations. The IHS only pays for required services outside of a beneficiary's home service area if she has been away from that service area for a period that does not exceed 180 days. This requirement contributes to mobility between cities and reservations that may be long distances apart.

Eligibility for services provided by the IHS requires enrollment in a federally recognized Indian tribe. Although the federal government recognizes 565 tribes, only approximately 100 tribes are recognized by states and

other tribes have no governmental recognition (4). Compared with those living in rural reservation areas who may share common tribal origins, American Indian and Alaska Native populations living in cities tend to be heterogeneous. There is no standard definition of an urban American Indian or Alaska Native. Individuals may self-identify as an urban American Indian or Alaska Native based on ancestry, shared culture, appearance, or participation in events organized by a local American Indian or Alaska Native community (1).

Health Status

More than 20% of urban American Indian and Alaska Native women live in families with incomes below the federal poverty line compared with 12–13% of the general population in metropolitan areas (1, 3). Compared with the general urban population, American Indian and Alaska Native women have higher unemployment rates; are more likely to live in dwellings that lack plumbing, kitchen facilities, or telephone service; have lower education levels; and have a higher percentage of children in single-parent households (1, 3).

Information on the health status of urban American Indian and Alaska Native women is difficult to obtain because these women represent a diverse and heterogeneous group. Many published studies are small and clinic-based and do not represent the larger population of urban American Indian and Alaska Native women.

In one study of birth outcomes, findings included higher rates of prematurity but lower rates of low birth weight infants in urban American Indian and Alaska Native women compared with those in the general population living in the same areas. American Indian and Alaska Native women in this study were nearly twice as likely to have late or no prenatal care as the general population of women nationwide. Rates of smoking during pregnancy were greater as well, although less than in all pregnant American Indian and Alaska Native women. Alcohol use in pregnancy was significantly greater among urban American Indian and Alaska Native women than all American Indian and Alaska Native women nationwide and greater than all pregnant American Indian and Alaska Native women (3). The number of births to teenagers younger than 18 years was significantly greater among American Indian and Alaska Native women than the general population, but unlike nonurban American Indian and Alaska Native women, did not decrease over time in the urban American Indian and Alaska Native women population (3).

National studies have shown that 37% of urban American Indian and Alaska Native women are overweight and 20% are obese (7); in some urban areas, up to 66% are overweight (8). These rates are higher than those seen in the general urban population (9). These trends extend to American Indian and Alaska Native children. A study from an American Indian and Alaska Native clinic in Oklahoma City reported that 60% of urban American

Indian and Alaska Native children were overweight or obese by age 12 years (10). American Indian and Alaska Native women are at increased risk of type II diabetes, although the differential rates for urban American Indian and Alaska Native women compared with American Indian and Alaska Native women who live on reservations have not been determined.

A Centers for Disease Control and Prevention study of cervical cancer incidence between 1998 and 2001 found the lowest rates among American Indian and Alaska Native women compared with other ethnic groups. Urban American Indian and Alaska Native women had lower rates than American Indian and Alaska Native women living in rural or suburban areas (11). However, the authors noted that American Indian and Alaska Native women in whom cervical cancer was diagnosed were more likely than women of all other ethnic groups except African Americans to have late-stage cervical cancer diagnosed. This statistic was not stratified by urban or nonurban residence (11). Data from 2002 to 2007 show that almost three times as many American Indian and Alaska Native women living in areas served by Urban Indian Health Organizations reported never having had a Pap test (14%) compared with white women (5%) (12).

Breast cancer is diagnosed at a later stage in American Indian and Alaska Native women than in non-Hispanic white populations. In addition, the 5-year survival rate of American Indian and Alaska Native women following a diagnosis of breast cancer was 78.3% compared with 89.9% for white women (12).

Health Care Coverage for Urban American Indian and Alaska Native Women

Most American Indian and Alaska Native women living on or near a reservation are eligible for services provided by and within the IHS or a tribal facility. If services, especially for emergent conditions, are not available at the IHS or tribal facility, the patient may be referred to non-IHS or non-tribal physicians or facilities. If she is eligible and funding permits, Contract Health Services may pay for health care from her home area. Indian Health Service care is limited to “persons of Indian descent belonging to the Indian community served by the facilities and programs” (13). Tribal facilities determine eligibility based on a number of factors such as tribal membership, enrollment, residence on tribal lands, and other pertinent factors. Contract Health Services are more restrictive because the person must be eligible for care and live in a contract care service delivery area, typically defined as residing on or near a reservation. Approximately 1.9 million American Indian and Alaska Native women living on or near reservations receive care in those facilities and through Contract Health Services. Except in certain cities, approximately 2.5 million American Indian and Alaska Native women who live in urban areas are rarely eligible

for direct or contract health care services (13). Exceptions include Phoenix, Albuquerque, Anchorage, and Tulsa, which all have IHS facilities where American Indian and Alaska Native women can receive direct care, but use of contract care funding is restricted. Although the system of direct and contract care for women on or near reservations is suboptimal, it is superior to the patchwork of services available to American Indian and Alaska Native women who live in urban areas.

The Urban Indian Health Program

In 1976, Title V of the Indian Health Care Improvement Act authorized the creation of the Urban Indian Health Program. Currently, 34 Urban Indian Health Programs offer services that range from primary outpatient medical and dental care to information and referral services only (14). Of the 20 cities in the United States with the largest American Indian and Alaska Native populations, 10 have centers that only provide outpatient care. Another six, including Los Angeles and New York, have urban centers that provide only informational and referral services. It is estimated that approximately 25% of urban American Indian and Alaska Native individuals live in a county with an urban program.

Urban Indian Health Program centers differ in many ways from IHS or tribal facilities. Only 1% of the annual IHS budget is allocated to urban American Indian and Alaska Native health programs. Urban programs must supplement their budgets with revenues from Medicaid and Medicare, private insurance, local and state support, grants, and cooperative agreements. Services are available to patients using a sliding scale, whereas services at IHS sites are provided at no cost to patients. Urban Indian Health Programs also help a larger proportion of non-Indians than IHS or tribal facilities because they are in urban areas and get most of their funding from sources outside of the government. With the outside funding, they cannot limit their services to American Indian and Alaska Native individuals only.

Issues confronting urban Indian clinics nationwide include lack of electronic medical records, which limits the collection and reporting of critical statistics and communication with referral facilities. There is also a critical lack of space, and the clinics are subject to inconsistent funding sources. In addition, unlike most IHS and tribal facilities where services such as radiology and a pharmacy are available on-site or by way of contract health funds, patients must obtain these services in the community often at their own expense. This frequently results in fragmentation of care or patients not receiving those services.

The Role of Other Coverage for Urban American Indian and Alaska Native Women

It is important to note that American Indian and Alaska Native women may be deterred from seeking care that

they may be entitled to because of the lack of cultural understanding in and established relationships with public and private health care environments. Nonetheless, other coverage is available to some and should be made more inviting to American Indian and Alaska Native women.

American Indian and Alaska Native women are eligible for standard public assistance programs such as Medicaid and the Children's Health Insurance Program if they meet eligibility requirements. Most state Medicaid programs currently exclude childless adults and set eligibility requirements such that individuals with children must be below the poverty line to be eligible. Under the Patient Protection and Affordable Care Act, Medicaid coverage is expanded to nearly all individuals younger than 65 years with incomes up to 133% of the federal poverty line. All states participating in Medicaid must cover these individuals by January 2014. In addition, the Patient Protection and Affordable Care Act prohibits cost sharing for American Indians below 300% of the federal poverty line enrolled in any qualified health insurance plan in the individual market through an Exchange. The Patient Protection and Affordable Care Act creates Exchanges through which individuals can purchase health insurance coverage. It also adds facilities operated by IHS and Indian, Tribal, and Urban Indian facilities to the list of agencies that can serve as an express lane agency. These agencies ensure that those eligible for Medicaid or the Children's Health Insurance Program have a fast and simplified process for having their eligibility determined or redetermined (15).

American Indian and Alaska Native individuals younger than 65 years are more dependent on public assistance programs than the general population. Overall, 28% of individuals younger than 65 years depend on Medicaid for coverage compared with 12% of non-Hispanic white individuals (16). Although approximately one third of American Indian and Alaska Native individuals younger than 65 years live below the poverty line, the highest percentage of any group and twice that of the general population, approximately one half of those below the poverty line are enrolled in Medicaid. Many eligible American Indian and Alaska Native women resist enrolling in Medicaid because of a lack of information about the programs, the invasive and cumbersome application process, and negative attitudes they may encounter from workers who feel they should not use such services because they may have access to care through IHS. In addition, the belief that IHS is responsible for providing care may keep some eligible American Indian and Alaska Native women from enrolling in Medicaid.

American Indian and Alaska Native individuals younger than 65 years are much less likely to have private insurance than other groups. Overall, 41% of American Indian and Alaska Native individuals younger than 65 years have private insurance coverage compared with 76% of non-Hispanic white individuals younger than 65 years (16). Approximately one fifth of American Indian and

Alaska Native individuals younger than 65 years live in a household with no employed member of the family and are thus excluded from employer-based policies.

Recommendations to Improve Care for Urban American Indian and Alaska Native Women

The Indian Health Service is chronically underfunded and only meets approximately 50% of need. The agency expends approximately \$2,741 per user compared with a national average of \$6,909 per user (17). Because the budget is calculated using the population that lives on or near reservations, funds for urban American Indian and Alaska Native women are minimal. Only approximately 1% (\$43 million in fiscal year 2010) of the IHS budget (\$4.05 billion) is dedicated to the Urban Indian Health Program (18). Increasing funding for health care for urban American Indian and Alaska Native women is critical to improving the health of this population. Recent passage of the Patient Protection and Affordable Care Act included provisions of the Indian Health Care Improvement Act, which should provide consistent and increased funding for American Indian and Alaska Native individuals' health care. This act provides a statutory basis for the provision of appropriate health care to American Indian and Alaska Native individuals, which had been provided with discretionary funding each budget year.

Urban American Indian and Alaska Native women are an "invisible" population for whom data about demographics, health care needs, and health issues are difficult to obtain (5). Systems must be put in place to collect accurate epidemiologic information. Such data are essential to design and implement programs to eliminate the health inequities for this population. The Patient Protection and Affordable Care Act begins to address this by making data analyses of federally or publicly conducted or supported health care programs or activities available to IHS and epidemiology centers funded under the Indian Health Care Improvement Act (15).

Barriers to public assistance programs should be eliminated for American Indian and Alaska Native women. The American College of Obstetricians and Gynecologists recommends that Fellows do the following:

- Be aware of the increased risk profile of their American Indian and Alaska Native patients.
- Recognize that American Indian and Alaska Native women living in urban areas often are not eligible for health care from the IHS.
- Be aware that many American Indian and Alaska Native women may not be eligible for, or may not apply for, health care safety net programs. Safety net programs provide health care for people regardless of their ability to pay. Physicians caring for American Indian and Alaska Native women should educate their patients about such programs and

provide information about and, where possible, assistance with enrollment.

- Recognize that American Indian and Alaska Native women's health care may be highly fragmented, geographically and otherwise.
- Encourage legislators to support adequate funding for the Indian Health Care Improvement Act, permanently authorized as part of the Patient Protection and Affordable Care Act.

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