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Gregory Kienholz

Eastern Washington University, [gregorybrw123@gmail.com](mailto:gregorybrw123@gmail.com)

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# Gaps in Indigenous Health Care

Gregory Kienholz and Rosalee Allan, FACHE  
Eastern Washington University, 526 5th Street, Cheney WA 99004

## Abstract

Indigenous people of the United States make up roughly 1.7% of the total population; this is including those of mixed race but still qualify for indigenous benefits. These 5.2 million individuals are dispersed across the nation and some live in rural and isolated locations where health care has not always been readily available. When the Indian Health Care Improvement Act of 1976 was implemented it meant that any indigenous person that met racial qualifications was financially covered if the care was provided by an indigenous health service or facility. Health and wellness of indigenous people across the nation increased and statistics regarding mortality rate and death due to illness began to decline. Although this implementation proved to be beneficial for short term care, there are still gaps in the care offered to indigenous people and the resources that are still readily available in rural and isolated communities. This dissertation will be discussing the gaps in indigenous health care across the nation and how they have hindered the improvements made by the Indian Health Care Improvement Act of 1976. By analyzing literatures and statistics that demonstrate health trends that correlate with the implementation of the act chronologically, it will analyze the need for improvements that are still a right to indigenous people in terms of care. It's important to understand the significance of reparations and how it has aided and will continue to aid indigenous health care and their future wellbeing.



## Background

- The Indian Health Care Improvement Act of 1976 provided states with a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid services that are provided through an indigenous health services or Tribal facility.
- In 1992, Congress amended the ISDEAA to authorize a Tribal Self-Governance Demonstration Project within the HIS, giving federally-recognized Tribes the option of entering self-governance compacts to gain more autonomy on the management and delivery of their health care programs.
- In 2000, all IHCA appropriations were extended through FY2001. Congress continued to appropriate funds for IHCA programs from 2001 until 2010.
- The Indian Health Care Improvement Act (IHCA) was made permanent when President Obama signed the bill on March 23, 2010, as part of the Affordable Care Act.

## Study Objectives

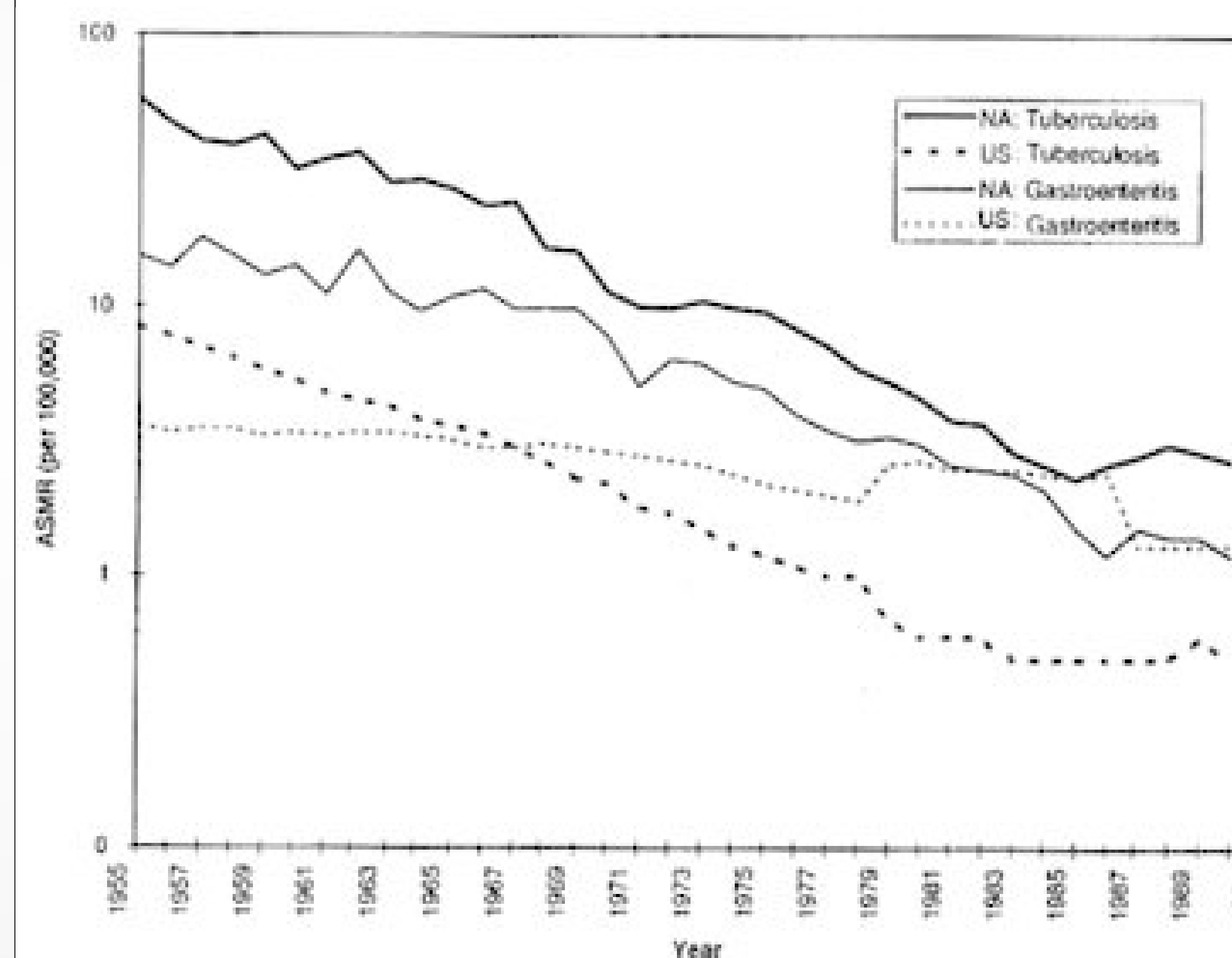
This research will chronologically track the health disparities of indigenous people within the United States in correlation to the Indian Health Care Improvement Act of 1976. By doing this, gaps within indigenous care can be examined and improved in order to provide necessary care for those living in rural and isolated locations across the country.

## Results

- American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population.
- In the years of 2009 to 2011 studies showed that one indigenous person to three U.S. individuals of all race is more likely to have diseases of the heart.
- Indigenous individuals have triple the chance of committing suicide between the ages of 15 to 24 than U.S. whites and all races within the U.S.

## Conclusion

Acts like the Indian Citizen Act of 1924, also known as the Snyder Act, as well as the Indian Health Care Improvement Act of 1976 made it feasibly possible for indigenous people to receive care in rural and isolated communities. With these reparations in mind, why are there still noticeable health disparities amongst indigenous people in comparison to all other races within the United States? It is evident with statistics like these where ultimately indigenous people are still more susceptible to having tuberculosis and gastroenteritis than the overall U.S. population.



It is apparent that an evident decline took place after the implementation of the Indian Health Care Improvement Act of 1976 with little to no spikes; as you can see, spikes took place more frequently before 1976. It is not just tuberculosis and gastroenteritis that affect indigenous people more it is also diabetes, pneumonia, influenza, and unintentional injuries. Although care of indigenous people have been reformed and continuously been improved upon, there are still gaps that lie within the regional and economical aspect of indigenous care and services that can be offered. Yes, care has become more accessible but not in a way where surgeries or proper medical testing can take place. Most indigenous hospitals, especially isolated ones, have traveling nurses and rotational doctors which changes the consistency of care. Medevacking is another way indigenous people receive care in urgent times.

## Future Implications

The Patient Protection and Affordable Care Act (PPACA) create facilities working with Indian Health Services (HIS) to bring them to rural communities while still upholding sanitary requirements. Unfortunately, there are still key health disciplines that continue to remain vacant, even compared to other federally-funded health centers. For example, studies in 2015 show that the following disciplines within HIS have a vacancy rate of: Physicians (25%), nurse practitioners (25%), and dentists (18%). In order to ensure quality care to indigenous people, there needs to be more skilled and consistent care to decrease the gaps in health disparities. As more specialized care is expanded and facilitated in indigenous communities there should be a decline in the health disparities between indigenous people and the rest of the nation.

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