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American Indian Veterans' Views about Their Choices in Health Care: VA, IHS, and Medicare

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Legislation during the past three decades has gradually drawn Indian Health Service (IHS)–funded clinics into the mainstream of the US medical care environment. The Indian Self-Determination and Education Reform Act of 1973 and its Indian Education Amendments of 1984 began a movement away from federal management of health services to local tribal control of the more than five hundred facilities serving American Indians.[1] At the same time the Indian Health Care Improvement Act granted authority to IHS-funded clinics to bill Medicaid, beginning a long and continuing negotiation among the tribes, states, IHS, and Centers for Medicare and Medicaid Services (CMS).[2] In 1990, 6 percent (72,000 individuals) of IHS beneficiaries were more than sixty-five and eligible for Medicare. Some 31.6 percent lived below the poverty level and were eligible for Medicaid.[3] The IHS has facilitated and encouraged enrollment of its beneficiaries in Medicare and Medicaid. By 2008, 18 percent of the IHS budget is assumed to be met by third-party collections, including CMS billing.[4] The Alaska Native and American Indian Direct Reimbursement Act of 1999 gave tribal clinics the authority to bill Medicaid directly for services without using the IHS as an intermediary, thus further facilitating

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access to CMS programs.[5] As annual appropriations for IHS-funded programs meet less and less of the health needs of American Indians, clinics depend more on third-party billing and begin to employ mainstream methods to maximize billing receipts. Discussions among the administrators of Indian clinics, which are available on the IHS Web site, are becoming similar to other public health care facilities centering on ideas of Federally Qualified Health Center look-alikes, Medicaid-like billing rates, and drug discount cards.[6] The hospitals and clinics that care for American Indians are beginning to resemble the mainstream facilities, which puts into question the need for a separate care system.

An alternative view of the changing landscape of IHS funding is that the number of American Indian people who use both IHS-funded health services and CMS programs is growing; they are joining the ranks of millions of Americans who receive services from more than one government health care program. In 2001, 45 percent of veterans were over age sixty-five and eligible for both Medicare and Veterans Administration (VA) health care.[7] An individual's simultaneous use of more than one health care system presents problems in the management of chronic disease, confusion about the definition of medical necessity, duplication of services, and higher costs.[8] Conversely, those who have access to more than one system of care may benefit from the greater diversity of services offered.[9] Carrigan et al., in their report commissioned by the Institute of Medicine, recommended that federal agencies work together and share information for quality assurance and cost reduction.[10] In February 2003 the VA and IHS entered into an agreement committing the agencies to cooperation and resource sharing.[11] As these efforts move forward, medical care systems need to evaluate carefully how and why people use multiple systems for care.

The Native American Project of the Veteran Identity Program (VIP) was designed to explore health system, personal, and cultural characteristics that influence access to VA health services specifically among a Native American veteran population.[12] Local tribal and American Indian organizations assisted in the recruitment of study participants; consequently, all participants had an affiliation with an American Indian community and were eligible to use IHS-funded clinics. This qualitative study provides data for a careful examination of how American Indian men, who have more than one choice for ambulatory health care services, select a provider for care.

METHODS

A total of nine group interviews were held. Five took place in and recruited residents of rural communities, each representing major Native American cultural areas in Southern California and Southern Nevada. Four were held in urban communities in the region. A written questionnaire and a semistructured group interview were used to collect data from Native American veterans about their health status, use of ambulatory health care, perceptions of the VA health care system, cultural identity, and military identity. The written questionnaire consisted of twenty-five items: eight about military service, two about

veteran identity, three about health care utilization, five about health status, and seven sociodemographic questions. The group interview guide was based on findings from the VIP study. Topic areas found to be significant predictors of ambulatory care use in the VIP study were explored in either the written questionnaire or the interview in the Native American Project. These topics were military experience, veteran experience, Native American experience, perceptions of VA health services, and recommendations for improvement of VA health care. The VA's Health Care System Institutional Review Board approved the project.

Local tribes and Indian organizations distributed participant recruitment information to their members. Forty-two men participated in the five group interviews held in rural communities and forty-three men participated in the four group interviews held in urban communities for a total of eighty-five participants. Women veterans were not included in these interviews. All group interviews were audio- and videotaped. The audiotapes were transcribed and imported into the qualitative analysis software QSR N6.[13] The investigators viewed videotapes, identified speakers, and assigned participant codes to the transcribed text. Data from question 12 of the written questionnaire ("In the past twelve months, where have you gone for health care?") were used in the Table Import function of QSR N6 to code text as VA users, IHS users, and private-sector users. Statements about health care were examined and coded for the type of health care system (VA, IHS, and private sector). The Node Search Matrix function of QSR N6 was used to create reports of statements about health care systems stratified by user status. Sorting in this manner allowed us to examine statements of people who were current, active users of the health care system in question. Because of changes in all three health care systems in the last decades, the ability to distinguish between past and current users is critical.

FINDINGS

Sample Characteristics

Veterans who participated in the group interviews were from many different subgroups within the American Indian populations in California and Southern Nevada. About half of our sample resided in rural areas and about half were from urban communities. Forty-eight percent were members of local tribes. About half of the sample was more than sixty years old and 43 percent were enrolled in the Medicare program. Most of our participants were Vietnam-era veterans; however, all war eras (World War II to the first Gulf War) were represented in the sample. Sixty percent had seen combat duty.

Health Care Plans

At the time of the study, all of the participants were beneficiaries of at least two managed health care programs: VA health care services and IHS-funded health care. The Veterans' Health Care Eligibility Reform Act of 1966 extended

Table 1
Distribution of Native American Veteran Participants' Health Care Use during the Past Year

Type of Service Used	No.	%
VA eligible	85	100.0
All VA users	31	36.5
VA only	18	21.2
VA and IHS	7	8.2
VA and private practice	3	3.5
VA, IHS, and private practice	3	3.5
IHS eligible	85	100.0
All IHS users	40	47.1
IHS only	23	27.1
IHS and VA	7	8.2
IHS and private practice	7	8.2
IHS, VA, and private practice	3	3.5
Insurance beneficiary	63	74.1
All private practice users	30	35.3
Private practice only	17	20.0
Private practice and VA	3	3.5
Private practice and IHS	7	8.2
Private practice, VA, and IHS	3	3.5
Did not use any health care	6	7.1

VA health care services to all veterans and developed networks of ambulatory clinics with access to care managed by the veteran's primary care provider.[14] However, federal law also mandated that the VA provide timely health care for all veterans enrolled in the system within the resources available to the agency. To that end the VA established an eight-tier benefit/copayment system that uses income, service-connected disability status, service record, and disability status not connected with military service to manage access to services.[15] The tier structure is so complex and variable over time that all veterans are advised that a full review of their documents is required to determine the scope and cost of an individual's benefits. In many cases, the VA patients are eligible to receive only a limited scope of service and must coordinate their care with other hospitals, clinics, and insurance plans. Fortunately, Native American veterans have other resources for health care. They are usually eligible for IHS-funded health care. Benefits offered by Indian programs vary greatly depending on the level of funding allocated to the clinic, which ranges from greater than 100 percent to 30 percent of need for reservation-based clinics and 22 percent of need for urban Indian clinics.[16] Some Southern California Native Americans receive private health insurance through their tribe. Also, Native American veterans who meet eligibility requirements may enroll in

state, federal, and work-related insurance programs. Sixty-three participants (74%) were covered by one or more public or private health insurance plans. Thirty-eight had Medicare plans, one had Medicaid, and twenty-six had a private insurance plan.

Some 25.8 percent of our participants used more than one health care plan to obtain health services during the past year. In the past year, 21.2 percent of the participants used only VA health care services and an additional 15.3 percent combined use of VA health care services with other sources. A total of 27.1 percent used only IHS-funded services, 20 percent used only private health care, and 7.1 percent did not have a medical visit. For each health care system (VA, IHS-funded, private), fewer than half of the beneficiaries use the health care services available through that system.

Veterans Administration Health Care Services

In fiscal year 2003 about 15 percent of eligible veterans in Southern California and Nevada used VA health services. Men who used the VA as their only health care provider shed light on how, and for what reasons, they were active VA users. For some, the choice of the VA for health services was driven by a belief in reciprocity for service to the country. They spoke about their choice of the VA using forceful language that demonstrated they viewed access to care as a political imperative. For example, one veteran who had been using care regularly since he was discharged said, "Plus . . . it's my VA. They owe me. I earned it. It's a veterans' hospital. It's made specifically for us." Another said, "That's why I tell you, go down there and get your card, vested, is what it's called. You get your card, you get vested. That means you're in the system. That means you strengthen our resolve. They strengthen our allocation to that clinic."

A larger group of our participants initially came to the VA health care system and continued in care because they believed the organization has a professional staff that is highly trained to treat their specific health problems. The VA was perceived as having an expertise in the treatment of combat-related injuries. As one participant explained, "When I came back from the Gulf War, I didn't know what was wrong with me and I couldn't explain it. Anyway, that's why I started going to the VA hospitals. I felt that they'd know how to deal with war wounds and war injuries or heal these things." Advances made by the VA research division have contributed to the understanding of combat-related health conditions such as diabetes related to Agent Orange exposure, long-term health effects of radiation exposure, and posttraumatic stress disorder (PTSD). Standards of care for diagnosis and treatment of such conditions have been incorporated into the VA health care system. For example, in the VA hospitals and clinics, general medicine practitioners are alert for patients who may be suffering from PTSD and related substance-abuse problems. One participant attested: "I think I was going to the VA and he diagnosed me with PTSD—you probably have it—he's a combat veteran—posttraumatic stress disorder." Primary care providers have the responsibility to assure that their patients receive comprehensive care. They are a point of entry to specialized mental health and substance abuse treatment. "Even

when I got into drinking and carrying on and remember they got me into the ADT program, been taking care of me there and continual things for me without my needing to. And they've done things for me I wouldn't have done for myself." Once the eligible veteran becomes an established patient, the primary care provider is his avenue to entry into specialized treatment programs as well as continuing coordination of care.

The men who participated in this study used the VA health care system for two very specific reasons. First, they felt the country had a responsibility to its veterans. Each individual veteran should use the VA health care system so that its vitality and responsiveness is maintained for now and the future. Second, they believed that some health problems are prevalent among veterans due to the nature of their service and that these problems are best recognized and treated by a service with expertise in treatment of veterans. The participants described a crucial role for a health care system specializing in care for veterans.

Indian Health Service–funded Care

In fiscal year 2001 the IHS funded the operation of sixty-one outpatient clinics but no inpatient facilities in California.[17] Nationally, about 50 percent of the eligible Native American population used IHS-funded clinics between 1 October 1998 and 30 September 2001.[18] The utilization rate of our participants is similar with 47 percent reporting access to Indian clinics in the past year.

The US federal government has accepted legal responsibility for delivering health services to Native Americans since the 1800s. The provision of health services to members of Indian tribes grew out of the government-to-government relationship between tribes and the US government based on Article I, Section 8, of the US Constitution. What began as a few physicians in frontier outposts has developed into a network of more than 550 hospitals and clinics.[19] Participants were keenly aware of the federal role and responsibility in their health care: "As Native Americans I think we are kind of indoctrinated as the federal government is responsible for our health," and "I think everybody uses IHS because here it's already established. You don't have to go out and look for a [medical provider] . . . if your tribe's taking care of you." Several participants had accepted personal responsibility for the scope and quality of health care provided at the IHS-funded facilities. At the national level, this involved appearing before congressional committees. "I've testified in Congress and [to] Senators in Washington, D.C. and tell them about treatment [needs]. I fought for the regional treatment centers for our youth and got that." At the local level it meant taking steps to assure a culturally competent workforce. "When I was on the health board, we used to—anybody that came and worked with Indian people, you had to go through a cultural sensitivity class." Tribal involvement and a comprehensive health services delivery system specifically for American Indians has fostered the growth of a program that can meet the unique health care needs of Native Americans. For example, the IHS and tribal clinics developed an Indian-specific diabetes education program and medical management protocols. The IHS users in

our sample access the clinics for their diabetic services, including educational, self-management, and comprehensive services.

> I think we have to educate them out here by classes or something. Just like I was involved in the diabetic thing.
>
> I do [use the Indian clinic] at times for glasses, for diabetes.
>
> I have diabetes and with my HMO, I couldn't get one of these kits that you have to cut your finger with. They gave me a kit right away. They gave me a whole ton of the little things that go in there.
>
> I gotta go get a diabetes test, and I'm having x-rays Friday, I got to go see the heart surgeon . . . they are just lining them up and getting done for me what's gotta be done . . . so it's been pretty good.

Indian-specific diabetes care is an example of how the IHS and tribal clinics have addressed health problems prevalent in Native American communities.[20]

Indian clinics are also in the position to be responsive to the cultural components of medical care. For many Native Americans, traditional medicine is a valid alternative to care provided in hospitals and clinics.[21] Respondents, when asked questions about the role of clinics in providing access to traditional medicine, gave examples of how the IHS and tribal clinics have accommodated this need. "They had a coalition of about six spiritual people within northern California, to identify these spiritual leaders. The tribal chief of that recognized tribe, he has to sign that you are a spiritual leader within that community. And that's how we were able to have the right system." For some people, having traditional healers available through the Indian clinics has been very successful. As one respondent said, "We asked if this one guy, he's a medicine man up north, they wanted to get him working here for the ones that want to go through our ways of healing and stuff like that. They wanted him to be a part of the clinic. The Native American ways of spirituality and all that helps in healing." This service can be crucial for patients and their families. "And when my father was sick, just to feel better, he was dying, just for his own mind, he had a medicine man coming in and soon as the guy walked in, everybody left to leave him alone. So they worked together that way."

The participants used the IHS-funded clinics, like the VA health care system, preferentially for two specific reasons. First, tribes now manage their own health care facilities. Many of our participants had been active in shaping the clinics they use to meet the community's needs. Similar to their perception of the VA health care system, our participants believed the IHS-funded clinics were specifically for them and that they had a responsibility to maintain the clinics. Second, our participants felt the IHS-funded clinics were responsive to the specific cultural and health characteristics of American Indians. Problems such as diabetes and integration of traditional medicine were best accomplished by clinics designed for American Indians.

Private-Sector Health Care

About 54 percent of Native Americans in California have job-based health insurance.[22] Our participants are similar to working adults in California in that 60 percent of those sixty years and younger have health insurance in addition to VA and IHS eligibility. Ninety-seven percent of participants over age sixty have Medicare. Native American veterans view their private-sector medical care as an individual service rather than a program designed to meet the needs of a specific community. All statements about private-sector health care were about specific medical procedures and payment. For example, "I was in a terrible car accident two and a half years ago on reservation. I was in the hospital for a month and I was on morphine and critical care. But I had good care because I had insurance." Another example is "I belong to an HMO and everything that I need is right there basically. You get an operation done. You go down, they have the exercise rooms down there where the therapists are all at. You need an x-ray, you go over there and you get your x-rays." There were no instances where participants encountered or expected their private-sector health services to address cultural needs. Health care in the private sector was always described as an individualized service.

DISCUSSION

The VIP Native American Program was a study of health services use among a very specialized population of American Indians. All the participants in the study were men and veterans, most were older adults, and most had a strong affiliation with both veterans and their own American Indian community. Many of them had taken on leadership responsibility for the health care program. These men each gave up their time to participate in the interview group because they felt they could contribute to making the health care system better for American Indians and veterans. The men who spoke out were probably more knowledgeable about health care and had more experience with both the VA and the IHS-funded services than the average user. Even though they may be different in their outlook from the average user, their concerns and observations should be given careful consideration as the IHS and the VA move forward in modernization and reform of the health care systems.

The IHS and the VA have entered into an agreement to improve coordination and resource sharing for the purpose of delivering quality health care for American Indian veterans.[23] During 2002 and 2003 the IHS patient-registration database recorded thirty-two thousand patients who reported that they were veterans, and 44 percent of these were also registered as patients of the VA health care system.[24] Harada et al. have suggested that because American Indian veterans have a strong identification with their military service, this coordination of services should be strengthened.[25] As this relationship develops, both agencies must be cautious in order to preserve the characteristics of their respective organizations that serve their patients well. The participants in this research have shown how individual American Indians have taken on the important role of shaping the IHS-funded clinical

services to meet the specific cultural needs of their communities, such as offering coordination with traditional medicine practitioners and cultural-sensitivity training for providers. In addition, they discussed how patients have grown confident that IHS-funded services, such as that for diabetes, address health needs that are more prevalent among American Indians. In the same way, American Indian veterans turned to the VA health care system for health and mental health problems specific to veterans, such as PTSD and the effects of combat. Coordination of care may enhance the health outcomes; however, there are advantages to maintaining separation of these two specialized health care systems.

Likewise, as the IHS and tribal clinics encourage more of their patients to enroll in the Medicaid and Medicare Insurance Program, the IHS-funded clinics must critically evaluate which characteristics of their services have developed because of the special cultural and health needs of their American Indian patients. Indian clinics must continue to respond to changes in the mainstream health care delivery system while maintaining their ability to meet the needs of their Native American communities. The California tribal leadership, a group who has demonstrated the willingness and ability to shape the Indian health care system, should be called upon to guide the future of Native American health care.

During the next decade, health care in the United States is sure to undergo significant changes. Coordination of medical care, sharing of records, consolidation of health care facilities, and the development of standards for health insurance will continue to be central to the national discussion. The participants in this research discussed advantages of maintaining separate health care systems for special purposes. They relied on their knowledge of the special expertise of different health care systems to select the service they felt was appropriate for them. American Indian organizations and tribes must understand what makes Indian clinics responsive to their clients so that the most valuable characteristics of the health care system are strengthened.

NOTES

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