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Author

Svendsen, Freida

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COMMENTARY: TRIBAL VOICES

Elder Care and Medicare

FREIDA SVENDSEN (as told to Felicia Hodge)

For many American Indian elders who are poor, uninsured and underinsured, there is a limited range of options from which to choose when seeking medical care. For many decades, the Indian Health Service (IHS) was the primary care for Indians. That may no longer be the case. Because of budgetary restraints and cutbacks within the IHS system, medical care for the poor and elderly in American Indian communities has become severely restrictive. There was once a time when “just being an Indian” meant that entry into an Indian clinic was expected. Although never quite enough, congressional outlays provided funds to run Indian hospitals and clinics in order to meet the demand of those individuals in need of medical care. Then came the “on or near” ruling meant to restrict eligibility to those living within or adjacent to the county boundaries of reservations. One’s definition of eligibility then depended upon tribal status, place of residence, and blood quantum. Now, one more limitation faces those in need: medical provider acceptance.

When Freida became an elder—when she was well into her sixties—she found herself being questioned endlessly at the local Alaskan Native clinic regarding her tribe (a California tribe), blood quantum (having a Norwegian last name brought questions), residence (moving from California to live with her son in Alaska), and ability to pay for medical care services. Diagnosed with cataracts, Freida struggled to survive from day to day on meager retirement funds. Having depended upon the IHS clinic to treat her diabetes and rapidly deteriorating eyesight, Freida was initially confident that she could also have her cataracts surgically removed with the support of the IHS. Her need for the surgery could not be contested; as it was, she greeted the morning through filmy gauze, which restricted her ability to see more than a few feet ahead. Although cataract surgery is available in Alaska, the ability to pay for such

services is not readily available. Referral to third-party providers brought a swift response for Freida: pay up (which she was not able to do) or seek other resources.

Limited numbers of medical care providers in Alaska translate to limited health care services. If a non-IHS medical care provider chooses not to accept a Medicare patient, there is little left for the patient to do but to save up for the cost of the surgery or to go without. Communities in which providers can deny care because of reduced or small reimbursement caps have serious repercussions in that the patient is forced to go without. Reduced reimbursement rates do little to save money because in the long run, patients progress to a poorer state, deteriorating rapidly, and requiring more intensive and costly care later on. For Freida, as well as countless other American Indian elders, the cost of blindness, coupled with such co-morbid conditions such as diabetes is compounded. The options seem dismal.

The above scenario paints a picture of gloom for the nation's American Indian elder who is uninsured or underinsured. Given the lack of options for the patient, we may find that the elder American Indian patient goes quietly without, as they have few alternatives. No longer can the IHS medical care system be considered the payer of last resort—if they cannot provide basic care or respond to the community's medical care needs. No longer can the IHS rely on third-party support for supportive care or services that tax the resources of the individual patient.

We find ourselves entering a new era of patient care—coupling the definition of an Indian with residence, blood quantum, and the ability to pay for medical care. More restrictions may call for new interventions to provide for needed care.