ANHB urges action on health care access

by the Alaska Native Health Board

Mary, a 22-year-old Native woman from a remote village in Interior Alaska, is six months pregnant. The health aide at the village clinic has recommended she visit Fairbanks for a pre-natal exam.

However, Mary has already been to Fairbanks twice in the last six months, exhausting the financial resources of her family. She decides to forego the exam.

Jim, an ivory carver, broke his wrist in a snowmachine accident. He used his only available funds to fly to Bethel to have his arm set. He returned home and after several weeks removed the cast himself to save an additional trip.

He re-broke his wrist and had to borrow money from family and friends to return to Bethel. He lived on the streets for a week, waiting for his family to scrape together enough money to bring him home.

Unfortunately, stories such as these are not isolated cases. Access to health care has become a critical problem for the tens of thousands of Alaskans who live in approximately 200 rural communities, most accessible only by air.

A report sponsored by the Alaska Native Health Board and prepared last month by a task force of representatives from the Association of Regional Health Directors, Alaska Area Native Health Service, Alaska Native Medical Center, and State Emergency Services, documents the severity of the problem and urges the federal government to address it with an appropriation for Fiscal Year 1991 of almost $5 million.

The 22-page interim report, "Access to Care: Crisis for Alaska Natives," describes the existing health care system for rural Alaska Natives as being "multi-tiered."

The first tier, consisting of basic health care services, is typically provided by community health practitioners. The second tier consists of primary health care in the 12 in-patient hospitals and out-patient clinics in the regional hub communities.

The third tier is the Alaska Native Medical Center — ANMC — in Anchorage. The fourth tier consists of referral hospitals for specialized medical treatment not available at ANMC.

In many cases, the local health clinic and community health practitioners are able to meet the needs of village residents. However, when referral to a regional hospital or ANMC is necessary, patients often find themselves faced with a serious dilemma — how to pay for the trip to get the medical attention they need.

The problem has become acute in the last year as the Indian Health Service has had to deal with rising costs and static funding.

In 1989, IHS quit paying for return fares from Anchorage to villages and instead shifted the responsibility for patient travel to the regional Native health entities. However, many of the regional Native health entities were unable to replace IHS travel funds from their own limited resources.

Consequently, the responsibility for patient travel has been shifted directly to the patient.

In researching the patient travel problem, the ANHB task force found that in FY 89, rural health providers made 10,375 referrals from villages to regional hubs and 4,008 referrals from regional hubs to ANMC. The report cautions that these figures may not reflect actual need, since rural health providers, aware of the high cost of patient travel, tend to make fewer referrals.

One example is seen in pre-natal care: In rural Alaska, one pre-natal trip per pregnancy is typical, compared with the more standard health practice of eight pre-natal visits.

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The ANHB report provides detailed information on round-trip travel and lodging expenses for patients visiting regional hospitals and ANMC.

For example, the total cost for a typical trip from a village in the Yukon-Kuskokwim region to Bethel, the regional hub, is $303. If a trip to Anchorage is necessary, the additional cost is $505. For persons at the extreme low-income level, the combined cost of $808 represents 26 percent of their annual income.

As stated in the report, "Few (Native) families have discretionary dollars available for patient travel. . . Commonly, choices must be made between food, fuel or health care — an unacceptable scenario for a people who have entrusted the United States government with their well-being."

The report notes that citizens in other parts of the country have access to health care facilities through federal or state subsidized highway systems, a service unavailable to rural Alaskans.

Although Medicaid coverage offers one possible solution to the high cost of patient travel, ANHB maintains that this is often not a realistic option. Among reasons given are that many Natives are philosophically committed to staying off the state's welfare system.

"Access to Care" states that "shifting (the patient travel) cost burden to these families forces them into social indebtedness, thus destroying the pride they hold so dear. The unintentional result may be to promote dependence on welfare programs by not providing for the basic costs of obtaining health care."

In addition, the Medicaid program is plagued with bureaucratic and funding problems of its own. Delays in payment to air carriers are so bad that some carriers refuse transport of Medicaid recipients, demanding "up front" payment for services.

ANHB also cites problems for Natives in gaining or retaining eligibility, a situation likely to get worse as the Medicaid program sees increased demand on limited dollars.

Extrapolating from past data to estimate travel needs for FY 90, ANHB's Patient Travel Task Force arrived at a total projected need of nearly $6.4 million for all 12 regions. Subtracting available IHS and General Relief Medical funds, the balance to be covered by the regional Native health entities and patients is almost $4.9 million.

The task force notes that the figures in this interim access to care document are higher than those provided in an earlier IHS report and in the Task Force Preliminary Report distributed in February. However, ANHB believes the interim report comes closer in estimating actual need for patient travel for the state's Native population.

Previous reports used estimates based only on current travel policies which typically limit "paid" travel to emergency cases, and which in most cases assume reimbursement for one-way travel only.

The interim report reflects expenditures for round-trip travel based on actual number of patient referrals made in FY 89.

Representatives of the Alaska Native Health Board and the Association of Regional Health Directors have approached legislators in Washington, D.C., to inform them of the need for increased funding for patient travel in Alaska, and report that interest in the access to care issue seems to be high.

However, legislators in turn have asked for more information and more time to study the problem.

In the meantime, rural Alaskans will continue to make difficult choices about whether they can afford medical treatment.