THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

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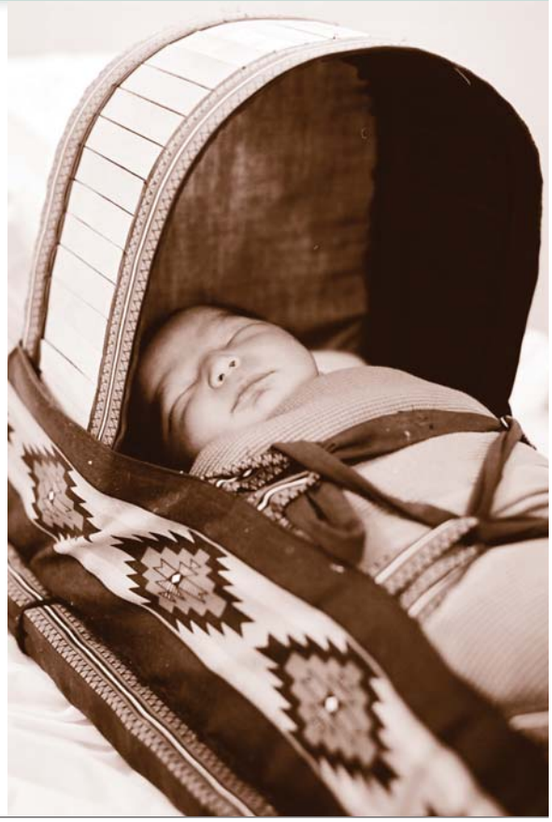
For American Indians, health care needs grow, money doesn't



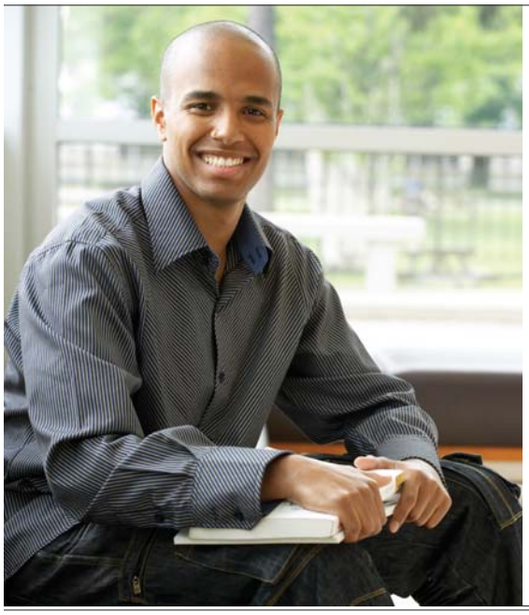
ON THE FORT APACHE RESERVATION IN ARIZONA, a pregnant woman who is a tribal member—usually Apache, Navajo, or Hopi—can get free prenatal care at the Whiteriver Indian Hospital. But women there who want and would benefit from tubal ligation are out of luck. The 40-bed US Indian Health Service hospital does not have surgical capabilities and doesn't have enough money to pay for the surgery somewhere else.

IHS funding has not kept pace with either medical costs or the growth of the population it serves. Per capita spending is less than half that of Medicaid and 36% that of the total US population. The gap has widened every year.

"From day to day we have to do workarounds to find ways to meet the challenges," according to Fellow Neil J. Murphy, MD, the IHS chief clinical consultant for ob-gyn services, who practices at the Alaska Native Medical Center in Anchorage.

David A. Yost, MD, the Whiteriver hospital's clinical director, echoed that perspective and explained how his hospital handles the

➤PAGE 10



Match numbers remain strong

THE PERCENTAGE OF OB-GYN residency positions filled by US medical seniors remained steady in 2008. In the National Resident Matching Program Residency Match, 99% of ob-gyn residency positions were filled, with 72% filled by US medical students, the same percentage as last year. A total of 1,163 ob-gyn residency positions were offered, eight more than in 2007.

"As in the last several years, the residency match again offers good news for women's health, as medical students continue to select ob-gyn as their top choice," said ACOG Executive Vice President Ralph W. Hale, MD, FACOG. "At all levels of the College, Fellows and Junior Fellows have made a concerted effort to mentor medical students and create programs and opportunities that introduce them to ob-gyn and show them how special and rewarding women's health care can be."

ACOG medical student recruitment efforts include hosting an ob-gyn residency fair and offering a medical student course, booth, reception, and hands-on courses at the Annual Clinical Meeting. ♀

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➤PAGE 1

financial shortfall. The hospital receives about $10 million from IHS, but it costs about $35 million a year to run. The difference is made up by billing Medicare and Medicaid. So, one of the workarounds at Whiteriver is to help patients enroll in Medicaid.

"We live in an impoverished community, so about 75% qualify for Medicaid," Dr. Yost said, adding that eligibility for Medicaid coverage swings dramatically from season to season due to the availability of summer employment in the forest industry. "We have 23 people in the [hospital] business office to help patients try to navigate the red tape of Medicaid and Medicare processing. It's to our benefit."

Lack of funds restricts care

While finding the money to run the Indian health care facilities can be difficult, the real money crunch is in the "contract health services" budget used to pay for services provided outside the IHS system, such as tubal ligations for women from the Apache reservation.

"The contract health services budget is not indexed to growth," Dr. Yost said. "We have essentially the same budget we had 15 years ago, while our population has grown by 70%. The money has to be prioritized to meet life-threatening matters."

Tony Ogburn, MD, the incoming chair of ACOG's Committee on American Indian Affairs, offers an example of how the shortage in contract services funding affects women who need elective gynecologic surgery. Pine Ridge Indian Hospital in South Dakota does not have an ob-gyn on staff and doesn't have enough funds to pay a locum tenens to do elective surgeries. When Dr. Ogburn and a colleague from the University of New Mexico volunteered to do surgery for a week at Pine Ridge, they operated on about 15 patients, some of whom had been profoundly anemic for years. Dr. Ogburn said that although the women's condition "was not acutely life-threatening, it certainly was life-altering."

Geography, poverty present challenges

Dr. Murphy said the biggest challenge of providing health care is "the remote nature of our practice."

"Our patients [in Alaska] live in primarily rural areas—in many cases off the road system."

Lack of transportation limits access even more. Dr. Yost said that on the Apache reservation in Arizona, "about 25% of our patients have access to vehicles, and there is no public transportation on the reservation." He clarified that "access to vehicles" could mean that 12 people who live with each other share a car. To get to the clinic, patients may walk five miles and then hitchhike.

Recruiting physicians and other professionals to these rural locations is difficult. The IHS reports a 17% vacancy rate for physicians, 18% for nurses, and 31% for dentists. Dr. Ogburn points out that the loan repayment program, which is used as an incentive to recruit graduating residents, is underfunded.

"The amount of money given is not enough to truly pay off someone's loans, and the program also doesn't have enough money to accept everyone who applies," he said.

The sparsely populated nature of rural locations also affects the services available. In the area of the Whiteriver hospital area there are only about 325 pregnancies a year. Women

with high-risk pregnancies must go 30 miles away—over a mountain pass—to be delivered, and some will be transferred to Phoenix, about four hours away by ground.

Health disparities recognized

The health status of American Indians and Alaska Natives is lower than that of other Americans. Infants die at a rate of nearly 12 per 1,000 live births, compared to 7 per 1,000 for all races in the US. The overall life expectancy is 2.4 years less than that of all others in the US.

"Their baseline health is not as good," Dr. Ogburn said. "People in poverty don't have ready access to preventive care and don't get diagnosed as early."

About 16.3% of American Indian/Alaska Native adults have diabetes, compared with 8.7% of whites, and the death rate from diabetes is three times higher than that of the general US population.

Progress has been made

Admitting that he prefers to look at the glass as half full, Fellow William H.J. Haffner, MD, points to the tremendous progress that has been made in health care among American Indians since the 1970s.

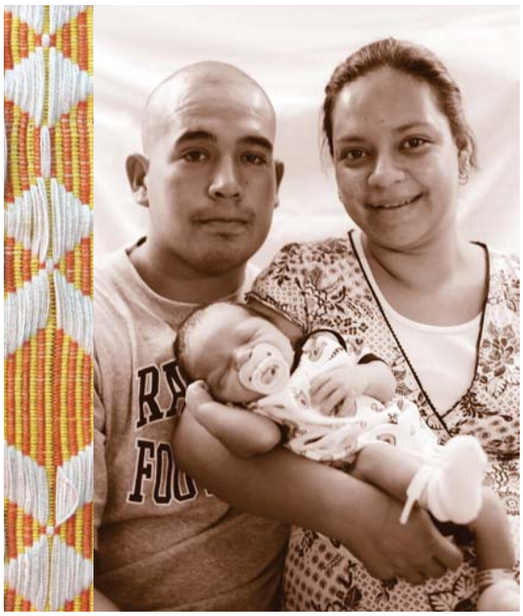
"Deliveries are safer. Newborns are born healthier."

Dr. Haffner brings a longtime, firsthand perspective to the issue. In 1971 he began a 10-year stint at the Gallup Indian Medical Center in New Mexico and then during the 1980s served as the IHS chief clinical consul-

tant for ob-gyn. He has continued to be involved in Indian health affairs and is currently a member of ACOG's Committee on American Indian Affairs.

"In the 1970s the obstetric issues were preeclampsia and eclampsia, with a significant number of maternal deaths related to hypertension," Dr. Haffner said.

This was addressed through improving prenatal and hospital care, he said.



Dr. Haffner credits the "conscientious partnership between the IHS leadership and tribal leadership" with improving health care.

"Initially, IHS ran everything in a centralized model. The partnership has evolved, and the tribes' taking a much stronger lead has been highly successful," Dr. Haffner said.

Dr. Murphy added that staff has a sense of mission and work hard.

"They work with the challenges. Most important, the native people themselves are very resilient and have worked hard."

Indian health care bill needs congressional action

Reauthorization of the Indian Health Care Improvement Act is a critical and long-overdue step needed to address the health care needs of American Indians. Since the act's original passage in 1976, it has been reauthorized every 5–7 years, but the last reauthorization, in 1992, has long since expired.

This February the US Senate passed a reauthorization bill that would expand health coverage and services.

"This is the first reauthorization where there's been a massive rewriting of the 1976 act," Dr. Yost said. "The health care picture looked very different in the 1970s. Diabetes was just an emerging problem. The act that passed in the 70s didn't recognize drug abuse and was very light toward preventive health care."

The Senate-passed bill would provide programs to recruit and train health professionals, address mental and behavioral issues such as substance abuse and suicide, and enhance prevention programs such as those dealing with diabetes and obesity. As *ACOG Today* went to press, a similar bill was pending in the House. ACOG supports the bill and urges members to contact their congressional representatives to ask them to support it. ♀

info

- ➜ On the ACOG website, www.acog.org, under "Women's Issues," click on "Indian Health Service"
- ➜ Indian Health Service: www.ihs.gov

About the photos used in this article

THE COVER PHOTO AND the photos on these pages decorate the walls of the Whiteriver Indian Hospital Birthing Center in Whiteriver, AZ. All the children in the portraits were patients at the hospital. The photos were taken in 2007 by one of the nurses, Jessica Bledsoe, an amateur photographer, after the staff wanted to add portraits of their patients to the walls of their newly remodeled birthing center.

"We wanted our birthing center to reflect the fact that this was a place for Native American women, and specifically for White Mountain Apache women and their families. We wanted patients to feel that the birthing center belonged to them because, in essence, it does," explains LeeAnn Beach, RN, SCN, the center's supervisory clinical nurse.

The cover photo shows a newborn in a "cradleboard," commonly used among the White Mountain Apache to carry their children. ♀

SHORT-TERM OB-GYN PLACEMENT AT INDIAN HOSPITALS

Since the mid-1970s ACOG has run a program to place ob-gyns at Indian hospitals for brief periods. ACOG Fellows Serving Native American Women provides coverage for ob-gyns on staff at Indian Health Service hospitals when they go on vacation or are participating in continuing medical education or when staff positions are vacant.

Fellows or Junior Fellows who are US citizens and have recent experience in high-risk obstetrics may be eligible for assignments of 3–4 weeks or more. ACOG encourages members to participate in this program. For more information, visit the ACOG website (see "info" above). ♀