POLICY BRIEF
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Reasons for Experiencing Delayed or Forgone Health Care among Rural American Indian/Alaska Native and Rural Non-Hispanic White Individuals, 2022

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Key Findings

- Almost one-fifth of rural American Indian/Alaska Native (AI/AN) people without access to Indian Health Service (IHS) care report experiencing delayed or forgone health care, a significantly higher percentage than rural AI/AN people with access to IHS care and rural white non-Hispanic people (18.0% vs 11.4% and 11.4%, $p<0.05$; Figure 1).
- Rural AI/AN people both with and without access to IHS care are more likely than rural non-Hispanic white people to cite issues with reliable transportation as reasons for experiencing delayed or forgone health care (13.2% and 10.9% vs 4.6%, $p<0.001$; Figure 2).
- Rural AI/AN people with access to IHS care are most likely to cite issues with health care appointment availability as reasons for experiencing delayed or forgone health care (15.4%), followed by rural AI/AN people without access to IHS care (11.4%) and rural non-Hispanic white people (7.9%, $p<0.05$; Figure 2).
- Rural AI/AN people with access to IHS care are more likely than rural non-Hispanic white people to cite issues with competing time commitments (15.2% vs 8.1%, $p<0.05$) as reasons for experiencing delayed or forgone health care (Figure 2).

Purpose

Rural residents and American Indian/Alaska Native (AI/AN) people both experience challenges in health care access.[1–5] The Indian Health Service, a federally operated health system intended to fulfill the trust responsibility of the United States to Native nations, is a source of health care for approximately 2.8 million AI/AN people;[6] just under 30% of the 9.7 million AI/AN people alive today.[6,7] The purpose of this policy brief is to show reported reasons for experiencing delayed or forgone health care and how this differs between rural AI/AN and rural non-Hispanic white people as well as by Indian Health Service (IHS) care access among rural AI/AN people.

Approach

Data came from the 2022 National Health Interview Survey (NHIS), an annual survey conducted by trained interviewers through computer-assisted personal interviewing, face-to-face in respondents' homes.[8] We used NHIS-provided person-level sampling weights in all analyses to produce nationally representative estimates. Only rural residents, defined as living in a non-metropolitan county using the National Center for Health Statistics (NCHS) Urban-Rural classification scheme,[9] were included in this study. Individuals self-reporting AI/AN race or ethnicity, alone or in combination with other races and ethnicities, were categorized as AI/AN (N = 1,044), consistent with Indigenous-led recommendations for measuring AI/AN identity in research.[10] These were further stratified by those who reported access to IHS care (N=507) vs those who did not report access to IHS care (N=537). The mutually exclusive comparison group included individuals self-reporting as non-Hispanic white and non-AI/AN (N = 22,586).

Individuals answered yes/no to survey questions on whether they had experienced delayed or forgone

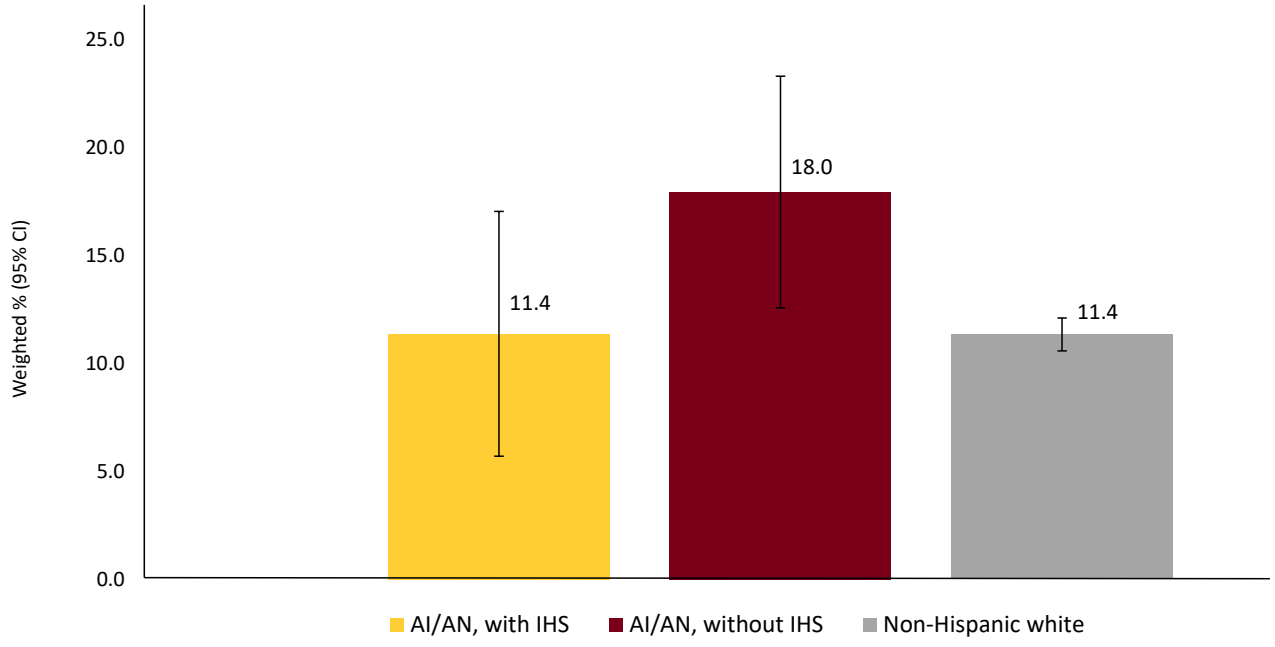
health care in the past 12 months, and whether delays were due to: cost issues (having delayed or forgone care due to worry about cost); transportation issues (having delayed or forgone care due to lacking reliable transportation); appointment availability issues (having delayed or forgone care due to being unable to get to a doctor's office or clinic when it was open, and/or an appointment was not available when needed); and/or having too many competing time commitments (having delayed or forgone care due to being too busy with work or other commitments).

Results

Figure 1 shows that a higher percentage of rural AI/AN people without access to IHS reported experiencing delayed or forgone care (18.0%) than their counterparts, rural AI/AN people with access to IHS (11.4%) and rural non-Hispanic white people (11.4%; $p<0.05$).

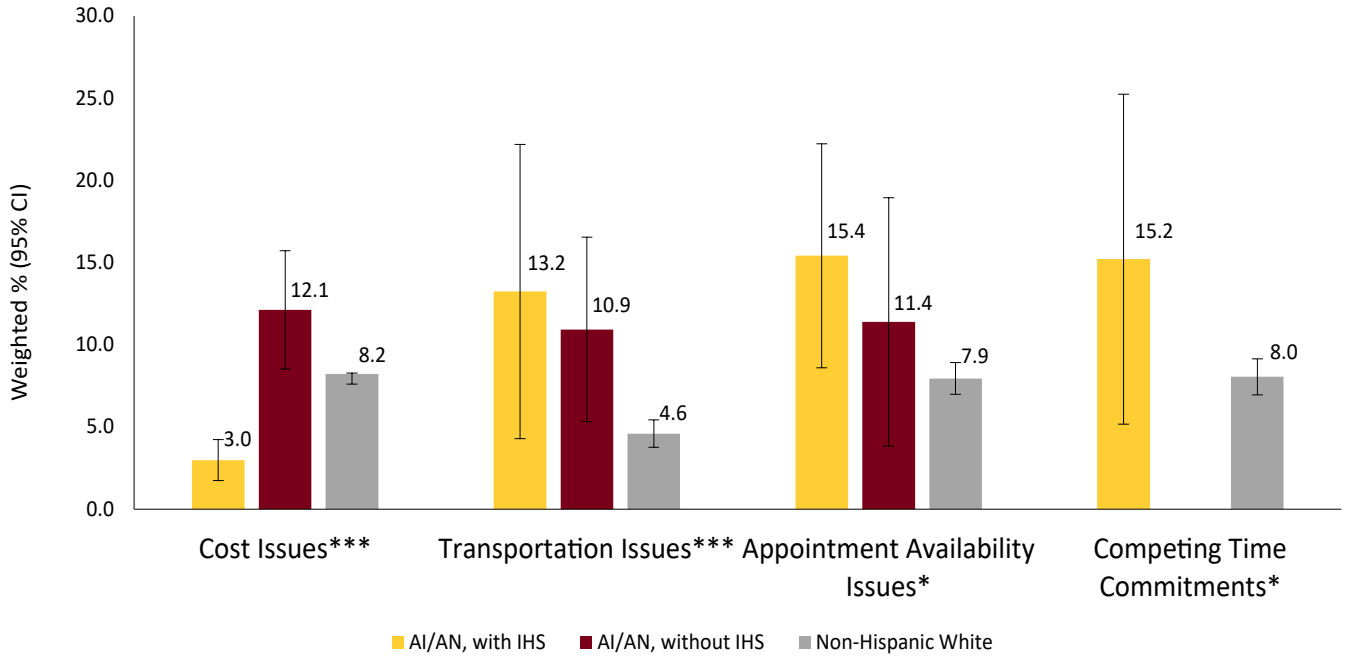
Figure 2 describes reasons for experiencing delayed or forgone care. Cost issues were most commonly cited by rural AI/AN people without access to IHS care (12.1%), followed by rural non-Hispanic white people (8.2%), while rural AI/AN people with access to IHS care were the least likely to cite cost issues (3.0%; $p<0.001$). Transportation issues were most commonly cited by rural AI/AN people with access to IHS care (13.2%), followed by rural AI/AN people without access to IHS care (10.9%) and rural non-Hispanic white people (4.6%, $p<0.001$). Similarly, appointment availability issues were most commonly cited by rural AI/AN people without access to IHS care (15.4%), followed by rural AI/AN people without access to IHS care (11.4%) and rural non-Hispanic people (7.9%, $p<0.05$). Competing time commitments were more commonly cited by rural AI/AN people with access to IHS care than rural non-Hispanic white people (15.2% vs 8.1%, both $p<0.05$).

Figure 1. Experiencing Delayed or Forgone Health Care among American Indian/Alaska Native and Non-Hispanic White Adults in the Rural U.S., 2022 (N = 23,647)



Comparisons were weighted Rao-Scott chi-squared tests with 95% confidence intervals shown as error bars. Resultant p-values comparing AI/AN without access to IHS care to AI/AN with access to IHS care and to non-Hispanic white were $p<0.05$.

Figure 2. Reasons for Experiencing Delayed or Forgone Health Care among American Indian/Alaska Native and Non-Hispanic White Adults in the Rural U.S., 2022 (N = 23,630)



** Indicates p<0.05; *** indicates p<0.001. Comparisons were weighted Rao-Scott chi-squared tests with 95% confidence intervals shown as error bars. [Notes on sample sizes: Cost Issues subsample is (N = 63,642); Transportation Issues subsample is (N = 8,812); Appointment Availability Issues and Competing Time Commitments subsamples are (N = 4,433); Results are suppressed for samples where N < 10].*

Discussion and Implications

The IHS helps facilitate access to care for rural AI/AN people, as demonstrated by the findings that rural AI/AN people without access to IHS care were more likely to report experiencing delayed or forgone health care than rural AI/AN individuals with access to IHS care. However, well-documented funding shortages limit the staff and services that the IHS can support,[4,5,11,12] and our findings show that rural AI/AN individuals with access to IHS care were most likely to cite issues with health care appointment availability as a reason for experiencing delayed or forgone care.

Access to IHS care helps ameliorate some barriers to care, as shown by rural AI/AN people with access to IHS care being the least likely to cite cost as a reason for experiencing delayed or forgone care. However, unmet treaty obligations as well as the cumulative effects of limited investments in rural tribal communities can create barriers to care for AI/AN people.[13–15] In this analysis, one particular barrier faced by rural AI/AN individuals – with and without access to IHS care – was issues with reliable transportation, cited as a reason for experiencing delayed or forgone health care. Transportation challenges could arise due to distance to care, lack of a reliable vehicle, affordability of gasoline, poor road conditions, lack of paved roads, or other issues.

In addition to transportation barriers, rural AI/AN individuals face significant challenges related to time availability when accessing health care. These data showed that rural AI/AN individuals with access to IHS care cited competing time commitments more often that rural non-Hispanic white individuals as a reason for experiencing delayed or forgone health care. Many AI/AN people must take hours or even days off work and other responsibilities to reach IHS services

due to the considerable distances between their homes and medical facilities.[16] Moreover, AI/AN individuals are also disproportionately impacted by health conditions that often require specialty care, such as certain cancers,[17] heart disease,[18] and liver disease.[19] Unfortunately, these specialized services are infrequently available at IHS facilities,[20] necessitating further travel and increased time away from daily responsibilities. There is also a need for additional social supports, such as childcare, in rural AI/AN communities to help caregivers seek their own care.[16]

Conclusion

Overall, these findings show that rural AI/AN people without access to IHS care experienced delayed or forgone care more often that rural AI/AN people with access to IHS and rural non-Hispanic white people. Rural AI/AN people with access to IHS care were less likely to cite cost as a reason for experiencing delayed or forgone care, but more likely to cite appointment availability issues and competing time commitments, than rural AI/AN people without access to IHS care and rural non-Hispanic white people. Rural AI/AN people with and without access to IHS care were also more likely to cite issues with reliable transportation as a reason for experiencing delayed or forgone care than rural non-Hispanic white people. Access to care has a profound impact on health in rural U.S. communities, and rural AI/AN residents face additional barriers to care. While the IHS helps support access for some AI/AN people, IHS resources may not be sufficient to entirely address these differences.[21]

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