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POLICY BRIEF

Improving Accountability and Performance in the Indian Health Service

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For many decades, Native Americans have experienced higher rates of health problems than the general American population and other racial minority groups.[1] Today, the average Native American dies five and a half years sooner than the average American.[2] During the first year of the COVID-19 pandemic, Native Americans faced the highest rates of infection, hospitalization, and death due to COVID-19 when compared with any other race or ethnicity in the United States.[3]

At least two important causes are behind the poorer health outcomes that Native Americans face. First, the Indian Health Service (IHS), a healthcare system funded and managed by the federal government, has struggled chronically with underfunding and bureaucratic shortcomings. Second, the pervasive poverty that many Native Americans experience has contributed to poor health outcomes. Institutions that raise transaction costs of economic development and innovation perpetuate poverty, contributing to worse health outcomes.

Improving Native American health will require both immediate, small-scale policy changes and long-term, large-scale institutional reforms. Increasing IHS funding will likely help improve health outcomes to a degree, but more funding will not solve the underlying management problems in the IHS or the institutional problems contributing to widespread poverty.

One of the most important ways to improve Native American health outcomes is to reform the IHS to resolve many of its management problems. As currently constituted, the IHS is a highly imperfect healthcare system. Long-term solutions must focus on institutional reforms that (a) align the incentives of IHS workers with improved performance and (b) increase accountability of decision makers in the IHS.

BUREAUCRATIC SHORTCOMINGS AND MISMANAGEMENT IN THE IHS

The IHS is subject to the same kinds of inefficiencies and shortcomings that all government bureaucracies face. However, the IHS also appears to have long-standing issues with mismanagement that go beyond ordinary bureaucratic inefficiencies. Acknowledging such problems in a bureaucracy does not imply that the individuals who work in the bureaucracy are inherently unknowledgeable, nefarious, or inept.

Bureaucrats in the IHS and all other bureaucracies face incentive problems; that is, they have weak motivations to provide quality goods and services in cost-effective ways. All people respond rationally to their institutional incentives, implying that an agency's particular institutional rules are very important for eliciting "desirable" kinds of behavior. The institutional rules that govern an agency can pose problems if those rules incentivize individual bureaucrats to shirk their responsibilities, obfuscate information, or generate pessimism, among myriad other potential problems.[4]

In general, all bureaucrats, no matter the agency, face similar incentives. Unlike private firms, bureaucrats are not residual claimants, meaning that they do not personally benefit from improving quality or reducing costs. Excessive costs or subpar services do not jeopardize the existence of a government agency. Overspending does not personally affect an individual bureaucrat's take-home pay. Additionally, bureaucrats are not rewarded for responsible, prudent spending. In fact, bureaucrats may be punished for spending money more prudently because Congress is likely to shrink an agency's future budget if that agency demonstrates it can fulfill its responsibilities with less funding. Thus, individual bureaucrats in the IHS, like those in all government agencies, face perverse incentives for spending efficiently and eliminating waste.[5]

IHS employees respond rationally to the institutional incentives they face. For example, IHS hospitals and health centers are having trouble retaining staff members because the IHS cannot usually match local market salaries and does not have enough housing to meet the demand of potential IHS healthcare providers. Thus, the IHS has become reliant on hiring temporary providers, which can cause problems because (a) it may be more costly on some margins and (b) it may result in lower-quality patient care over time.[6] A 2019 *New York Times* analysis and a 2018 Government Accountability Office (GAO) report find that roughly a quarter of all medical positions in the IHS are vacant. In some locations, the vacancy rate is roughly 50 percent.[7] Whereas the IHS has taken some steps to recruit and retain providers, such as offering financial incentives and housing, vacancies remain a problem.

Because of the current institutional incentives and constraints, mismanagement and poor performance are widespread in IHS headquarters, area offices, and service units. The US Department of Health and Human Services Office of Inspector General and the GAO have identified several forms of mismanagement, such as providing substandard healthcare services and inadequately following administrative policies. In a 2019 audit, the OIG identifies three broad categories of

institutional problems in the IHS system: (a) a lack of clarity and understanding regarding the IHS's formal structure, policies, and roles; (b) a lack of information on hospital performance and problems; and (c) a lack of confidence in the IHS's ability to succeed.[8]

First, the structural problems are rooted in the lack of transparency and clarity in the hierarchy of the bureaucracy. IHS officials have said that the most common negative issue they face is "the lack of a solid organizational structure regarding management of IHS hospitals, including policies that would direct the work of IHS headquarters, area offices, and hospitals, and distinguish their respective responsibilities."[9] The obscurity and vagueness of policies and administrative structures, as well as a high turnover rate, have caused widespread confusion in the agency, leading to poor performance on multiple margins.

Second, because of this lack of clarity with structure and policy, IHS employees have said that there is no clear view about what constitutes good performance or how to go about solving problems. A lack of communication in the agency compounds the problems of the obscurity and vagueness of policies and administrative structures. Bureaucrats in the IHS headquarters often lack knowledge of what is going on in the area offices. Workers in area offices and hospitals have reported that they "received poor or incomplete information about operations, and that they did not feel that anyone in IHS HQ had a comprehensive view of Area Offices and hospitals."[10] In the audit, several IHS officials articulate a "tendency to avoid conflict and frank discussion and feedback" and acknowledge that administrative meetings "did not include practical discussions about operations and problems."[11] This combination of uncertainty and a lack of communication has caused confusion and discord at all levels regarding the IHS's goals and ability to solve problems.

Third, the persistent internal and external criticisms of the IHS have led to a widespread pessimism in the managers and the medical staff. IHS officials have openly questioned the IHS's efficacy as an agency because of "protracted bureaucratic processes; lack of a clear vision for how to meet goals; lack of trust within IHS; and lack of trust between IHS and the broader beneficiary community."[12] In the 2019 audit, several IHS officials say that "they could not recall any celebrations of success" in the agency.[13] IHS employees have said that a change in the organization's culture is necessary to overcome the widespread sense of defeatism.[14]

In addition to the administrative problems mentioned previously, hospitals and healthcare centers, run by both the IHS or tribes, have often failed to meet federal and tribal standards for health, safety, and quality, which potentially puts patients in jeopardy. Substandard healthcare services have been compounded by the underlying organizational and management problems that affect the entire IHS system.

OIG investigations find that IHS-run hospitals have a relatively high rate of patient harm. In fiscal year 2017, roughly 13 percent of patients in IHS hospitals experienced patient harm events during their stays. Smaller hospitals in the IHS system often had higher rates of harm. In IHS hospitals

with fewer than 1,000 admissions in fiscal year (FY) 2017, 19 percent of patients experienced patient harm events; in IHS hospitals with more than 1,000 admissions in FY 2017, 9 percent of patients experienced patient harm events. The OIG has found that more than half of the instances of patient harm were related to the use of medication. Pediatric patients had the lowest rate of patient harm (5 percent), whereas the highest rates were seen among elderly patients (30 percent) and patients delivering children (21 percent). The OIG has found that an estimated 7 percent of all IHS patients experienced instances of harm that could have been prevented if the patients had been given better care.[15] In reality, patient harm numbers might be significantly higher owing to missing records and other inadequacies with IHS data.

In a 2020 review, the OIG finds that 56 percent of labor and delivery patients had some aspect of care that did not follow national clinical guidelines, did not use best practices for blood-loss estimation, or both. Although postpartum hemorrhage affects only about 1 to 3 percent of births in the entire United States, 33 percent of the OIG's sample of labor and delivery patients experienced a postpartum hemorrhage.[16]

IHS hospitals do not always follow their own protocols, even with dangerous drugs. In 2019, the OIG found that IHS hospitals do not consistently follow the Indian Health Manual or other IHS policies and procedures when prescribing and dispensing opioids.[17] In particular, its review finds that many IHS hospitals do not always "review the course of patient treatment and causes of pain within required timeframes," "perform the required urine drug screenings within recommended time intervals," "review patient health records before filling a prescription from a non-IHS provider," or "maintain pain management documents to support that the provider had performed his or her responsibilities."[18]

In addition to providing substandard healthcare services and causing suffering because of organizational issues, the IHS and tribal offices have, as repeatedly found by the OIG, inadequately followed administrative policy on many margins, including hiring practices and use of funds, which have sometimes been improper or illegal. For example, in 2020 the OIG found that tribal health programs in the IHS system do not always follow established protocols for conducting background checks for people working with children. The OIG concluded that this noncompliance increased the risk that an individual with a disqualifying criminal history could have regular contact with children. The OIG is currently working with the IHS and these tribes to make plans for compliance.[19]

Illegal or noncompliant uses of funds have been found throughout the IHS system, including in federally run and tribally run entities. For example, the OIG has found that the IHS does not follow its own protocols for purchased and referred services, which can directly affect how and when patients receive services.[20] Investigations have also found the improper use or inadequate monitoring of the IHS Loan Repayment Program, which allows the IHS to pay for education loans for health professionals who join the IHS.[21] Relatedly, the IHS's travel-card and purchase-card pro-

grams also have relatively high rates of noncompliance with federal requirements and the IHS's own policies. OIG officials have concluded that purchase-card errors occur because policies for monitoring and educating cardholders are not adequate.[22] Even in some tribally administered parts of the IHS system, compliance with funding policies has been problematic. In an OIG report from 2016, inspectors find that the Rocky Boy Health Board of Montana's Chippewa Cree Indians of the Rocky Boy's Reservation had incurred and paid unallowable salary and benefit expenses using IHS money. The OIG concludes that these noncompliant payments occurred for two reasons: (a) the Rocky Boy Health Board had inadequate internal controls and (b) the Rocky Boy Health Board staff was not adequately trained in accordance with federal requirements, the tribe's policies, and the health board's policies.[23]

REFORMS TO IMPROVE ACCOUNTABILITY AND PERFORMANCE IN THE IHS

The IHS has taken steps in recent years to improve management and organizational accountability. In 2016, the IHS launched the Quality Framework, which implements telehealth consultation in some areas, and also created an Accountability Dashboard for Quality. In 2017, the IHS implemented policies to enhance recruitment and retention of staff, and in 2018, the IHS began using a new credentialing system to enhance the screening of people before they are hired. In 2019, the IHS established the Office of Quality and released the *IHS Strategic Plan FY 2019–2023*, which outlines new goals to improve access, quality, and management in the agency.[24]

It remains to be seen how effective these recent initiatives will be in improving IHS hospital quality and management. More drastic steps are likely necessary to overcome the pervasive failures in communication, accountability, and healthcare quality.

The difficult problem of public administration reform is developing new policies that are accompanied by as little waste and as few unintended consequences as possible. The fundamental problem with making or reforming policies in a complex system is that unintended consequences inevitably arise. In theory, policymakers can take steps to minimize the likelihood and magnitude of unintended consequences, but doing so requires that they be flexible and willing to make changes when a particular policy or institutional rule produces undesirable results. There is no simple solution to problems embedded in complex systems. A common pitfall for policymakers is to acknowledge that they are working with complex systems, yet still engage in simplistic, linear thinking when making decisions.[25]

Perhaps the best and most effective policy recommendation to improve the IHS is to better align the incentives of IHS employees at every level with the interests of Native Americans. The incentives that individual employees face also must align with the goals of the agency. Otherwise, individuals will not be motivated to contribute to the achievement of the agency's goals. Thus, one way to improve accountability and communication in the IHS is to reform institutional structures to better align the incentives of the officials, doctors, and other employees with the desired outcomes.

Incentives to improve accountability might include a system of rewards for good performance or rewards for discovering innovations. What good performance means, what constitutes an innovation, or what a system of rewards looks like depends on the local conditions and internal culture of the IHS. Outside observers face a problem in knowing exactly what the institutional incentives are and knowing which reward systems are likely to be effective. Because IHS employees have local and tacit knowledge about the institutional details and incentives of the agency, they have the best knowledge about how to align incentives for the desired outcomes. Therefore, any potential reforms should include consultation with IHS employees at every level so that reforms incorporate knowledge of the very people they are meant to help.

Another important policy recommendation is to focus on effective constraints so that instances of noncompliance with established standards and policies are minimized. As the OIG has already determined, employees of the IHS have disregarded administrative policies, including by improperly hiring personnel and by improperly using funds. The repeated disregard of administrative policies at various levels of the IHS is evidence that employees do not view their institutional constraints as especially binding. More stringent punishments for violations of federal and tribal policies could constrain unproductive behavior, such as hiring unqualified employees and using IHS funds in unauthorized ways.

Moving toward a system of more effective incentives and constraints would improve the effectiveness and efficiency of the IHS. No single reform will solve all the problems of the IHS, and policymakers should be wary of purported panaceas. The use of panaceas has a track record of repeated failures in various forms of governance.[26] It is difficult to improve the incentives and constraints of a complex government agency. Such reforms require trial and error to find a workable set of incentives and constraints that accommodate the differences at the various levels of the agency and in various communities. Thus, as the IHS moves forward with institutional reforms, officials at all levels require humility. Proposed reforms would require intensive, context-specific analysis and an awareness of the complexities of social life.[27]

Policymakers can and should develop a more ideally constituted set of institutions that improve the IHS's performance. The IHS bureaucratic system suffers from many shortcomings, and long-term solutions must focus on implementing better methods of internal accountability and communications in the IHS.

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NOTES

1. Donna E. Shalala et al., *Regional Differences in Indian Health: 1998–99* (Rockville, MD: Indian Health Service, 1999); Joseph P. Kalt et al., *The State of the Native Nations: Conditions under U.S. Policies of Self-Determination* (New York: Oxford University Press, 2007); Karen Chartier and Raul Caetano, "Ethnicity and Health Disparities in Alcohol Research," *Alcohol Research & Health* 33, no. 1-2 (2010): 152–60; Indian Health Service, *Indian Health Disparities*, October 2019.
2. Indian Health Service, *Indian Health Disparities*.
3. "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity," Centers for Disease Control and Prevention, last updated November 22, 2021, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.
4. *The Selected Works of Gordon Tullock*, ed. Charles Rowley, vol. 6, *Bureaucracy* (Indianapolis: Liberty Fund, 2005); James M. Buchanan, "Politics without Romance: A Sketch of Positive Public Choice Theory and Its Normative Implications," in *The Logical Foundations of Constitutional Liberty*, ed. Geoffrey Brennan, Hartmut Kliemt, and Robert D. Tollison, vol. 1, *The Collected Works of James M. Buchanan*, ed. Geoffrey Brennan, Hartmut Kliemt, and Robert D. Tollison (Indianapolis: Liberty Fund, [1979] 1999), 45–59.
5. Christopher J. Coyne, *Doing Bad by Doing Good: Why Humanitarian Action Fails* (Stanford, CA: Stanford University Press, 2013); William A. Niskanen Jr., *Bureaucracy and Representative Government* (Chicago: Aldine, Atherton, 1971).
6. Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies" (report no. GAO-18-580, Government Accountability Office, Washington, DC, August 15, 2018); US Department of Health and Human Services, Office of Inspector General, "Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care" (report no. OEI-06-14-00011, US Department of Health and Human Services, Washington, DC, October 2016).
7. Mark Walker, "Fed Up with Deaths, Native Americans Want to Run Their Own Health Care," *New York Times*, October 15, 2019; Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies."
8. US Department of Health and Human Services, Office of Inspector General, "Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals" (report no. OEI-06-16-00390, US Department of Health and Human Services, Washington, DC, August 2019).
9. US Department of Health and Human Services, Office of Inspector General, "Organizational Challenges," 11.
10. US Department of Health and Human Services, Office of Inspector General, 15.
11. US Department of Health and Human Services, Office of Inspector General, 16.
12. US Department of Health and Human Services, Office of Inspector General, 19.
13. US Department of Health and Human Services, Office of Inspector General, 20.
14. US Department of Health and Human Services, Office of Inspector General, 20.

15. US Department of Health and Human Services, Office of Inspector General, "Incidence of Adverse Events in Indian Health Service Hospitals" (report no. OEI-06-17-00530, US Department of Health and Human Services, Washington, DC, December 2020).

16. US Department of Health and Human Services, Office of Inspector General, "Instances of IHS Labor and Delivery Care Not Following National Clinical Guidelines or Best Practices" (report no. OEI-06-19-00190, US Department of Health and Human Services, Washington, DC, December 2020).

17. "Indian Health Manual," Indian Health Services, accessed December 20, 2021, https://www.ihs.gov/ihm/pc/.

18. US Department of Health and Human Services, Office of Inspector General, "IHS Needs to Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Function" (report no. A-18-17-11400, US Department of Health and Human Services, Washington, DC, July 2019), 11.

19. US Department of Health and Human Services, Office of Inspector General, "Tribal Health Programs: Concerns about Background Verifications for Staff Working with Indian Children" (report no. A-01-20-01500, US Department of Health and Human Services, Washington, DC, August 28, 2020).

20. US Department of Health and Human Services, Office of Inspector General, "Most Indian Health Service Purchased/Referred Care Program Claims Were Not Reviewed, Approved, and Paid in Accordance with Federal Requirements" (report no. A-03-16-03002, US Department of Health and Human Services, Washington, DC, April 2020); Government Accountability Office, "Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs" (report no. GAO-19-74R, Government Accountability Office, Washington, DC, December 10, 2018).

21. US Department of Health and Human Services, Office of Inspector General, "Audit of the Indian Health Service's Internal Controls over Monitoring of Recipients' Compliance with Requirements of the Loan Repayment Program" (report no. A-09-10-01005, US Department of Health and Human Services, Washington, DC, December 2010).

22. US Department of Health and Human Services, Office of Inspector General, "The Indian Health Service's Controls Were Not Effective in Ensuring That Its Travel Card Program Complied with Federal Requirements and Its Own Policy" (report no. A-07-16-05091, US Department of Health and Human Services, Washington, DC, April 2018).

23. US Department of Health and Human Services, Office of Inspector General, "Expenses Incurred by the Rocky Boy Health Board Were Not Always Allowable or Adequately Supported" (report no. A-07-15-0422, US Department of Health and Human Services, Washington, DC, March 2016).

24. US Department of Health and Human Services, Office of Inspector General, "Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals" (report no. OEI-06-16-00390, US Department of Health and Human Services, Washington DC, August 2019).

25. Coyne, *Doing Bad by Doing Good*, 147–65.

26. Elinor Ostrom, Marco A. Janssen, and John M. Anderies, "Going Beyond Panaceas," *Proceedings of the National Academy of Sciences* 104, no. 39 (September 2007): 15176–78.

27. Stefanie Haeffele and Anne Hobson, eds., *The Need for Humility in Policymaking: Lessons from Regulatory Policy* (Lanham, MD: Rowman & Littlefield International, 2019).