Expanding Access to Care in the Indian Health System: Facility Growth, Population Change, and Policy Implications, 2000–2025

Abstract

Background: The Indian Health System (IHS), comprising federally operated, tribally operated, and urban Indian health programs, has expanded its physical footprint over the past two decades. The relationship between this expansion and actual care capacity remains insufficiently examined.

Methods: We analyzed changes in the number and distribution of Indian Health System facilities across 15 states with the largest American Indian and Alaska Native (AI/AN) populations between approximately 2000 and 2025. Facility growth was compared with population trends and assessed in relation to system capacity.

Results: Facility counts increased substantially across all states, with most experiencing growth between 65 percent and 150 percent. Expansion was concentrated in tribally operated outpatient clinics, with limited and uneven growth in hospital and specialty care infrastructure. States followed distinct development pathways: outpatient-centered expansion (e.g., Arizona), hub-and-spoke systems anchored by regional hospitals (e.g., Alaska), and more balanced clinic and hospital growth (e.g., Oklahoma). Despite increased access points, capacity constraints persist due to underfunding, workforce shortages, and limited specialty services.

Conclusions: The Indian Health System has achieved meaningful gains in geographic access to care, but these gains have not been matched by proportional increases in clinical capacity. Without sustained federal investment, continued expansion risks reinforcing structural inefficiencies and increasing reliance on Medicaid and external providers.

Introduction

Over the past 25 years, the Indian Health System has undergone a significant transformation in the delivery of care to American Indian and Alaska Native (AI/AN) populations. While persistent underfunding has been well documented, less attention has been given to the system's expansion in physical access points, particularly through tribally operated facilities under self-determination and self-governance authorities.

This expansion reflects the combined effects of tribal leadership and capital investment, federal construction funding and program growth, and increasing integration with Medicaid and other third-party payers. However, increases in the number of facilities do not necessarily translate into improved system performance. A central question remains whether expanded access has been accompanied by sufficient growth in the capacity to deliver comprehensive care.

This paper examines facility growth across high AI/AN population states from 2000 to 2025 and evaluates the extent to which expanded access has translated into functional capacity. It finds that while geographic access has improved substantially, clinical capacity has not kept pace, resulting in a structurally imbalanced system.

Conceptual Framework: Access and Capacity

This analysis distinguishes between two core dimensions of health system performance: access, defined as the geographic availability of facilities and entry points into care; and capacity, defined as the ability to deliver comprehensive, timely, and appropriate services, including specialty and inpatient care.

Over the study period, the Indian Health System expanded access more rapidly than capacity, particularly through the growth of outpatient clinics. Expanded access improves geographic proximity, increases availability of primary care, and supports community-based service delivery. However, without parallel investments in workforce, specialty services, and hospital infrastructure, expanded access may function primarily as an entry point into a system that cannot fully meet demand.

Methods

We constructed a comparative dataset of Indian Health System facilities across 15 states with the largest AI/AN populations. Facility counts for approximately 2000 and 2025 were estimated using Indian Health Service facility listings, tribal health system reports, and secondary policy sources.

States were selected based on AI/AN population (alone or in combination) using 2020 Census data. Facilities include federally operated IHS facilities, tribally operated facilities under P.L. 93-638, and urban Indian health programs.

The analysis focuses on absolute and percentage growth in facility counts, regional variation in expansion patterns, and the alignment between facility growth and system capacity. This is a descriptive, policy-oriented analysis intended to characterize system-level trends.

Results

State-Level Expansion in Access to Care

Facility growth was substantial across all examined states (Exhibit 1). Most states experienced increases between approximately 65 percent and 150 percent, with several states effectively doubling their number of facilities.

Exhibit 1. Growth in Indian Health System Facilities by State, 2000–2025 (Estimated)

State	AI/AN Population (2020 Census, approx.)	Facilities (~2000)	Facilities (~2025)	% Growth
California	~1.1 million	~35	~70	+100%
Oklahoma	~520,000	~45	~75	+65%
Arizona	~400,000	~35	~65	+85%
New Mexico	~220,000	~25	~45	+80%

State	AI/AN Population (2020 Census, approx.)	Facilities (~2000)	Facilities (~2025)	% Growth
Alaska	~190,000	~90	~180	+100%
Washington	~170,000	~20	~40	+100%
Texas	~120,000	~5	~15	+200%
North Carolina	~130,000	~5	~10	+100%
Michigan	~140,000	~15	~30	+100%
Minnesota	~120,000	~10	~25	+150%
Oregon	~100,000	~10	~25	+150%
South Dakota	~90,000	~15	~25	+65%
Montana	~80,000	~12	~20	+65%
Utah	~60,000	~8	~15	+85%
Nevada	~60,000	~10	~20	+100%

Outpatient-Centered Expansion

Across states, expansion was concentrated in primary care clinics, satellite facilities, and community-based access points. Growth in hospital and specialty care infrastructure was limited and uneven, resulting in a system that is broader in reach but not proportionally deeper in service capability.

Regional Variation in System Development

Distinct development pathways are evident across states.

In Arizona, expansion since approximately 2005 has focused on outpatient clinics, supplemented by a limited number of smaller hospitals. The absence of major new tertiary hospital capacity, particularly in the Phoenix area, has reinforced reliance on external systems for higher-acuity care.

In Alaska, a distributed village-based system is supported by regional hubs, including modern tribally operated hospitals in Nome, Fairbanks, and Anchorage. Despite this infrastructure, geographic and transportation barriers continue to limit consistent access to higher-acuity services.

In Oklahoma, a mature tribal health system demonstrates sustained growth in both outpatient clinics and tribally operated hospitals, representing a more balanced expansion of access and capacity.

West Coast states show strong outpatient and urban program growth, while Plains states reflect more modest expansion tied to continued reliance on federally operated facilities.

Taken together, these patterns indicate that Indian Health System expansion has followed multiple structural pathways, each with distinct implications for access and capacity.

Access Growth Relative to Population

In several states, facility growth has kept pace with or exceeded AI/AN population growth. However, population measures understate the true service population. Tribal health systems commonly serve non-enrolled AI/AN individuals, descendants of tribal citizens, and non-Indian residents within service areas. As a result, effective demand for services has increased faster than both population counts and facility expansion.

Capacity Constraints

Despite expanded access, workforce shortages limit service availability, specialty care remains insufficient, and hospital infrastructure is unevenly distributed. Many facilities function as access points without full service capability, contributing to increased reliance on Purchased/Referred Care, greater use of Medicaid-funded external services, and persistent unmet need.

Discussion

The Indian Health System has achieved meaningful gains in geographic access to care over the past two decades, largely through tribally driven expansion of outpatient facilities. However, these gains have not been matched by proportional increases in system capacity.

This divergence reflects structural constraints, including chronic underfunding, capital investment patterns that favor outpatient facilities, and persistent workforce shortages. The result is a system that is more accessible at the point of entry but remains dependent on external providers for comprehensive care.

These findings are consistent with prior analyses of Medicaid financing and Indian Health System structure, which have documented the growing reliance on external funding mechanisms to compensate for internal capacity limitations.[16–18]

State-level variation further illustrates that expansion alone does not determine system effectiveness; rather, outcomes depend on how access and capacity are jointly developed.

Policy Implications

Facility expansion should be aligned with investments in workforce, specialty services, and hospital infrastructure. Capacity gaps that shift care outward underscore the structural role of Medicaid and the importance of federal financing policies, including 100 percent FMAP. Capital strategies should balance distributed clinic models with regional specialty and inpatient capacity. Ultimately, full federal funding remains foundational to achieving a functionally complete system.

Conclusion

Since 2000, the Indian Health System has significantly expanded its geographic footprint, improving access to care for AI/AN communities. However, this expansion has not been accompanied by equivalent growth in clinical capacity.

Absent sustained and comprehensive federal investment, the system risks evolving into a network of access points without the resources necessary to deliver complete care—shifting costs outward while leaving underlying needs unmet.

The analyses in this section document a central paradox: insurance coverage among AI/AN populations has increased substantially, yet access to care through the Indian health system has not expanded proportionally. This divergence points to a deeper issue that coverage alone cannot resolve—whether the system itself is adequately funded to meet its obligations. The next paper addresses this question directly by developing an obligation-based framework for estimating the full-funding requirement for Indian health services.

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