PANDEMIC MAGNIFIES HEALTH DISPARITIES IN INDIAN COUNTRY

Andrew Steinfeldt and Allison Empey

The uncertainty of how the COVID-19 pandemic will affect the world we live in is growing day by day. Many Americans are grappling with fear of losing friends and loved ones coupled with lost wages, and the broader economic impact this pandemic will have. While we will all feel the impact of this novel virus, it will have a disproportionate effect on already vulnerable populations, especially Native American communities. The impact of COVID-19 will magnify the ever-growing health disparities American Indians face as tribal communities struggle to maintain an already fragile health care system with inadequate support and funding.

There was tremendous foresight long ago by tribal leaders and elders as they elected to take part in the first pre-paid health care service under the federal trust responsibility, to ensure the survival and welfare of their people. This health care system is largely run under the Indian Health Service (IHS), which has historically been underfunded and understaffed by medical providers, making it difficult to provide high-quality, safe and culturally competent care.1,3 While many tribes have opted to run and manage their own health care systems, they are still funded by IHS.

While we have seen that severe complications of COVID-19 can affect anyone, elders, and those with existing health conditions and compromised immune systems, are at increased risk. American Indians have higher rates of heart and lung disease compared with the national average, and higher rates of conditions that compromise the immune system including chronic hepatitis C and HIV infections. Additionally, type 2 diabetes mellitus is rampant with rates that are three times the national average.2 Further exacerbating the risk American Indians suffer are housing shortages with nearly one-third of homes on reservations considered overcrowded,4 making social distancing almost impossible and a nidus for infection. The CDC recommendations for isolation of a sick family member are impossible to follow for families without extra rooms to place the sick and medically fragile.

Across the country, health care providers have begun sounding the alarm about the lack of availability of personal protective equipment (PPE) and adequate testing resources. In Oregon, a case of confirmed COVID-19 was found on tribal lands with no known exposure, indicating community spread. Despite confirmation of this early case, and the exposures of a number of community members, federal emergency funds were not released to IHS clinics for 20 days.5 The funding comes at a much-needed time for these communities, but the time taken to act exacerbates an already uphill battle.

This is not the first time a new disease has threatened to devastate Indigenous Nations, and it appears that history is on the verge of repeating itself. There is a tradition of reconstructing life ways and putting individualism to the side for the good and well-being of the collective. This wisdom is passed down as the basis for social distancing where we place our selfish desires aside for the good of the community. We must take our social responsibility seriously to protect ourselves, to protect our loved ones, to protect our vulnerable populations and to protect our elders. And while we, like the rest of the U.S., are still grappling with uncertainty, the one thing we are certain of is that when push comes to shove, American Indians are here to stay as we are strong, resilient … Indigenous.

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AMERICAN INDIAN HEALTH DISPARITIES

National Indian Council on Aging, Inc.

American Indian and Alaska Native elders have long experienced disparities in health and healthcare. A health disparity is a preventable burden of disease, injury, or violence experienced by populations who have been subjected to disadvantages like discrimination in society.

Health disparities show the difference in health outcomes for different groups within the population. One such disparity is that on average American Indians die 12 to 13 years earlier than white Americans. Native people have higher death rates at most ages, but particularly at younger ages, and higher mortality for most of the top leading causes of death.

In 2018, the five leading causes of death for Native elders over age 65 were heart disease, cancer, chronic lower respiratory diseases, diabetes, and stroke.

Social Determinants of Health

While it's easy to focus on the numbers, the statistics represent the symptoms of the problem rather than the cause. The specific reasons for health disparities are complex and represent where people live and the services available and accessible to them. Factors such as having a regular source of care, language and communication barriers, lack of diversity in the healthcare workforce, high rates of poverty, lack of insurance coverage, discrimination against American Indians and Alaska Natives, and large distances from healthcare services have all added to the disparities that effect Native communities.

These factors are what the U.S. Department of Health and Human Services define as the "Social Determinants of Health." Broadly, the factors fall into the following categories: economic stability, education, social/community setting, health and healthcare, and the neighborhood/environment. Disparities in Native health will not improve just by focusing on the numbers. Instead, improvement can be made through community health education, and economic standing, and by creating healthier and engaged communities.

American Indian and Alaska Native health disparities are symptoms of systemic problems. Six "Social Determinants of Health" are used to explain health outcomes, reduce risk factors, and implement systemic changes.

1. Income and wealth gaps

Native people can face greater challenges in getting higher paying jobs with good benefits due to less access to high-quality education, geographic location, language differences, discrimination, and transportation barriers.

2. Education

The historical trauma caused by the government relocation of Native children away from their families and tribal way of life to boarding schools created generational mistrust of educational systems. American Indians have the lowest educational attainment rates of any group in the United States. The approximately 180 Bureau of Indian Education schools are chronically underfunded, and while the majority of Native students attend public schools, they do not provide a culturally relevant curriculum or teacher training that promotes Indigenous history or identity.

3. Social/community setting

Centuries of racism in our institutional structures, policies, cultural norms, values, and individual behavior have impacted the places and relationships where Native people live, work, learn, play, and worship.

4. Health access and use

Many barriers to health care exist for people with disabilities, lower incomes, rural residences, and membership in a racial/ethnic group. Common barriers are lack of insurance, transportation, childcare, ability to take time off work, culturally insensitive patient-provider interactions, and inequities in treatment.

5. Neighborhood and physical environment
Native people residing in poor communities often lack access to public transportation, quality education, infrastructure (i.e. broadband), housing, affordable and nutritious food, jobs, and health care. Their communities may have higher crime, pollution, accident, and injury rates.

6. Workplace conditions
Some causes for work inequities are temporary work arrangements, lack of worker safety measures, limited or no health insurance benefits, and discrimination based on age, gender identity, race, and class.

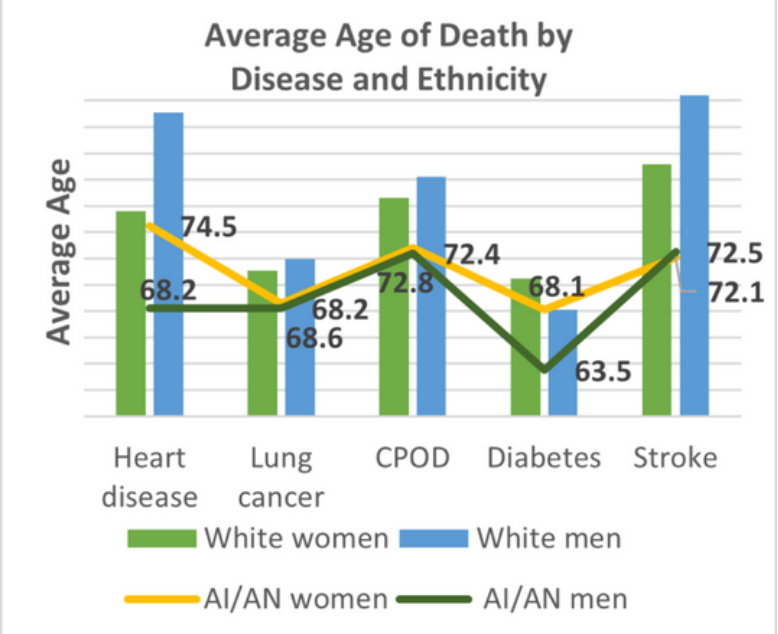
Historic and Contemporary Injustices on Native Health

American Indian and Alaska Native populations have long experienced poorer health outcomes compared to other groups in America. The reasons are complex and connected to historic and ongoing racism, poverty, poor education, limited access to quality healthcare, forced relocation, and forced assimilation into non-Native culture.

Contemporary reasons for Native health differences include communication barriers, lack of diversity in the healthcare workforce, lack of insurance coverage, discrimination, and the need to travel long distances to hospitals and clinics for prevention, diagnosis, and healthcare services.

Indian Health Service (IHS)
The treaties negotiated between Native communities and the federal government established that tribes have a right to healthcare services. As such, the Indian Health Service (IHS) provides healthcare to over 500 federally recognized tribes. Because many tribes are seeking federal recognition, some Native people do not have access to IHS.

IHS services exist primarily in rural areas, yet approximately 70 percent of Native people live in cities and urban areas. Despite improvements in expanding healthcare and preventative services over the last 20 years, there is still a lack of hospitals and clinics on or near Native homelands.



What is Health Equity?

Health equity is when everyone has a fair and just opportunity to attain their highest level of health. It requires societal efforts to:

- Address historical and contemporary injustices
- Overcome economic, social, and other obstacles to health and health care
- Eliminate preventable health disparities

NICOA's Commitment to Health Equity

Disparities in health are a major issue in American Indian and Alaska Native communities and stronger advocacy is needed to address these pressing needs. The National Indian Council on Aging (NICOA) strives to inform American Indian and Alaska Native elders and others about healthcare disparities so that there is greater understanding about the many factors that influence health statistics – especially those that impact Native communities.

As a National Center of Excellence, NICOA's mission is to advocate for improved comprehensive health, social services, and economic well-being for Native elders. To help improve health equity among Native elders, NICOA supports policies that:

- Establish health education, awareness and prevention programs for Native elders
- Fund on-going research of health disparities in aging
- Improve health care access and quality for elders
- Promote inclusion of American Indians and Alaska Natives in gerontology and geriatric research

NATIVE AMERICANS: A CRISIS IN HEALTH EQUITY

Mary Smith

By any measure, health care for Native Americans lags behind other groups, despite a legal obligation on the part of the United States to provide health care to American Indians and Alaska Natives. Native American communities face significant inequity in health care and health status compared to other U.S. populations. Health outcomes for Native Americans are adversely impacted by wholly inadequate access to comprehensive health services.

American Indians and Alaska Natives born today have a life expectancy that is 4.4 years less than the United States' all races population, and they continue to die at higher rates than other Americans in many categories of preventable illness, including chronic liver disease and cirrhosis, diabetes, and chronic lower respiratory diseases.

The Indian Health Service (IHS)—an agency within the U.S. Department of Health and Human Services—provides care to over 2.2 million Native Americans across the country. Although IHS fulfills treaty responsibilities to provide health care for members of more than 560 recognized tribes, Congress has consistently underfunded the agency, forcing hospital administrators to limit the services offered. As a result, tribal members have a different health care reality than many other U.S. citizens. For example, to match the level of care provided to federal prisoners, funding would have to nearly double, according to an analysis by the National Congress of American Indians. Funding would need to be even higher to match the benefits guaranteed by programs such as Medicaid.

Against this decades-long underfunding, there are overarching challenges in health care that further exacerbate access to care for American Indians. For example, a common challenge in many rural communities is the shortage of medical personnel; a problem that is even more severe in tribal communities, especially those in remote reservation locations. The IHS Scholarship Program provides qualified American Indian and Alaska Native health profession students an opportunity to establish an educational foundation for a career in health care and serve medically underserved Indian health programs throughout the country. Since IHS began providing scholarships in 1978, nearly 7,000 students have received awards.

The Loan Repayment Program awards repayment of up to $40,000 for qualified health profession education loans to clinicians. These new providers are typically placed in Indian Health Program facilities with the greatest staffing needs. With shortages of clinicians that number in the thousands across American Indian and Alaska Native communities, markedly expanding these programs is essential to ensuring communities have needed providers.

Changes contemplated in other federal programs will also be felt by Native Americans. For example, recent attempts to roll back Medicaid expansion or add new barriers to obtaining Medicaid would have devastating effects on Native Americans. In FY 2016, the IHS collected over $649 million in Medicaid reimbursements—comprising over two-thirds of total third-party reimbursements. Third-party coverage also plays a significant role in the provision of health care services by non-Indian health care providers when certain services are not available through the Indian health system. Between 2014 and 2015, when Medicaid expansion took effect, IHS saw a considerable increase in health care services in the user population that had Medicaid coverage.

In July 2003, the U.S. Commission on Civil Rights published a report that outlined civil rights disparities in health care for Native Americans. Unfortunately, most of the findings in that report are still true 15 years later. Moreover, the scale of the crisis has expanded given population increases and the inability of funding to keep pace.