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An Analysis of Disparities and Political Implications in Native American Healthcare

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ABSTRACT

For centuries, an agenda of colonialist-driven politics has left the Native American community alienated from society. Generally stemming from the negligent political values pushed by the United States government, multiple external factors have left Native Americans with a fraction of the prosperity and unity that they once held. Through a series of statistical and holistic analyses of Native American culture and population levels over the years, it has become evident that the lack of attention and support from publicly funded institutions has increased Native vulnerability to a world of rising health threats. In addition to an already meager amount of financial support, organizations directed at helping Natives are met with stubborn governmental legislation that has refused to create the substantial change necessary to modernize a failing system. As such, even though recent advancements have been made and new establishments are on the rise, the most prominent issue regards the government's unwillingness to expand and create meaningful change. With these issues in mind, this analysis of health disparities impacting the Native American community provides support for the argument that the United States Federal Government must take more action towards making reparations for its past mistakes, in addition to providing the basis for a healthcare system that American Indians can rely on.

Introduction

Historical Factors contributing to Healthcare Disparities

Despite previous scrimmages and small-scale conflicts, sufficient governmental action against pushing the Native Americans out of their land had not occurred before 1830. Fueled by targeted language and propaganda dubbed as the "Indian Problem" by President Andrew Jackson, that year, with the enactment of the Indian Removal Act, the United States Federal Government was able to push over 100,000 Native Americans westward toward land reserved for Indians (now present-day Oklahoma), without any regard for ethics or human rights (*Trail of Tears*). These impacts were exacerbated by the ensuing Homestead Act of 1862, where the government facilitated the migration of over 4 million people into remote lands, including Indian reservations (Beatrice).

Met with retaliation and discontent by Native populations, the government decided to transition into an era of assimilating Native Americans into Western society by enacting agricultural and land ownership policies under the General Allotment Act. Effectively serving as an extension of the Homestead Act by convincing Natives that they could integrate their society with the rest of the States, the government was able to land grab nearly two-thirds of tribal land (tribal land decreased from 138 million acres in 1871 to 48 million in 1934) and sell it off to landowners (*Native American Lands*). In the grand scheme of it all, displacing and fracturing Native communities that relied on each other for their sense of community undermined health and created immense vulnerability. With the outbreak of multiple diseases throughout the 15th-17th century (smallpox, malaria, viral influenza, yellow fever, measles, typhus, etc.) and virtually no access to any advances in health innovation and

governmental healthcare programs, Natives saw massive reductions in population count, with certain tribes such as the Sauks and Mesquakies experiencing erasures of more than 85% (Green, 1983).

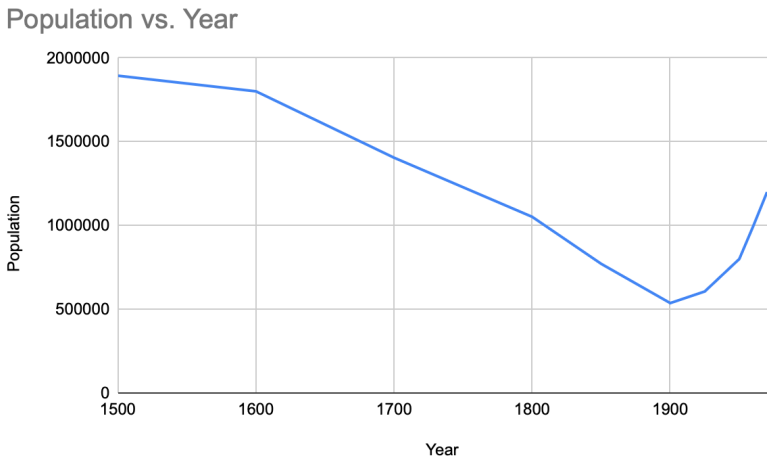

Figure 1. North American Native American Population from 1500-1970 (Ubelaker 1988).

Since these initial actions, the U.S. government has only expanded its disguising of colonial policies by passing major bills that forced Natives out of their reservations, with the false promise that they could successfully integrate into large cities. However, because Native Americans neither wanted these changes nor knew how Western society operated, they were left only with the termination of tribal contracts and recognition. Despite developments by the Kennedy and Johnson administrations resulting in the recuperation of tribal recognition through the Indian Civil Rights Act, this proved to be too little, too late, with certain Native populations standing at a meager 15% of what they were before European colonization, and previously established heritage and traditions being damaged (Ubelaker 1988).

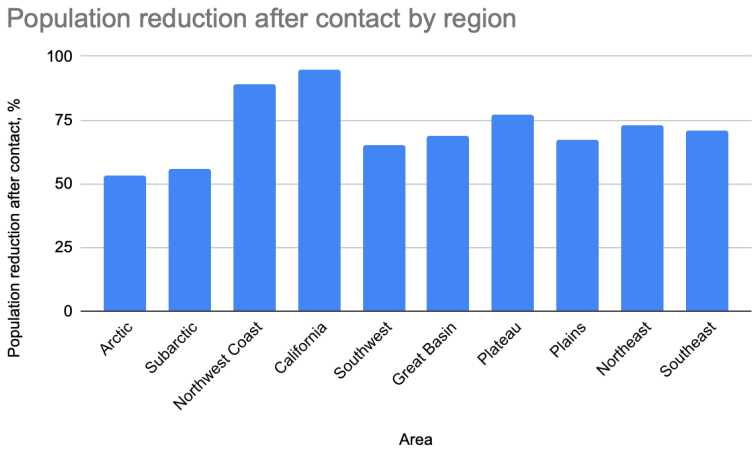

Figure 2. Native American Population Reduction by Percentage Throughout North American Regions (Ubelaker 1988)

With regards to governmental policies supporting Native healthcare, subsections of the U.S. government such as the Bureau of Indian Affairs oversaw vaccination efforts from the 1830s. Considerable recognition of Native healthcare shortcomings only came through the Snyder Act of 1921, which provided primary care for Natives. Even these efforts were lacking, as funding started with a meager $10 million budget, which is negligible in comparison to the over $3 billion in national healthcare expenditures. Calls for an expansion of this system resulted in the creation of the Indian Health Service in 1955. Despite changing the entire landscape for Native Americans by providing benefits that never existed before, the IHS continues to lack that, creating challenges for Native Americans to this day.

Healthcare System Disparities

Transitioning to issues in modern society, in addition to lacking resources for obtaining healthcare, providers and facilities directed towards helping Native Americans are heavily lacking as well. Even with the federal government's involvement in the Indian Health Service's funding, it is estimated that the IHS receives only half of the funding it truly needs to provide adequate services (DiCarlo, 2023). Concerning other publicly funded operators, the IHS can only spend less than 10% of what the Veterans Health Administration spends, and around 1% of spending is done by Medicaid and Medicare(Calvert, 2018).

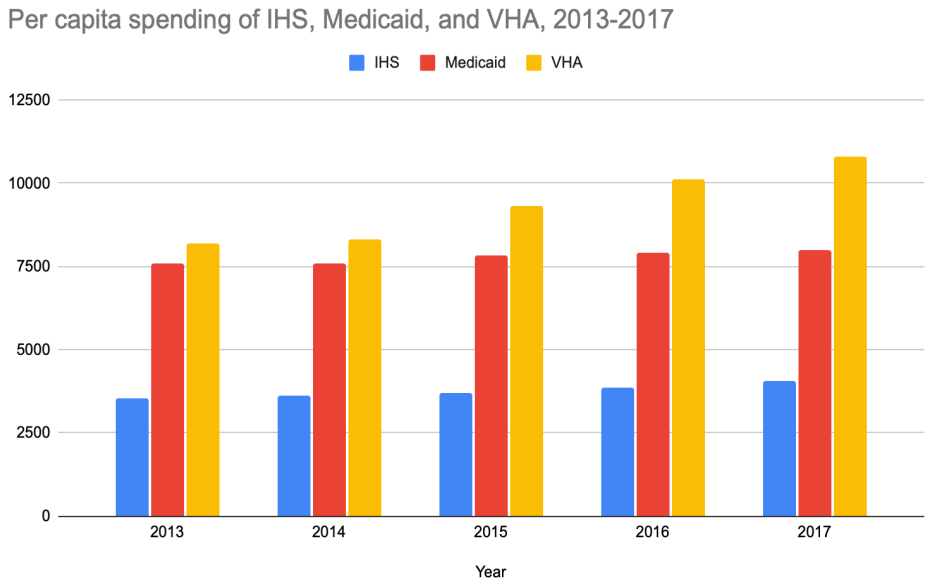

Figure 3. Indian Health Service Funding in Comparison to Medicaid and the Veterans Health Administration from 2013-2017 (Calvert, 2018).

Regarding the Indian Health Service's specific shortcomings, there are several factors concerning both internal and external issues. The IHS's capability is significantly slashed by a lack of staff, with a 2018 report released by the Government Accountability Office determining that 25% of working jobs in the IHS system were unfilled (Reed, 2018). This is primarily caused by the lack of incentive for healthcare professionals to work in this sector of health, with compensation from the IHS standing at only a third of the national average in salary. As such, many physicians involved with the Indian Health Service primarily are temporary workers with short-term contracts, and plan to move on to larger facilities immediately (Mangla, 2023).

Operational facilities also remain heavily outdated and insufficient for growing demands. Specifically, facilities that serve Native Americans are on average 4 times older than establishments in the private sector and lack basic necessities. Indian Health Service hospitals tend to have less than 50 hospital beds, compared to the national average of 130. In regards to repairs and technology changes, these hospitals are expected to require over $500 million in repairs to become serviceable and to meet national standards (Siddons, 2018).

In some areas, funding shortages have led to complete shutdowns that tend to happen in the most vulnerable regions of the United States for Natives: rural and small towns. Holding over 54% of Native Americans, these areas tend to be highly overlooked and neglected by the government because of their remoteness (Dewees, 2017). Detrimentally, over the last decade, at least 136 rural hospitals have closed as a result of low reimbursement (American Hospital Association, 2022). 45% of these closures have involved "safety net" hospitals, which provide healthcare regardless of insurance status, and have been crucial to providing for uninsured natives (Moura, 2021).

With historical precedent in mind, waiting lines have become a major issue in areas like Canada, and have resulted in over 63,000 deaths in females alone (Barua, 2014). The Foundation for Economic Education has estimated that if the United States were to trend in this direction, the population could experience over 400,000 deaths under similar conditions (Barakat, 2017). In fact, in some Native American health centers, patients generally waited for more than a month for care and oftentimes did not have access to treatment for 2-6 months (Lofthouse, 2022). Urgent care is also widely inaccessible, with emergency room wait times reaching upwards of 48 hours (KOTA, 2017).

A specific detriment that inadequate resources have exacerbated is mental health. The Government Accountability Office reported that a fourth of IHS mental healthcare services cannot meet demand, and certain facilities even need 2 to 3 times the amount of funding to make ends meet. These shortcomings have proven effects: Native Americans were nearly twice as likely (17.5% vs. 9.3%) to require treatment for substance abuse than the *Special Diabetes Program for Indians*). Overall, expanding coverage is key, especially for younger patients, as a study by the American Addiction Center found that 1 in 5 Native Americans aged 18-25 years had a substance use disorder (American Addiction Centers).

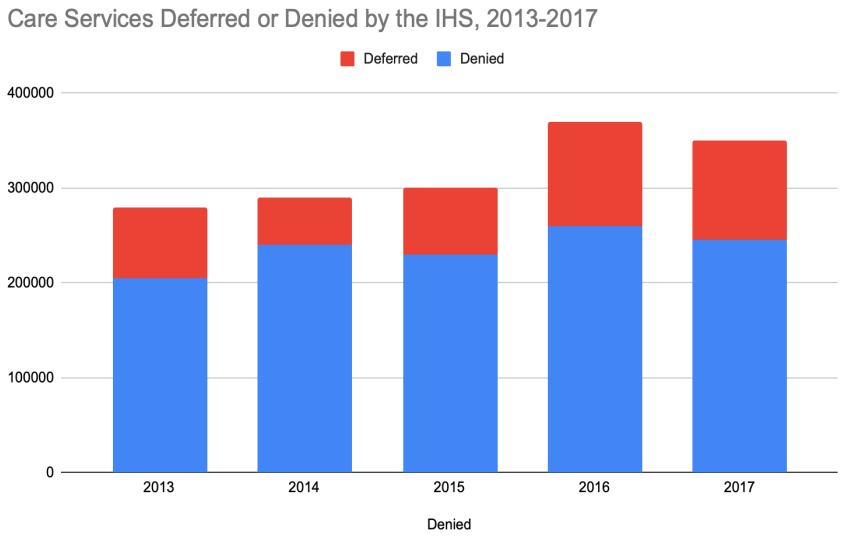

Figure 4. Healthcare Service Requests Given to the Indian Health Service that Were Deferred or Denied (Calvert, 2018).

These shortcomings are worse when put in the perspective of all government health agencies.The US Department of Defense has policies that mandate care within a certain period, and the Veterans Health Association receives advance payments to pay expenses in times of necessity. However, a recent investigation by the Government Accountability Office found that the Indian Health Service has not sufficiently overseen operations to provide timely care, which has significantly halted productivity. As a result, the IHS has moved towards standardizing wait times since enacting the 2017 IHS Circular on Wait Time Standards for Primary and Urgent Care Visits in Indian Health Service Direct Care Facilities.

Socioeconomic Factors and Disparities

Socioeconomic issues have been prevalent in the Native American community. Generally, Natives tend to have less economic stability and perform much worse on all economic averages than the rest of the nation's demographics. The average income of a Native American household was approximately $43,825, a meager amount compared to the national average of $68,785, which was almost 57% higher (Skipper, 2023).First and foremost, most reservations limit economic mobility, and those not in reservations are victims of economic stigma and other inequalities. The current unemployment rate of Native Americans is 11.1%, which is nearly triple of the national average rate of just 4.0% (*BLS,* 2022). Taking into factors such as recent recessions and the health of the overall economy, this is simply part of a worsening trend: while the general population's unemployment rate has decreased by 3 percentage points since the Great Recession, Native American unemployment has increased by 3 percentage points (U.S Bureau of Labor Statistics, 2022).

In addition to personal economic inequalities, Natives receive a significantly smaller share of total healthcare spending. Due to the aforementioned factors related to low incomes and poor infrastructure, over 42.1% are reliant on publicly funded healthcare, such as the IHS and Medicaid programs (*American Indian/Alaska Native Health*). Even in a space where healthcare equality and expanded coverage are heavily emphasized, Natives only receive about $1,300 in annual healthcare benefits, which is approximately a tenth of the national average. Such vulnerabilities leave Natives helpless and significantly more susceptible to contracting and developing diseases. A study performed by Luohua Jiang from the NCBI found that living in a higher median household income area decreased the risk of diabetes development by more than 38% (Jiang, 2018). More recently, as displayed in the COVID-19 pandemic. Native Americans were hit the hardest in terms of economic stability and overall health. With immediate economic shockwaves being sent across the national economy, Natives immediately lost their jobs, with 28.6% of their entire population becoming jobless (U.S Bureau of Labor Statistics, 2022)

Cultural Competencies in Healthcare

Cultural competency plays a large factor in the relationship between Native Americans and the U.S. government's publicly funded healthcare system. A deep-rooted history of colonialism and decades of human rights violations from the United States has caused Natives to lack trust and become wary of any services provided by the government. The establishment of Native reservations throughout the 19th and 20th centuries also forced Natives into confined areas that barred them from access to services. As such, Native Americans have become wary of using any government-funded institutions for the care of their well-being.

One of the main issues in the current Indian Health Service concerns the fact that the involved medical professionals are unaware of solutions to the cultural barrier that exists. In fact, only 15% of practitioners are Native Americans who have experience providing need-based treatment (Forrest, 2022). The importance of

having doctors who understand Native American culture is perfectly exemplified by the spike in diabetes between 1960 and 1970, as rates of the disease increased by 42% from the 1940s directly as a cause of the U.S. government enforcing improper diets that the Natives could not properly adjust to (Edwards, 2009).

These issues have created a rift that has led Native Americans to shift towards other, more culturally compatible, methods of receiving health treatment. A prime example of this gradual change is the usage of traditional healers (often referred to as a shaman, who is a person thought to hold connections between the spiritual world and the real world), who use Native conceptions to provide spiritual healing. These ideologies include elements of the "Spirit, Creator, and Universe", and are often performed through prayer, chants, sacred objects, and healing plants. Statistically, 40% of Native Americans actively see a healer, and 86% say that they would consider seeing a healer (Marbella, 1998).

The possible consequences of seeing a healer reach beyond immediate health effects. In fact, only 18% of healer patients report to their physician that they see a healer, which creates immense amounts of uncertainty (Marbella, 1998). Jacquelene Moghaddam of the Community Mental Health Journal determines that having multiple sources of medical aid including healers can complicate therapeutics, as professionally trained physicians are unaware of other treatments. In some medical instances, these practices directly trade off, with Natives saying that their spiritual healers are more culturally understanding, and in turn, would only go see a physician 14% of the time for issues regarding mental health (Moghaddam, 2014). Overall, rather than disregarding the effectiveness of Native healers themselves, the disconnection that results from having multiple sources of medical treatment with differing views only invites complications.

Existing Healthcare Policies and Programs

In addition to the existing Indian Health Service programs, there are several other policies and programs that provide benefits for Native Americans across the board. These include existing programs that have been expanded to provide unique benefits for Native Americans and new policies that serve to adhere properly to the Native population's needs.

Medicaid

Medicaid plays a secondary role in Native American healthcare coverage, usually being coupled alongside Indian Health Service provisions. For example, Medicaid is the largest third-party funding source for the IHS, with $810 million out of the total $1.3 billion being sourced from the government-funded program (Aritga, 2017). These allocations allow for infrastructure repairs, increases in physician hires, and generally keeping up with rising demands.

In terms of Medicaid as a healthcare provider, while it is harder to qualify for in Native American communities, it is a great supplement, as it allows participants to gain access to a larger range of services than initially available. Medicaid currently provides access to 1.8 million Native Americans. This is especially crucial in closing the healthcare inequality gap, as Medicaid per capita spending ($8,109) stood at over double the spending of the Indian Health Service ($4,078) (Calvert, 2018). Statistically speaking, Medicaid expansion geared towards Natives has decreased the uninsured rate by 11 percentage points from 31% in 2013 to 20% in 2017 (Cross-Call, 2020).

Recent bills have also drastically changed trends in Medicaid's effectiveness and general coverage of the Native American population. For example, the Affordable Care Act's Medicaid Expansion bill of 2014 played a key role in bolstering Native American healthcare, as access for American Indians increased by 45% in states that were affected by the expansion bill, and 25% in states that were not (*Advising Congress on Medicaid and CHIP Policy,* 2021). Part of the Balanced Budget Act of 1997, the Children's Health Insurance Program (CHIP) was also created as an extension of Medicaid, providing access for children who are no longer

eligible for Medicaid because their family's income is too high. The CHIP provides free eligibility to all Alaskan Natives, in addition to lowering thresholds to access specifically for Native Americans living on reservations.

On the flip side, new policies have also moved towards minimizing coverage for Native Americans as well. While families who experienced changes in income were able to retain Medicaid coverage for up to a year in the case that they were no longer eligible, the Consolidated Appropriations Act of 2023 gave states the ability to terminate Medicaid immediately. Also dubbed "Medicaid Unwinding", the policy is estimated to relieve between 8 to 24 million people of their Medicaid benefits and over 236,000 Native American patients (*Medicaid Unwinding*).

Special Diabetes Program for Indians

Another component of the Balanced Budget Act, the Special Diabetes Program for Indians (SDPI) was created to combat high rates of diabetes in Native American communities. Given that the American Indian demographic holds a rate of diabetes double that of the national average, and has the highest rate overall. In certain communities, 50% of all adults have Type 2 diabetes or a more severe case. The SDPI focuses on preventing and treating diabetes through a collection of community-based programs, educating the public, and individualized clinical services. In cooperation with the Indian Health Service, the SDPI has worked to reduce costs for often expensive diabetes treatments, with patients receiving certain operations, like hemodialysis (blood purification), saving on average $88,000 (*Special Diabetes Program for Indians*). Through these cost-effective solutions, the SDPI has reduced diabetic eye disease rates in Native communities by over 50%, and decreased the average blood sugar level by 0.9 percentage points. Overall, these efforts have reduced diabetes prevalence from 15.4% in 2013 to 14.6% in 2017, and has become instrumental in providing services that would have been otherwise out of reach for most patients. In terms of governmental support, even with consistent renewals of the SDPI project, its funding has remained stagnant at $150 million per year, despite calls to raise it to $200 million because of its proven effectiveness (*Special Diabetes Program for Indians*).

Telehealth Expansion

Telehealth is the use of digital technology to distribute long-distance health services without the use of an in-person medical visit. The Affordable Care Act, headed by the Obama administration, had begun efforts to increase telehealth programs throughout rural areas, where a majority of Native Americans reside in. Through these efforts, educating the Native public has become more accessible, as digital communication has allowed for seminars regarding cancer and diabetes to reach a larger audience. These opportunities are possible independently because costs and barriers involved in regular patient visits - such as transportation and intensive care - no longer exist. Simultaneously, telehealth allows practitioners to assist multiple people in a single session, which allows progress against the healthcare worker shortage to be made.

While a cause-effect relationship cannot be entirely determined, in the 22 years since telehealth technology was directed toward Native Americans, their population's life expectancy has risen from 63.6 to 72.5 years (Kruse, 2016). This simply emphasizes the importance of expanding existing telehealth programs, and also handling two major barriers that may make a large-scale expansion to occur. First, even with more innovation and increased usage rates, the accessibility to the technology requires more investment. In fact, only 10% of Native American tribal lands have adequate internet access. Second and more importantly, because acceptance of new programs is a prerequisite to usage, it is important to educate Native populations on accepting telehealth as mentioned above. An unwillingness to use these services has created slow progress in certain areas, but in areas that do implement telehealth systems, usage increased by a factor of 6 (Kruse, 2016).

Tribal Self Governance

As one of the few bipartisan bills, Tribal Self Governance remains one of the most effective means of attaining benefits for Natives. In 1975, Congress enacted the Indian Self-Determination and Education Assistance Act, which allowed federally recognized tribes to gain autonomy to operate programs that helped tribal members. By relieving the government of certain duties and simultaneously providing the Native peoples with what they needed, it continues to serve as a mutually beneficial act. Since 2000, titles V and VI have been enacted which have provided tribes with control over the majority of health services. With the passing of these acts, tribes have gained control of 451 out of 568 total healthcare facilities, encompassing clinics and health treatment centers, in addition to controlling certain parts of the Department of Health and Human Services' Native American programs (*Advising Congress on Medicaid and CHIP Policy*). The act also helps Natives with their economic mobility, which in turn boosts healthcare access as well. Tribal Self Governance has created over 115 funding agreements directed towards aiding over 350 tribes since 2016 (Indian Health Service, 2013). Importantly, under the guidance of self-governance programs, the per capita income of the average Native American resident of a reservation has risen by 61%, and the proportion of children living in poverty has decreased from 47.3% in 1989 to 23.5% today (Kalt, 2022).

Conclusion

Centuries of dispossession and systemic inequities have woven a situation of disadvantage for Native American communities, leaving them disproportionately vulnerable to health disparities. The Indian Health Service, though vital, struggles with persistent underfunding, staffing shortages, and cultural disconnect, further amplifying these disparities. Additionally, while other existing programs like Medicaid and Tribal Self-Governance offer glimmers of progress, addressing this crisis demands bolder action. There also coexist underlying issues that have been overlooked, mainly related to cultural reservations that Natives hold against the United States Federal Government. The aforementioned differences in cultural understanding between the government and indigenous peoples directly stem from the number of human rights violations, beginning with early colonialist policies, to current negligence in modern policies. Paired with poor quality care, these factors have also led Native Americans to avoid seeking care in the first place, preferring tribal resources which, while more culturally agreeable, could create dangerous situations. Generally speaking, the path forward towards nationwide prosperity necessitates increased funding for the IHS and culturally competent care and meaningful reparations for past injustices, investments in social determinants of health, and empowered self-governance initiatives. Solving these issues not just on the surface but also at the root paves the way not only for short-term resurgences in quality of care and patient satisfaction but also more opportunities to mend the relationship between the government and indigenous tribes, which will be critical in the future developments. Only through such multifaceted efforts, we can truly mend the historical wounds and weave a new era of health equity for Native Americans.

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