Healthcare for Marginalized Native Americans 2021

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Native Americans are truly the first Americans, and they are also the first marginalized Americans. When European explorers arrived at what would later become the continental United States, they brought weapons, domesticated animals, and new infectious diseases. They stole land, natural resources, and the freedom of the people they encountered. Centuries of subjugation, discrimination, forced assimilation, and institutionalized marginalization have all contributed to poverty, poor health, limited socioeconomic mobility, and little hope for improvement. Yet today, there is a renewed sense of self-reflection in our country, and potentially a greater commitment to social justice that challenges us to think more productively about the plight of Native Americans. From a healthcare perspective, the systemically tragic history of the Native American experience deserves study, resources, and solutions.

The purpose of this essay is to focus on the healthcare needs of Native Americans in the United States and how they can be better served. The size and geographic diversity of this population present unique challenges for a unified approach to healthcare delivery. Despite a federal commitment to providing health care to Native peoples, the health outcomes of Native Americans remain poor. After defining these healthcare disparities and need for improvement, the existing resources under the Indian Health Service will be explored. I will then describe the resources required to improve Native healthcare, as well as the obstacles that continue to make this difficult. I will conclude with some strategies that may poise this population for greater success in the Biden Administration.

Native Americans currently comprise approximately 1.7% of the population of the United States, including individuals who self-identify as American Indian or Alaska Native, whether alone or in combination with other races. It may be surprising for many Americans to learn that nearly 80% of Native Americans live outside a reservation, and approximately 70% live in urban areas, including many large cities. With 574 federally recognized tribal governments and considerable geographic diversity, Native Americans are a heterogeneous population with a variety of unmet needs. However, inadequate access to quality healthcare is a common problem, as well as poor health outcomes as compared to the rest of the American population .

Native Americans die approximately five years earlier than other Americans. They are twice as likely to die during childbirth, three times more likely from diabetes, and five times more likely from tuberculosis. They are 60% more likely to die of suicide, twice as likely to smoke, and 50% more likely to be addicted to drugs or alcohol. These disparities stem from centuries of

multigenerational poverty, poor educational access, structural and overt racism, and substandard social and medical services.

Native Americans are unique among marginalized communities in the United States given their legal rights to federally-provided healthcare. This trust relationship began in the form of treaties between the tribes and the United States federal government, and has evolved over many years in legislation including the Snyder Act of 1921, the Indian Facilities Act of 1957, the Indian Sanitation Facilities and Services Act of 1959, and the Indian Health Care Improvement Act of 1976, which was permanently reauthorized as part of the Affordable Care Act in 2010. The Indian Health Service (IHS) was officially developed in 1955.

Today, the Indian Health Service is a massive organization, with a yearly multi-billion-dollar budget. The IHS serves Native Americans in 36 states, with approximately 46 hospitals, 59 health centers, and 32 health stations, employing thousands of healthcare professionals – with a hiring preference to qualified Native applicants when possible. In addition, there are 33 different urban Indian health programs and multiple other health systems operated by tribes independent of the IHS. While seemingly comprehensive, the IHS suffers from chronic underfunding, crumbling infrastructure, outdated facilities, and a deficit of highly-trained personnel.

Although funding has increased overall during the past decade from approximately 4 billion to approximately 6 billion dollars, the National Indian Health Board believes that a yearly budget of 32 billion dollars is more appropriate. This funding divide is even more concerning when one considers the annual amount spent on Indian health as compared to Medicare, Medicaid, or even the prison system. For example, the IHS spent approximately $3700 per patient in 2015, whereas Medicare spent $11000, Medicaid spent $5700, and state prisons spent on average $5700 - and well over $10000 in states like California and New Mexico.

As a result of underfunding, the Indian Health Service lacks sufficient healthcare providers and facilities are not well maintained. For example, a 2014 survey of emergency departments found that only 85% of respondents had continuous physician coverage. Only 10% were using telemedicine. And only 13% of physicians were board certified in emergency medicine. In general, hospitals and health centers are understaffed by about 20%. One reason for this is that it is difficult to recruit healthcare providers to work in remote, rural areas. On average, IHS facilities are four times older than facilities in the private healthcare sector, and need at least 500 million dollars in repairs. The Indian Health Service is unfortunately not fulfilling the promise made by the United States government to its first nation citizens, despite billions of dollars of investment and the hard work and commitment of thousands of IHS

healthcare providers. The solution is as complex as he problem itself. It falls into four general categories: funding, personnel, access, and resourcing.

Funding is at the core of the limitations of the Indian Health Service. Part of the reason for this may lie in how the IHS is funded. The IHS is part of the Department of Health and Human Services, but given the history of tribal issues being managed by the Department of the Interior, funding of the IHS is actually controlled by a subcommittee that deals with the Department of the Interior and the Environmental Protection Agency. This is important because the Interior subcommittee has approximately $31 billion to manage, whereas Health and Human Services manages over $150 billion. Therefore, the IHS is always less likely to receive funding similar to Medicare or Medicaid. In addition, Medicare and Medicaid have mandatory funding, whereas IHS is considered a discretionary program; the odds are stacked against it from the start. The benefits of increased funding are obvious – improved facilities, higher pay for personnel and better recruitment, and greater infrastructure to support information technology, supply chain, and innovation of all kinds. The obstacles are primarily political. Not only is the IHS viewed differently from Medicare and Medicaid, but its funding is structurally different, making it challenging to expect significant increases in future funding – especially in the current political climate in which entitlements are under scrutiny more than ever. But at the very least, we should hope for an increase in funding to Medicaid levels.

Even if the Indian Health Service is adequately funded, guaranteed healthcare also needs to reach the approximately 1.5 million Native Americans who aren't served by the IHS because they do not live on reservations or reside in urban areas. The funding needs to reach these individuals in the form of medical healthcare services as well as social services. One of the many challenges facing the IHS is its geographic diversity – resources need to reach people in every state, regardless of how far they might live from an IHS facility.

Recruiting healthcare providers to serve Native Americans has long been a challenge. Early in our history, military physicians were deployed to vaccinate Native Americans in their communities, and today, the majority of Indian Health Service professionals are deployed from the United States Public Health Service. Additional providers are hired from the communities themselves. Recruitment challenges are multifactorial. Many IHS facilities are rural and remote, and are also culturally isolating for outsiders, resulting in difficulties with longer-term recruitments. And given the low patient volumes in many hospitals, work is not as dynamic – and often inadequate for practitioners like surgeons to keep up their own skills. For example, ten IHS hospitals had fewer than 10% of their beds filled in 2018. And according to the American Hospital Directory, rural hospitals generally have an occupancy rate of less than 40%.

Access to care is the third challenge experienced by Native Americans. Within the Indian Health Service system, people may need to travel for hours to find an acute care facility. And in many cases, there is inadequate staffing and particularly low access to specialists. Financial concerns impact people's decisions to seek care. And in urban areas, where most Native Americans actually live, there are far fewer IHS facilities. Outside the IHS, it is less clear how Native Americans should access our fractured healthcare system, and how their Native rights will impact payment for services. The heterogeneity of Native American tribes further complicates this challenge; given the differences in healthcare needs among different communities, there is no one-size-fits-all solution. Each community requires an individualistic approach.

Finally, the distribution of resources presents a unique challenge to this geographically diverse population that is in great need of preventive care and social supports. The Indian Health Service was developed in an acute care medical healthcare model, which finds it today with crumbling hospital infrastructure and widespread understaffing. Ironically, inpatient volumes are generally low, such that increased spending in acute care will be underutilized. Given the significant rates of diabetes, hypertension, depression and substance abuse among Native Americans, culturally competent preventive care, addiction medicine, and social services should be the priority. But similar to non-Native populations, these have been under-prioritized and under-resourced.

Improving the care of any marginalized population is a daunting task – and even more so when it compromises a geographically diverse people who represent over 1% of the United States population, who utilize a federally mandated would-be solution that is chronically underfunded and under-budgeted. I propose three main avenues for improving the care of Native Americans in the United States. These include increasing funding, augmenting the healthcare workforce, and enhancing our approach to Native American care to utilize technology to improve primary care and social services.

Inadequate funding of the Indian Health Service is the primary reason for its shortcomings; we need strategies to improve it on an annual basis. One structural shift that may help accomplish this includes shifting funding from under the Department of the Interior to the Department of Health and Human Services. This would enable the IHS to access a greater overall sum of money. It would also force lawmakers to consider IHS funding in direct comparison to Medicare and Medicaid. As previously noted, IHS funding is a fraction of either of those; perhaps a common distribution mechanism would bring IHS funding to a similar level. A second recommendation would be to change the Indian Health Service toward federally mandated funding. Currently, legislation does require the United States government to provide healthcare for Native Americans, but the funding itself is not federally mandated as it is with

Medicaid and Medicare. If the IHS was brought up to a similar standard, improved funding might follow. It would also allow for Native Americans in non-reservation settings to access care similarly to reservations.

The second strategy is augmenting the workforce that serves the Native American population. I would recommend an expansion of the United States Public Health Service (USPHS). Currently, approximately 6100 members of the Commissioned Corps work in a variety of settings throughout the United States – some of whom serve with the Indian Health Service. Currently, the maximum age for joining the USPHS is 44 years old. I believe that the USPHS should be expanded to include older practicing physicians, retired physicians, and foreign medical graduates. Similar expansion should be made available for the nurses, pharmacists and other healthcare professionals who wish to serve. Public service needs to be made more accessible to employees and volunteers on a part-time basis in a “reserve” capacity, much like the United States military – a weekend a month and two weeks per year would help fill care gaps, which would make it easier for full-time Public Health Service officers to serve in needy areas. For example, as a medical student and after completing my residency, I volunteered and worked on Northern Cheyenne and Choctaw reservations as part of an IHS program which matched me with practice settings in which the full-time physician was on vacation. That program unfortunately no longer exists. The Public Health Service should be also expanded to include a community health worker role – this would improve opportunities for preventive care and social support, and could create job opportunities for Native Americans in their communities. The Indian Health Services does create preferences to hire Native peoples when possible. However, limited educational infrastructure and opportunities for advancement result in fewer Native people achieving professional healthcare degrees and leadership roles in delivering care. A scholarship system to incentivize higher education contingent upon future service to the community in the model of military scholarships could enhance the workforce from within the community, which would be ideal.

Rethinking access to care invites an opportunity to reimagine what services might be provided under a new paradigm. I believe that a renewed focus on mental health care and substance abuse treatment as well as a primary care focus on diabetes, hypertension and dyslipidemia could be accomplished with an expanded role of clinical pharmacists and telemedicine. Clinical pharmacists and nurses could drive a protocol-driven care model that addresses these more common causes of chronic disease. Kiosks with telemedicine capabilities could be situated in pharmacies such that patients could access remote care – from primary care providers as well as specialists – with less of a need to travel significant distances to acute care hospitals or clinics. Investing in a preventive approach would reduce the need for hospitalizations, which would reduce costs downstream. A telemedicine primary care model would also reduce the number of on-site providers, and would allow for opportunities for more

caregivers to participate in Native American healthcare, regardless of location. IHS physicians could consolidate in fewer hospitals which would improve staffing and clinical outcomes. This approach would also allow for similar kiosk-driven care to be made available in urban environments, thus allowing urban Native Americans to access the healthcare that they are entitled to receive.

Native Americans have been marginalized for hundreds of years. Their experience in our country is unique, but they do share diminished opportunity, multi-generational poverty, and deep-seated health challenges with other marginalized groups within our society. But unlike other groups, our country has committed to providing healthcare services to them. Unfortunately, even after hundreds of years, our government has fallen short time and time again. I am hopeful that the current administration will have the opportunity to reconsider the funding structure of the Indian Health Service, and that the current coronavirus pandemic might cause the United States Public Health Service to expand opportunities to more physicians who would like to serve these and other marginalized Americans.

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