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The Federal Neglect of the Indian Health Service: Root Causes of Inadequate Health Systems for Native Americans and Recommendations for Future Action

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Introduction

The Native American population experiences disproportionately high rates of negative health outcomes compared to the U.S. population as a whole, with the average Native American life expectancy five years lower than the U.S. average and the disease burden of Native Americans 1.3 times that of the U.S. average ("Disparities," IHS). Specific negative health outcomes of Native Americans include a disproportionate burden of colon and lung cancer, diabetes-related morbidity, alcohol-related conditions, intentional injury rates (including homicide and suicide), and cardiovascular disease (Sequist et al., 2011). Though structural and social determinants account for the existence of these disparities, inadequate medical and preventive care for members of the Native American community has allowed these negative health outcomes to persist.

Given the aforementioned health care disparities, the Indian Health Service (IHS) was created to provide health care services to approximately two million Native Americans, mainly those who reside on or near tribal communities (Sequist et al., 2011). Court cases and federal laws—including the Snyder Act and the Indian Health Care Improvement Act—mandate the U.S. government to provide economic, social, and healthcare programs for Native Americans, with the intention of eliminating disparities between the Native American community and the non-Native American population (Westmoreland & Watson, 2006). As such, the mission of the IHS, in accordance with these laws, is to "raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level" ("About IHS," para. 1). Despite these lofty goals and the IHS' crucial role in lessening the health disparities experienced by the Native American community, the department's shortcomings—especially visible throughout the COVID-19 pandemic—reveal an agency frequently unable to make significant progress towards bettering the health outcomes of this population. This paper argues that IHS funding must be guaranteed and bolstered through changing the federal budget classification of the IHS from discretionary to mandatory—in the same fashion as Medicare and Medicaid—to ensure that IHS funding will be allocated annually and will increase adequately in order to meet rising costs. In addition, specifically nuanced programs must be created within the IHS—in collaboration with community members—to recruit more Native American physicians, increase community-based health programming, and update educational materials to allow the IHS to provide more culturally conscious services.

The federal government's historical relationship with Native Americans has often propagated the marginalization of tribes and an inadequate emphasis on the needs and desires of tribal communities. Native Americans make up semi-sovereign nations within the United States and have historically negotiated their rights with the U.S. government through the use of treaties (Deloria & Lytle, 1984). The earliest, rudimentary version of the IHS itself was laid out in the Fort Laramie Treaty of 1868, which guaranteed healthcare to the Sioux Nation in return for their ceding of land to the U.S. government (National Library of Medicine, n.d.). Though the federal government has contended that it maintains a "government-to-government" relationship with Native American tribes—with many Native Americans possessing dual citizenship with both their tribe and the United States—the bargaining positions of these entities are far from equivalent (Deloria & Lytle, 1984). Tribes remain largely dependent on federal funding for operating funds and federal permissions to access the natural resources present on their own reservations; as such, tribes continue to hold limited negotiating power with the U.S. government (Deloria & Lytle, 1984). Because Native Americans are afforded "self-government" rather than "nationhood" status, the federal government only recognizes a small measure of tribal decisionmaking and carefully monitors this process to ensure that all decisions are in line with the goals of the U.S. government (Deloria & Lytle, 1984). This form of self-governance has been inadequate in addressing the cultural needs and desires of the Native American population, as it permits oversight of tribes by a federal government that has an extremely limited understanding of these needs (Deloria & Lytle, 1984). The semi-sovereign status of tribes insinuates that Native Americans are only able to assume some of the responsibilities for their own governance and should not be able to completely prioritize their own preferences for government structure. Despite the supposed "government-to-government" relationship between Native Americans and the U.S. government, the federal government has often failed to provide Native American reservations with adequate resources or programming, while many legislators have continually emphasized reducing tribal "dependence on federal largess" (Deloria & Lytle, 1984, p. 7). The Indian Health Service is only one of numerous programs for Native Americans that remain chronically underfunded, understaffed, and neglected by the U.S. government.

IHS Structure

There are three branches of service that make up the modern IHS: the federally operated direct care system, independent tribally operated health care services, and urban Indian health care services (Sequist et al., 2011). The federally operated direct care system consolidates its funds and resources at the national level and funds 28 hospitals and 89 outpatient IHS facilities that provide primary care, limited specialty care, and prescription drug coverage (Sequist et al., 2011). Independent tribally operated health care services claim half of the IHS annual budget and allow tribes to independently allocate their funding and manage their own health care programs, including 17 hospitals and 493 outpatient facilities (Sequist et al., 2011). Urban Indian health care services are delivered through nonprofit programs and serve Native Americans living in or near urban centers across the United States (Sequist et al, 2011). These three branches of the IHS are all funded through annual federal appropriations as well as through revenues from external sources, including Medicaid, Medicare, private insurers, and the Department of Veterans Affairs (Sequist et al., 2011).

Literature Review

Increasing Indian Health Service Funding. Previous research regarding the funding level of the Indian Health Service has been nearly unanimous in contending that the program is severely underfunded. Sequist et al. (2011) argue that increasing funding for the IHS is integral to achieving parity between the health of Native Americans and the U.S. population as a whole. Although the IHS is funded through the federal appropriations process each year and is able to collect funding from Medicare, Medicaid, and private insurers, this funding has not been sufficient for allowing the IHS to perform its necessary functions (Sequist et al., 2011). Westmoreland and Watson (2006) are in agreement with other researchers that the IHS is significantly underfunded, and they argue that the most effective way to increase IHS funding is through a change in the program's budget classification. The IHS is currently classified as a "discretionary" program, meaning it is not mandated to receive federal funding during annual fiscal appropriations. Westmoreland and Watson (2006) argue that IHS appropriations should be mandatory each year—in the fashion of Medicaid, Medicare, and Social Security—and, as such, argue that the IHS would be funded more reliably, keep pace with changes in need and cost, and be more effective at addressing health disparities.

Henley and Boshier (2016) propose that the IHS avert further cuts to its funding through the creation of a federal exemption that prevents the agency from being affected by any Medicaid funding cuts. Because many who use IHS services are also insured under Medicaid, the

IHS is extremely vulnerable to losing a substantial amount of its revenue if Medicaid reimbursements are reduced (Henley & Boshier, 2016). Henley and Boshier (2016) argue that, if there are cuts to Medicaid, the federal government should ensure that these cuts do not apply to Native Americans and do not reduce revenues for the IHS. The authors also propose that some individual tribal communities—such as the Navajo Nation—become recognized as states and be allowed to establish their own independent Medicaid agencies (Henley & Boshier, 2016). By these means, tribal communities could shape their Medicaid programs to their own population's specific needs and could address the gaps in coverage experienced under current state-level programs (Henley & Boshier, 2016).

The authors of "The Affordable Care Act and Implications for Health Care Services for American Indian and Alaska Native Individuals" note that the Affordable Care Act (ACA) initially provided an opportunity for the IHS to standardize and stabilize its source of Medicaid funding (Ross et al., 2015). The expansion of Medicaid eligibility under the ACA initially mandated all states to provide Medicaid coverage for residents with an income at or below 138 percent of the federal poverty level (Ross et al., 2015). When the Supreme Court ruled this nationwide Medicaid expansion unconstitutional in the case *National Federation of Independent Business v. Sebelius* in 2012, states were able to choose—and, in many cases, restrict—their own Medicaid eligibility requirements. As a result, IHS reimbursements from Medicaid are no longer standardized across all facilities (Ross et al., 2015). The authors contend that, though the Medicaid expansion provision has been rolled back, the initial ACA provision allowed standardized, predictable, and, in many areas, increased funding for the IHS through Medicaid reimbursements (Ross et al., 2015). Though research on the IHS provides numerous solutions for increasing the program's funding, there is a near-consensus that the IHS is severely underfunded, and, as a result, is largely prevented from taking actions that could ameliorate the Native American community's disproportionately negative health outcomes.

IHS Community Involvement and Cultural Competency. Despite the success of some culturally conscious IHS programs, many researchers have noted that IHS programming continues to be lacking in community involvement and in sensitivity to specific tribal cultures. Sequist et al. (2006) note the success of the IHS' Injury Prevention Program as well as the Special Diabetes Program, two initiatives that have relied on partnerships with tribal leadership and that emphasize cultural consciousness. Because of these partnerships, community members have been extremely receptive to these programs and to the applicability of the initiatives to each specific tribe's culture and values (Sequist et al., 2006). Other research has also recognized the importance of involving tribal communities in IHS programming and has highlighted areas where the IHS is lacking in cultural awareness. A study by Guadagnolo et al. (2014) on disparities in hospice utilization among Native Americans found that there are few hospice locations for Native Americans that provide culturally relevant care. The authors contend that the IHS should take on more responsibility for creating hospice services in conjunction with tribal communities in order to provide culturally conscious end of life care (Guadagnolo et al., 2014). Henley and Boshier (2016) have also documented issues with the IHS' disconnect with tribal communities, as evidenced in the lack of consultation that occurred with local tribal leaders regarding changes to the Medicaid billing system. Leaders from the Navajo Nation have experienced critical issues with provider credentialing, billing, and access to care for tribal communities because of both the IHS' and state governments' lack of consultation and communication with local tribal leaders (Henley & Boshier, 2016). Because of the issues that a disconnect with the tribal community can cause, the authors argue that including Native

American leaders in all policy processes associated with the IHS or other health programs affecting Native Americans should be maintained as common practice (Henley & Boshier, 2016). Researchers have noted that the most successful IHS programs have been those that involve tribal community members in order to create culturally relevant health initiatives.

Accessibility to Care. The IHS has continually faced issues with physician recruitment, staffing shortages, and caring for patients who live far from IHS facilities, which all contribute to limited access to healthcare for many Native Americans. Each year, the IHS physician vacancy rate typically approaches 20 percent (Sequist et al., 2011). Sequist et al. (2011) have recommended that current IHS recruitment initiatives be expanded—such as scholarship and loan repayment opportunities to attract physicians—and that the IHS increase its use of telemedicine and partnerships with academic medical centers. The authors argue that these tactics could be used to increase access to care for many Native Americans, especially those who have been unable to schedule timely appointments due to physician shortages and those who live far from IHS facilities (Sequist et al. 2011). Tobey et al. (2020) also advocate for addressing physician shortages through IHS partnerships with academic medical centers. These authors contend that partnering with academic medical centers would encourage medical students to participate in residency training programs at the IHS and would also allow for a sharing of resources to underfunded IHS facilities (Tobey et al., 2020). Other authors have emphasized the importance of addressing the shortage of specialty care at the IHS. Research by Wilson et al. (2007) found that funding and staffing shortfalls at the IHS contribute to delays in patients' access, diagnosis, and treatment. Though the IHS attempts to rely on contract care—off site coverage for specialties not available at IHS facilities—in order to provide Native American communities with specialists, IHS contract care programs are severely underfunded, and many Native

Americans are ineligible for receiving these services (Wilson et al. 2007). Henley and Beshear (2016) have, similarly, stated that offsite specialty care has not sufficiently addressed the health needs of Native Americans, for travel to specialists is often time consuming and costly, especially for patients who already struggle to travel to IHS facilities.

Though these proposals to increase the use of telemedicine, increase funding and eligibility for contract specialty care, form partnerships with academic medical centers, and bolster physician recruitment programs would increase access to care for Native Americans, they may not increase access to culturally relevant care. Multiple studies have noted that, though the proportion of Native American physicians in the IHS—15 percent of all IHS physicians—is much higher than the national average, up to 10 percent of all IHS physicians still report experiencing issues with cultural and language barriers during clinical encounters (Sequist et al., 2011; Henley & Boshier, 2016). Native Americans already experience extreme difficulty in accessing care, and they struggle even more to access culturally conscious care; therefore, researchers have suggested that it may be beneficial to increase the recruitment of Native American physicians to the IHS to lessen the cultural barriers that separate physicians and patients (Sequist et al., 2011). Research regarding physician shortages and the inaccessibility to care—especially culturally conscious care—experienced by Native American communities highlights some of the proximate causes of Native Americans' disproportionately poor health outcomes.

Research Questions

- What improvements can be made to the IHS—in regards to access to care, research, and cultural competency—to better the health outcomes of Native Americans?
- In what ways has the IHS helped to decrease the health disparities of Native Americans, and what lessons can be learned from these experiences?
- How can the IHS better collaborate with members of the Native American community to create culturally conscious programming and resources?
- How has the COVID-19 pandemic highlighted and exacerbated the problems facing the IHS?
- What source of funding—and how much funding—would allow the IHS to run most effectively?

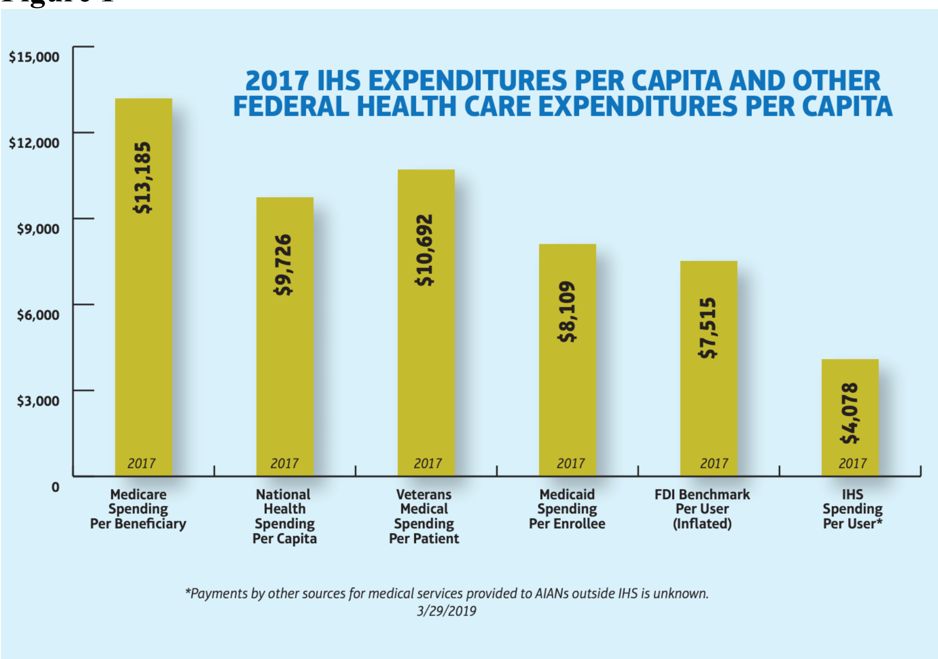
Methodology

This paper is a qualitative meta synthesis of numerous research articles, news articles, and independent reports regarding the Indian Health Service. Though there is some reference to quantitative findings regarding IHS funding, the research conducted for this paper mainly synthesizes works that are qualitative in nature.

Findings and Discussion

Indian Health Service Funding. The current level of funding for the Indian Health Service per beneficiary is much lower than for any other government-run health program and is insufficient for addressing the health inequities experienced by Native Americans.

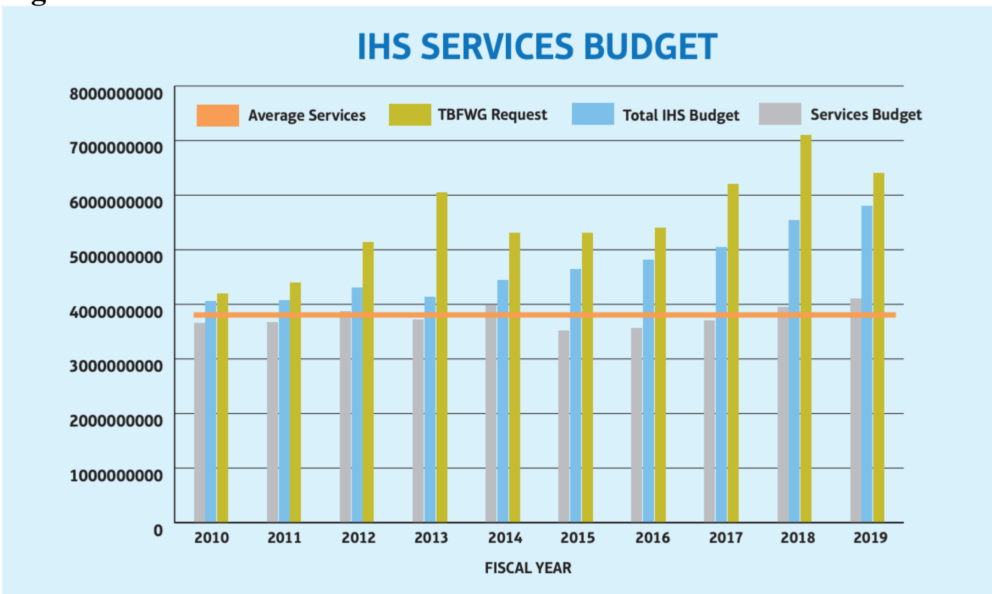
Figure 1



Joseph, A., Pratt, B., & Joseph, V. (2019, April). *The National Tribal Budget Formulation Workgroup's recommendations on the Indian Health Service fiscal year 2021 budget*. https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF, p.10.

According to Figure 1, in 2017, IHS spending per user was $4,078—almost half of the spending per Medicaid enrollee and less than one-third of the spending per Medicare beneficiary. This scant funding per IHS user prevents the IHS from adequately serving tribal communities and allows the perpetuation of health disparities between Native Americans and other populations in the United States.

Figure 2



Joseph, A., Pratt, B., & Joseph, V. (2019, April). *The National Tribal Budget Formulation Workgroup's recommendations on the Indian Health Service fiscal year 2021 budget*. https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF, p. 11.

As evidenced in Figure 2, the total IHS budget has, for the most part, increased each year from 2010 to 2019; though the IHS budget has grown from around $4 billion in 2010 to just below $6 billion in 2019, these increases in allocations have only served as "maintenance funding" for the organization. Recent increases in the IHS budget have only been able to cover the growth of the Native American population, inflation, and contract support costs to maintain current administrative funding (Joseph et al., 2019). According to Figure 2, in 2018, The National Tribal Budget Formulation Workgroup's (TBFWG) request for IHS fiscal year funding was $1.5 billion higher than the actual amount eventually allocated to the IHS, signifying a lack of adequate funding for the organization. TBFWG has stated that, in order to address the quality and safety issues at IHS facilities and to improve upon the substandard health outcomes experienced by Native Americans using the Indian Health Service, IHS funding in fiscal year 2021 must be increased by 46 percent (Joseph et al., 2019). Although many politicians, independent organizations, and tribal communities have called for increased IHS funding in order to address Native Americans' poor health outcomes—which have largely remained the poorest of any racial or ethnic group in the United States—any increases seen in the IHS budget have only been able to maintain the subpar status quo at IHS.

The determination of Indian Health Service funding in the Interior, Environment, and Related Agencies Subcommittee of the House of Representatives' Committee on Appropriations has prevented IHS funding from reaching parity with other government-run healthcare programs. Although the IHS is part of the Department of Health and Human Services (HHS), IHS allocations are left to the discretion of the Interior Subcommittee, as many tribal issues are traditionally handled by the Department of the Interior (Siddons, 2018). The Interior Subcommittee only has around $31 billion to allocate each fiscal year, while the Labor, Health and Human Services, Education, and Related Agencies Subcommittee—which appropriates funding for the rest of the HHS—has an annual budget of around $154 billion (Siddons, 2018). The separation of the IHS from the rest of its parent agency during fiscal year appropriations has allowed disparities between the IHS and other programs at the HHS—which are largely used by non-Native populations—to grow.

The disparities between IHS funding and other government-run healthcare programs' funding also persist due to differences in budget classification. While Medicare and Medicaid are classified as "mandatory" programs—their funds are guaranteed in advance of fiscal year appropriations and are not capped—the IHS is classified as a "discretionary" program (Westmoreland & Watson, 2011). As a result, IHS funding can be revoked or decreased each year without any legal consequences and can, despite being increased, fall behind its true need for spending (Westmoreland & Watson, 2011). Medicare and Medicaid's mandatory appropriations grow each year to reflect, at a minimum, the previous year's funding plus costs associated with increases in users, inflation, and new technologies and pharmaceuticals (Westmoreland & Watson, 2011). In contrast, IHS appropriations are never guaranteed and are never required to reflect the previous year's funding, population growth, inflation, or the costs of any new or improved technologies. Many Native American organizations, including the National Congress of American Indians (NCAI), have advocated for a change in the IHS' budget classification. The NCAI, one of the premier nonprofits dedicated to serving the interests of tribal communities and governments, has, since 2017, officially advocated for the IHS budget to be classified as mandatory spending (National Congress of American Indians [NCAI], 2017). The organization argues that, because the IHS' underfunding has highlighted the U.S. government's failure to uphold its obligation to "provide economic and social programs necessary to raise the standard of living and well-being of the Indian people to a level comparable to non-Indian society," the IHS budget should be classified as a mandatory spending program (NCAI, 2017, para. 3). The disparities in the budget process between the IHS and other government-run healthcare programs allow the IHS to continually receive substandard funding and to struggle to maintain—let alone improve upon—the already poor health outcomes of the Native American community.

IHS Cultural Consciousness. Despite a lack of adequate funding, the IHS has been successful in creating many culturally conscious, collaborative programming that has addressed some of the health issues that disproportionately affect Native Americans. The IHS' Special Diabetes Program for Indians is one program that has seen success in bettering Native Americans' health outcomes while also accounting for the culture of the population (Sequist et al., 2011). The Special Diabetes Program ensures that its healthy eating programming is based on diets that incorporate the traditional foods of each specific tribal community and uses traditional methods—including talking circles and storytelling—to increase these communities' awareness and knowledge regarding diabetes (Sequist et al., 2011). As a result of these culturally-conscious methods, the Special Diabetes Program has seen success in promoting healthy lifestyles and in lowering blood pressure, blood glucose, and cholesterol among Native Americans (Sequist et al., 2011). The IHS' Injury Prevention Program has, similarly, utilized community participation to successfully decrease the unintentional injury rate among Native Americans (Sequist et al., 2011). The program is based on a partnership between the IHS and tribal leadership to create and implement community-based injury prevention programs due to previously high rates of unintentional injury among tribal communities (Sequist et al., 2011). One such partnership is with the Apache Tribe of Oklahoma, whose Injury Prevention Program Coordinator continually reaches out to prominent members of the tribal community—including community elders and tribal princesses—to collaborate with them on public service announcements regarding unintentional injury prevention (Tribal Injury Prevention Cooperative Agreement Program [TIPCAP], 2020). These collaborative PSAs, which have addressed fall risks and child safety seats, have been able to reach tens of thousands in the Apache community (TIPCAP, 2020).

Though some IHS programs have been successful in collaborating with tribal communities in order to create culturally-conscious health efforts, the IHS struggles in many other aspects to bridge cultural divides with Native Americans. Educational materials used in IHS facilities are often not written at suitable health literacy levels for Native American patients and are frequently unavailable in the more than 130 tribal languages spoken in the US (Sequist et al., 2011). As such, these health education materials have been ineffective at accurately assessing the health literacy levels and linguistic needs of many Native Americans, which may result in patients' lack of adherence to treatment plans and overall worse health outcomes. Cultural and language barriers also exist between patients and the providers working for the IHS, who are rarely Native American themselves or members of the specific tribal community they serve (Sequist et al., 2011). Both providers and patients continually struggle to bridge these cultural divides. One IHS provider remarked that, for IHS patients:

> There's a lot of reluctance about coming into an agency...especially the fact that all of our staff are primarily Caucasian, I think that that can be a little intimidating of an environment but even, even with that once they get to know the staff the trust building timeline kind of is much longer. (Wille et al., 2017, p.8)

Native American patients have also noted that racial and cultural divides between themselves and their providers has led to a weak provider-patient relationship and to instances of discrimination:

> I think yes, it has affected actions with doctors and hospitals… I haven't lied to them about anything, and I just feel like sometimes that…they choose not to hear me. And do I want to call it a race thing? I don't want to call it that, but I do believe that's what it is, you know? (Wille et al., 2017, p.6)

Another source of disconnect between patients and providers lies in cultural differences regarding traditional healing practices. Seventy percent of Native Americans—both those who live in rural and urban areas—partake in traditional healing practices, which has led to conflicts with providers who solely use Western practices (Henley & Boshier, 2016). Because the IHS is not designed to account for spirituality in the treatment plans of Native Americans and because many providers are not Native American themselves, the spiritual needs of IHS patients are frequently overlooked. Recently, the IHS has taken some steps to incorporate traditional healing methods into the treatment regimens of their patients by hiring medicine men or women to treat

IHS patients alongside physicians (Akridge, 2020). These medicine men and women educate hospital workers about traditional healing practices and cultural sensitivity, are able to perform traditional healing ceremonies for patients, and act as liaisons to connect patients with community resources (Akridge, 2020). In spite of recent actions to increase culturally and spiritually-inclusive IHS services, the IHS' original disregard for Native cultures also speaks to the U.S. government's historical pattern of dismissing tribal communities' desires to incorporate spirituality into their governance (Deloria & Lytle, 1984).

Physician Shortage at the IHS. Staffing shortfalls at the Indian Health Service have led to delays in diagnosis, access, and treatment for IHS patients and, as is also the case with funding shortfalls, have rendered the organization incapable of improving the disproportionately negative health outcomes experienced by Native Americans. The average vacancy rate for nurses, physicians, and other care providers at the IHS averages 25 percent, which prevents the IHS from providing quality or timely care for its patients (US Government Accountability Office [GAO], 2018). Despite efforts by the IHS to recruit providers through scholarship and loan repayment programs, vacancy rates have remained extremely high ("Recruitment and Retention," para. 2). Physicians are often hesitant to accept jobs at the IHS, for the organization struggles to match local market salaries and is often unable to provide housing for providers, largely because tribal communities are frequently located in rural areas (GAO, 2018). The IHS has attempted to address these issues by allowing physicians to participate in telemedicine, which does not require living on or near tribal communities, in order to serve the Native American population (Sequist et al., 2011). Despite the utility of telemedicine, physician recruitment is still necessary for ensuring that emergency medicine and face-to-face consultations are available for all IHS patients who require or prefer these services (Sequist et al., 2011).

The IHS has also attempted to address its high physician vacancy rate by partnering with academic medical centers. Partnerships with academic medical centers allow the IHS to refrain from hiring full-time physicians and instead allow recent medical school graduates to work at IHS facilities as “visiting providers” for short-term assignments (GAO, 2018). Oftentimes, members of tribal communities are aware that their care is coming from recent graduates or trainees, which creates a lack of trust in the medical care being provided (Shah et al., 2014). Members of the Zuni Nation have remarked: “a lot of times they (the physicians) don’t really know what’s going on with you, They’re just basically trainees” and “we’re just a training ground for them (the physicians)” (Shah et al., 2014, p.8). Though these academic partnerships were created as a possible solution to the provider shortage at the IHS, hiring short-term providers is often costly, creates a lack of trust in the community, and results in a lack of continuity of care for IHS patients (GAO, 2018). Additionally, few substantive partnerships between the IHS and academic medical centers currently exist; partnerships with the University and Utah and the University of San Francisco are some of the only programs that provide tribal communities with short-term physician placements (GAO, 2018). Other IHS partnerships with academic medical centers—such as Dartmouth’s Geisel School of Medicine and the Mayo Clinic—only include nonspecific and noncommittal dedications to addressing the IHS physician shortage, such as “promoting career opportunities,” or working with young Native American children “‘to spark in them an interest in being a doctor’” (“IHS Partnerships,” para. 4; Dartmouth Geisel School of Medicine, para. 9). These few current partnerships with academic medical centers have not been sufficient in addressing the IHS’ substantial physician shortage.

Case Study: COVID-19 and the Navajo Nation

The COVID-19 pandemic has shed light on existing issues plaguing the IHS and has revealed the inability of the IHS to cope with public health crises. The experience of the Navajo Nation throughout the COVID-19 pandemic has been especially fraught with chaos and challenges and illustrates the larger issues facing the IHS at facilities across the country. From the beginning of the pandemic through July 2020, the COVID-19 positivity rate for IHS patients in the Navajo Nation reached 20 percent, compared with a national positivity rate of 7 percent during this same period (Walker, 2021). As of January 2021, the Navajo Nation has a COVID-19 death rate higher than that of New York, Florida, and Texas (Walker, 2021). The Navajo Nation, in response to the lack of aid provided by the federal government, was forced to take matters into their own hands. One Navajo coronavirus coordinator remarked: "If we would have waited for the federal government's help, our deaths could have been in the thousands" (Walker, 2021, para. 11).

The Navajo response to the COVID-19 pandemic has illuminated the existing issues with the IHS' chronic underfunding and inability to retain providers at their facilities. The IHS has never been provided with adequate funding to be able to respond to a public health crisis; Dr. Jill Jim, the health director for the Navajo Nation, remarked that "they (the IHS) don't have a public emergency office, they don't have dedicated staff that are hired for public health emergencies" (Walker, 2021, para. 45). Inadequate funding and preparedness for IHS facilities during the COVID-19 pandemic has at times become so dire that nurses at Navajo Nation health facilities took it upon themselves to pool money together to provide their patients with medication, food, and masks (Walker, 2021). In addition, IHS facilities have been unprepared to serve the high volume of patients needing to be treated during the pandemic. For the 170,000 residents of the

Navajo Nation, only 222 hospital beds are available at IHS facilities; this ratio of hospital beds to population is around a third of the ratio for the US general population (Walker, 2021). The existing physician shortage at IHS facilities has also exacerbated the situation for IHS patients throughout the pandemic. The vacancy rate for physicians—over 25 percent—and for nurses—around 40 percent—has prevented IHS facilities from being able to treat numerous patients with severe COVID-19 illness (Walker, 2021). Jonathan Nez, president of the Navajo Nation, noted in September 2020 that a lack of providers and the low capacity of IHS facilities has forced residents to travel extremely long distances in order to access health care—an issue that existed long before the COVID-19 pandemic reached this community (Walker, 2021).

The IHS' continual struggle to provide culturally competent services to the populations it serves has also been highlighted throughout the Navajo Nation's experience with the COVID-19 pandemic. Navajo Nation residents are frequently under informed about the severity of the coronavirus illness, with many believing that the disease is a "simple cough or flu you get over" (Gable, 2020). The lack of dissemination of health information to this community—especially information written in the native language of the residents and at suitable health literacy levels—has led to much of the Navajo community remaining uninformed about COVID-19. Around 48 percent of Native Americans across the U.S. have limited health literacy levels, rendering much of this population unable to adequately navigate the health care system (Brega et al., 2016). Because Native American elders are disproportionately burdened by low health literacy levels as well as low English proficiency rates, elders are put at a significant disadvantage in the dissemination of health information (IHS Health Literacy Workgroup, 2009).

The IHS has also been slow to adapt COVID-19 precautions to the living situations of many Navajo Nation residents. Navajo Nation citizens frequently live without electricity, and one third of this population does not have access to running water (Walker, 2021). Additionally, housing units frequently house multigenerational families—with grandparents, parents, and grandchildren under one roof—and often house more than one family (Walker, 2021). The settings that Navajo residents live in make it extremely difficult for them to follow the social distancing, hand washing, and isolation guidance provided by the Centers for Disease Control and Prevention. Despite these difficulties, the IHS has been extremely slow to provide their own adaptable guidelines for this population and unable to provide the resources necessary for these individuals to adhere to guidelines. The inadequate response of the IHS has led many young Navajo members to devise their own solutions for protecting their community's elders, who are considered sacred in the Navajo community. These young Navajo members have mobilized to provide their elders with assistance, resources, and health information so that they can stay safe at home—effectively performing services that the underfunded and understaffed IHS has been unable to carry out (Gable, 2020). One young Navajo Nation member remarked that "tied to our elders are our language and our traditional practices, stories and culture. With this virus, there's a threat to that. Because when our elders are dying, that knowledge goes with them that we're still learning" (Gable, 2020, para. 5). Despite the value that this community places on its elders, the IHS has been unable to keep these individuals safe or provide them with adequate resources, culturally and linguistically appropriate health information, or accessible health care services.

The shortcomings of the IHS highlighted throughout the COVID-19 pandemic are also accompanied by a more general disregard by the federal government of the toll this virus has taken on Native American communities. Early CDC reports tracking coronavirus cases across the country included incomplete data for many Native American populations—including large swaths of the Navajo Nation (Sofia, 2020). Because federal agencies tracking COVID-19 cases often omit information regarding the race and ethnicity of individuals, the CDC and other executive healthcare agencies have been unable to assess the true severity and prevalence of COVID-19 in tribal populations (Conger et al., 2021). The inaccurate and, often, nonexistent data available regarding COVID-19 illness rates among Native American populations has resulted in tribal communities struggling to receive federal funding for protective equipment as well as economic recovery services (Conger et al., 2021). The federal government's neglect of both the needs of the IHS and the wellbeing of the Native American population have become increasingly apparent throughout the COVID-19 pandemic. The disproportionate impact that this public health crisis has had on the Native American community, as evidenced by the experience of the Navajo Nation, is a direct consequence of the federal government's disregard for the resource needs of the IHS, the cultural needs of the Native American community, and the historical promises made to protect this vulnerable population.

Recommendations

Recommendation 1: Reclassification of the IHS as a Mandatory Spending Program. Based on the findings regarding the IHS' funding, level of cultural consciousness, and staffing shortages, certain changes should be made to the Indian Health Service in order to help eliminate the health disparities experienced by the Native American community. The IHS is often too under-resourced to provide its patients with high quality routine care, let alone provide these communities with a sufficient response to a deadly public health crisis—as evidenced by the struggles of the Navajo Nation throughout the COVID-19 pandemic. Though there is much room for improvement at the IHS, few changes are able to be made at the organization without secure and adequate federal funding. The most effective means of eliminating gaps between IHS funding per user and funding provided per Medicare and Medicaid user is to reclassify IHS appropriations as "mandatory." By these means, IHS funding would never be allowed to diminish and would be increased each year based on the size of the Native American population, inflation, and new or improved technologies. Though IHS funding would, ideally, be increased by at least the recommended 46 percent in order to strive for parity with other federal health programs, there is no means of ensuring that this exact increase will occur, even under a mandatory appropriations process (Joseph et al., 2019). The annual appropriations for the IHS could be moved to the Labor, Health and Human Services, Education, and Related Agencies Subcommittee so that the program would have access to a larger budget, yet this action would require unanimous consent from all relevant subcommittee chairmen—a daunting task—and could result in funding being cut from other health programs appropriated in this subcommittee (Siddons, 2018). As a result, the most effective means of ensuring stability and increases in IHS funding would be to include the program in the mandatory appropriations process. Support for IHS mandatory spending has grown in recent years, with numerous Democratic and Republican politicians favoring the change in budget classification. During his 2020 presidential campaign, President Joe Biden stated as part of his platform that: "(a)s President, I'll make meaningful investments in Indian Country—including dramatically increasing funding for Indian Health Services and making it mandatory" (Sanchez, 2020, para. 5). Similarly, Republican Congressman Tom Cole—himself a member of the Chickasaw nation—has stated that: "I normally oppose taking discretionary programs and putting them in mandatory spending, too. But in this case, it's (the IHS) so underfunded compared to any other kind of health care" (Siddons, 2018, para. 50). Though ensuring majority support in Congress for this budget reclassification would be a difficult task, existing bipartisan support for the change may indicate some chance of achievability for this improvement to the IHS.

Recommendation 2: Increase Community-Based Programming. Funding issues at the IHS have greatly influenced the organization's issues with programming and staffing, which have limited the IHS from reaching its maximum capacity for providing care. If funding to the IHS is increased, the organization may be able to hire more traditional healers, fund more community engagement projects—such as the Special Diabetes Program and the Injury Prevention Program—increase community based participatory research to identify the direst needs of the population, and update educational materials to more accurately reflect the various cultures, languages, and health literacy levels of the population. Using programs such as the Special Diabetes Program for Indians (SDPI) as models for future community-based programming would be extremely useful in this process. As noted by Stacy Bohlen—a member of the National Indian Health Board—during a House Committee on Natural Resources hearing, SDPI has been successful for multiple reasons:

> One, each Tribal grantee develops a community-driven program that is uniquely tailored to address the health needs of their specific population. Two, the programs address a wide variety of social factors such as limited access to healthy food and lack of safe spaces for physical activity and exercise, thus promoting a higher culture of health in the community. And three, many SDPI programs integrate traditional and culturally appropriate activities and strategies that promote community buy-in and support for the program. (Bohlen, 2019, p. 10)

If the IHS uses the SDPI as a framework for building other community-based programming, research, and engagement, patients may feel less of a cultural divide between themselves and the

IHS, and the health outcomes of Native Americans may be able to reach parity with the rest of the non-Native population. In order to emphasize the origin of these issues at the IHS, Stacy Bohlen further states that because of:

> Acts of physical and cultural genocide; forced relocation from ancestral lands; involuntary assimilation into Western culture; and persecution and outlawing of traditional ways of life, religion and language, the inevitable result are the disproportionately higher rates of historical and intergenerational trauma, adverse childhood experiences, poverty, and lower health outcomes faced across Indian Country. (Bohlen, 2019, p.3)

It is time for the federal government to begin taking into account the cultural, spiritual, language, and traditional needs of the Native American community within the IHS in order to both ameliorate poor health outcomes and to provide tribal communities with the respect, resources, and semi-sovereignty that they have been assured.

Recommendation 3: Recruitment of Native American Physicians. The recruitment of future IHS providers should increasingly focus on engaging members of the Native American community. Funding increases to the IHS may enable the organization to entice more providers to practice at IHS facilities for the time being, yet future emphasis should be placed on providing education and funding for young Native Americans interested in becoming health care professionals. Some existing programs, such as the IHS Scholarship Program, provide scholarships for Native Americans to attend pre-medical degrees in college or to attend medical school, yet these efforts have not been sufficient in increasing the amount of Native American providers at the IHS. In 2015, only 149 new applicants of the 289 who applied to one of the IHS Scholarship Programs were able to receive funding for their pre-medical or medical schooling

("IHS Scholarship Programs"). If the IHS had an additional $3.3 million available for scholarship funding, they would have been able to fund all qualified scholarship applicants ("IHS Scholarship Programs"). Though federal IHS funding should be increased in order to create more scholarship and recruitment activities, if this does not occur, then more contractual agreements should be created between the IHS and academic medical centers to provide mentorship and financing opportunities for Native Americans. As a result, more Native American children may be able to gain an interest in medicine and will have access to the financial resources necessary for pursuing professions in the medical field. By encouraging the recruitment of future Native American providers, the IHS' issues regarding both staffing shortages and providing culturally competent care could be addressed. Though hiring traditional healers and training non-Native providers on the culture of the communities they serve are helpful in creating a more culturally conscious healthcare system, the most effective means of ensuring that patients' cultures are understood by their providers may be to hire providers who are a part of this culture themselves.

Conclusion

The Native American community—a population already deprived of true self-governance and historically manipulated by the federal government through the use of treaties—has been denied access to an adequately funded, culturally competent, and fully staffed health care delivery system. The first-rate treatment given to other government-funded healthcare programs—such as Medicare and Medicaid—compared with the substandard treatment of the IHS mirrors the federal government's historical neglect and mistreatment of the Native American community. As such, future reforms to the Indian Health Service must center around the specific spiritual, language, and resource needs of this community and must prioritize funding at the same level as other government-funded healthcare programs. Despite the historic lack of attention paid to this agency, recent scrutiny of the IHS response to the COVID-19 pandemic as well as some recent bipartisan support for IHS reforms may indicate a window of opportunity to pursue desperately needed systemic change at the Indian Health Service. Each day without IHS reform only prolongs the federal government's default on its treaty obligation to provide the Native American community with a high-quality healthcare delivery system.

Bibliography

Akridge, S. (2020, May 14). *Returning to roots, Indian Health Service seeks traditional healers.* Kaiser Health News. https://khn.org/news/reversing-history-indian-health-service-seeks-traditional-healers/

Bohlen, S. A. (2019, November 19). *Hearing on Reviewing the Broken Promises Report: Examining the Chronic Federal Funding Shortfalls in Indian Country.* National Indian Health Board. https://files.constantcontact.com/a3c45cb9201/fa159631-dd6b-4a2a-a261-4a9d6393e2de.pdf

Brega, A. G., Thomas, J. F., Henderson, W. G., Batliner, T. S., Quissell, D. O., Braun, P. A., Wilson, A., Bryant, L. L., Nadeau, K. J., & Albino, J. (2016). Association of parental health literacy with oral health of Navajo Nation preschoolers. *Health Education Research, 31*(1), 70–81. https://doi.org/10.1093/her/cyv055

Conger, K., Gefeloff, R., & Oppel, R. A. (2021, January 3). Native Americans Feel Devastated by the Virus Yet Overlooked in the Data. *The New York Times.* https://www.nytimes.com/2020/07/30/us/native-americans-coronavirus-data.html

Dartmouth Geisel School of Medicine. (n.d.). *Indian Health Service (USA).* The Center for Health Equity. https://geiselmed.dartmouth.edu/che/programs-partners/indian-health-service-usa/

Deloria, V., & Lytle, C. M. (1984). *The nations within: The past and future of American Indian sovereignty.* Pantheon Books.

Gable, M. (2020, May 26). As Covid-19 tears through Navajo nation, young people step up to protect their elders. *STAT News*. https://www.statnews.com/2020/05/26/navajo-nation-covid-19-youth-response-elders-health/

Guadagnolo, B. A., Huo, J., Buchholz, T. A., Petereit, D. G. (2014) Disparities in hospice utilization among Medicare beneficiaries dying of cancer. *Ethnicity and Disease, 24*(4), 393-398.

Henley, T., & Boshier, M. (2016). The future of Indian health services for Native Americans in the United States: An analysis of policy options and recommendations. *Health Economics, Policy and Law, 11*(4), 397-414.

Indian Health Service Health Literacy Workgroup. (2009). *Indian Health Service: White Paper on Health Literacy*. https://www.ihs.gov/sites/healthcommunications/themes/responsive2017/display_objects/documents/IHSHealthLiteracyWhitePaper.pdf

Indian Health Service. (n.d.). *About IHS*. IHS.gov. https://www.ihs.gov/aboutihs/

Indian Health Service. (n.d.) *IHS Scholarship Programs*. IHS.gov. https://www.ihs.gov/dhps/programperformancedata/scholarship/

Indian Health Service. (2015, January). *IHS Partnerships*. IHS.gov. https://www.ihs.gov/newsroom/factsheets/ihspartnerships/

Indian Health Service. (2019, October). *Disparities*. IHS.gov. https://www.ihs.gov/newsroom/factsheets/disparities/

Indian Health Service (n.d.). *Recruitment and retention*. IHS.gov. https://www.ihs.gov/retention/

Joseph, A., Pratt, B., & Joseph, V. (2019, April). *The National Tribal Budget Formulation Workgroup's recommendations on the Indian Health Service fiscal year 2021 budget*. https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF

Joseph, V. (2017). *Proceedings of the annual convention of the National Congress of American Indians.* National Congress of American Indians. http://www.ncai.org/resources/resolutions/reclassification-of-ihs-budget-to-mandatory-spending-program

Ross, R. E., Garfield, L. D., Brown, D. S., & Raghavan, R. (2015). The Affordable Care Act and implications for health care services for American Indian and Alaska Native individuals. *Journal of Health Care for the Poor and Underserved, 26*(4), 1081-1088.

Sanchez, Y. W. (2020, May 21). *Joe Biden vows more funding for Indian health services.* AZCentral. https://www.azcentral.com/story/news/politics/elections/2020/05/21/presidential-election-2020-joe-biden-increased-funding-indian-health-services/5232306002/

Sequist, T. D., Cullen, T., & Acton, K. J. (2011). Indian Health Service innovations have helped reduce health disparities affecting American Indian and Alaska Native people. *Health Affairs, 30*(10), 1965-1973.

Shah, V. O., Ghahate, D. M., Bobelu, J., Sandy, P., Newman, S., Helitzer, D. L., Faber, T., & Zager, P. (2014). Identifying barriers to healthcare to reduce health disparity in Zuni Indians using focus group conducted by community health workers. *Clinical and Translational Science, 7*(1), 6-11.

Siddons, A. (2018, March 5). *The never-ending crisis at the Indian Health Service*. Roll Call. https://www.rollcall.com/2018/03/05/the-never-ending-crisis-at-the-indian-health-service/

Sofia, M. (Host). (2020, September 28). The CDC Doesn't Know Enough About Coronavirus in Tribal Nations. In *Short Wave.* NPR. https://www.npr.org/transcripts/916824718

Tobey, M., Armstrong, K., & Warne, D. (2020). The 2019 partial government shutdown and its impact on health care for American Indians and Alaska natives. *Journal of Health Care for the Poor and Underserved, 31*(1), 75-80.

Tribal Injury Prevention Cooperative Agreement Program. (2020, March). *TIPCAP News.* Indian Health Service. https://www.ihs.gov/sites/injuryprevention/themes/responsive2017/display_objects/documents/tipcap-newsletters/March2020.pdf

United States Government Accountability Office. (2018). *Indian Health Service: Agency faces ongoing challenges filling provider vacancies*. https://www.gao.gov/assets/700/693940.pdf

U.S. National Library of Medicine. (n.d.). *1868: Fort Laramie Treaty promises to provide health care, services.* Native Voices. https://www.nlm.nih.gov/nativevoices/timeline/619.html#:~:text=A%20treaty%20signed%20at%20Fort,any%20services%20the%20government%20withdraws

Walker, M. (2021, January 3). Pandemic Highlights Deep-Rooted Problems in Indian Health Service. *The New York Times.* https://www.nytimes.com/2020/09/29/us/politics/coronavirus-indian-health-service.html

Westmoreland, T. M., & Watson, K. R. (2006). Redeeming hollow promises: the case for mandatory spending on health care for American Indians and Alaska Natives. *American Journal of Public Health, 96*(4), 600-605.

Wille, S. M., Kemp, K. A., Greenfield, B. L., & Walls, M. L. (2017). Barriers to Healthcare for American Indians Experiencing Homelessness. *Journal of Social Distress and the Homeless*, *26*(1), 1–8.

Wilson, R. T., Adams-Cameron, M., Burhansstipanov, L., Roubidoux, M. A., Cobb, N., Lynch, C. F., Edwards, B. K. (2007). Disparities in breast cancer treatment among American Indian, Hispanic and Non-Hispanic White women enrolled in Medicare. *Journal of Health Care for the Poor and Underserved 18*(3), 648-664.