

Disparities in Native American Health

July 23, 2021

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I have nothing to disclose.

Objectives:

- Understand the differences of the Native American Communities in New Mexico.
- Understand how Native Americans came have health care coverage through the Indian Health Services.
- Recognize the health disparities among Native Americans in New Mexico and the United States compared to other races.
- Understand some of the reasons for health disparities among Native Americans.

- Understand how the Indian Health Service functions.
- Understand where Native Americans get their health care.
- Recognize the ways to address the health disparities in Native American populations.

Introduction:



Native Americans of New Mexico

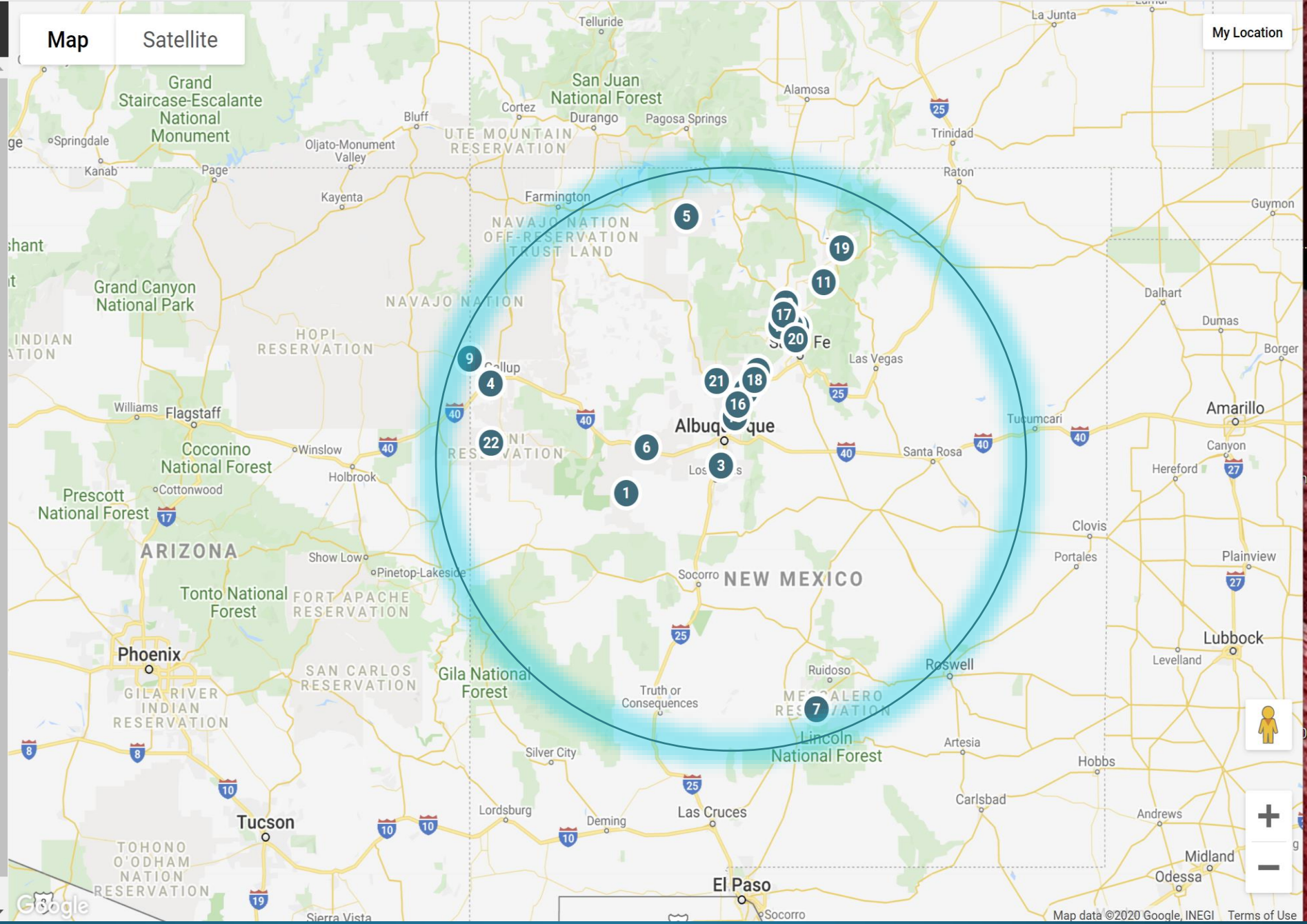
- There are 5 million American Indians in the United States. New Mexico has over 200, 000 Native Americans. 10% of the state's population.
- There are 23 Native American tribes in NM. 19 Pueblos, 3 Apache tribes (Fort Sill, Jicarilla, and Mescalero) and the Navajo Nation (Dine').
- The 19 Pueblos in New Mexico are: Acoma, Cochiti, Isleta, Jemez, Laguna, Nambe, Ohkay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santo Domingo, Taos, Tesuque, Zia and Zuni.
- Ysleta del Sur is in El Paso, TX. They originated from NM.
- Each Tribe has its own government, religion and language.

Native American Communities

☒ Pueblos, Tribes & Nations

- 1 Acoma Pueblo (Sky City)
- 2 Cochiti Pueblo
- 3 Isleta Pueblo
- 4 Jemez Pueblo
- 5 Jicarilla Apache Nation
- 6 Laguna Pueblo
- 7 Mescalero Apache Tribe
- 8 Nambe Pueblo
- 9 Navajo Nation (Dineh)
- 10 Ohkay Owingeh Pueblo
- 11 Picuris Pueblo
- 12 Pojoaque Pueblo
- 13 Sandia Pueblo
- 14 San Felipe Pueblo
- 15 San Ildefonso Pueblo
- 16 Santa Ana Pueblo
- 17 Santa Clara Pueblo
- 18 Santo Domingo Pueblo
- 19 Taos Pueblo
- 20 Tesuque Pueblo
- 21 Zia Pueblo
- 22 Zuni Pueblo

Hide



How do we address Native Americans?

In 1995 the Census Bureau polled indigenous people and the results were as follows:

- 49% preferred American Indian
- 37% preferred Native American
- 3.6% said “some other name”
- 5% had no preference
- The name used in legal documents in the United States is American Indian.
- Christina Berry (Cherokee) wrote an essay called “*What’s in a name? Indians and political correctness*”. She likens grouping indigenous people to grouping Europeans. Romanians and Irishmen are both European but the history, culture and language are all different.. BUT they are all European.

Which do we use?

Ask

- The person you ask will tell you.
- Some tribes also have different names for themselves. For example, the Navajo call themselves the Dine'.
- I will be using **American Indian** and **Native American** in this presentation.

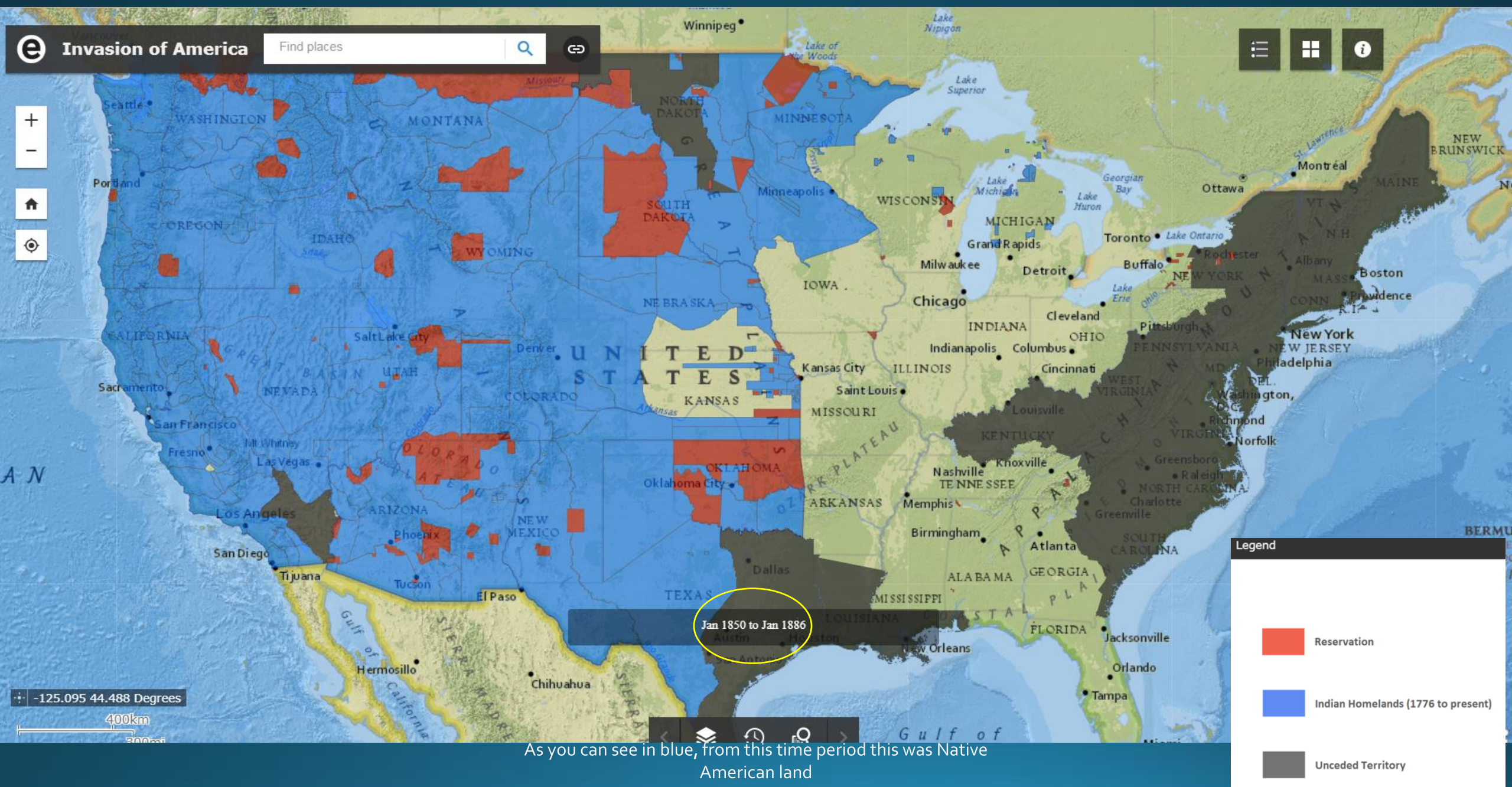
Why do the Native Americans live on Reservations?

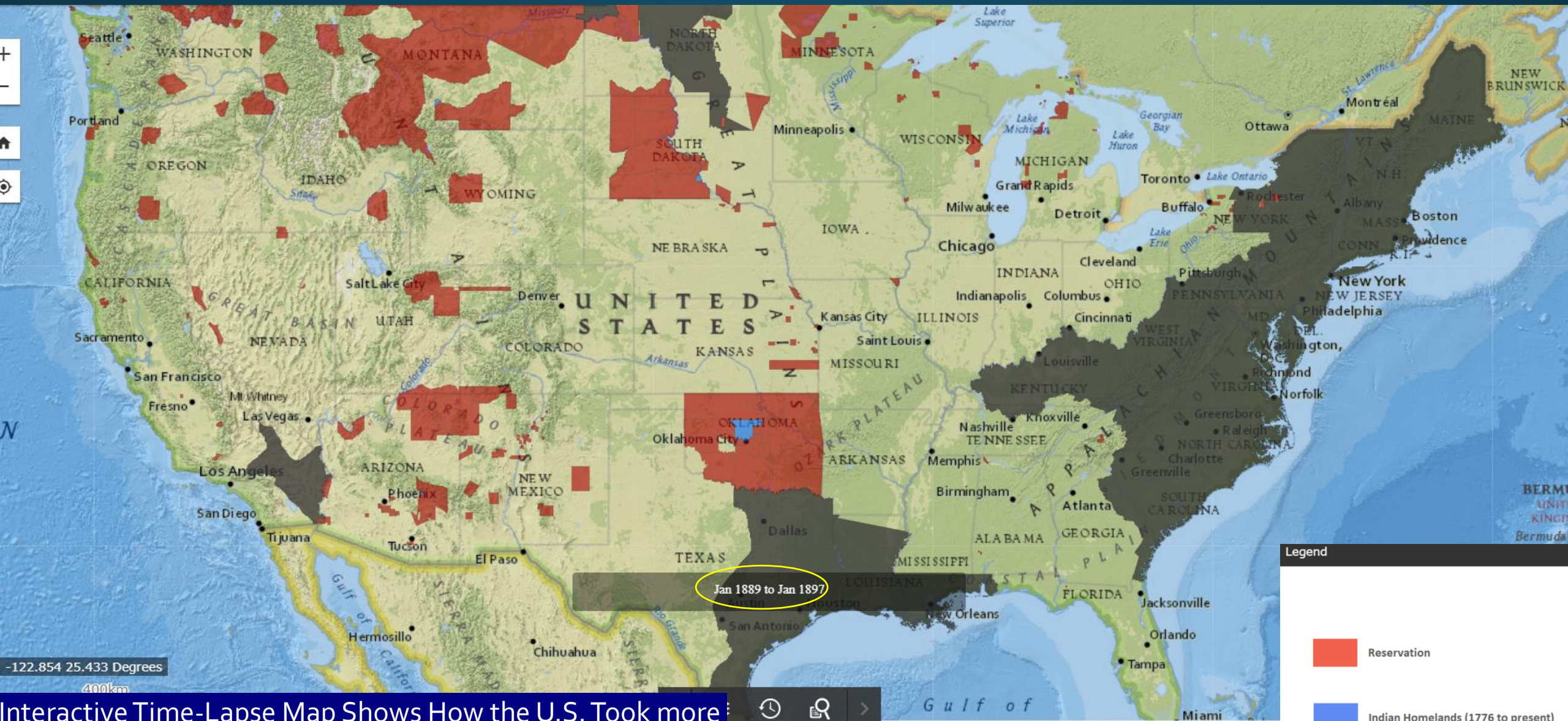
- What are reservations?

- It is land **reserved** for and managed by Native American tribes. The tribes are **sovereign** nations. They have their own governments and are able to negotiate with the Federal government.
- In NM the pueblo tribes were able to stay on their **ancestral lands** (although they were reduced in size).
- The Navajo and Apache also were able to stay mostly on the lands they lived on historically , but as opposed to the Pueblo who stayed and lived in one area, the **Navajo and Apache** were **nomadic** people and roamed various areas in the Southwest.
- In other parts of the country Native Americans were not as fortunate. In the East, and the South the Native Americans were **forcibly removed** from their tribal lands by the federal government after a series of legislation including **The Indian Removal Act** signed by President Andrew Jackson in **1830**.
- (Can watch *How the Brutal Trail of Tears got its Name* <https://www.youtube.com/watch?v=SosZ2ZRJymU>).

- Throughout this period the federal government continued to subject the Native Americans to **annihilation of their culture**. Boarding school was mandated to indoctrinate children into white culture. They were forbidden from speaking tribal languages and required to wear American-style dress.
- The **Dawes Act of 1887** further tried to assimilate Native Americans by supporting the American ideal of **individual** land ownership. This allowed individual Native Americans to own the tribal lands. Tribal lands were sold off. Nearly **2/3 of reservation lands** were taken from tribes and given to settlers. It also changed many tribal member status to individuals and termination of tribal affiliations.
- Native Americans who lost their affiliation were no longer eligible for health care or education from the federal government.







Interactive Time-Lapse Map Shows How the U.S. Took more than 1.5 billion Acres from Native Americans By Rebecca Onion and Claudio Saunt

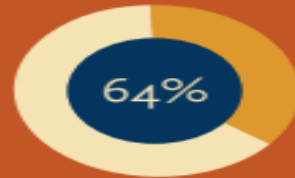
INDIAN HEALTH SERVICE³⁹



APPROXIMATELY
2.56 Million

American Indians and Alaska Natives are served by the IHS, which operates a comprehensive health service delivery system.

The majority of those who receive IHS services live primarily on reservations and in rural communities in 37 states, mostly in the western United States and Alaska.



Percentage of
IHS service area
population
residing in
tribal areas

The IHS funds 41 urban Indian health organizations, which operate at sites located in cities throughout the United States.⁴⁰



600,000

Approximately 600,000 American Indians and Alaska Natives are eligible for programs in urban clinics.⁴¹

National Congress of American Indians

TRIBAL TRUST LANDS³¹

There are approximately 334 Indian land areas in the United States administered as federal Indian reservations (i.e., reservations, pueblos, rancherias, missions, villages, communities, etc.).

Through the Dawes Act, the federal government forcibly converted communally held tribal lands into small parcels for individual ownership, most often without compensation to the tribal nations. In addition, the Termination Era of the 1940s and 1950s resulted in the loss of huge amounts of reservation land.



Nearly $\frac{2}{3}$ of reservation lands were taken from tribal nations and given to settlers as a result of the General Allotment Act of 1887.

90M

ACRES IN THE
CONTINENTAL
UNITED STATES
TAKEN BY THE U.S.
GOVERNMENT
BETWEEN 1887 AND 1934

56
MILLION

ACRES CURRENTLY HELD
IN TRUST BY THE FEDERAL
GOVERNMENT FOR VARIOUS
TRIBAL NATIONS AND
INDIVIDUALS

Federal Indian Reservations

There are three types of reserved federal lands in the U.S.: military, public, and Indian.

A federal Indian reservation is defined by the U.S. Department of the Interior as “an area of land reserved for a tribe or tribes under treaty or other agreement with the United States, executive order, or federal statute or administrative action as permanent tribal homelands, and where the federal government holds title to the land in trust on behalf of the tribe.”

The ways in which reservations were determined vary; some include a tribal nation’s original land base, while other reservations were established by the federal government to resettle Native people forcibly removed from original homelands and areas. Not all federally recognized tribal nations have a reservation. A number of states have established reservations for state-recognized tribal nations.

Debunking Common Myths

Does the federal government pay all health care, housing, and college tuition for individual Indians?

Generally, no. The federal government provides basic health care for many Indian people through the Indian Health Service (IHS). Unfortunately, these health programs have been inadequately funded for many decades, and Indian people have the worst health status of any group in the country. The Department of Housing and Urban Development provides some housing, but Native people have the highest rates of homelessness and overcrowding. The federal government also provides some educational assistance to tribal colleges, but investments often lag behind those provided to other Americans. Higher education generally is not provided and remains beyond the reach of many Native people.

Do all tribal citizens receive free money from the federal government?

Tribal citizens do not receive free money from the federal government. Some tribal citizens receive distributions of money derived from land claim settlements or income generated from the sale, development, and/or use of trust lands.

Aren’t per capita distributions “free money?”

Per capita distributions from tribal enterprise or claims settlements with the U.S. government represent the tribal nation’s decision to redistribute tribal revenue (ordinarily generated from a tribal business) through individual payments to every tribal member.

Background:



Why does the federal government cover health care for the Native Americans?

- Through a series of treaties with the federal government (367 were ratified between 1778 and 1868), a guarantee of **health care** and **education** for all American Indians was negotiated in exchange for peace and tribal lands. **Over 400 million acres of tribal land were ceded to the United States.**
- There were however problems with the funding of this guarantee from the beginning. The **IHS** has never operated on a full budget. They operate at about **50%** of what their budget should be to provide adequate care to Native American patients.

There are about 5 million Native Americans in the United States

- The IHS only covers 2.5 million. The others live away from Reservations and in urban areas. Many Native Americans in urban areas do not have access to urban centers covered by the IHS.
- The IHS has never been fully funded.
- The uninsured American Indian population was 36% in 2008. After the affordable care act and exchanges and Medicaid expansion (which NM took) the rate went down to 28% in 2015.
- NM Medicaid covers nearly 40% of the state's population(2 million people in NM). About 800,000 on Medicaid.

What does the Indian Health Service Cover?

- Does not cover ALL health care. It is only a **service provider**. It is **NOT** an insurance coverage.
- Many service areas are severely underfunded, so care is provided as **life-saving care first**. If there are remaining funds, then preventative care services take place.
- Once funding runs out for the year, services are over.

10 Important Facts about Indian Health Service and Health Insurance

For American Indians and Alaska Natives

Why your Indian health benefits may not be enough



FACT #1: IHS is not health insurance

The Indian Health Service (IHS) is a part of the federal government that delivers health care to American Indians and Alaska Natives (AI/ANs) and provides funds for tribal and urban Indian health programs. Health insurance, on the other hand, pays for health care covered by your plan. It protects you from paying the full costs of medical services when you are injured or sick and pays for services to prevent you from becoming ill.



FACT #2: Even people eligible for IHS need insurance

Health insurance covers many things Indian health care programs do not provide. With health insurance, you can:

- Get in to see specialists
- Get health care for covered services without IHS Purchase Referred Care authorization
- Get health care when you are away from home

FACT #10: Even though health care is a treaty right, you should still get insurance

IHS has to work within yearly budgets approved by Congress and does not receive enough funds to meet all the health needs of American Indians and Alaska Natives. That is why IHS does not offer certain services and why some services aren't available at certain times of year. In fact, the IHS budget only meets about half of the need, so enrollment in health insurance helps expand needed care. And with insurance, health care is available when you need it.

Signing up for the Marketplace or Medicaid is easy and affordable

The Health Insurance Marketplace is a resource where you can learn about options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in a Qualified Health Plan. You can apply for the Marketplace or Medicaid through healthcare.gov call centers and in-person assistance.

- Ask for help from your Indian health program,
- Call 1-800-318-2596, or
- Go online to healthcare.gov/tribal



HealthCare.gov



@CMSGov



#CMSNativeHealth



IHS Profile

Based on 2000-2016 data -- Numbers are approximate

- **The Indian Health Care System:**

- **Indian Health Service (IHS) direct health care services**

IHS services are administered through a system of 12 Area offices and 170 IHS and tribally managed service units.

- **Tribally operated health care services**

Titles I and V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), provide Tribes the option of exercising their right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1992, the IHS has entered into agreements with tribes and tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, over sixty percent of the IHS appropriation is administered by Tribes, primarily through self-determination contracts or self-governance compacts.

- **Urban Indian health care services and resource centers**

There are 34 urban programs that provide services ranging from community health to comprehensive primary health care.

- **Per Capita Personal Health Care Expenditures Comparison:**

- FY 2015 IHS expenditure on user population: \$3,688
 - Total CY 2014 U.S. population expenditure: \$9,523

- **Population Served:**

- Members of 573 federally recognized Tribes
 - 2.2 million American Indians and Alaska Natives

- **Annual Patient Services (Tribal and IHS facilities):**

- Inpatient Admissions: 39,305
 - Outpatient visits: 13,742,078

- **Appropriations:**

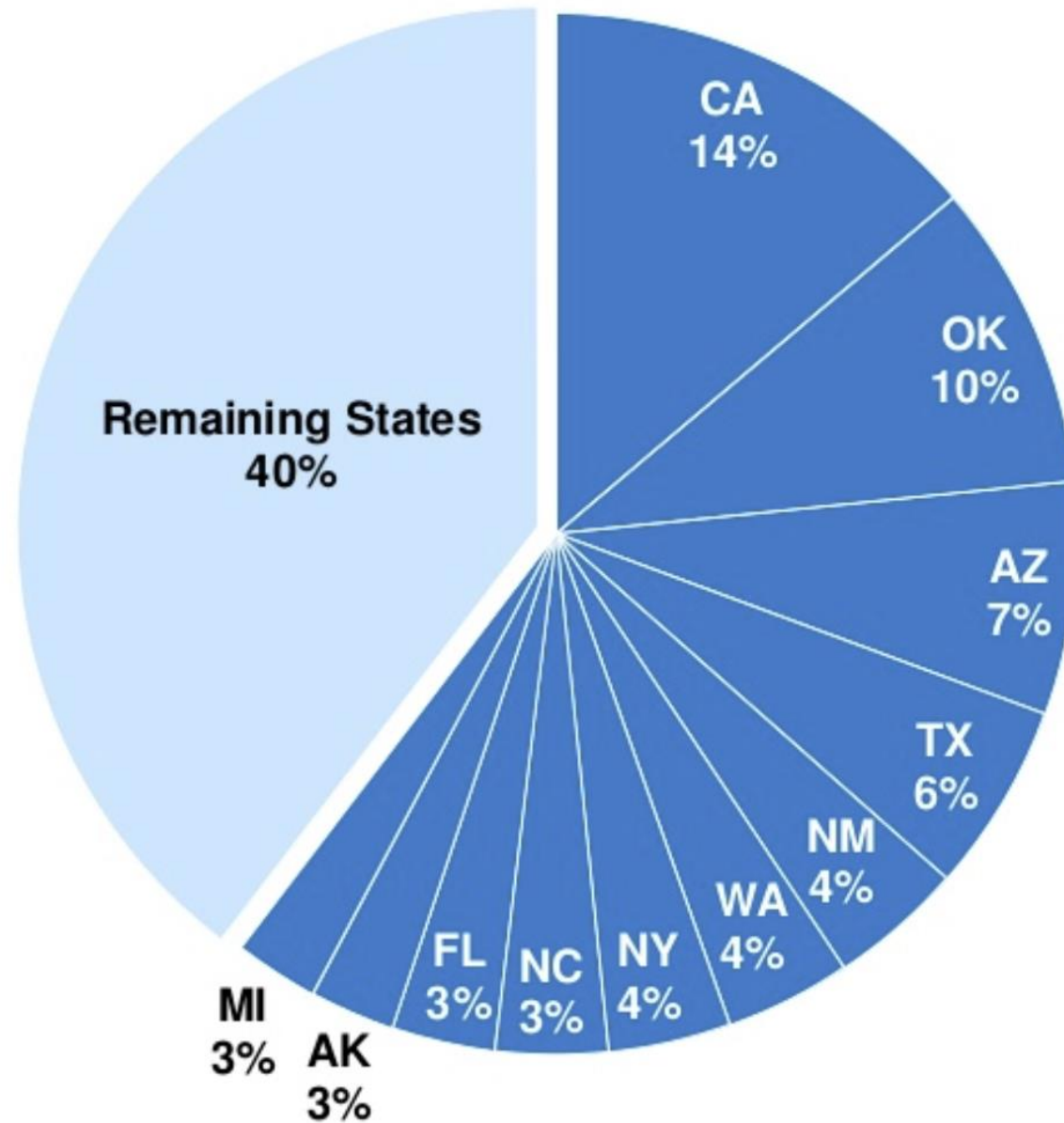
- FY 2014 IHS budget appropriation: \$4.4 billion
 - FY 2015 IHS budget appropriation: \$4.6 billion
 - FY 2016 IHS budget appropriation: \$4.8 billion

Native American Health Care

- Where do the majority of Native Americans get their health care?
- Where do the majority of Native Americans live?

states. The majority of AIANs live outside of tribal areas.

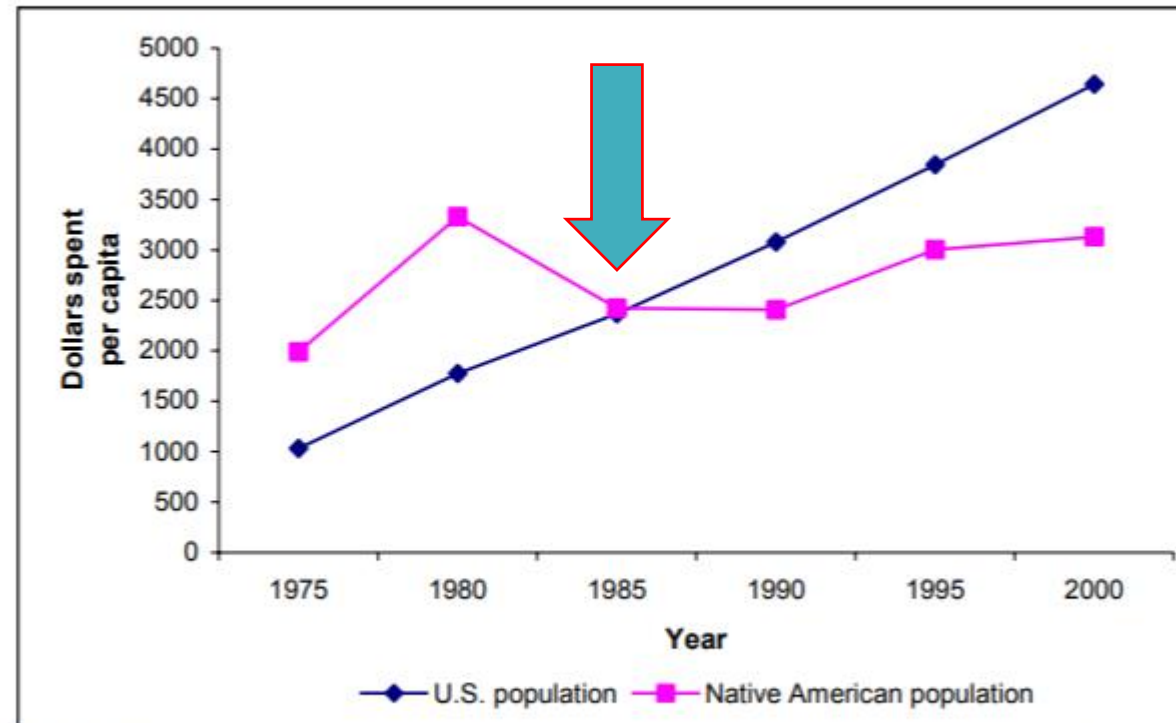
SHARE OF AIAN POPULATION BY STATE, 2017



- When Urban Native Americans have Medicaid, they can get health care in any facility that takes it and can even get preventative care.
- The federal government spends 50 percent less for Native American health care than Medicaid or for federal prisoners and 60% less than the average American.

FIGURE 1.2

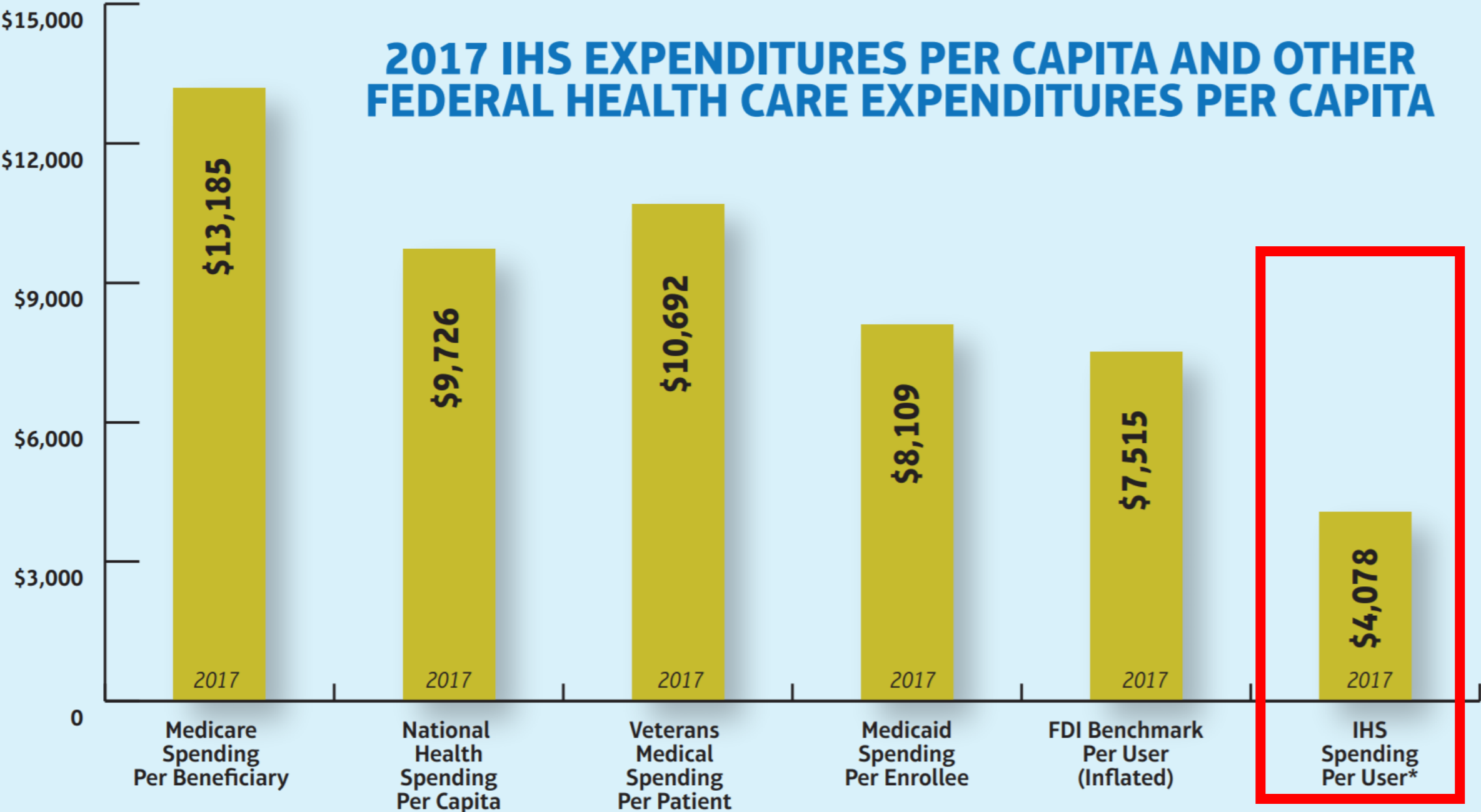
Per Capita Government Expenditures, U.S. Population vs. Native American Population, 1975–2000, in Current Dollars



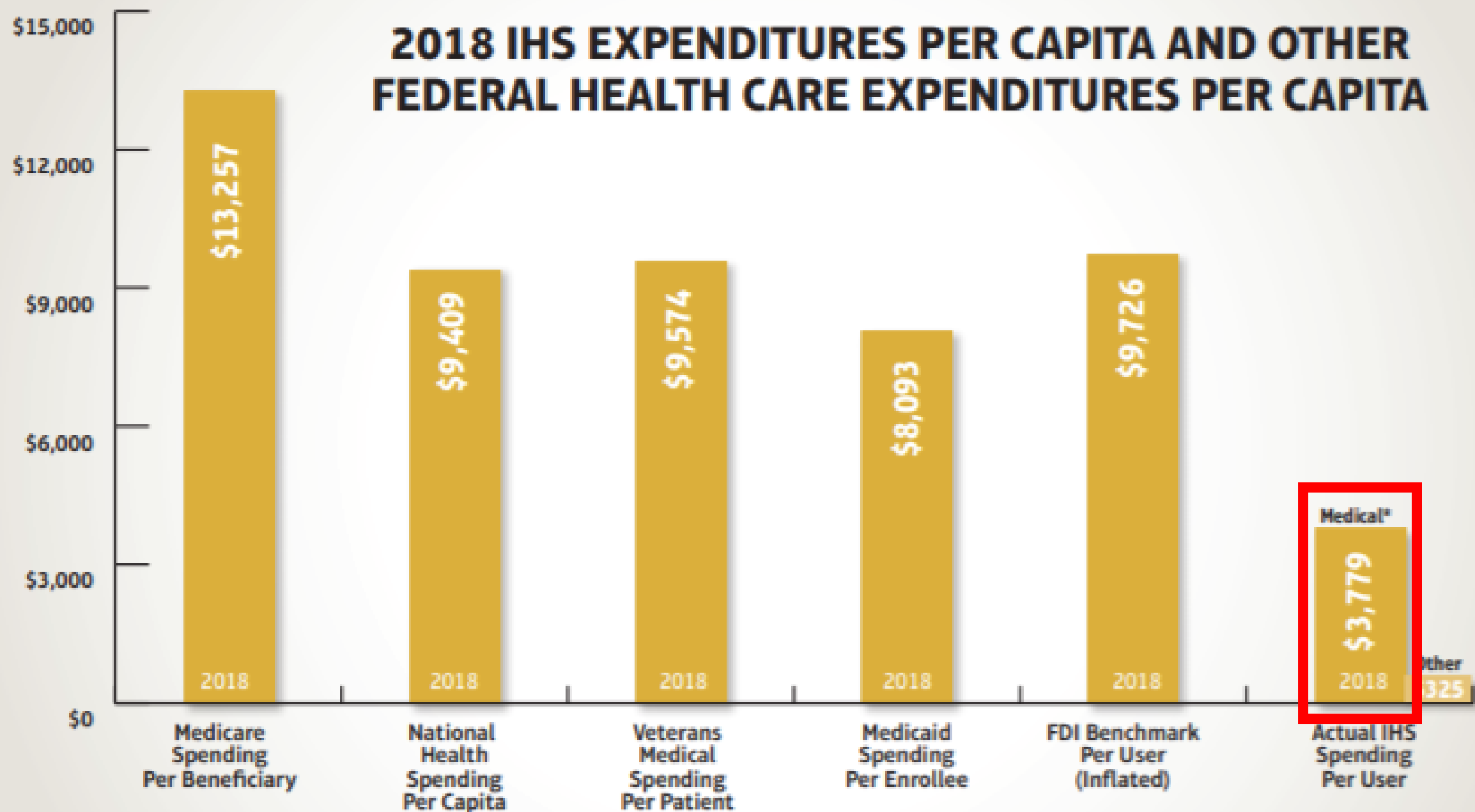
Note: Data used for this analysis compare funding for major Indian-related programs and federal non-defense funding.

Source: Roger Walke, specialist in American Indian policy, Domestic Social Policy Division, Congressional Research Service, memorandum to the Senate Committee on Indian Affairs, Mar. 1, 2000, re: Indian-related federal spending trends, 1975–2001, appendix, table 1.

2017 IHS EXPENDITURES PER CAPITA AND OTHER FEDERAL HEALTH CARE EXPENDITURES PER CAPITA



2018 IHS EXPENDITURES PER CAPITA AND OTHER FEDERAL HEALTH CARE EXPENDITURES PER CAPITA



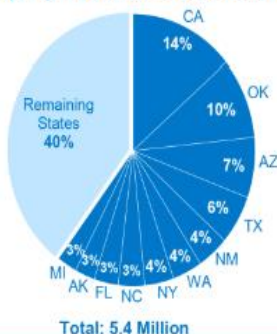
HEALTH AND HEALTH CARE FOR AMERICAN INDIANS AND ALASKA NATIVES (AIANS) IN THE UNITED STATES

As of 2017, over **5M** people or **2%** of the U.S. population identified as AIAN alone or in combination with another race.



Under treaties and laws, the U.S. has a unique responsibility to provide certain rights, protections, and services to AIANs, including health care.

AIANs live across the United States, but 60% reside in 11 states. The majority of AIANs live outside of tribal areas.



Compared to Whites, AIANs are...

YOUNGER



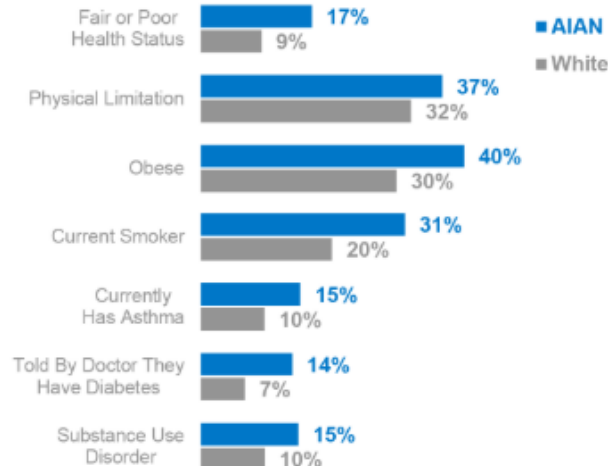
MORE LIKELY TO BE POOR



LESS LIKELY TO HAVE A FULL-TIME WORKER IN THE FAMILY



Nonelderly adult (18-64) AIANs fare worse than Whites across many health measures.



Although the Indian Health Service (IHS) provides services to AIANs, health coverage is important for AIANs.



IHS is the primary vehicle through which the federal government provides health services to AIANs.

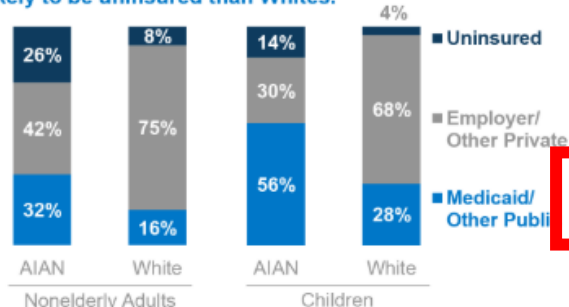


IHS has historically been underfunded to meet the health care needs of AIANs.



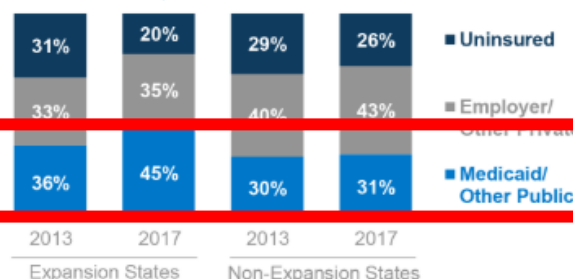
Enrolling AIANs in health coverage, including Medicaid or Marketplace coverage, expands their access to services and increases revenues to IHS and Tribal facilities.

Medicaid and CHIP help fill gaps in private coverage for AIANs, particularly AIAN children, but they remain more likely to be uninsured than Whites.



AIANs have gained coverage under the ACA, with larger increases in states that expanded Medicaid.

HEALTH INSURANCE COVERAGE FOR NONELDERLY AIANS BY EXPANSION STATUS, 2013-2017



Source: Original source information and data are available at: <https://kff.org/infographic/health-and-health-care-in-the-u-s-by-race-and-ethnicity>.

kff.org / Email Alerts: kff.org/email / facebook.com/KaiserFamilyFoundation / twitter.com/KaiserFamFound

Filling the need for trusted information on national health issues, the Kaiser Family Foundation is a nonprofit organization based in San Francisco, California.

KFF
HENRY J KAISER
FAMILY FOUNDATION

National Indian Health Board

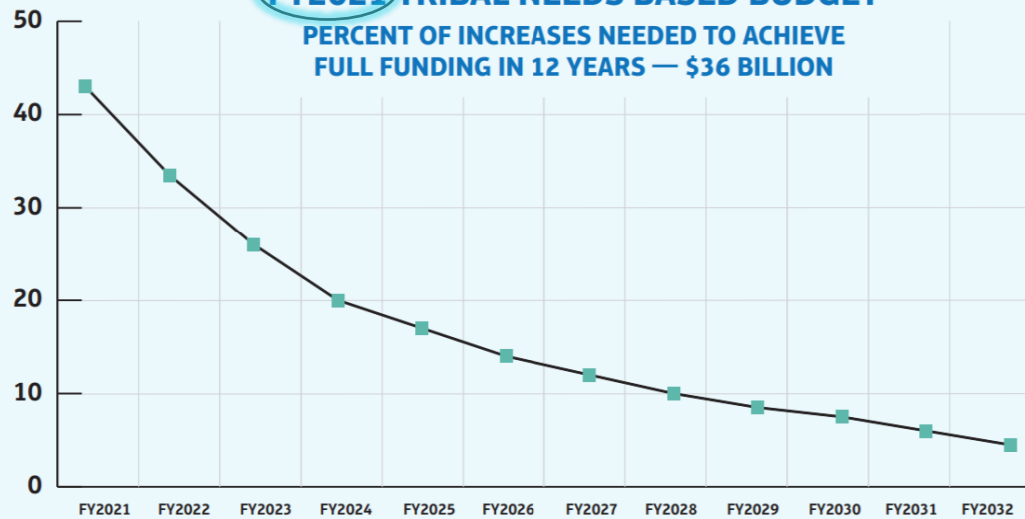
Recommendations:

- Provides recommendations for annual federal budget formulation cycle via the **IHS Tribal Budget Formulation Workgroup (TBFWG)** **Represents the 12 IHS areas**. This group makes recommendations to the IHS on tribal budget priorities.
- Recommendations for 2021:
- Urge administration to take immediate action to address unfulfilled Trust and Treaty obligations with Tribal Nations.
- End unacceptable health disparities and urgent life-safety issues at IHS and Tribal Health facilities.
- Implement a budget which fully funds the IHS at **\$48 billion**

1st Recommendation

Fully Fund IHS at \$37.6 Billion Phased In Over 12 Years

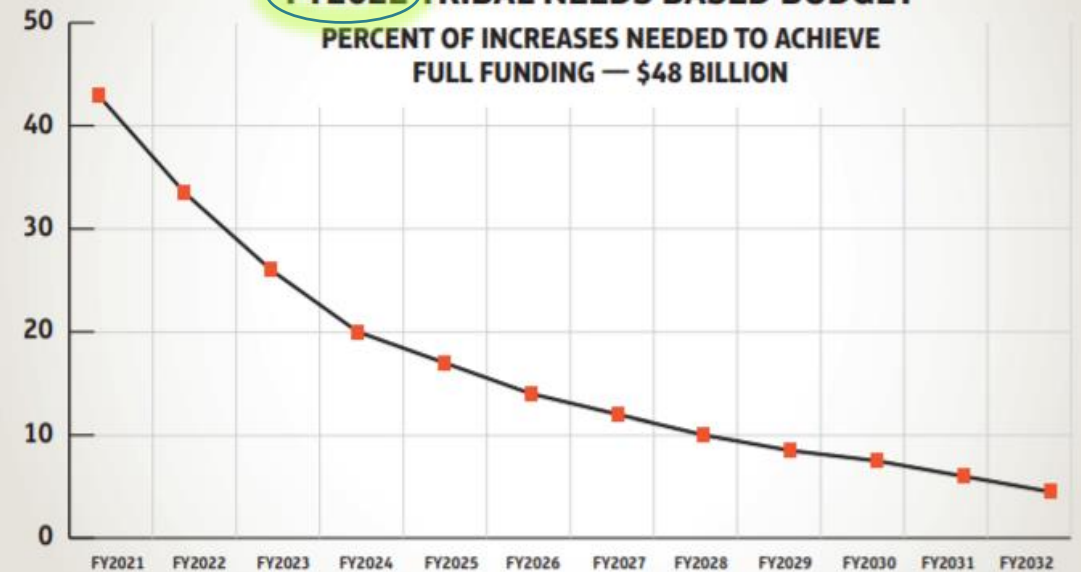
FY2021 TRIBAL NEEDS BASED BUDGET
PERCENT OF INCREASES NEEDED TO ACHIEVE
FULL FUNDING IN 12 YEARS — \$36 BILLION



1st Recommendation

Fully Fund IHS at \$48 Billion

FY2022 TRIBAL NEEDS BASED BUDGET
PERCENT OF INCREASES NEEDED TO ACHIEVE
FULL FUNDING — \$48 BILLION



Over-all there are 9 recommendations

What did we learn about the causes of disparities in the pandemic?

AMERICAN INDIANS

Economic



-\$20,000

Median household income is \$20,000 lower for American Indians than for White households

-\$4.4 billion

A 6-week shutdown of casinos in early March led to an estimated loss of over \$4.4 billion in economic activity

The Doctrine of Discovery was used to colonize and control lands occupied by American Indians and continues to impact land ownership and wealth

Social & Built Environment



Native Americans are more likely to live in multi-generational households



In the Navajo Nation:

1 in 3

residents do not have access to electricity



1 in 3

residents do not have access to running water

Lower broadband & technology access has impacted access to COVID-19 information & health care

Health

Native Americans have higher rates of *diabetes, obesity & heart disease*

23% of American Indian & Alaska
Native adults are smokers
compared to **14%** of the general population

23%

14%



*Those living on tribal lands
sometimes have to drive hours
to get to a health care facility*



*Unrecognized tribes did
not receive federal
COVID-19 aid*

Social & Built Environment



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1 in 3

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1 in 3

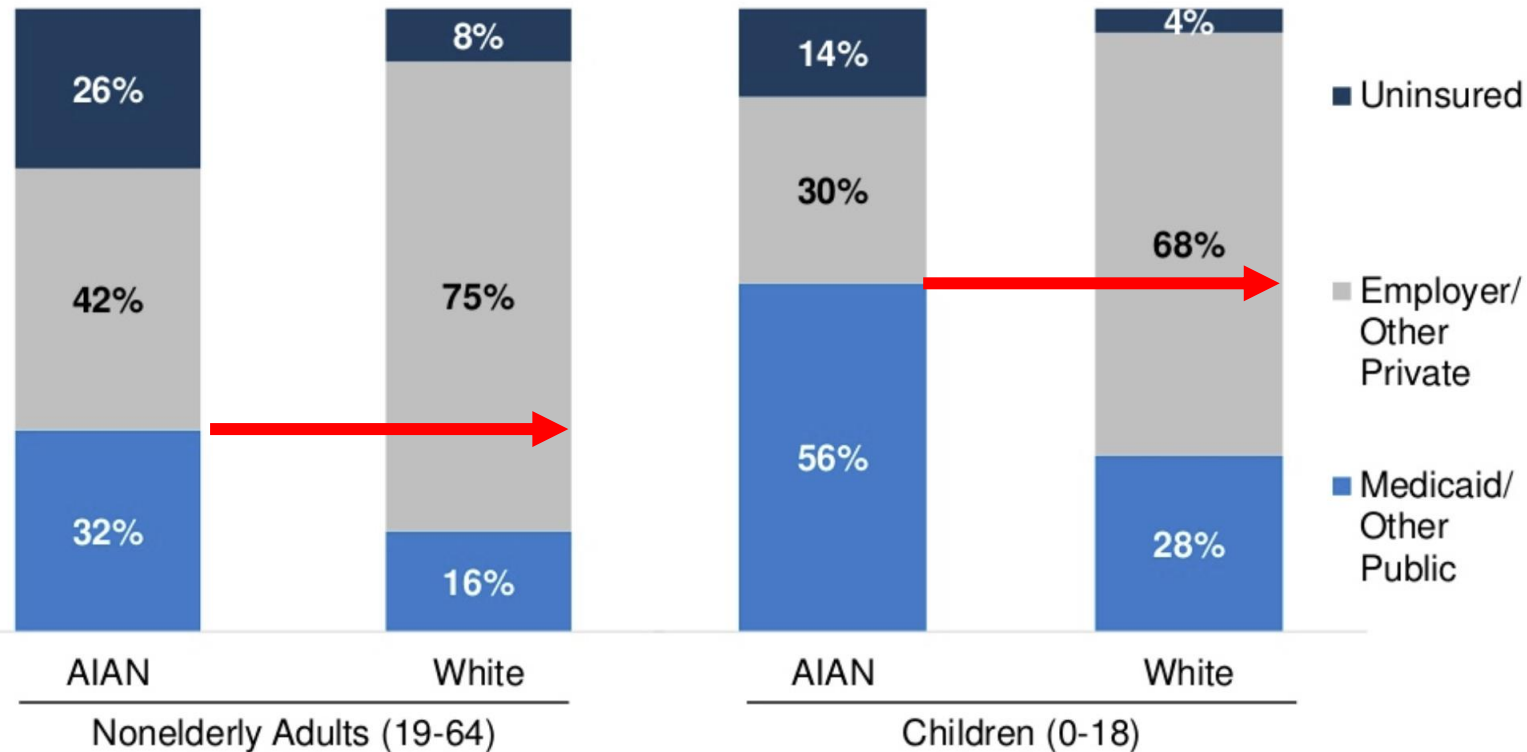
residents do not have
access to running water

*Lower broadband & technology access has impacted access to
COVID-19 information & health care*

- Poor economic conditions on reservations have forced many to relocate. The “Urban Indians” are also at risk of living in poverty and having poor health status.
- IHS funds 34 urban health centers. 605, 000 are eligible to use these facilities (Remember there are 2.5 million not in IHS covered areas) and **therefore not all Native Americans are covered with these services.**

Figure 6

Medicaid and CHIP help fill gaps in private coverage for AIANs, particularly AIAN children, but they remain more likely to be uninsured than Whites.



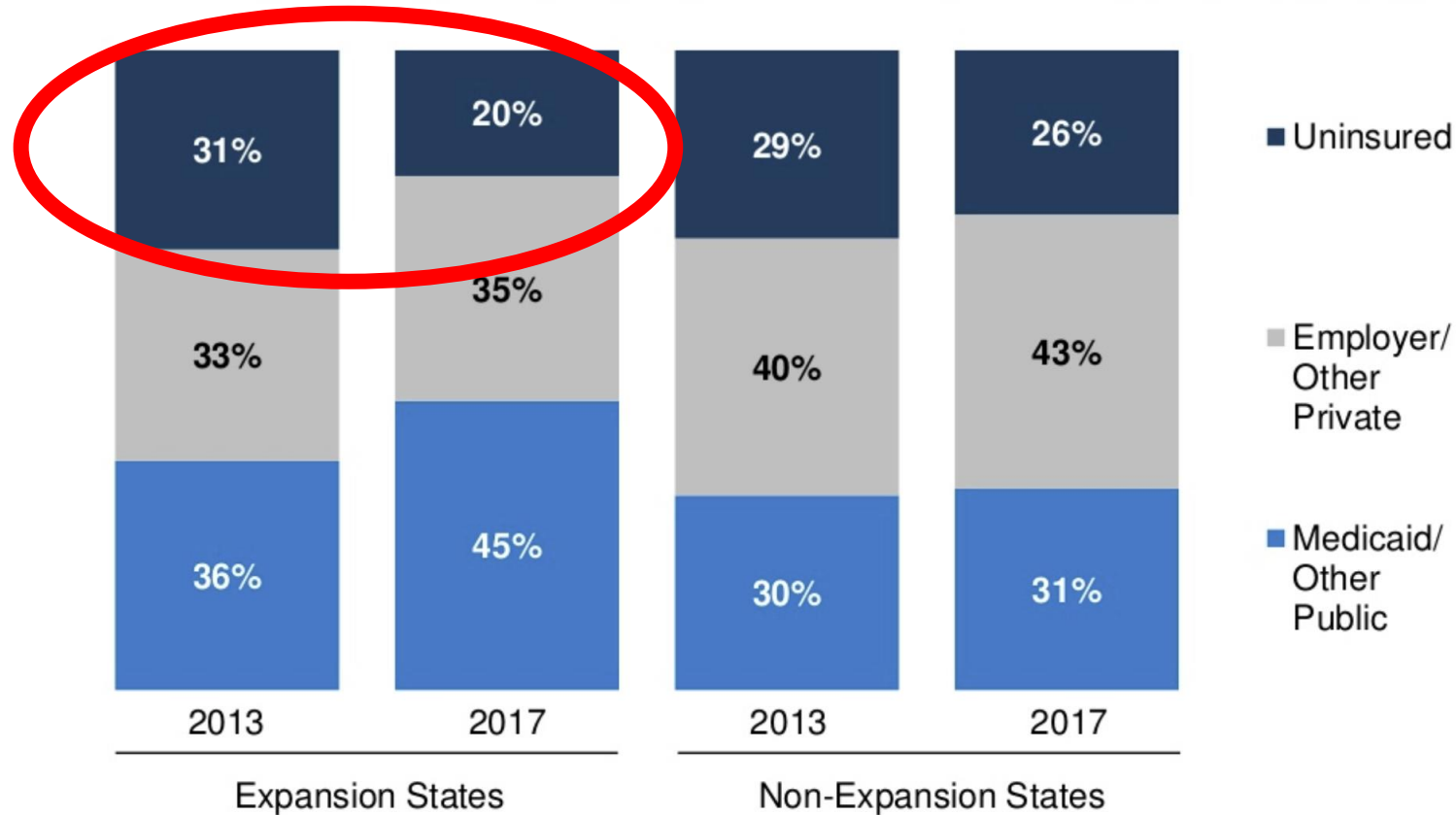
Note: AIANs and Whites are non-Hispanic. Excludes individuals of mixed race. Includes nonelderly adults 19-64 years of age and children 0-18 years of age. Totals may not sum to 100% due to rounding. All values have a statistically significant difference from the White population at the $p < 0.05$ level.

Source: Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.

Figure 7

AIANs have **Gained Coverage** Under the Affordable Care Act, with Larger Increases in States that Expanded Medicaid.

HEALTH INSURANCE COVERAGE FOR NONELDERLY AIANs BY EXPANSION STATUS, 2013 & 2017



Note: AIANs are non-Hispanic. Excludes individuals of mixed race. Includes nonelderly individuals 0-64 years of age.
Source: Kaiser Family Foundation analysis of the 2013 & 2017 American Community Survey (ACS), 1-Year Estimates.

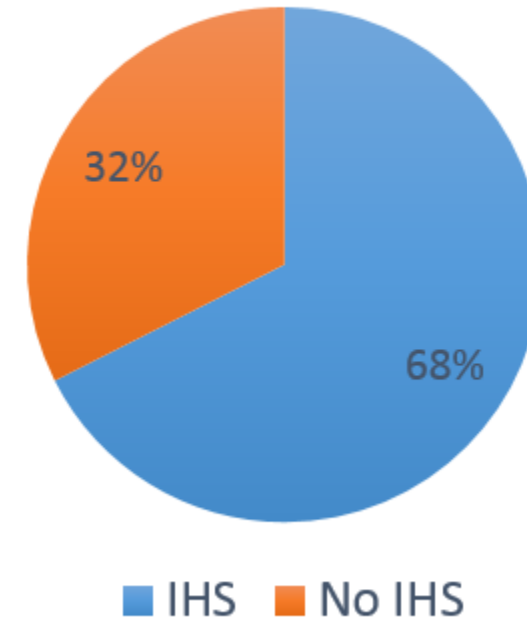
American Indian and Alaska Native Population 2012 and 2016	
2012	2016
217,755	221,075

American Indian and Alaska Native Uninsured 2012 and 2016	
2012	2016
74,010	43,798

Uninsured Rate 2012 and 2016	
2012	2016
34%	20%

Medicaid Enrollment 2012 and 2016	
2012	2016
70,676	103,280

2016 Total Medicaid



NEW MEXICO MEDICAID COVERAGE FOR AMERICAN INDIANS AND ALASKA NATIVES: THE IMPACT OF THE AFFORDABLE CARE ACT 2012-2016



Public Law 93-580
93rd Congress, S. J. Res. 133
January 2, 1975

Joint Resolution

To provide for the establishment of the American Indian Policy Review Commission.

CONGRESSIONAL FINDINGS

The Congress, after careful review of the Federal Government's historical and special legal relationship with American Indian people, finds that—

(a) the policy implementing this relationship has shifted and changed with changing administrations and passing years, without apparent rational design and without a consistent goal to achieve Indian self-sufficiency;

(b) there has been no general comprehensive review of conduct of Indian affairs by the United States nor a coherent investigation of the many problems and issues involved in the conduct of Indian affairs since the 1928 Meriam Report conducted by the Institute for Government Research; and

(c) in carrying out its responsibilities under its plenary power over Indian affairs, it is imperative that the Congress now cause such a comprehensive review of Indian affairs to be conducted.

25 USC 174
note.

American Indian Policy Review Commission

6

INDIAN HEALTH

Statement:

Health of Indian people is significantly below the United States population. Most federal, state and local agencies are unresponsive to our needs.

Support (Special Reports):

Hearings Review.

Review of the Reservations Questionnaire

Recommendations:

1. Establish a free Basic Health Care Guarantee for all our people to counter the existing "crisis" oriented health care system.
2. Establish a disease-prevention system.
3. Improve environmental health protection, mental health, nutrition, accident prevention, transportation and accessibility, social services, self-determination, training and technical assistance.
4. Create an Indian Agency, funded by Federal monies and operating on the cabinet level.
5. The tri-agency agreement between BIA, HUD and IHS in the area of environmental services is not functional and must be redesigned.
6. The Food Stamp Program must be improved to handle the problems of a lack of knowledge of money management and the high price of food on reservations.
7. USDA surplus commodities food program must be upgraded, and food quality must be improved.
8. A unique day care program must be established for women, infants, children and the elderly.
9. Preventive accident/safety programs need to be strengthened. The National Red Cross must

teach first aid and safety to our people as they do other Americans.

10. We must have guarantees of Medicare and Medicaid.

11. A National Mental Health Center must be set up to study our mental health problems.

12. We require management training to manage health care.

13. Legislation giving tribal authority over the IHS is essential.

14. Legislation creating an Indian health agency to specifically include Nutrition, Mental Health, Data collection and a training center for professionals and paraprofessionals must be enacted.

The Indian Health Task Force has compiled "conclusive evidence" to show that the health level of Indians is significantly

14

below the level of health of the general United States population.

Major problem areas in the Indian health field are:

1. Inadequate policy to solve the problem of Indian health.
2. Lack of adequate appropriations to implement whatever policy exists.
3. Lack of adequate and strong mechanisms for the delivery of health care.
4. Lack of oversight and accountability at all levels of the Indian Health Service (IHS).

The Task Force has developed a set of basic remedies and recommendations to be submitted to Congress. They are as follows:

1. Development of a "Basic Health Care Guarantee" to guarantee health care to any Indian.
2. Making available supplementary benefits to insure the prevention of health problems and assist Indian tribes. Specifically, more services are needed in environmental health protection, preventative and outreach mental health, nutrition, accident prevention, transportation and accessibility, social services, training and technical assistance.
3. The Health Task Force has concluded that most federal, state and local agencies are not responsive to the needs of Indians. In order to consolidate all the services and make the delivery system more responsive, an Indian agency funded by federal monies and operating on the Cabinet level should be created.

This was 1975. Many government reports over 100 years have been reporting the same thing.

What health problems are the most pressing in the Native American population?

- The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

MORTALITY DISPARITY RATES

American Indians and Alaska Natives (AI/AN) in the IHS Service Area

2009-2011 and U.S. All Races 2010
(Age-adjusted mortality rates per 100,000 population)

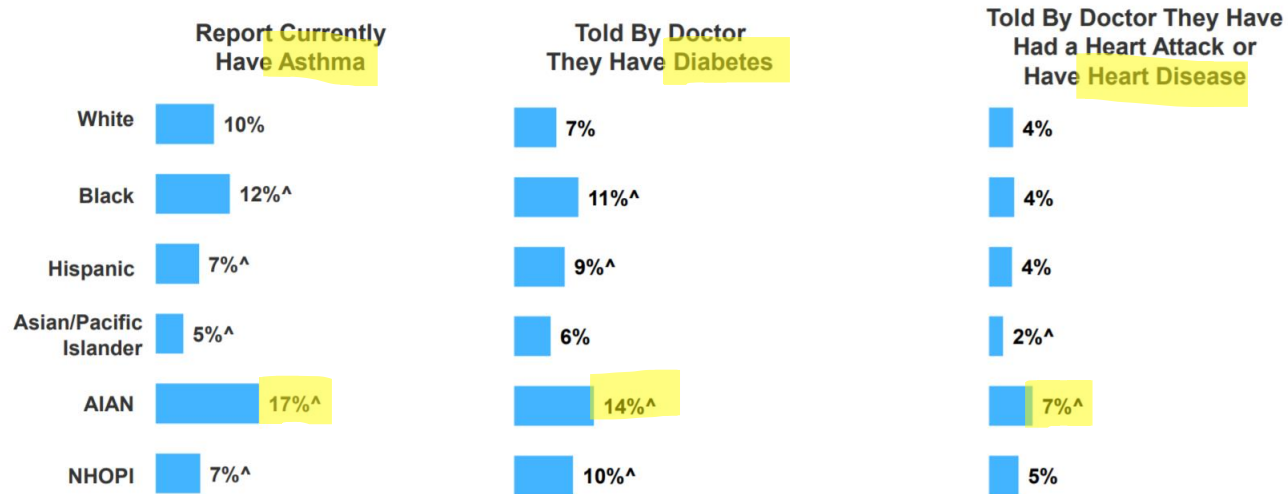
	AI/AN Rate 2009-2011	U.S. All Races Rate – 2010	Ratio: AI/AN to U.S. All Races
ALL CAUSES*	999.1	747.0	1.3
Diseases of the heart (heart disease)	194.1	179.1	1.1
Malignant neoplasm (cancer)	178.4	172.8	1.0
Accidents (unintentional injuries)*	93.7	38.0	2.5
Diabetes mellitus (diabetes)	66.0	20.8	3.2
Alcohol-induced	50.5	7.6	6.6
Chronic lower respiratory diseases	46.6	42.2	1.1
Cerebrovascular disease (stroke)	43.6	39.1	1.1
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Influenza and pneumonia	26.6	15.1	1.8
Drug-induced	23.4	12.9	1.8
Nephritis, nephrotic syndrome (kidney disease)	22.4	15.3	1.5
Intentional self-harm (suicide)	20.4	12.1	1.7
Alzheimer's disease	18.3	25.1	0.7
Septicemia	17.3	10.6	1.6
Assault (homicide)	11.4	5.4	2.1
Essential hypertension diseases	9.0	8.0	1.1

* Unintentional injuries include motor vehicle crashes.

NOTE: Rates are adjusted to compensate for misreporting of American Indian and Alaska Native race on state death certificates. American Indian and Alaska Native age-adjusted death rate columns present data for the 3-year period specified. U.S. All Races columns present data for a one-year period. Rates are based on American Indian and Alaska Native alone; 2010 census with bridged-race categories.

Figure 31

Percent of Nonelderly Adults with Selected Health Conditions by Race/Ethnicity, 2018

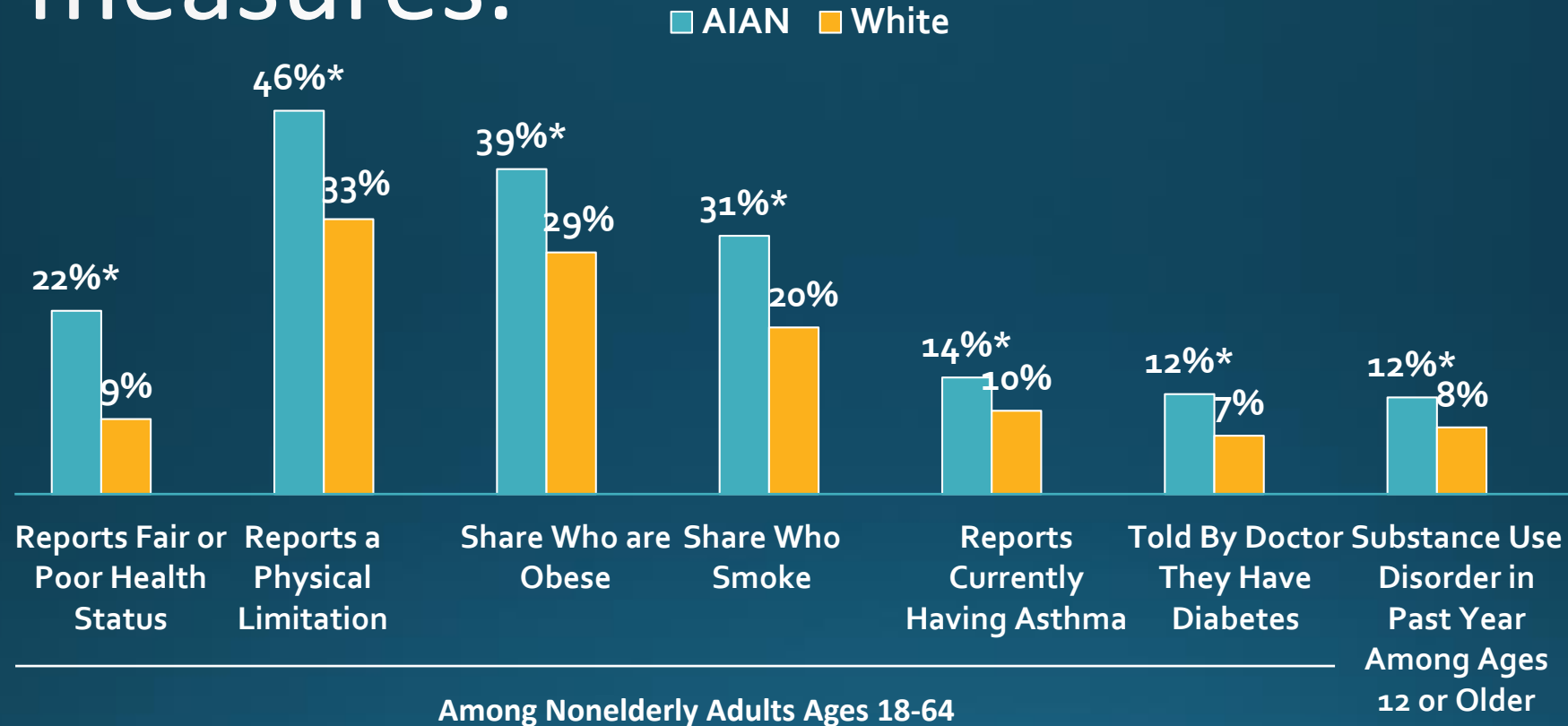


^ Indicates statistically significant difference from Whites in the respective year at the $p < 0.05$ level.

Note: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly adults 18-64 years of age.

Source: Kaiser Family Foundation analysis of 2018 Behavioral Risk Factor Surveillance System.

AIANs fare worse than Whites across many health measures.



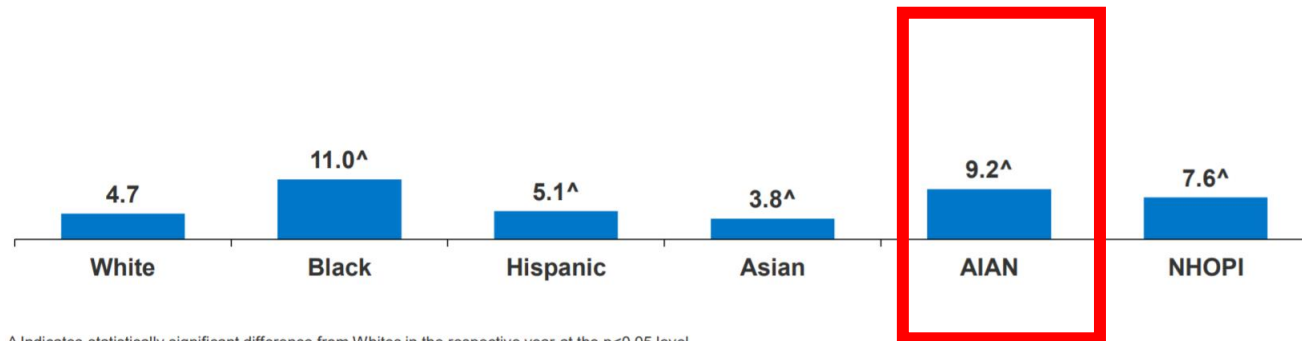
*Indicates statistically significant difference from White population at the $p < 0.05$ level.

Note: Whites and AIANs are non-Hispanic.

Source: Kaiser Family Foundation analysis of CDC, National Health Interview Survey, 2016, Kaiser Family Foundation analysis of CDC, Behavioral Risk Factor Surveillance System, 2016 and Results from the 2015 National Survey on Drug Use and Health: Detailed Tables, <http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#toc>.

Figure 28

Infant Mortality Rate (per 1,000) by Race/Ethnicity, 2017



^ Indicates statistically significant difference from Whites in the respective year at the $p < 0.05$ level.

Note: AIAN refers to American Indians and Alaska Natives. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, Linked Birth/Infant Death Records, 2013 & 2017, WONDER Online Database.

Of all AI/AN people who died during 2007-2009, 25 percent were under 45 years of age. These AI/AN rates have been adjusted to compensate for misreporting of AI/AN race on the state death certificates. This compared to 8 percent for the U.S. all races population (2008).

Chart 4.14 Deaths by Age

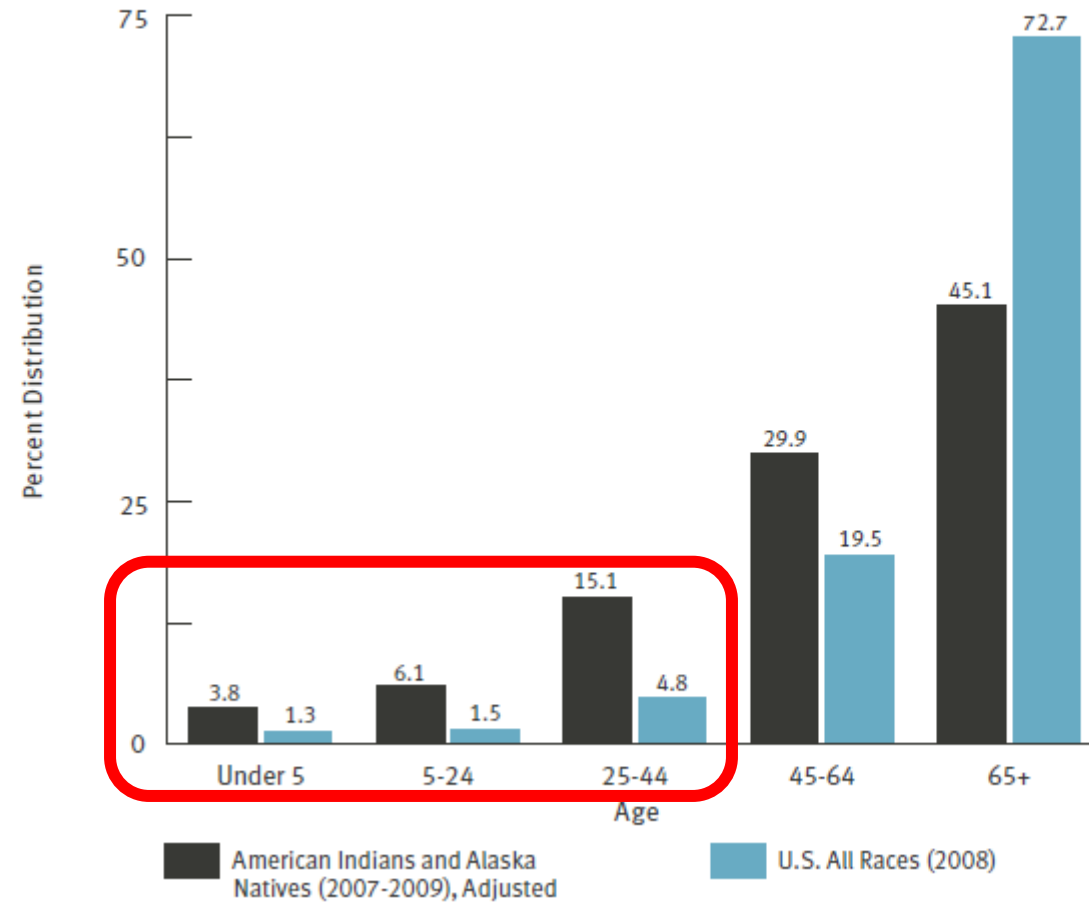
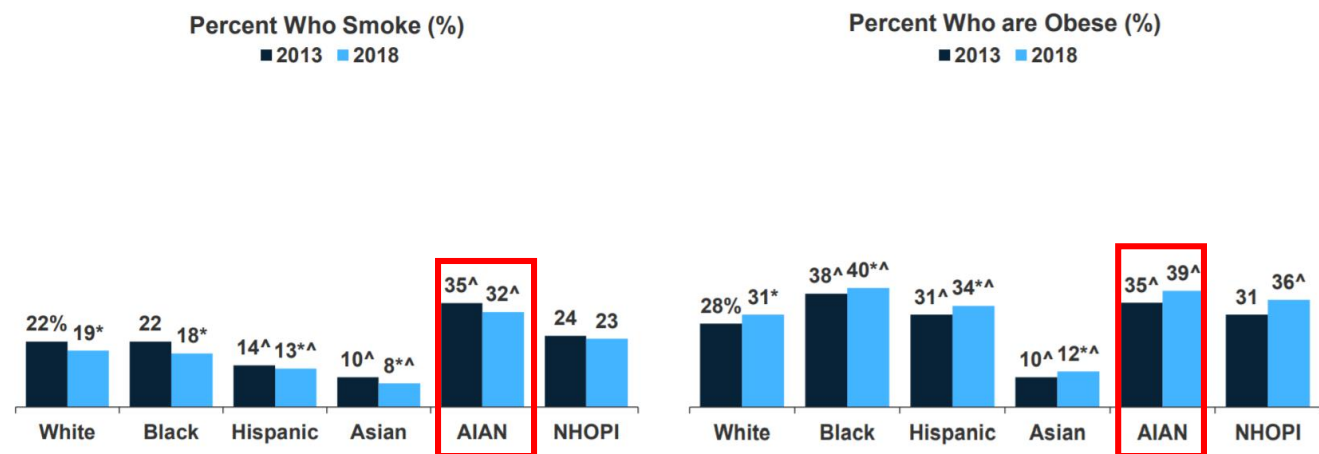


Figure 35

Smoking and Obesity Rates Among Nonelderly Adults by Race/Ethnicity, 2013 and 2018



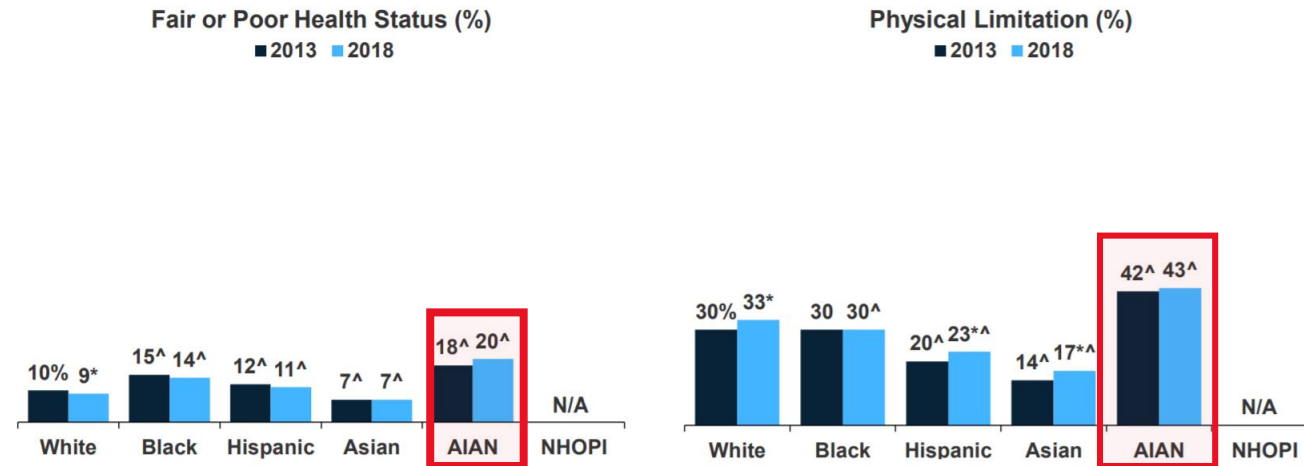
* Indicates statistically significant difference from 2013 at the $p < 0.05$ level. ^ Indicates statistically significant difference from Whites in the respective year at the $p < 0.05$ level.

Note: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 18-64 years of age. Share of adults who are obese is the share with a BMI of 30 or greater.

Source: Kaiser Family Foundation analysis of 2013 & 2018 Behavioral Risk Factor Surveillance System.

Figure 24

Percent of Nonelderly Adults Reporting Fair/Poor Health Status and a Physical Limitation by Race/Ethnicity, 2013 and 2018



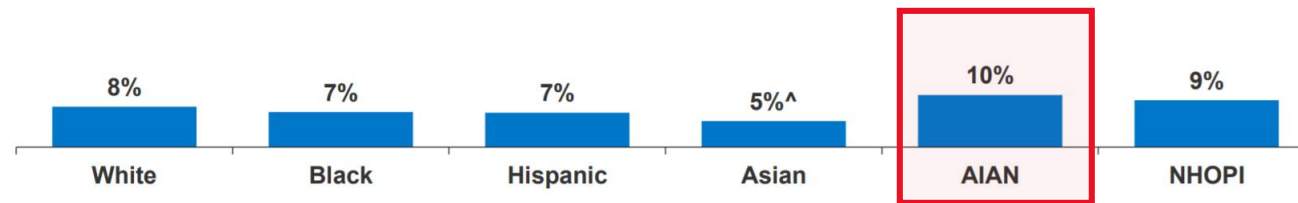
* Indicates statistically significant difference from 2013 at the $p < 0.05$ level. ^ Indicates statistically significant difference from Whites in the respective year at the $p < 0.05$ level.

Note: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 18-64 years of age. N/A: Data are included in an "other" racial category and cannot be separately identified.

Source: Kaiser Family Foundation analysis of 2013 & 2018 National Health Interview Survey.

Figure 37

Alcohol and/or Illicit Drug Dependence or Abuse in the Past Year Among Teens and Adults Age 12 and Older by Race/Ethnicity, 2018



^ Indicates statistically significant difference from the White population at the $p < 0.05$ level.

Note: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. See source for classifications of illicit drugs and dependence or abuse.

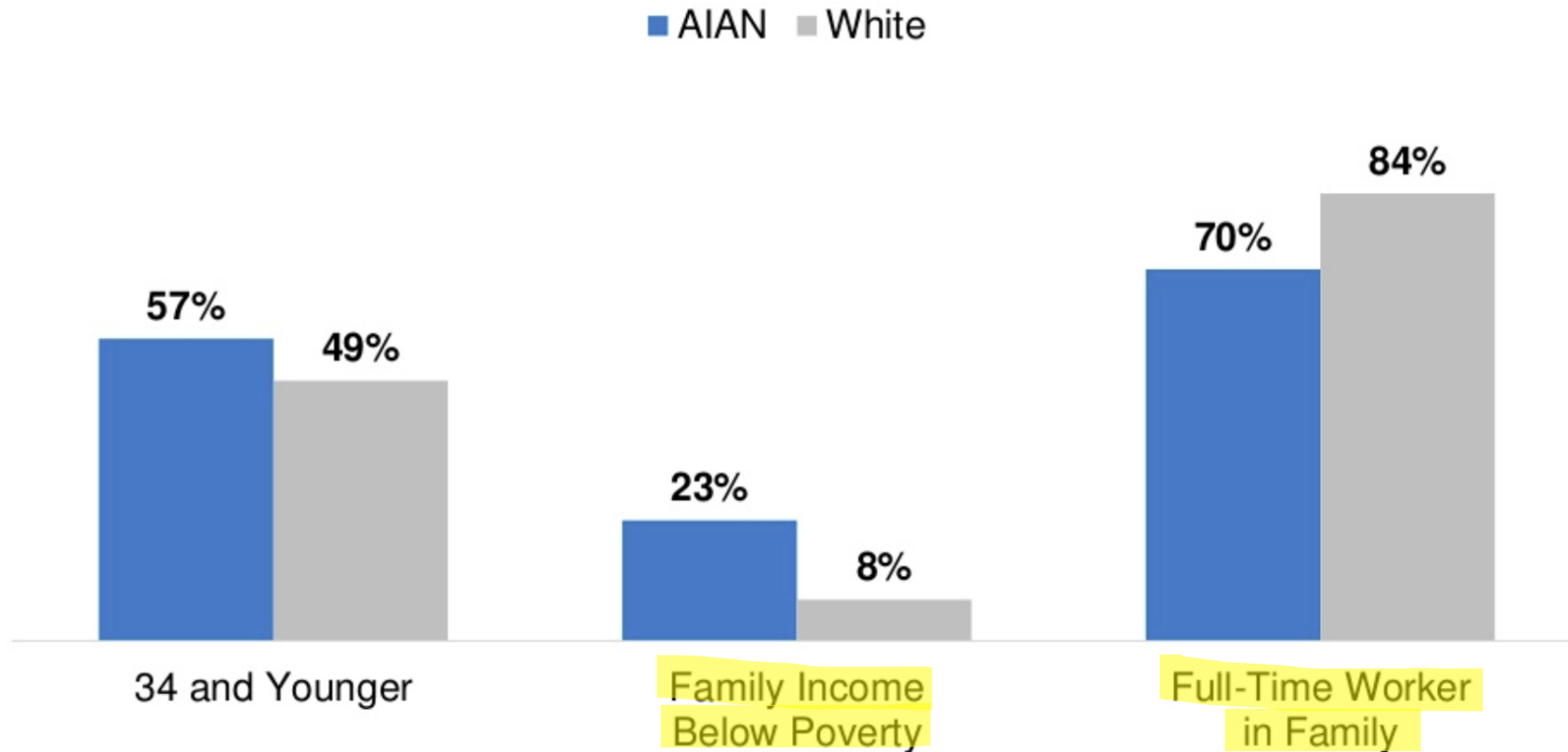
Source: Substance Abuse and Mental Health Services Administration. (2019). Results from the 2018 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetailedTabs2018.pdf>, Table 5.5B.

Why do these disparities exist?

- Many of the Native Americans were removed from ancestral lands and relocated to areas that are rural or remote. Many do not have the access to private health insurance even if they have jobs. Many do not have access to preventative care. **Many do not have running water and reside in crowded living conditions.**
- **The IHS has been underfunded since its inception.** The amount of money it would take to bring it up to full budget is in the **billions (\$48 Billion).**
- Historically, Native Americans have not had representation in the federal government. The 116th Congress had four Native Americans representing the people. **Deb Haaland of Laguna Pueblo** is one of the first two Native American women elected to serve in congress (**Sharice Davids** of Kansas was the other). Now Deb Haaland has been appointed to U.S. Secretary of the Interior.

Figure 3

Nonelderly AIANs are younger, more likely to be poor, and less likely to have a full-time worker in the family compared to Whites.

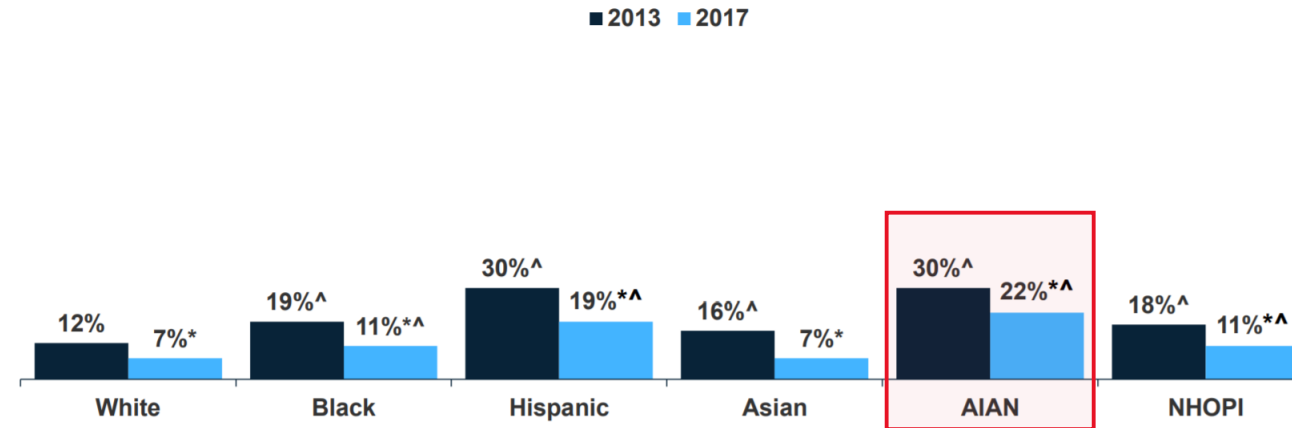


Note: AIANs and Whites are non-Hispanic. Excludes individuals of mixed race. Includes nonelderly individuals 0-64 years of age. All values have a statistically significant difference from the White population at the $p < 0.05$ level.

Source: Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.

Figure 14

Uninsured Rate for the Nonelderly Population by Race/Ethnicity, 2013 and 2017



* Indicates statistically significant difference from 2013 at the $p < 0.05$ level. ^ Indicates statistically significant difference from Whites in the respective year at the $p < 0.05$ level.

Notes: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age.

Source: Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.

What can we do?

- Fund the IHS at 100% of its budget.
- Medicaid expansion to all states.
- Federal funding for **education** as in its treaty obligations.
- More to promote health. **Social determinants of health.**
 - Providing clinical care only contributes about **20%** overall in health outcomes
 - **Social and economic factors** are much more important in health outcomes overall contributing **40%** to health outcomes.

What's needed to move toward health equity?

Address biases ingrained in health care systems & medical school education



Education and anti-racism training in academia and medical school



Address racial biases in algorithms and other tools



Incorporate incentives for improving health outcomes



Consider accountability standards for unmet metrics

Support & strengthen community resources



Invest in community health workers and centers



Build and maintain trust by working within the community



Health systems should link patients to existing community resources

Address factors that impact health outside of the health care system



Address social determinants of health, including food and housing security



Address equitable access to clean air, water and land



Establish initiatives & policies that prioritize equitable access to resources

Invest in infrastructure



Build capacity for equitable public health emergency preparedness



Increase broadband access



Expand tribal public health services



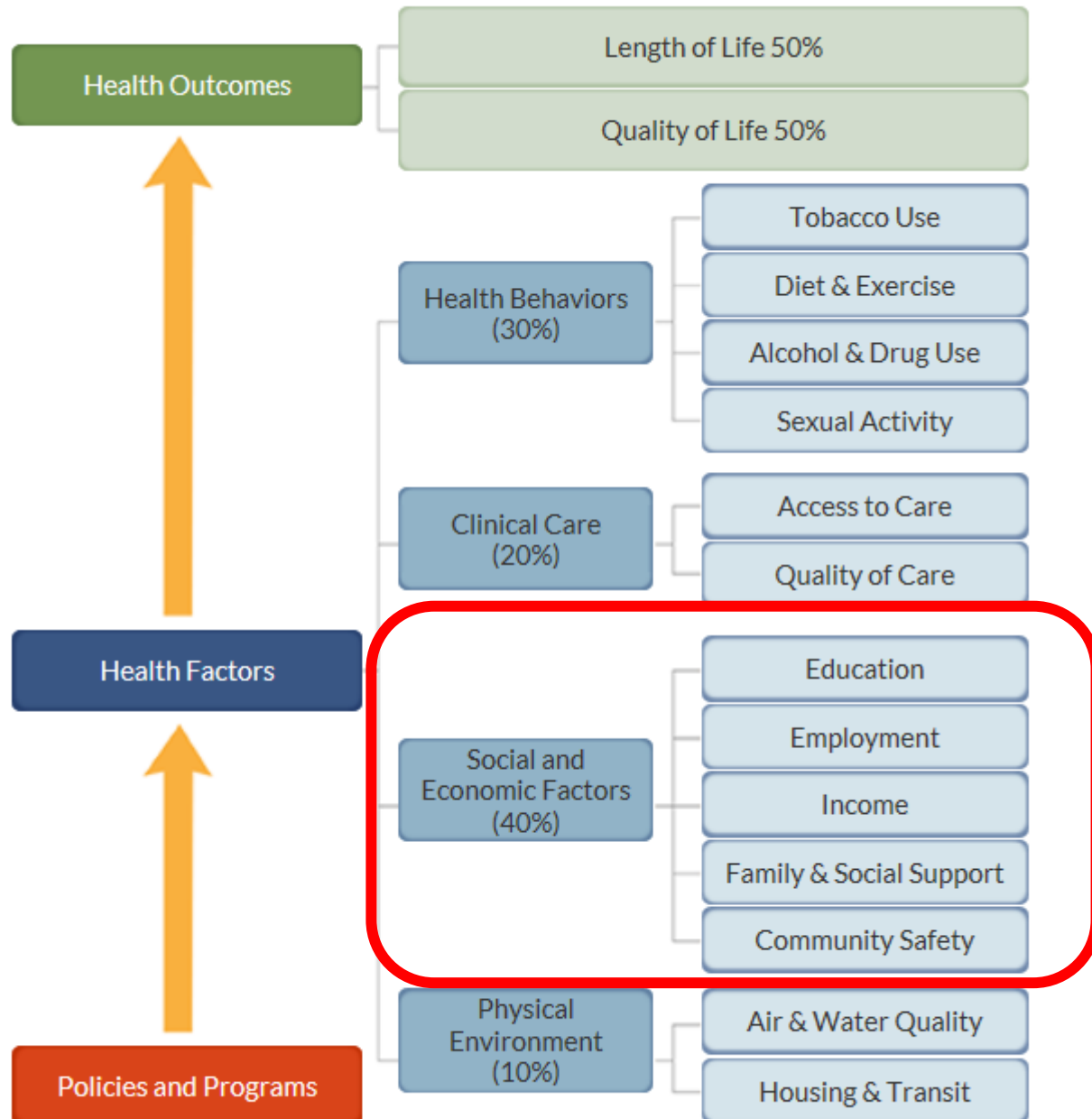
Improve transportation options to increase accessibility

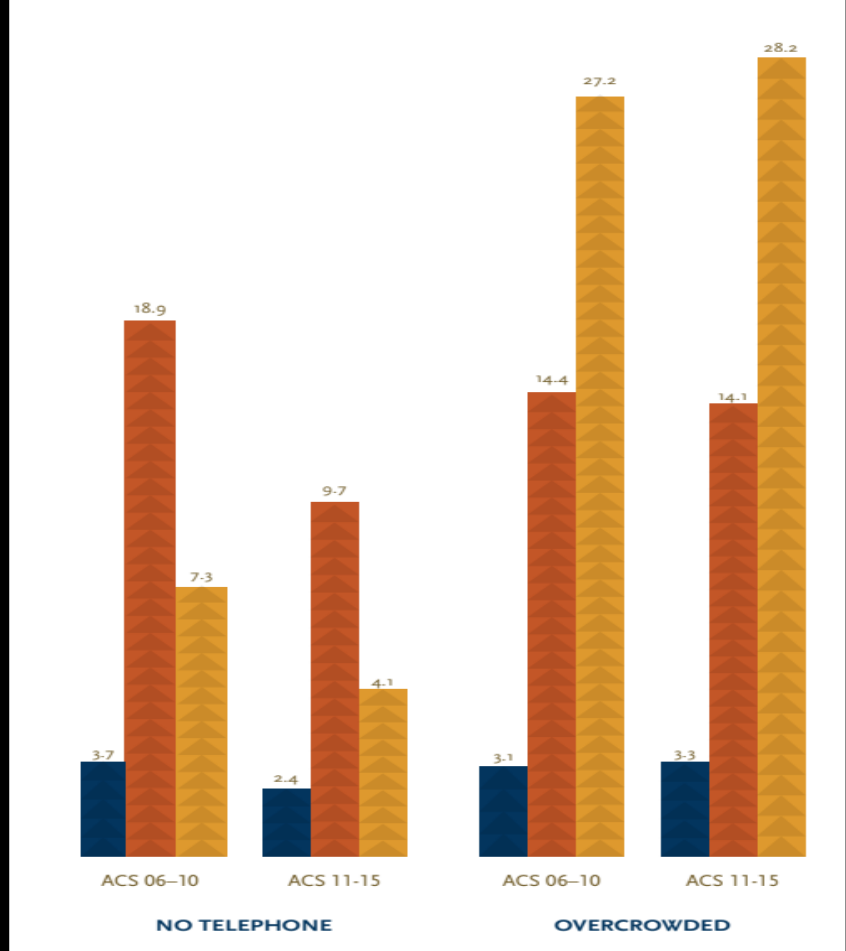
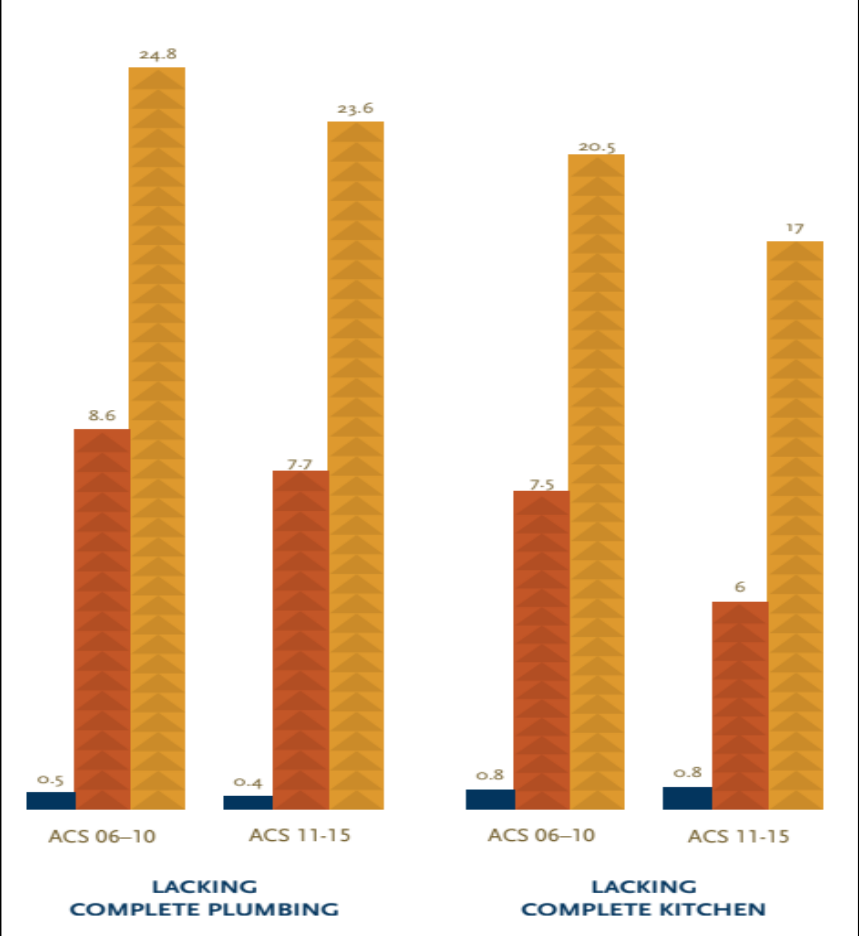


County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program





National Congress of American Indians

Conclusion

In sum, disparities in health and health care remain a persistent challenge in the United States. The data presented here show that despite improvements in some measures since implementation of the ACA coverage expansions, people of color continue to face significant disparities in coverage, access to, and utilization of care, and health status and outcomes. The scope and types of disparities vary across racial and ethnic groups. These disparities are driven by a wide range of factors both inside and outside the health care system. Moreover, although the ACA included provisions designed to increase data available to identify and monitor disparities, there remain key gaps in data, particularly for some racial and ethnic subgroups.

COVID-19 Infections

- In New Mexico counties with high Native American populations were hit especially hard with the infection.
- McKinley, Sandoval, and San Juan counties have large poor Native American populations.
- Poverty, lack of running water and electricity, over-crowded housing and chronic health conditions.

2009: Many reservation homes lack clean drinking water

Safe drinking water and sanitary sewage disposal are unavailable in 13 percent of American Indian/Alaska Native homes on reservations, compared with 1 percent for the overall U.S. population. The Indian Sanitation Facilities Act directs the Indian Health Service (IHS) to provide sanitation facilities such as safe drinking water and sewage systems to Indian homes. An IHS study recently finds that every dollar it spends on sanitation facilities yields a 20-fold return in health benefits.

The cost of providing sanitation facilities is estimated at \$2.6 billion, with a backlog of more than 3,000 planned sanitation facilities.

2009: H1N1 flu mortality four times higher among American Indians

The 2009 H1N1 influenza virus infects American Indians and Alaska Natives, with overall death rates four times higher than in all other racial and ethnic groups combined. H1N1 mortality is similar to that of the 1918 Spanish Influenza pandemic, when American Indians and Alaska Natives died at a similar rate. Dr. L. Castrodale and his associates from the Alaska Division of Public Health theorize that the higher mortality rate among American Indians and Alaska Natives is be related to their higher prevalence of chronic health conditions, poor living conditions, and delayed access to care.

TABLE 2. Comparison of the number and percentage of deaths related to 2009 pandemic influenza A (H1N1) among American Indian/Alaska Natives (AI/ANs)* and persons in non-AI/AN populations with diabetes, asthma, and any high-risk health condition† --- 12 states, April 15--November 13, 2009

	AI/AN deaths		Deaths in non-AI/AN populations§		Prevalence ratio	
	(n = 42)		(n =384)		AI/AN % to non-Ai/AN %	(95% CI¶)
Health condition	Number	%	Number	%		
Diabetes	19	45.2%	92	24.0%	1.9	(1.3--2.8)
Asthma	13	31.0%	54	14.1%	2.2	(1.3--3.7)
Any high-risk health condition**	34	81.0%	298	77.6%	1.0	(0.9--1.2)

* All AI/ANs were non-Hispanic.

† CDC defined groups at high risk for influenza complications: children aged <2 years; persons aged ≥65 years; pregnant women and women up to 2 weeks postpartum (including after pregnancy loss); persons of any age with certain chronic medical or immunosuppressive conditions (i.e., chronic pulmonary [including asthma], cardiovascular [except hypertension], renal, hepatic, hematologic [including sickle cell disease], or metabolic disorders [including diabetes]); disorders that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders); immunosuppression, including that caused by medications or by human immunodeficiency virus; and persons aged <19 years who are receiving long-term aspirin therapy. Available at <http://www.cdc.gov/h1n1flu/recommendations.htm>.

§ Includes 19 persons with unknown race/ethnicity.

¶ Confidence interval.

** Including diabetes and asthma.

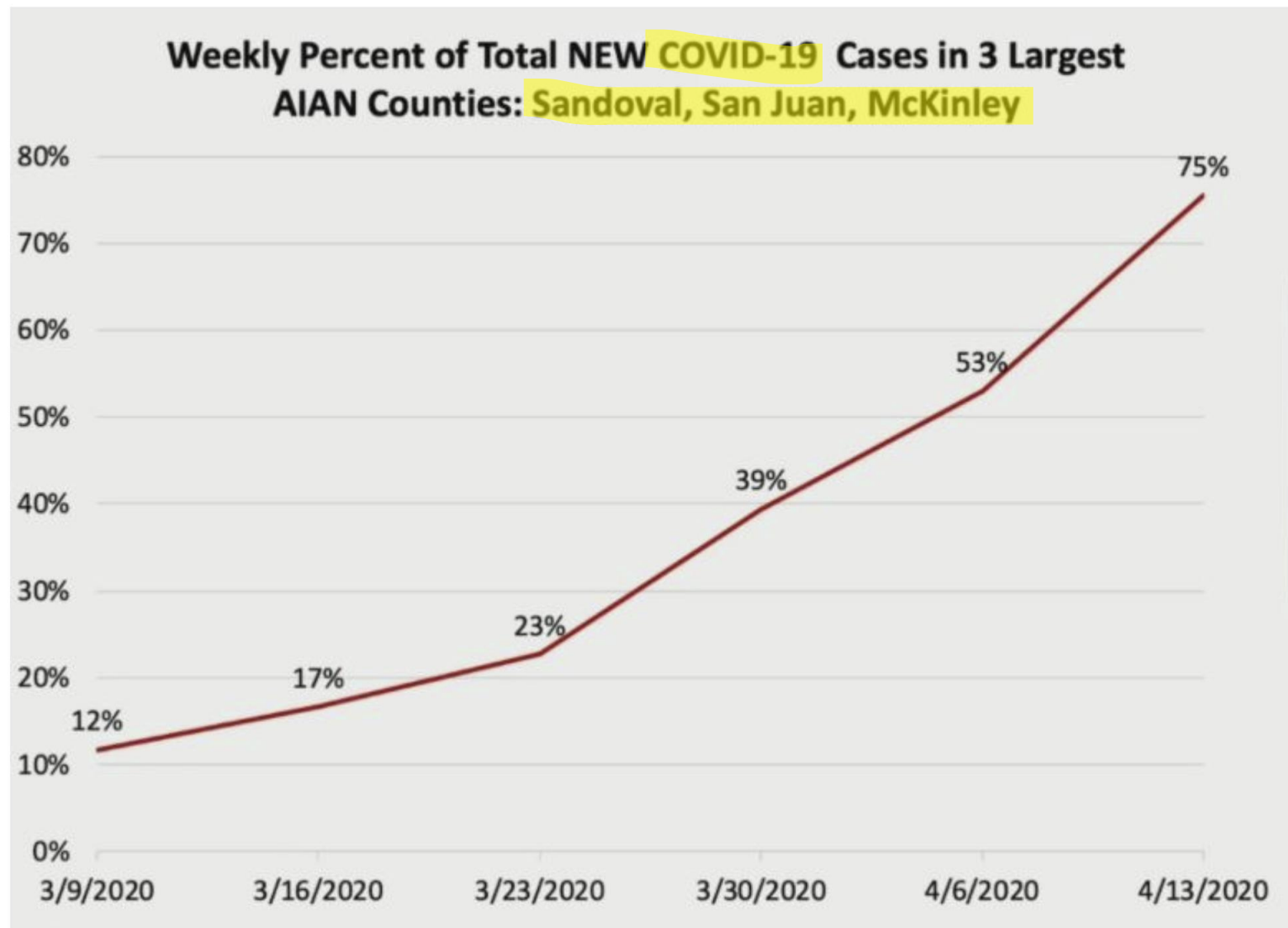


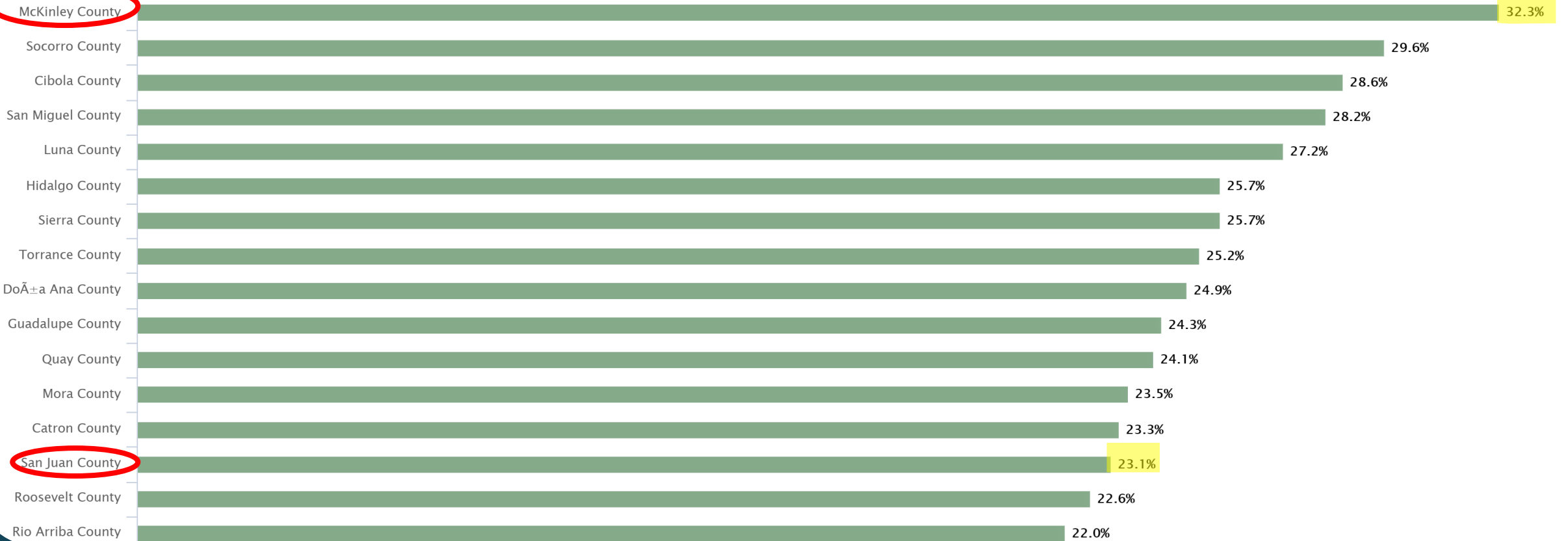
Chart shows the weekly percent of total new COVID-19 cases in Sandoval, San Juan and Mckinley County. They are the three largest counties in the state. The graph was shown during Gov. Lujan Grisham's April 15 news conference.

Persons in poverty, percent by County

■ Individuals Below Poverty Level

Percentage

0 2 4 6 8 10 12 14 16 18 20 22 24 26 28 30 32 34



COVID-19 in Native Americans

- As of April 19, 2020 more than 38% of New Mexicans who tested positive were Native American. The tribal population in the state of NM is only 11%.
- The Navajo Nation infection rate was 664 cases per 100,000 people, more than 8x higher than NM overall (Infection rate is 78 cases per 100,000).
- (This was in June of 2020).

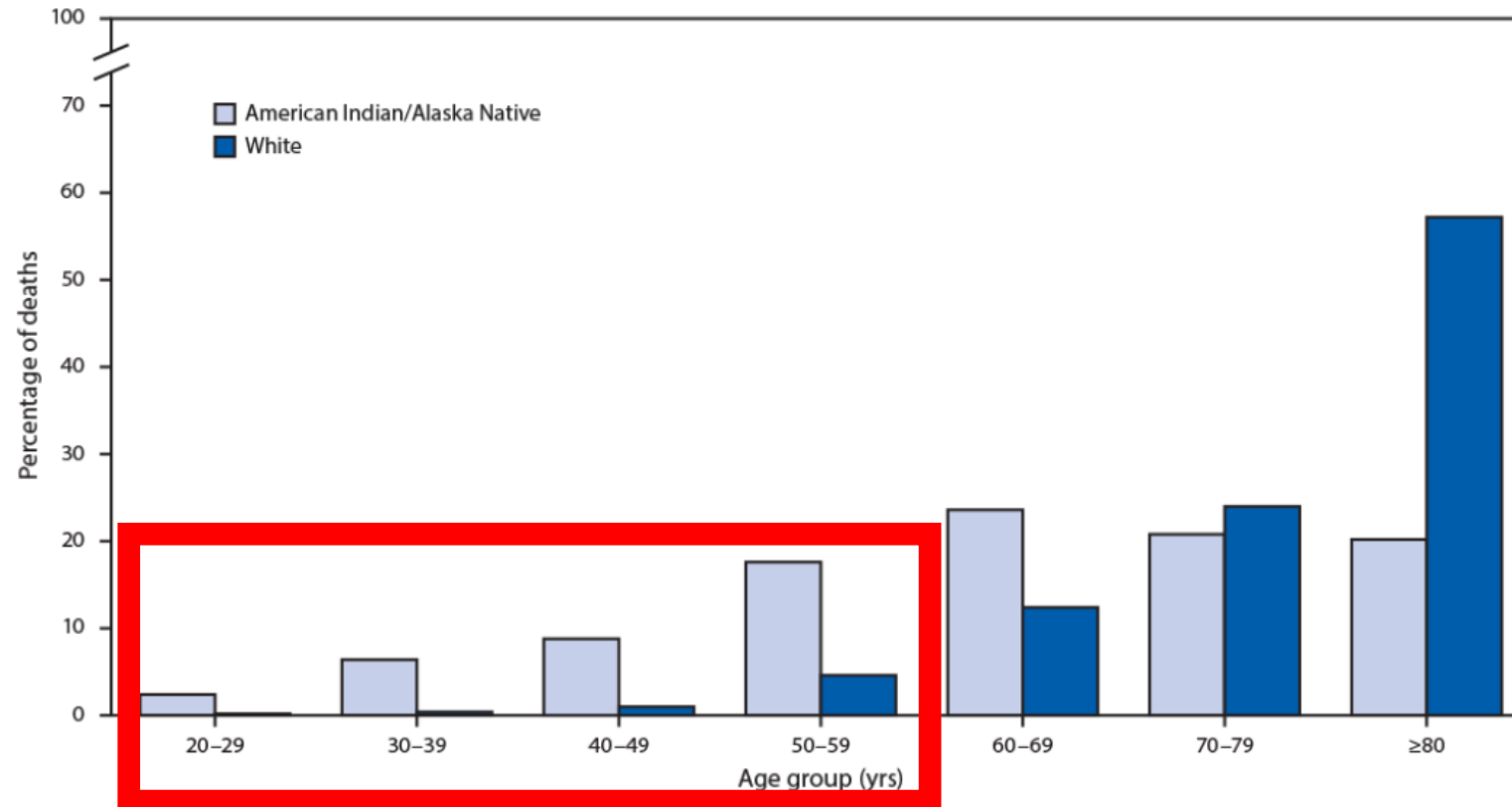


Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases ¹	1.7x	0.7x	1.1x	1.3x
Hospitalization ²	3.7x	1.0x	2.9x	3.1x
Death ³	2.4x	1.0x	1.9x	2.3x

Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., among frontline, essential, and critical infrastructure workers.

FIGURE. Percentage distribution of COVID-19–associated deaths among American Indian/Alaska Native* and non-Hispanic White persons aged ≥ 20 years, by age group[†] — 14 states,[§] January 1–June 30, 2020



Abbreviation: COVID-19 = coronavirus disease 2019.

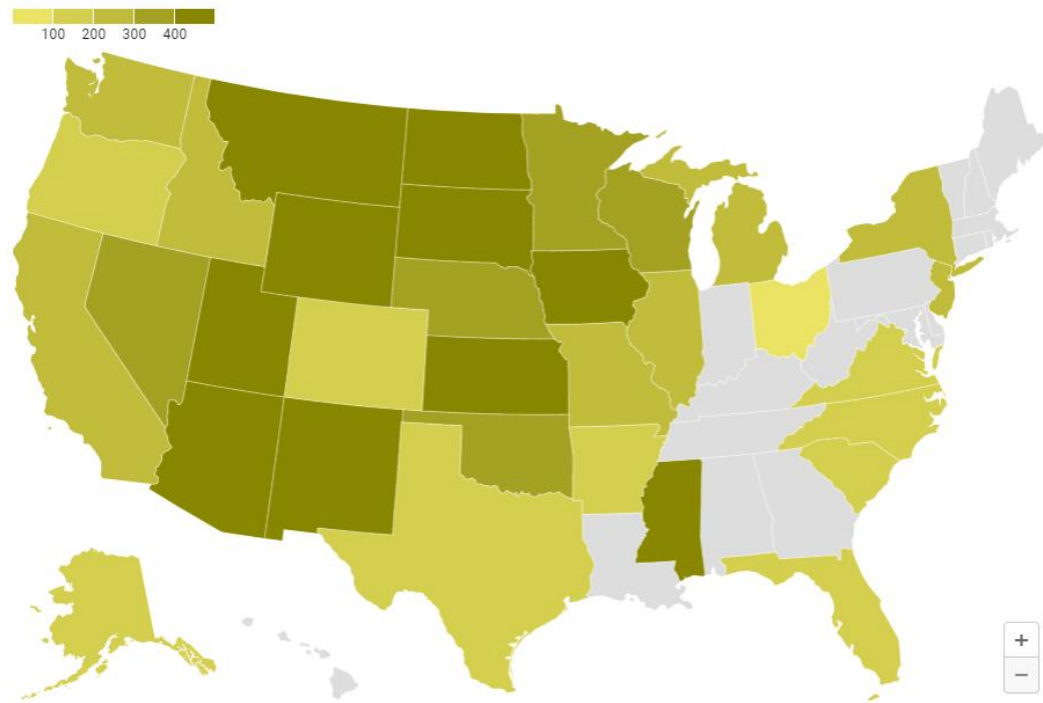
* Includes Hispanic and non-Hispanic ethnicities.

[†] Percentages by age group are not age-adjusted.

[§] Alaska, Arizona, Louisiana, Minnesota, Mississippi, Nebraska, New Mexico, New York, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and Washington.

Indigenous Americans: Age-adjusted COVID-19 mortality rates, through March 2, 2021

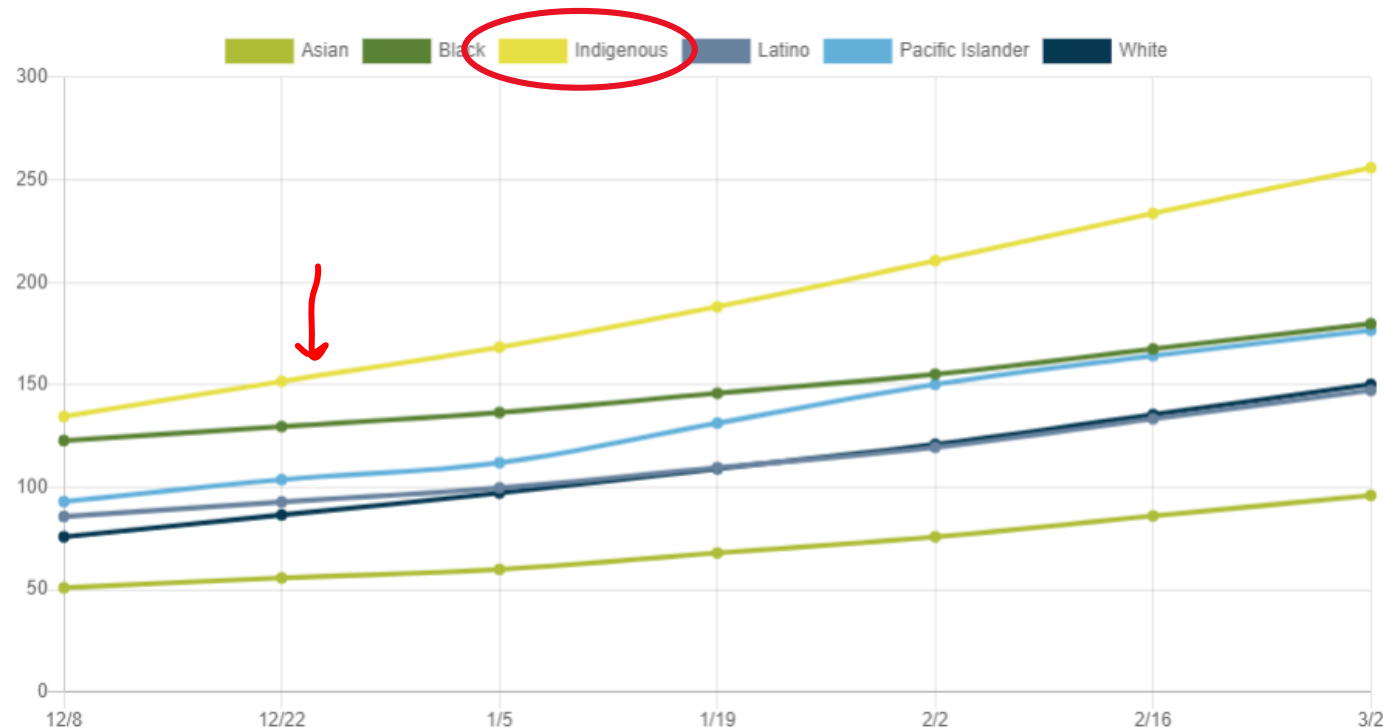
Deaths per 100,000 Indigenous residents. For all U.S. states with available data, where 15 or more deaths among Indigenous residents have occurred.



The nationwide rate (based on the 43 states reporting) is 401.3. A rate was not calculated for the District of Columbia as it did not meet the reporting threshold. Indirect age-adjustment has been used. Population data from the U.S. Census Bureau, 2015-2019 American Community Survey five-year estimates. On April 15, 2021 the age-adjusted mortality rate for the nation's Indigenous population was corrected from what had previously been published on this page.

Source: [APM Research Lab](#) • [Get the data](#) • Created with [Datawrapper](#)

RATES OF DEATH FROM COVID-19 (PER 100,000 PEOPLE) IN ALL STATES, DEC. 8-MARCH 2, 2021



Notes: Rates were not calculated when there were fewer than 15 deaths for a particular group. Rates for Indigenous and Pacific Islander residents could only be calculated for some states. Additionally, rates were not calculated for those identified as "Other" race. All intervals are two weeks apart. Data for 12/22, 1/19 and 2/16 has been interpolated. Users are cautioned that both estimates of deaths and rates graphed over time have slight idiosyncrasies including occasional reductions. We capture data at a point in time, after which provisional data sometimes gets back-revised by states after review. E.g. Tennessee's count of Latino deaths was downwardly revised from 288 on 1/5 to 274 on 2/2, resulting in a declining (corrected) rate. Data for states that post only percentages are more prone to rounding errors, as we have had to estimate number of deaths. For these reasons, all data should be considered approximate. Some states have changed their treatment of ethnicity over time. Please contact us for additional details.

- 1 in 390 Indigenous Americans has died (or 256.0 deaths per 100,000)
 - 1 in 555 Black Americans has died (or 179.8 deaths per 100,000)
 - 1 in 565 Pacific Islander Americans has died (or 176.6 deaths per 100,000)
 - 1 in 665 White Americans has died (or 150.2 deaths per 100,000)
 - 1 in 680 Latino Americans has died (or 147.3 deaths per 100,000)
 - 1 in 1,040 Asian Americans has died (or 96.0 deaths per 100,000)
- Indigenous Americans have the highest actual COVID-19 mortality rates nationwide—about 2.7 times as high as the rate for Asians, who have the lowest actual rates. Indigenous people have also seen their mortality rate accelerate the fastest in the past four weeks.
 - Adjusting the data for age differences in race groups widens the gap in the overall mortality rates between all other groups compared to White and Asian Americans, who have the lowest age-adjusted rates. The Indigenous population has the highest age-adjusted mortality rate, followed by Pacific Islander, Latino and Black residents, as shown in the graph below. (A fuller discussion of our indirectly age-adjusted rates follows.)

- National Congress of American Indians
www.ncai.org
- *Broken Promises: Evaluating the Native American Health Care System*
September 2004 U.S. Commission on Civil Rights
www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf
- National Indian Health Board: National Tribal BFWG Testimony to the Department of Health and Human Services
www.nihb.org/legislative/budget_formulation.php
- County Health Rankings and Road Maps
www.countyhealthrankings.org
- New Mexico True (New Mexico Department of Tourism)
www.newmexico.org
- Kaiser Family Foundation www.kff.org
- Indian Health Service www.ihs.gov
- The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. (APM Research Lab)

- National Institute for Health Care Management
<https://nihcm.org/publications/native-americans-health-equity>