



**COVID-19 Policy Brief: Disparities Among Native American Communities in the United States**  
**Version: July 7, 2020**

The COVID-19 pandemic has resulted in over 2.8 million cases and more than 129,000 deaths in the United States as of July 6, 2020.<sup>i</sup> While the pandemic has touched every community in our country, it has revealed the striking socioeconomic and healthcare inequities in the U.S. that disproportionately impact Black/African Americans, Latinx, and Native American communities in addition to underserved communities such as individuals in correctional facilities, rural and immigrant populations, people with disabilities and individuals experiencing homelessness. Native American communities are defined as members of any of the indigenous peoples of the western hemisphere.

The Infectious Diseases Society of America and its HIV Medicine Association represents more than 12,000 infectious diseases and HIV physicians and other healthcare providers, public health practitioners and scientists committed to ending the health disparities that have historically impacted the lives of Black and Brown and other underserved Americans and that have been exacerbated by COVID-19. This brief calls attention to the significant health, environmental, structural and economic disparities among Native American populations that put these individuals at significant risk for contracting COVID-19 and experiencing adverse health outcomes due to COVID-19.<sup>ii</sup> This brief is part of a series that examines [COVID-19 and health disparities in the United States](#).

## **BACKGROUND**

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is working with tribal partners and state and local public health officials to coordinate the response to COVID-19 pandemic. IHS is accountable for delivering federal health services to approximately 2.6 million Native Americans through a network of hospitals, clinics, and health stations on or near tribal reservations.<sup>iii</sup>

As of June 28, IHS has reported more than 19,378 positive tests for coronavirus among its service population.<sup>iv</sup> In particular, the Navajo Nation is among the hardest hit reservations in the U.S., with a higher per capita rate of infection than any U.S. state, including New York, and even greater than that of Wuhan at the peak of the outbreak in China.<sup>v</sup> As of June 30, the Navajo Department of Health reports 7,532 positive cases of COVID-19 and 363 confirmed deaths.<sup>vi</sup>

In states where there is a large Native American population, they comprise a significantly higher proportion of the case count as compared to the general population. Native Americans made up 18% of the deaths and 11% of the cases compared to 4% of the total population in Arizona; 57% of the cases compared to 9% of the total population in New Mexico; and 30% of the cases compared to 2% of the total population in Wyoming (Figure 1).<sup>vii</sup>

Native American communities experience similar barriers to accessing testing and personal protective equipment as other Americans during the COVID-19 pandemic. However, the underfunding of Native

American health systems is a contributing factor to Native American health disparities and has put the Native American community at risk for serious illness from COVID-19.<sup>viii</sup> Compounding this problem, many of the rural hospitals upon which these communities rely for inpatient care do not have the large numbers of intensive care beds, ventilators and staffing required to care for severely ill COVID-19 patients. Native American and other underserved communities disproportionately impacted by COVID-19 share the following:

- Higher rates of pre-existing, underlying health conditions,<sup>ix</sup>
- Lack of environmental and public health infrastructure,<sup>x</sup>
- Disproportionate impact of structural racism and socioeconomic factors,<sup>xi</sup> and
- Limited and poor accessibility to healthcare.<sup>xii</sup>

### Higher Rates of Pre-existing, Underlying Health Conditions

According to the Centers for Disease Control and Prevention (CDC), people with heart disease, diabetes and lung disease are 6 times more likely to be hospitalized and 12 times more likely to die due to COVID-19.<sup>xiii</sup> Native American adults have disproportionately higher rates of many health conditions that may put them at higher risk for serious illness if they contract COVID-19, including diabetes, obesity and heart disease:

- Native American adults are almost three times more likely than non-Hispanic white adults to be diagnosed with diabetes.<sup>xiv</sup>
- Native American adults are 50% more likely to be obese than non-Hispanic whites.<sup>xv</sup>
- Native American adults are more likely to have high blood pressure and more likely to be cigarette smokers than white adults - all risk factors for heart disease.<sup>xvi</sup>
- Native American children are 60% more likely to have asthma than non-Hispanic white children.<sup>xvii</sup>

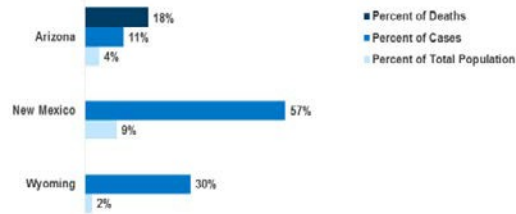
### CALL TO ACTION

Policies should be centered on eliminating socioeconomic and racial and ethnic disparities to improve the health of Latinx, Black/African Americans, Native Americans and other underserved communities. We call on policymakers to provide medical relief and financial assistance, such as allocating appropriate funding through IHS to meet Native American health needs, and to develop strategies to address the underlying inequities in the public health infrastructure that have been further exposed by the COVID-19 pandemic. The federal government is uniquely positioned to provide healthcare services to Native American peoples and improve a healthcare system that has been chronically underfunded.

Figure 1

### Data Point to Stark Impacts of COVID-19 for American Indian and Alaska Native People in Some States

American Indians and Alaska Natives as a Share of Confirmed Coronavirus Cases, Deaths, and Total Population in Select States, as of May 11, 2020



SOURCE: KFF, "COVID-19 Confirmed Cases & Deaths by Race/Ethnicity as of May 11, 2020," <https://www.kff.org/coronavirus/covid-19/issue-brief/state-data-and-policy-actions-to-address-coronavirus/>



## Environmental & Public Health Infrastructure

Significant investment in tribal public health and household infrastructure is necessary to respond appropriately to the current COVID-19 (and future) pandemic(s).<sup>xviii</sup>

Guidance from the CDC for preventing the spread of COVID-19 includes practicing social distancing and handwashing.<sup>xix</sup> However, it is challenging to adhere to these guidelines in Native American communities. Native American people living on tribal reservations are more likely to share a household with large or extended families than the average U.S. household (6.9% for the average reservation versus 3.4% for the United States).<sup>xx</sup> Additionally, many of these households often lack complete kitchens and bathrooms, have heating and electrical problems, or are structurally unsound.<sup>xxi</sup> Without electricity to run refrigeration systems, for example, families cannot store food and stock up on supplies needed for COVID-19 quarantine or for recommended isolation if infected. Native American households on tribal reservations are 3.7 times more likely to lack complete indoor plumbing than all other homes in the U.S.<sup>xxii</sup> The lack of complete indoor plumbing and access to potable water on tribal reservations are important determinants of disease transmission in this pandemic.

Limited income exacerbates the household and environmental challenges described above. Household crowding and lack of running water have been associated with higher rates of infectious diseases and lower respiratory tract infections, which is a leading cause of infectious disease hospitalizations for Native Americans.<sup>xxiii</sup> We recommend that:

- Congress provide sustained and increased public health funding to tribes for environmental health infrastructure, such as indoor plumbing, housing and healthcare systems to redress and help close health disparities.
- Congress develop and implement both non-congregate sheltering, such as housing in hotels and other appropriate venues, as well as congregate sheltering programs.
- Congress prioritize delivery of necessary supplies (food, clean water, disinfectant, personal hygiene items, and masks) to those testing positive or exposed to COVID-19.
- The U.S. Census Bureau accurately count the Native American population, to correctly determine things such as school district definitions, the allocation of Congressional seats in the House of Representatives, and the distribution of federal funds to tribal, state, and local governments for various programs in criminal justice, healthcare, education, housing, economic development, and others.

## Socioeconomic and Occupational Factors

Tribal governments are experiencing the same economic downturn affecting the rest of the U.S. Tribal governments operate under unique and highly constrained economic and fiscal limitations and depend on income from gaming and other enterprises to pay for public safety and social services. Household incomes for Native Americans were close to half that of the typical household in the U.S. before the shutdown of gaming enterprises in response to the COVID-19 outbreak.<sup>xxiv</sup> Declining income and unemployment for people at those enterprises threatens the ability of tribal governments to provide critical governmental services and respond to COVID-19. We recommend that:

- The Treasury Department immediately disburse Coronavirus Relief Funds to hospitals and providers serving tribal populations and minimizes barriers on tribes to apply for and receive future funding.<sup>xxv</sup>

- The Employment and Training Administration enforces federal standards to determine whether workers can maintain their eligibility to receive regular state unemployment insurance and Pandemic Unemployment Assistance when their employers do not take the proper health and safety precautions to protect against COVID-19, including nonadherence to established CDC guidelines.<sup>xxvi</sup>
- Congress pass the Healthy Families Act (H.R. 1784) that will provide paid and unpaid sick leave for employees to meet their personal and familial medical needs.<sup>xxvii</sup>
- Congress provide resources that specifically address the disproportionate impact on racial and ethnic populations and strengthen COVID-19-related support for other underserved populations, including individuals in correctional facilities<sup>xxviii</sup> and nursing homes.
- Congress pass the Improving Social Determinants of Health Act of 2020 (H.R. 6561) to establish a CDC program to support organizations in building capacity to address the social determinants of health in underserved communities.<sup>xxix</sup>
- Congress provide a 15% increase in the Supplemental Nutrition Assistance Program maximum benefit level, which would provide all SNAP households, including those with the lowest incomes, additional resources to purchase food.<sup>xxx</sup>

### **Ensure the Collection of COVID-19 Data by Race, Ethnicity, Gender, Age and Zip Code**

The inclusion of information about race, ethnicity, gender, age and disability status by zip code for COVID-19 is critical to allow federal, state, local, tribal, and territorial public health officials to better respond to the current COVID-19 pandemic and future public health emergencies. Uniform data collection including race and ethnicity will also allow for more targeted resource allocation and recovery planning to communities hardest hit by COVID-19. Many states do not include Native American as a category in their data collection making it very difficult to fully evaluate and respond to the impact on these populations. We recommend that:

- Congress increase funding to ensure a coordinated, national surveillance system across tribal, federal, state and territorial entities that ensures timely and comprehensive data collection. Congressional and state support for public health officials to specifically collect data to ensure quality and completeness. Funding should be allocated from the tribal, federal, state and territorial governments to local health departments for these officials.
- CDC collect and publicly report COVID-19 data on testing, emergency room visits, hospitalizations, deaths, and other clinical outcomes information, and, eventually, vaccination rates by race, ethnicity, gender, zip code, and tribal community membership.
- Ensure that race and ethnicity data in weekly epidemiology reports for COVID19 and future public health threats explicitly include Native Americans instead of categorizing them under the label “other.”
- CDC prepare to collect data on vaccination rates by race, ethnicity, gender, age, zip code and disability status.

### **Strengthen Native American Health Services**

Access to public health information and directives in tribal languages in addition to English are vital to reducing transmission rates during pandemics. Disseminating public health messages in local languages and enhancing other communication infrastructure in tribal communities such as access to cellular signal and broadband help communities prepare more effectively. Lack of access to reliable

broadband at IHS facilities and tribally operated health facilities has exacerbated the impact of COVID-19 on tribal communities.<sup>xxxix</sup>

Accurate monitoring of case and death rates in tribal communities, and the implementation of comprehensive and inclusive research on ethnic, tribal, and geographic groups, are needed to inform the response to spikes in COVID-19 cases. Health systems are further strained by limited geographic accessibility, chronic underfunding and significant workforce shortages, which affects the ability to obtain COVID-19 services, including rapid lab testing, treatment and data collection.<sup>xxxix</sup>

Congressional inaction to appropriately fund IHS, delays in distributing federal relief funds, and inadequate attention to addressing the social determinants of health have put Native Americans at an elevated risk of adverse COVID-19 related outcomes. IHS, which is mandated to ensure that public health services are available and accessible to Native Americans, has reported workforce shortages that can adversely impact public health outcomes.<sup>xxxix</sup>

To improve Native American health, we recommend that Congress:

- Provide funding to IHS to support the translation of critical information and resources in Indigenous languages, ensure cultural competence of healthcare providers, and implement organizational accommodations and policies that reduce administrative, cultural and linguistic barriers to healthcare.
- Pass the COVID-19 DISASTER in Indian Country Act (H.R.6819), which provides for the immediate deployment of temporary wireless broadband service on tribal lands and Hawaiian Homelands.<sup>xxxix</sup>
- Pass the Tribal Medical Supplies Stockpile Access Act of 2020 (S.3514), which allows tribal governments to access resources from the strategic national stockpile and qualified pandemic or epidemic products directly from the Department of Health and Human Services.<sup>xxxix</sup>
- Include the Indian Health Service Director on the White House's COVID-19 Task Force and future pandemic working groups to ensure that the needs Native Americans and the IHS, Tribal, and Urban health systems are represented in discussions about how to address pandemics.
- Increase and sustain funding for IHS to bring its workforce and training to the required level.
- Provide funding to implement the Indian Health Care Improvement Act, including job training programs to address chronic shortages of health professionals in tribal lands and a mental health technician training program.
- Increase investment in health worker training programs and technical schools within tribes to increase the local pipeline of human technical resources for health.
- Increase Urban Indian Health Programs (UHIPs) for tribal citizens living off-reservation.
- Develop interventions to address structural inequities and lack of trust in rapidly developed or new vaccines that may restrict access to a COVID-19 vaccine and other necessary vaccines, and to reduce vaccine reluctance while research is underway to develop a vaccine for COVID-19.

### **Ensure Timely Access to High-Quality, Culturally Competent COVID-19 Testing, Care, and Prevention**

The populations disproportionately impacted by COVID-19 should be prioritized for COVID-19 testing, care and treatment and when available, vaccines. We recommend that:

- Congress provide resources geared specifically to address the disproportionate impact on the Black/African American, Latinx and Native American communities and to strengthen COVID-related support for other vulnerable populations.
- Testing and treatment delivery that is culturally competent and both geographically and economically accessible.
- Contact tracing programs and staff are culturally and linguistically competent and reflect the communities they work with, and fully engage existing organizations with experience and expertise in the community.
- Congress work with all public and private health insurers and vaccine and drug developers and manufacturers to provide access to affordable prevention, care and treatment services for COVID-19 for all patients regardless of ability to pay, including by sustaining the CARES Act Provider Relief fund.
- Health systems and institutions implement cultural competency training for healthcare providers and provide organizational accommodations and policies to reduce administrative, cultural and linguistic barriers to healthcare.

### **Increase Services for Individuals with Opioid Use Disorder**

The impact of COVID-19 on Native American communities that are already facing significant challenges from the opioid overdose epidemic, puts people who use drugs and individuals in recovery at increased risk. People with Opioid Use Disorder (OUD) may be at higher risk as a result of the impact of drug misuse on their respiratory function. The U.S. Substance Abuse and Mental Health Services Administration and the U.S. Drug Enforcement Administration have provided flexibility for practitioners in providing buprenorphine and methadone to patients with opioid use disorder in response to emerging evidence that the overdose crisis is worsening during COVID-19.<sup>xxxvi</sup> Accessing treatment services can be especially challenging in rural areas such as tribal lands. The COVID-19 pandemic has resulted in increased rates of drug overdoses,<sup>xxxvii</sup> and mass unemployment<sup>xxxviii</sup> that greatly increases homelessness.

Syringe services programs (SSPs) and other harm reduction service providers engage individuals who are vulnerable both to adverse drug use-related outcomes and COVID-19. These programs are essential in preventing overdose deaths and hepatitis C and HIV infections, as well as facilitating access to an array of other services including medication assisted treatment for OUD. We recommend that:

- Congress appropriate \$58 million for CDC's Infectious Disease and Opioid Program, fully lift the ban on the use of federal funding to purchase syringes for SSPs and increase access to naloxone, especially since physical distancing has created social isolation that can increase overdose risk.
- The Substance Abuse and Mental Health Services Administration allow for 28-day methadone take-home doses.
- States adopt SAMHSA and DEA rules and guidance in full for the duration of the national emergency, including flexibility for evaluation and prescribing requirements using telemedicine to help patients with OUD and patients with chronic pain obtain necessary treatment.<sup>xxxix</sup>

### **Increase Access to Affordable Healthcare Coverage and Healthcare Services**

Following the passage of the Patient Protection and Affordable Care Act (ACA), the uninsured rate among Native Americans dropped from 32% in 2010 to 21.8% in 2018 but remains 2.9 times higher than the uninsured rate for whites.<sup>xl</sup> In addition to strengthening the Indian Health Service, improving access

to healthcare and allied services is critical to support early and more regular access to high-quality prevention and care. To improve access to healthcare, we recommend that Congress:

- Ensure the 14 remaining states expand Medicaid coverage without restrictions.<sup>xii</sup>
- Support the temporary enhancement of the federal matching rate for state Medicaid programs to prevent eligibility and coverage restrictions due to increased demand and strains on state budgets.
- Support enhanced coverage for COVID-19 treatment and prevention for Medicaid and Medicare patients.
- Support subsidies for furloughed or unemployed individuals to maintain employer-sponsored insurance coverage through COBRA.
- Provide a nationwide special enrollment period for individuals without healthcare coverage to enroll in an Affordable Care Act compliant marketplace plan.
- Provide adequate funding for community health centers and take steps to ensure their long-term financial viability, that are often the only source of healthcare for lower-income individuals in many communities—especially rural areas-- and that care for patients regardless of their ability to pay.

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