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Clinical Practice Issues in American Indians and Alaska Natives

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Continuing Education Activity

The disparity in the healthcare provided to the American Indians and Alaskan Natives is a long-standing issue that continues to plague the United States. Since the establishment of Indian health services, many of these issues have been addressed. However, the disparities continue to exist along with the rise of new issues like heart disease, cancer, and other non-communicable diseases. This activity reviews the history of the American Indian and Alaskan Native community, the etiology and epidemiology of the healthcare disparities, and highlights the interprofessional team's role in bridging this gap in healthcare disparity.

Objectives:

- Review the etiology of healthcare disparity in the American Indian and Alaskan Native communities.
- Review the epidemiology of healthcare disparity in the American Indian and Alaskan Native communities.
- Review the role of Indian health services in healthcare disparity in the American Indian and Alaskan Native communities.
- Identify the areas of improvement that the interprofessional healthcare team can use to bridge the gap in the healthcare disparity in the American Indian and Alaskan Native communities.

[Access free multiple choice questions on this topic.](#)

Introduction

"The American Indian, once proud and free, is torn now between white and tribal values; between the politics and language of the white man and his own historic culture. His problems, sharpened by years of defeat and exploitation, neglect and inadequate effort, will take many years to overcome." - Excerpt from the speech of Lyndon B. Johnson, 36th President of the United States delivered on March 06, 1968, as "Special Message to the Congress on the problems of American Indian: *"The Forgotten American"* (The American Presidency Project- Peters G and Woolley JT, University of California. Santa Barbara).

American Indians and Alaska Natives (AIAN) are the original indigenous people of North America. Since the Iroquois League of Five Nations (Mohawk, Oneida, Onondaga, Cayuga, and Seneca) was established in the 1100s, the individual tribal nations have undergone a series of upheavals. Since the arrival of European colonists, they became aliens in their own land. It was not until June 2, 1924, that American Indians were granted full citizenship when the Indian Citizenship Act was signed into law by President Calvin Coolidge. However, it took another 22 years until the US government recognized the sovereignty of the tribal nations. To show gratitude for their service in the second world war, the US government passed the Indian Claims Act in 1946 to set up the Indian Claims Commission

that acted as a Judicial arbiter between the US government and the land claims of the AIAN. The last of these claims were settled in the early 21st century. Although it may seem that the tribal nations exist as sovereign nations within a nation, the disparities in economics, literacy, and healthcare continue to be an egregious challenge in the 21st century. These disparities have been further laid bare with the raging pandemic that has come to pass as a defining moment of this century.

Despite the progress being made in recognizing the sovereignty of AIAN people, the stark disparities between the healthcare provided to the indigenous people and the non-Hispanic whites (NHW) have continued to exist. The first arrival of European settlers 500 years ago brought devastating diseases like smallpox, measles, yellow fever to the virgin lands and wiped out multiple tribes over the next two centuries, since the recognition of the right of Indian Nations to health in 1832 (Supreme Court Chief Justice John Marshall, *Worcester v. Georgia*, 31 (6 Pet.) 515, 561 (1832), little changed in the health care allotment towards AIAN communities. The federal government continued to provide healthcare to the AIAN community under various treaties, executive orders, and legal bases over the next century. In 1849, the AIAN community's healthcare passed from the war department to the department of the interior. [1] However, little change came about with the transfer of the responsibility. These treaties were broken numerous times, leading to high mortality and morbidity in the AIAN community. It was not until 1921 when the Snyder Act provided a clear mandate for delivering improved healthcare to the AIAN community. It led to a concentrated effort towards providing the healthcare rights of the AIAN community.[2]

Post-second world war, under the mandate of "the highest attainable standard of health" from the World Health Organization (WHO) and the Universal Declaration of Human Rights by the United Nations, a progressive change began in the Indian health policy. The transfer of health affairs from the Bureau of Indian Affairs to the Indian Health Services (IHS) in 1955 was a pivotal point in integrating the services and administration of healthcare to the AIAN community. Nixon-administration passed the Indian Self-Determination and Education Assistance Act in 1975 and the Indian health care Improvement Act in 1976, which have been instrumental in improvement in the health of the AIAN community.[2][1]

Since the establishment of IHS in 1955, and through commitments shown by various governments in the following years, the health of the AIAN community has improved significantly. Better sanitation programs, increased immunization rates, increased use of antibiotics, and healthcare provision have reduced morbidity and mortality in the AIAN community. An 82% decline in the infant mortality rate (IMR) is an astonishing feat achieved since the establishment of IHS. Although the morbidity and mortality from communicable diseases have reduced since the establishment of IHS, non-communicable diseases like obesity, diabetes, alcohol abuse have risen to the forefront.[3] Several 'social' parameters like poverty, low literacy level, unemployment, etc., remain higher amongst indigenous tribes than the rest of the country. Currently, these social disparities are the main drivers behind the numerous health care disparities seen in the AIAN community. This chapter reviews the health care disparities in the AIAN community compared to the non-Hispanic White (NHW) group. We also address the AIAN community as "indigenous people/tribe" at various points for this review.

Etiology

The etiology of health care disparities in AIAN includes both policy issues and personal factors. The personal demographic differences in the community (compared to the NHW population) coupled with the policy failure that plagued the health care services for centuries have certainly added to the disparities in healthcare.

Policy Failures

- The federal government's initial commitment to provide healthcare to the AIAN community was through a series of treaties. For example, at least 367 treaties were signed between the federal government and the tribes between 1778 and 1868.[1] As the Bureau for Indian Affairs (BIA) changed hands from the War Department to the Department of Internal Ministry in 1849, the vested interest of various lobbyists led to the poor execution of

healthcare policies.[1] Throughout the latter half of the 19th century and early 20th century, BIA worked as a tool to meet the "assimilation" goals of the government without much regard for the healthcare needs of the AIAN community. Despite this, few people worked tirelessly and, at times, aggressively towards the welfare of the AIAN community.[4]

- In the 19th century and early 20th-century, several policies were introduced to improve the living standards of the AIAN community's welfare. However, most of these policies were either misguided or were outright attempts to diminish the sovereignty of the indigenous tribes- For example, the New Deal (Launched during the Great Depression), the Termination era (federal attempt at terminating its responsibility toward the AIAN community), and the relocation policies (relocating returning soldiers to urban areas to achieve a better economic status)- led to the increased burden of healthcare in the AIAN community.

Demographic Differences

The stark prevalence of poverty, lack of education, and higher unemployment rates in the AIAN community also add to healthcare disparity.[5][6]

- Poverty and unemployment:
 - According to the 2018 US Census, 25.4% of the AIAN population lived in poverty, the highest amongst all ethnicities.
 - The median household income for AIAN is \$45,448, as compared to \$65,845 for NHW households. 30.5 percent of AIAN of the age 16 and over; work in management and professional occupations, compared to 42.9 percent of NHW. Also, 21.9 percent of this racial group live at the poverty level compared to 9.6 percent of NHW in 2017. The scarcity of employment puts pressure on the communities to seek hazardous employment that increases injury and death.[7]
 - According to the US Bureau of Labor Statistics data, in 2018, the unemployment rate was higher than the national rate (3.9%) for the AIAN community (6.6 percent).
 - AIAN are more likely to live in so-called food deserts, which is a major factor contributing to the high rates of diabetes, obesity, and heart disease in the community. For example, in the Navajo Nation, the second biggest tribe in North America, there are 13 grocery stores and 12 medical facilities scattered across more 27 000 square miles of land. One in three inhabitants does not have access to electricity, and one in three does not have access to running water.
- Literacy levels:
 - The differences in literacy levels are apparent in the most recent census. In 2017, 83.8 percent of AIAN alone or in combination had at least a high school diploma. In comparison to this, 92.9 percent of NHW had received at least a high school diploma. 19.6 percent of AIAN age 25 and over had at least a bachelor's degree, compared to 35.8 percent of NHW. 6.8 percent of AIAN held an advanced graduate or professional degree than 13.8 percent of the NHW population.

Mistrust in the Federal System

- One of the principal reasons for healthcare disparities in the AIAN population is the community's mistrust in the federally supported clinics. The long history of trauma, ethnocide, and genocide has left a deep void in the minds of the AIAN community that is hard to fill.[8] Since the late 19th century, multiple policies were adopted by respective federal governments in an attempt to destroy the native culture and identity. These policies led to the confiscation of land, banning native language and religious practices, use of traditional healers, etc. that left a deep mistrust in the AIAN community.[8] One of the most vivid practices is exemplified by policies

introduced by Captain Richard H. Pratt, founder of Carlisle Indian Industrial School. His motto of "Kill the Indian, and save the man" led to forcibly removing young children from families and put them in federally owned Indian Boarding School, where they were subjected to the federal government's Indian Education Program, designed explicitly to extinguish Indian cultures.[8] These practices continued well into the early 20th century.[8]

- Although the situation started to change after the passing of the Snyder Act in 1921 and the establishment of Indian health Services in 1955, there were still periods when federal policies led to discrimination of the AIAN community. For example, the period between 1946 and 1964 was called the 'Termination era' when the federal government attempted to end its trust relationship with AIAN nations. Congress adopted the House Concurrent Resolution 108 (HCR 108) on August 1, 1953, which was designed to terminate the sovereignty of the tribal nations and impose on the federal authority. During the Termination period, 109 tribes were terminated, 12,000 tribes lost affiliations, and approximately 2.5 million acres of tribal land were taken away from the tribes.[8]
- The social injustice continued even after the establishment of IHS. Multiple instances of social injustices (like forced sterilization, unethical research, and clinical misconduct in the name of research) have come forth that explain the mistrust of the AIAN community in the federal health services.[8] The most recent of these is the sterilization of American Indian women between 1973-76 by either force or coercion to consent. Several high-level lawsuits like *Havasupai Tribe v Arizona State University Board of Regents* and *Tilousi v Arizona State University Board of Regents* mark misrepresentation of research projects in the AIAN community.[8]

Underfunding of the Indian Health Services

The IHS suffers from chronic underfunding. For example, between 1993 and 1998, although the appropriations of IHS increased by 8%, medical inflation jumped by 20.6%. When adjusted for the growth in the AIAN population, per-capita appropriations decreased by 18% for this period. A level of need-funded (LNF) workgroup created in 1998 reported that the AIAN community's funding falls short by 46% compared with Federal Employee Health Benefits.[9]

Federal funding is divided into discretionary funding and mandatory funding. As the name suggests, discretionary funding is at the discretion of Congress and the President. The funding for AIAN healthcare programs is under the category of discretionary funding. In comparison, Medicare funding comes under mandatory funding. A few illustrative examples of the gaps in the IHS funding are listed here:

- Between 1980 and 2002, the disparity between Medicare and IHS funding and spending is glaring.
 - The growth in the per capita spending of IHS (4.8% per year) lags far behind the growth in per capita spending of Medicare (7.8% per year) and Medicaid (6.9% per year).
 - The Medicare spending per person grew by \$5200, IHS per person appropriations grew by only \$1121.
 - The gap in the IHS per capita spending and the Medicare per capita spending has widened between 1980 to 2002. The gap was 90% the size of IHS per capita spending in 1980, and the gap has increased to 250% by 2002.
 - In dollars per capita, the gap between IHS and Medicare widened from \$569 to \$4448.
 - Nothing has changed in 2017 either-According to a report by the National Congress of American Indians, in 2017, the IHS spent \$3,332 per patient. In contrast, Medicare spent \$12,829 per patient that year, and Medicaid spent \$7,789 per patient.
- The salaries paid to physicians and allied health workers working for AIAN have never equaled the national average:

- The Commissioner of Indian Affairs annual report in 1890 stated that clinicians working in the AIAN communities were paid almost a third of the salary (\$1028) compared to the army (\$2983) and navy clinicians (\$2622).

The above examples demonstrate the lack of resources that have plagued the Indian healthcare services. Although many governments have taken steps to increase the funding for IHS, it remains an underfunded organization.

Epidemiology

Since the inception of IHS in 1955, the agency has been working relentlessly to improve the AIAN population's healthcare outcome. Although communicable diseases have drastically reduced within the AIAN community, the incidence of chronic conditions, cancer, obesity, and diabetes have risen to the forefront. The latest data available on the Center for Disease Control (CDC) website and the Office of Minority Health website gives an idea of the healthcare disparities in the AIAN community.

Demographics

- There are 574 federally recognized Indian Nations in the United States (also called tribes, bands, pueblos, nations, communities, and native villages). Alaska houses approximately 229 of these linguistically, culturally and ethnically, diverse nations. The rest of the federally recognized tribes are established in 35 other states. In addition to this, there are state-recognized tribes located throughout the United States recognized by their respective state governments. There also are tribes that the state or federal governments do not recognize.
- As of 2017, an estimated 5.6 million people identified themselves as AIAN. This comprises 1.7% of the entire US population.
- The 2010 Census reported that 78 percent of the AIAN population live outside of tribal areas.
 - 22 percent of AIAN live on reservations or other trust lands. This is a sharp fall from the estimated two-third of the AIAN population living in reservation areas in the 1960s.
 - 60 percent of AIAN live in metropolitan areas; this is the lowest metropolitan percentage of any racial group.
- In 2017, 28.7 percent of the entire AIAN population (1.6 million) were under 18 years. Arizona, California, Oklahoma, New York, New Mexico, Texas, Washington, North Carolina, Florida, and Alaska are the states with the largest AIAN population.

Insurance Coverage (2018 data from CDC)

- AIAN community has the largest percentage distribution of uninsured individuals amongst all races.
- Age below 65: 34.6 percent of AIAN alone or in combination had private health insurance coverage. 32.2 percent of AIAN relied on Medicaid or public coverage, and 28.8 percent of AIAN had no health insurance coverage. In comparison, 64.9 percent of NHW have private insurance, 20.1 percent have Medicaid or public coverage, and 10.1 percent have no health insurance.

Life Expectancy and Overall Health

- The 2015 life expectancies at birth for AIAN are 77.5 years, which very close to the national average of 79.8 years for NHW. The life expectancy for AIAN women is 80.3 years and 74.7 years for men. For NHW, the projected life expectancies are 82.0 years for women and 77.5 years for men.

- This is a marked improvement in the overall life expectancy compared to 1968, when President Johnson has stated that the average life expectancy of AIAN is 44 years compared to the national average of 65.
- However, differences within different states exist.
 - For example, in Alaska, a state with a 15% AIAN population, the age-adjusted mortality rate is 1222.6 per 100,000 AIAN population, which is almost 3.5 times higher than NHW (393.7 per 100,000 NHW population).
 - Likewise, in Montana, where 9.3% of the population identifies itself as AIAN, the age-adjusted mortality rate is 1386.9 per 100,000 AIAN population, which is almost double compared to NHW (678.1 per 100,000 NHW population)
- The 2018 Infant Mortality rate in the AIAN population continues to be double at 8.15 per 1000 live births compared to 4.63 per 1000 live births in the NHW population. In some states, the differences in IMR are more vivid-
 - For example, in Alaska, where AIAN constitutes 15% of the population, the IMR is 14.5 per 1000 live births, compared to 4.8 per 1000 live births in NHW.
 - Likewise, in Montana, where 9.3% of the population identifies itself as AIAN, the IMR is 12.5 per 1000 live births, compared to 5.9 per 1000 live births in NHW.
- In 2018, 17.4% AIAN population reported being in fair or poor health compared to 10% of the NHW population.

Chronic Health Conditions

- 17.4 percent of AIAN reported having fair or poor health compared with 8.3 percent of NHW.
- AIAN have a rate of HIV infection twice as high as that of NHW
- In 2017, AIAN adults were almost three times more likely to have diabetes and 2.5 times more likely to die from the same than NHW adults.
- AIAN adolescents are 30 percent more likely than NHW adolescents to be obese.

Tobacco Consumption [10]

- Tobacco consumption is highly prevalent in the AIAN community. This is different from the consumption of traditional tobacco that is used for ceremonial and medicinal purposes. The CDC's data alludes to the commercially produced tobacco from Tobacco companies as cigarettes, cigars, etc. The tobacco companies do NOT manufacture the 'traditional' tobacco- this is made locally within the tribes, and its use has been prevalent for centuries.
- AIAN youth and adults have the highest cigarette smoking rate among all racial and ethnic groups in the United States.[5]
- They are more likely to have tobacco-related diseases and deaths.
 - Cardiovascular disease and lung cancer are amongst the leading causes of death in the AIAN community.
 - The risk of developing diabetes is almost 40% higher amongst the AIAN community who smoke versus those who do not smoke.

- They also have the lowest motivation to quit tobacco amongst all races. An estimated 55.6% of AIAN report that they want to quit compared to 72.8% of African Americans, 67.5% of Whites, 69.6% of Asians, and 67.4% of Hispanics.
- More AIAN women smoke during their last 3 months of pregnancy—26.0% compared to 14.3% of whites, 8.9% of African Americans, 3.4% of Hispanics, and 2.1% of Asians/Pacific Islanders.

Leading Causes of Death

- Heart disease, cancer, and accidents are now the leading causes of death among the AIAN community.
- In 2018, chronic liver disease was listed by CDC as the fourth-leading cause of death in the AIAN community.
- Like the rest of the country, lung cancer leads the pack amongst the cancer-related deaths in the AIAN community.
- In 2017, accident, suicide and homicide were the top three reasons for death in the AIAN population between 5-34 years.

Cancer Screening

Cancer mortality rates for AIAN are among the highest of all racial and ethnic groups in the United States.[11][12] In addition to this, it is also known that the AIAN population utilizes fewer screening tools and presents with a higher stage of cancer.[13]

- In 2015, only 51.5% of AIAN women above 40 years of age received mammography compared to 65.3% of NHW women. However, one must note that where the percentage of NHW women receiving mammogram have stayed consistent since 2005 to 2015 (65-67%), the numbers have seen a sharp variation in the AIAN population (71% in 2005 to 62% in 2013 to 51% in 2015).
- In 2015, only 60.9% of AIAN women (18 years and over) received a pap smear, compared to 69.8% of NHW women. Again, a declining trend has been noted since 2005 in the pap-smear screening of the AIAN population.

Psychiatric issues and Mental Health

Mental health disorders are amongst the top 10 reasons for IHS hospitalizations and outpatient visits.[14] A study exploring the epidemiology of psychiatric issues reported that AIAN men have a significantly higher incidence of a psychiatric disorder than NHW men (70.09% versus 62.1%). Similarly, AIAN women were also at a significantly higher risk of a psychiatric disorder than NHW women (62.9% versus 52.86%). The study also showed a higher incidence of 'any Axis I disorder,' 'any substance abuse disorder,' and 'any alcohol use disorder' amongst AIAN men and women compared to NHW men and women, respectively. Some of the important ones are listed here.

- Trauma and Post-Traumatic Stress Disorder
 - The people of the AIAN community are at a higher risk of experiencing trauma than the general population and are twice as likely to develop post-traumatic stress disorder.[15]
 - The largest healthcare survey amongst the native tribes showed that two-thirds of people from the AIAN community reported levels of lifetime trauma, which is much higher than those in the general population. [16]
 - In addition to this, unintentional trauma, like a motor vehicle accident, is also higher in the AIAN community.[15]
- Substance Abuse:

- The rate of substance abuse is also higher in the indigenous population than in the general population. [17]
- AIAN adolescents (age 12-17 years) have a significantly higher incidence of marijuana use than NHW counterparts (6.1 to 3.3%).
- Data from the 2007 to 2009 national Youth Risk Behavior Survey (YRBS) demonstrated that AIAN youth are more likely to drink alcohol, use cocaine, marijuana, or an over-the-counter prescription drug before 13 years of age compared to their NHW counterpart.[18]
- Suicide:
 - Suicide rates in the US are 33 percent higher than in 1999. However, it rose by 139 percent in AIAN women and 71 percent in AIAN men (Centers for Disease Control and Prevention's National Center for Health Statistics).
 - Native communities have a higher suicide rate compared to every other racial and ethnic group in the U.S.
 - In 2017, suicide was the second most cause of death between ages 10-34 years in the AIAN community.
 - For Native youth ages 15 to 19, the suicide rate is 2.3 times higher than the NHW.
 - Overall the age-adjusted rate of suicide is 1.2 times higher in the AIAN community compared to NHW.

Mental Health [19] [17] [19]

- In 2018, 4.5 percent of AIAN adults reported serious psychological distress.
- In 2018, 14.1 percent of AIAN adults received mental health services compared to 18.6 percent of NHW adults.
- 11.6 percent of AIAN adults received prescription medication for mental health services than 15.4 percent of NHW adults.

Violence

- Four in five AIAN women experience violence in their lifetime- Out of these, up to 56% experienced sexual violence, 55.5% experienced physical violence by an intimate partner, 48.8% experienced stalking, and 66.4% experienced psychological aggression from an intimate partner. This adds up to 1.5 million AIAN women experiencing violence in some form.
- A 2016 National Institute of Justice funded study found that AIAN women are at 1.2 times higher risk of experiencing violence than NHW women and 1.7 times higher in the previous year alone.
- The situation is no better with men either, where AIAN men are also 1.3 times more likely to experience violence than NHW men.
- AIAN women are 2.3 more likely to 'need' remedial services (like medical care, legal service, housing, advocacy) than NHW women. However, they are 2.5 times as likely to lack access to this care compared to NHW women.
- One in three AIAN women and one in six AIAN men cannot get the services they need in case of violence.

COVID-19 and Impact on AIAN community

Each pandemic brings an insurmountable amount of suffering in the world and exposes the fault lines in the healthcare of underserved communities. Historically all pandemics have hit the AIAN community much harder compared to other communities. For example, during the H1N1 pandemic in 2009, the AIAN community had four times higher mortality rates than the general population.[20] Likewise, during the Spanish flu in 1918, natives comprised 80% of the death toll in Alaska. The COVID-19 pandemic laid bare the vulnerability of the AIAN communities. From January to June 2020, AIAN were noted to have 3.5 times higher risk of being diagnosed with COVID-19 than NHW. The risk of mortality amongst the AIAN community was twice as high compared to NHW. [21][22] Until December 2, 2020, CDC has reported 4,506 COVID-19– related deaths in the AIAN community. As of Feb 7, 2021, 181 576 cases of COVID-19 among AIAN have been reported to the IHS.

The Color of Coronavirus (CoC) project looking at the racial disparities in the death toll from COVID-19 brings out the stark differences in the healthcare disparities in the AIAN community. The latest figures have reported that 1 in 475 Indigenous Americans has died (or 210.6 deaths per 100,000) through February 2021 since the start of the pandemic. This death rate is the highest amongst all racial and ethnic groups and is twice as high as NHW, which stands at 120.9 deaths per 100,000. As of Feb 2021, the CoC project has reported 4,506 COVID-19– related deaths in the AIAN community. In another study, collecting data between January to June 2020 from 14 states and representing 46.5% of all the AIAN population in the US reported that the age-adjusted COVID-19 related mortality was higher in AIAN (55.8 deaths per 100,000) compared to NHW (30.3 death per 100,000). Although the death rate amongst various age groups increased with increasing age for both AIAN and NHW, 35.1% of AIAN deaths occurred in age group less than 60 years compared to 6.3% in the NHW population. The mortality from COVID-19 on the AIAN community in different age groups is much higher compared to NHW. In the 20 to 29 year age group, the mortality is 10.5 times higher. In the 30-39 years age group, it is 11.6 times higher, and in the 40 to 49 years age group, mortality is 8.2 times higher in the AIAN community than NHW.[21]

History and Physical

The clinicians and social workers working for the IHS face a special challenge. The mistrust of the AIAN community in the IHS and the inability to provide comprehensive services due to chronic underfunding raises innumerable barriers to providing care to the AIAN community.

When approaching a patient from the AIAN community, it is important to pay special attention to their traditions and history. Many patients, especially those living in non-urban areas, use the services of traditional healers. It is important to note this, as a negative approach towards a traditional healer may break the communication with the patient. It is important to note the habits of the patient (like the use of alcohol, tobacco, etc.), occupational history, family history.

As noted above, post-traumatic stress disorder is prevalent in the AIAN community, and the majority of the community reports trauma in one form or the other. The history of trauma, especially in women and children, must be elicited. In addition to this, every opportunity should be used to suggest and promote vaccinations and cancer screening.

Evaluation

The clinical exam should be thorough and complete, looking for signs of disease. Due to disparities in care afforded by the IHS, it is often challenging to perform a diagnostic procedure in time for such patients. Hence it becomes all the more important to perform a complete and thorough clinical exam.

Treatment / Management

Bridging the healthcare disparities in the AIAN community needs a multifaceted approach. Some of this has been possible through the enactment of many historical acts that have not only brought more clarity and commitment on

the part of the federal government but have also recognized the sovereignty of the tribal nations and have provided them with more authority to guide their local health system according to the needs of the community. The provisions of the health care delivery system for the AIAN community have evolved due to numerous legislative measures. It is now called the “I/T/U” system, where “I” represents IHS, “T” stands for the tribal 638 programs, and “U” stands for the urban health centers.

The Four Historical Acts

1. The Snyder Act:

- Enacted in 1921, this was the first law that allowed Congress to appropriate funds directed towards healthcare for the AIAN community.
- The funding authority for many of the current activities of the IHS is rooted in the Snyder Act.

2. Transfer Act:

- Passed in 1954, this act made the Indian Health program the responsibility of the Public Health Service.
- The language of the act recognized the sovereignty of the indigenous tribes and afforded them some degree of self-determination in health policy decision-making.
- The authorities contained in the Snyder Act were also transferred to the Secretary of Health, Education, and Welfare (now Health and Human Services).

3. Indian Self Determination and Education Assistance Act:

- Passed in 1975, this act is considered one of the most crucial healthcare reforms for the AIAN community.
- This act allowed the indigenous tribes to assume the management of BIA and IHS programs.
- Under the "638 contract," responsibility for any program, function, service, or activity of the IHS can be taken over by the tribe.
- The act provides several financial and administrative advantages to the tribes.
 - 'Carry over' funding: Any funding left at the end of the fiscal year can carry over to the next year without any explanation required from the tribal organization.
 - Third-party Revenue: The revenue collected from public or private funding is separate from the dollars obtained in grants through 638 funding agreements and is independent of the 638 funding agreement.
 - Eligibility for grants: The act made tribes eligible for several federal grants, which are not available to IHS (being a federal agency).
 - Contract support costs: Helps the tribes by supporting the indirect costs. This support is not available to IHS independently.
- In essence, the act allows the tribe the flexibility of spending healthcare dollars the way they envision it and has many substantial provisions that help in obtaining federal grants to supplement funding for the IHS.

4. Indian Healthcare Improvement Act:

- Passed in 1976, this act brought more clarity to the US federal government's role in providing healthcare to the AIAN community.
- Title V of the Indian Healthcare Improvement Act established the Urban Indian Health Programs. Today, 34 such programs exist in the US.
- The act also reauthorized the provision to the IHS and tribal 638 health programs to bill Medicare and Medicaid. This step was crucial in providing ease of access to AIAN patients who depend on Indian health programs for medical services.

The impact of the Affordable Care Act

The Affordable Care Act (ACA) is a major health insurance reform that brought several advantages to the AIAN community.

1. It led to the permanent reauthorization of the Indian healthcare improvement Act,
2. The ACA extended the current law and provided authorization to several new programs and services within the IHS.
3. The ACA allows provisions that help extend preventive care to the AIAN community by making the health insurance companies pay for preventive services, including cancer screening. For example, when a screening colonoscopy was not available through IHS, it was challenging to get one through the contract system. The ACA remedies this challenge and makes the insurance company liable to cover the cost of screening colonoscopy.

Indian Health Services

The IHS is a federally funded program that provides healthcare to the AIAN community. They provide primary care services and limited dental services to nearly 2.6 million AIAN citizens and descendants. The establishment of IHS has attempted to bridge the gap in the disparities. For instance, since the IHS came into being, the overall mortality rate has dropped by 15 years. However, several parameters in the AIAN community continue to show poor outcomes and reveal the stark disparity in healthcare. In this review, we will discuss the disparities in healthcare for the AIAN community.

Currently, the IHS funds 41 urban Indian health organizations. These organizations operate in various cities throughout the United States, providing care to the AIAN community that lives in the urban area. Apart from the medical services, the programs also extend dental services, community services, HIV and sexually transmitted disease education, alcohol and drug use prevention. Apart from this, they also provide prevention services, mental health services, nutrition education, counseling, pharmacy services, health education, optometry services, social services, and home health care.

When IHS came into being, the disparity in the health of the AIAN community seemed insurmountable. The infant mortality rate (IMR) was three times higher than other races, and life expectancy was nine years lower than the average population. A quarter of all deaths occurred in infancy before attaining one year of age. Maternal deaths associated with childbirth were three times higher than NHW. Infectious diseases like diarrhea, tuberculosis, chlamydia eye infection were rampant. Despite the chronic issues faced by the IHS (listed above), there are some notable achievements of the organization in reducing the disparities in the healthcare of the AIAN population.

- In the first 25 years of its existence, the IMR dropped by 82%, whereas the maternal mortality rate (MMR) dropped by 89%. By 1992, the IMR in the AIAN community was only 4% higher than the general population, and the MMR was 12% lower than the general population.

- Similarly, the death rate from tuberculosis dropped by 96%, and the deaths from diarrhea and dehydration dropped by 93%.
- The AIAN community's rate of improvement outpaced other underserved communities (between 1980-1994, IMR dropped by 50% in the AIAN community, compared to a 25% drop in the African-American community).
- Mortality from dehydration has dropped from 138% in the earlier years to less than 15% in the early 1990s.
- Although non-communicable diseases have risen in the AIAN community, the IHS has been phenomenal in implementing a sanitation program and immunization programs that have brought down the mortality rates from communicable diseases.

Approaching a Patient from the AIAN Community

The approach to the AIAN population is multifaceted. Psychological/Psychiatry support is a critical part of providing healthcare to the AIAN community. It is important to understand the cultural differences that exist amongst various tribes as well the differences that exist in the belief of people from the AIAN community. Although many tribes may have adopted Christianity, their culture is still deep-rooted in their traditions. It is important to understand these differences and apply them when serving the AIAN community.

The American Psychiatric Association has listed a few steps in approaching patients from the AIAN community. It is important to understand the cultural beliefs of any native/tribe that the healthcare providers are serving.

The psychiatric assessment of a patient belonging to the AIAN community starts by knowing the history of the indigenous people.

1. PTSD should be high on the list given the history of trauma (loss of sacred lands, forced assimilation, loss of family, etc.).
2. All providers (doctors, nurses, support staff, etc.) must understand that mistrust for IHS clinics runs high in the AIAN community.[23] Try to create a familiar environment in the office (decorating office according to local cultural sensitivity and customs. Engage patients in a supportive way without imposing any restrictions. All forms require translation into the local language for ease of answering.
3. Evaluation should be thorough to avoid stereotypes and misdiagnosis. If an indigenous person does not speak the native language, it does not mean that they do not practice their culture. Avoiding stereotypes at all points helps in preventing misdiagnosis.
4. Allow the patients to tell their story with extreme sensitivity towards their culture and identity. It is critical in establishing a rapport with the patient and understanding their background.
5. Soft-hand off should be practiced between primary care provider, therapist, and psychiatrist. The therapeutic process should be tailored according to the individual and not according to the facility. Starting at lower doses is always advisable to prevent the negative effects of polypharmacy.
6. The accessibility of care should be made clear to the patients with a thoughtful discharge process.

Differential Diagnosis

The reasons for disparities in the healthcare of the AIAN community have been discussed above.

Deterrence and Patient Education

Providers serving the AIAN community must appreciate the cultural differences and the history of the community. Although many of the AIAN community has moved out of reservations into the urban areas, significant disparities

still exist in their healthcare and health outcomes. Coupled with the constant lack of resources and funding in the IHS, healthcare disparity tends to increase exponentially. Having a flexible approach towards individual patients may help to navigate tough situations and provide optimal care.

Pearls and Other Issues

- Significant healthcare disparities exist in the healthcare of the AIAN people compared to NHW.
- Many of these disparities are because of the poor economic situation and literacy levels in the AIAN community.
- An unfortunate history and a series of misdoings have resulted in a chronic mistrust of the AIAN community in the Indian health services. Hence, building trust to serve this community is an important first step.
- Indian health services have been serving the AIAN community since 1955. The improvement in the immunization rates has led to a significant reduction in deaths from infection and improved maternal and infant mortality rates. Their efforts have reduced the burden of communicable diseases within the AIAN community.
- Non-communicable diseases like obesity, cancer, substance, and alcohol abuse have risen in incidence and now are the major health issues plaguing the AIAN community.
- A large number of psychiatric and mental health diseases are prevalent in the AIAN community. Post-traumatic stress disorder is very common in the AIAN community and should be first on the list of differentials.
- The AIAN community has been afforded more sovereignty and independence in managing their own health care issues through a series of acts enacted by the federal government. However, significant issues still exist in providing them optimal healthcare.
- Some tips for managing a patient from the AIAN community:
 - Know the history of the tribe/ indigenous people, and respect the differences.
 - Have an interpreter ready to understand the health issues.
 - Be patient and listen, and respect their strong belief in their culture.

Enhancing Healthcare Team Outcomes

The clinical issues in the AIAN community need to be addressed through a coordinated care plan amongst all healthcare providers, including doctors, nurses, and the supportive staff. The entire interprofessional healthcare team (clinicians, mid-level practitioners, nurses, pharmacists, therapists, ancillary staff) needs to understand the history of the tribe they are serving and respect their culture and differences. There is Level 3 to 4 evidence (in terms of historical cohorts, cohort-case control studies) demonstrating an improvement in the care provided to this community when the providers respect the culture and differences in the AIAN community.

Review Questions

- [Access free multiple choice questions on this topic.](#)
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