A RIGHT, NOT A PRIVILEGE: AMERICAN INDIAN ACCESS TO HEALTHCARE

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What is the Issue?

A lack of access to healthcare for urban American Indians

2009-2013 American Indian and Alaska Native Metro Populations

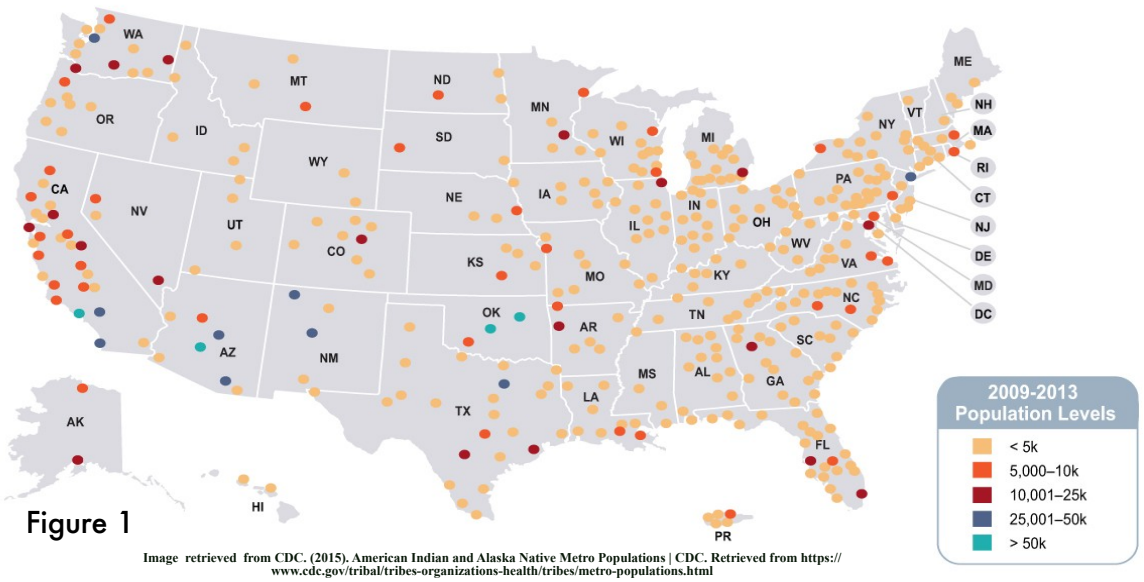

Figure 1

Image retrieved from CDC. (2015). American Indian and Alaska Native Metro Populations | CDC. Retrieved from https://www.cdc.gov/tribal/tribes-organizations-health/tribes/metro-populations.html

Approximately **70%** of American Indians currently live in urban ,or metropolitan, areas.[1] Of this population, **25%** live in counties where there are IHS funded health facilities that provide culturally competent healthcare.[2] However, these facilities make up only **1%** of the IHS budget, while leaving over half of urban American Indians without a facility nearby.[3] My target population belongs to a minority group that has historically faced **high disparities** in incidences of disease, with **low access** to healthcare.[4] Now, urban American Indians face particularly steep disparities in access to care in the forms of distance to adequate facilities and the ability to receive treatment at culturally competent health facilities. Why do these points matter? **Health care access can be the difference between life and death.** Therefore, I propose the building of facilities in urban areas with significant American Indian populations, which will require an increase in IHS funding.

Significance

Healthcare access promotes reductions in disease, premature death, and health inequity.[5] Insurance , timeliness of care, and adequate health facilities are the greatest determinants of healthcare access.[5] For urban American Indians not within an area with an Urban Indian health facility, timeliness may be impacted in ways that significantly decrease the ability to receive adequate healthcare. For a population that has historically faced significant disparities in disease rates, and had their culture undermined, healthcare that is sensitive to these histories is imperative so as not to perpetuate them within medical interactions.[6] Cultural sensitivity is then a matter of adequacy. Low access to healthcare in combination with high disease disparities is a situation that places urban American Indian populations on the fringes of healthcare, directly impacting the longevity and continuation of these communities. In this way, healthcare is very much a question of quality of life and of the ability to live.

Key Terms

- **Culturally Competent Health Care:** Health care that thoroughly considers the social, cultural, or religious background of the patient.[7]
- **Federally Recognized Tribe:** Tribe that receives benefits and political recognition through the Bureau of Indian Affairs' (BIA).[8]
- **Urban American Indian:** American Indian who resides in an urban location (large city, metropolitan area).[1]
- **IHS (Indian Health Services):** Department of Health and Human Services agency that provides health services to federally recognized American Indians and Alaskan natives.[8]

URBAN AMERICAN INDIAN HEALTH FACILITIES (2019)

Figure 2

Data retrieved from Indian Health Service, & U.S. Department of Health and Human Services. (n.d). Office of Urban Indian Health Programs National Programs. Retrieved from https://www.ihs.gov/urban/nationalprograms/

#1 Prevailing Myth

American Indian health disparities are the result of bio-medical ignorance and not issues of healthcare access

Higher levels of medical distrust have been observed in populations with oppressive histories of institutional medical and/or social violence.[9] In such context, medical distrust functions as the enduring legacy of medical violences, and is not the result of bio-medical ignorance. However, even medical distrust (a valid barrier), does not explain American Indian higher incidences of certain conditions, low healthcare access (distance), nor the inability to reach culturally sensitive health institutions (adequacy).[10] Therefore, it can be deduced that access is the greater determinant of disparities in healthcare in American Indian populations currently.

"Of all the forms of inequality, injustice in health is the most shocking and inhumane."

-Martin Luther King

POLICY SOLUTIONS

I lay out the following two-part policy, recommending the most immediate implementation

As of now, there are forty-one IHS funded non-profit urban American Indian health centers that provide care to urban American Indians in various cities across the country.[11] These urban centers seek to empower American Indians through the implementation of community engagement programs that engage in health education, screenings/treatment and preventative care, and cultural unity.[11]

These centers are incredibly important in providing urban American Indians with health care that is adequate and accessible. However, in 2018, funding for urban health programs was only $45,000.[3] Not only this, the urban health centers did not provide care to almost 50% of urban American Indians due to lack of nearby facilities; the IHS has recognized 18 other cities as having a large enough population to warrant the implementation of urban American Indian health programs, but has not yet initiated programs for these populations.[3]

So, there are two issues that must be tackled when I refer to the expansion of IHS funded urban American Indian health programs: physical locations and funding. The expansion of IHS urban programs through the allocation of a greater percentage of total IHS funds, may increase the ability of these centers to care for their target population, while also increasing the effectiveness of their services. However, to maximize the population served, the budget would need to be further increased to account for the supply and management of facilities in areas that do not yet have one.

Regarding the issue of physical location, I recommend the building of centers that are able to be reached through public transport in cities where there exist significant American Indian populations. In most cases, the center would need to be located in a city that supports an active public transport system that is easily accessible to that population (free, near low-income areas). For the purposes of implementation over the next couple of years, I define significant as populations over 5,000 within a particular city, or populations within neighboring urban areas that jointly have a population of over 5,000. The continued operation, and initial implementation of these buildings will far exceed the current amount of money allocated to urban American Indian health programs as a high end medical bed alone can cost approximately 5% of the overall IHS urban health programs budget.[12] This leads me to my next point, increasing IHS funds.

In regards to increasing the allotment of funds to urban Indian health programs, one must first understand that the IHS is severely underfunded, and that funds are heavily considered before being implemented in one particular way.[13,14] It is imperative then that for urban health programs to become a point of greater funding, the IHS is able to expand its budget. The budget is set annually indicating that there is the potential for funding to increase through advocation, especially by tribes that have large percentages of urban members. However, the budget must be approved by Congress, leaving it politically vulnerable as the makeup of Congress changes.

Another vulnerability of IHS funding is that it is often not in the forefront of most political conversations about budget allotments. Part of this is an issue of how American Indian health is perceived, as noted in the section regarding the myth of American Indian bio-medical ignorance. Another issue is that American Indians are often not referenced in national debates about race, health disparities, and healthcare access. It is crucial that American Indian health becomes a part of the broader public awareness.A more informed public may result in greater scrutiny and push back against any proposed budget cuts to IHS programs, and increased support for broadening the budget. Implementation of my recommended policies begins with the understanding that American Indian access to healthcare is

A MATTER OF LIFE AND DEATH[15]

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