



# NATIONAL CONGRESS OF AMERICAN INDIANS

## U.S. House Committee on Oversight and Reform Select Subcommittee on the Coronavirus Crisis Hearing on An Unequal Burden: Addressing Racial Health Disparities in the Coronavirus Pandemic

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### Written Testimony of President Fawn Sharp National Congress of American Indians June 4, 2020

On behalf of the National Congress of American Indians (NCAI), thank you for holding this hearing on “An Unequal Burden: Addressing Racial Health Disparities in the Coronavirus Pandemic.” I am Fawn Sharp, President of the Quinault Indian Nation and President of the National Congress of American Indians (NCAI).

Founded in 1944, NCAI is the oldest and largest representative organization serving the broad interests of tribal nations and communities. Tribal leaders created NCAI in response to federal policies that threatened the existence of tribal nations. Since then, NCAI has fought to preserve the treaty and sovereign rights of tribal nations, advance the government-to-government relationship, and remove structural impediments to tribal self-determination.

There are over 574 federally recognized tribal nations within the United States that are rich in their geographic, political, and cultural diversity. Like all other governments, tribal nations strive to ensure the health and wellbeing of their citizens and all those who reside in their communities. As part of tribal nations’ responsibilities to their communities, they provide a range of governmental services including health and public health services.

These services are funded by the United States government due to the unique political relationship between tribal governments and the U.S. which resulted from the forced cessation of tribal nations’ lands and resources. For over two hundred years, the United States has consistently maintained a government to government relationship with tribal nations whereby it has recognized a trust and treaty relationship to deliver health care to tribal citizens and safeguard tribal rights and resources. Tribal health care is delivered through a three-tiered system as follows:

IHS provides health care either directly or through facilities and programs operated by Indian tribes (ITs) or tribal organizations (TOs) through self-determination contracts and self-governance compacts authorized under P.L. 93-638. IHS also provides services to urban Indians through grants or contracts to Urban Indian Organizations (UIOs). The system is referred to as the I/T/U system, and services available vary. UIOs offer outpatient services, while the IHS and the ITs may provide both outpatient and inpatient care....<sup>1</sup>

<sup>1</sup> COVID-19 and the Indian Health Service Updated May 1, 2020, Congressional Research Service, <https://crsreports.congress.gov/product/pdf/IN/IN11333>

Despite its fiduciary responsibility, the federal government has consistently neglected its legal obligations to tribal nations and citizens resulting in a 21<sup>st</sup> century health and socio-economic crisis in Indian Country.<sup>2</sup> This existing crisis created disparities that led to American Indians and Alaska Native's (AI/AN) vulnerability to the coronavirus-19 (COVID-19) pandemic and resulted in our communities having the highest per-capita COVID-19 infection rate in the United States.<sup>3</sup> Today I look forward to highlighting current health impacts of COVID-19 in Indian Country, identifying the cause of these health disparities, and addressing solutions to protect the health and wellbeing of AI/ANs.

## **COVID-19 Has Disparately Impacted American Indians and Alaska Natives**

Infectious diseases have historically ravaged AI/AN populations and threatened the existence of our peoples. These diseases brought to the North American continent from European settlers led to an estimated death of 90 percent of Native peoples.<sup>4</sup> In the 20<sup>th</sup> century, the 1918 influenza pandemic disparately impacted AI/AN communities with mortality rates four times higher than in the general population.<sup>5</sup> Even within AI/AN populations, the disease disproportionately devastated some communities such as the Iñupiat village of Brevig Mission, Alaska, where 72 of the 80 Iñupiat residents died of influenza within five days.<sup>6</sup> More recently, in the 2009 H1N1 flu outbreak, AI/ANs again died at four times the rate of all other racial and ethnic groups combined.<sup>7</sup>

Presently, the rate of infection and deaths from COVID-19 continues to grow in AI/AN communities. As of June 3, 2020, the Indian Health Service (IHS) reports nearly 11,475 positive cases within the IHS, tribal, and urban Indian health care system (I/T/U).<sup>8</sup> According to the Centers for Disease Control and Prevention (CDC), AI/AN communities have lost at least 395 lives to COVID-19, the majority of whom are over the age of 55.<sup>9</sup> Today, despite being only 0.2 percent of the weighted distribution of the U.S. population, non-Hispanic AI/AN COVID-19 deaths represent 0.5 percent of all U.S. deaths related to the COVID-19 virus. This disparity is even greater in some parts of Indian Country. For example, in New Mexico, AI/ANs make up approximately 11 percent of the weighted population, yet represent at least 43.7 percent of the state's deaths caused by COVID-19. In Arizona,

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<sup>2</sup> A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country, U.S. Commission on Civil Rights, <https://www.yumpu.com/en/document/read/32869468/a-quiet-crisis-federal-funding-and-unmet-needs-in-indian-country>

<sup>3</sup> Coronavirus Resource Center, COVID-19 United States Cases by County, Johns Hopkins University of Medicine, <https://coronavirus.jhu.edu/us-map>

<sup>4</sup> The Cultural Implications of European Disease on New World Populations: With Primary Focus on the Abenaki, Powhatan, and Taino Groups, Mariel Rivera, <https://www.monroecc.edu/fileadmin/SiteFiles/GeneralContent/events/scholarsday/documents/rivera-finaldraft.pdf>

<sup>5</sup> The Influenza Epidemic of 1918–1920 among the Navajos: Marginality, Mortality, and the Implications of Some Neglected Eyewitness Accounts, American Indian Quarterly, Brady, Benjamin R., and Howard M. Bahr, [https://www.jstor.org/stable/10.5250/amerindiquar.38.4.0459#metadata\\_info\\_tab\\_contents](https://www.jstor.org/stable/10.5250/amerindiquar.38.4.0459#metadata_info_tab_contents)

<sup>6</sup> 1918-19: 'Spanish Influenza' Claims Millions of Lives, National Institute of Health, National Library of Medicine, Native Voice, <https://www.nlm.nih.gov/nativevoices/timeline/420.html>

<sup>7</sup> H1N1 Influenza (Swine Flu), Talha N. Jilani; Radia T. Jamil; Abdul H. Siddiqui, <https://www.ncbi.nlm.nih.gov/books/NBK513241/>

<sup>8</sup> Coronavirus Cases by IHS Area, Indian Health Services, <https://www.ihs.gov/coronavirus/>

<sup>9</sup> Deaths involving coronavirus disease 2019 (COVID-19) by race and Hispanic origin group and age, by state, May 28, 2020, National Center for Health Statistics, <https://data.cdc.gov/NCHS/Deaths-involving-coronavirus-disease-2019-COVID-19/ks3g-spdg>

the weighted distribution of the AI/AN population is 2 percent; however, the distribution of COVID-19 deaths is at least 21.6 percent.<sup>10</sup>

While stark, these statistics undercount the extent of COVID-19 within AI/AN communities due to three critical issues with data collection. First, the complexities of the health service delivery system for AI/ANs make it difficult to provide comprehensive hospitalization and mortality data for our population.<sup>11</sup> The IHS system includes a network of facilities, including those directly operated by the IHS, Tribal health programs, and Urban Indian Organizations (collectively referred to as the “I/T/U system”). Only those facilities that are directly operated by IHS are required to report their data, representing about 19 percent of the facilities in the I/T/U system.<sup>12</sup> Additionally, gathering national IHS data is hindered by an outdated electronic record system that has yet to be replaced.<sup>13</sup>

Second, the inability to provide coronavirus testing across Indian Country has greatly hindered tribal government’s ability to respond to this pandemic. In March 2020, the CDC published a fact sheet assuring that all IHS facilities had access to COVID-19 testing.<sup>14</sup> However, many tribal nations have reported shortages of test kits and an inability to test their citizens. Further, in April, the CDC, through IHS provided the Oyata Health Center, a tribally-managed facility in Rapid City, South Dakota with only 24 test kits per week. The Great Plains Tribal Chairmen’s Health Board estimated need for test kits in Rapid City alone was 1,400 test kits.<sup>15</sup>

Third, 71 percent of AI/ANs live in urban areas and utilize county and state health services.<sup>16</sup> Current data collection practices by many state and local entities often omit or misclassify AN/AN populations, providing us with an inaccurate reality. Further, accessing state data is difficult for tribal nations and tribal epidemiology centers due to state data capacity issues and access fees.

### **COVID-19’s Disparate Impact on Tribal Communities is a Result of the Underfunding of the Federal Trust and Treaty Responsibility**

The COVID-19 pandemic has disproportionately impacted AI/AN communities due to underlying health and living disparities that are a result of the chronic underfunding of the federal government’s trust and treaty responsibilities.

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<sup>10</sup> Weekly Updates by Select Demographic and Geographic Characteristics, Provisional Death Counts for Coronavirus Diseases, Centers for Disease Control and Prevention, [https://www.cdc.gov/nchs/nvss/vsrr/covid\\_weekly/#Race\\_Hispanic](https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/#Race_Hispanic)

<sup>11</sup> Disaggregating American Indian & Alaska Native data: A review of literature, National Congress of American Indians Policy Research Center, <https://www.policylink.org/sites/default/files/AIAN-report.pdf>

<sup>12</sup> IHS Profile Fact Sheet, Indian Health Services, <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>

<sup>13</sup> Information Technology, Agencies Need to Develop Modernization Plans for Critical Legacy Systems, June 2019, United States Government Accountability Office, <https://www.gao.gov/assets/700/699616.pdf>

<sup>14</sup> IHS Frequently Asked Questions Regarding COVID-19, U.S. Department of Health and Human Services, Indian Health Service, [https://www.ihs.gov/sites/newsroom/themes/responsive2017/display\\_objects/documents/IHS\\_COVID-19\\_FAQs\\_03162020.pdf](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/IHS_COVID-19_FAQs_03162020.pdf)

<sup>15</sup> NR Dems Forum: Coronavirus Response in Indian Country hosted by Chairman Raúl M. Grijalva, U.S. House Natural Resources Committee, <https://naturalresources.house.gov/hearings/coronavirus-response-in-indian-country>

<sup>16</sup> 2010 Census Shows Nearly Half of American Indians and Alaska Natives Report Multiple Races, United States Census Bureau Newsroom, [https://www.census.gov/newsroom/releases/archives/2010\\_census/cb12-cn06.html](https://www.census.gov/newsroom/releases/archives/2010_census/cb12-cn06.html)

## *Disparate Health and Living Conditions*

AI/ANs have a life expectancy that is 5.5 years less than the overall U.S. population and have many of the factors that increase their risk for severe illness from COVID-19.<sup>17</sup> Compared to other groups, AI/ANs have disproportionately high rates of diabetes, heart disease, and asthma which are health conditions that increase the lethality of COVID-19.<sup>18</sup> With regard to diabetes, AI/ANs are twice as likely as whites to have diabetes and die from this disease at a rate 3.2 higher than that of all other races.<sup>19</sup> Further, due to these comorbidities, 34% of AI/AN nonelderly adults are at risk of developing a severe illness compared to 21% of white nonelderly adults.<sup>20</sup>

Similarly, substandard and overcrowded housing make compliance with CDC health guidelines infeasible and increase AI/AN risk for COVID-19. According to the Department of Housing and Human Development (HUD), “the lack of housing and infrastructure in Indian Country is severe and widespread, and far exceeds the funding currently provided to tribes.” Tribal communities experience overcrowded homes at 16 percent, roughly eight times the national average. The same report also noted that between 2003 and 2015, the number of overcrowded households or households without adequate kitchens or plumbing, grew by 21 percent to approximately 110,000 households.<sup>21</sup>

Additionally, the lack of access to water and basic sanitation has been a longstanding public health challenge for AI/ANs. According to the World Health Organization (WHO) and the CDC, the provision of safe water, sanitation, and hygienic conditions are essential to protecting human health in response to the COVID-19 outbreak.<sup>22</sup> Unfortunately, according to the 2018 Annual Report to Congress on Sanitation Deficiency Levels for Indian Homes and Communities, over 31 percent of homes on tribal lands are in need of sanitation facility improvements, while nearly 7 percent of all AI/AN homes do not have adequate sanitation facilities.<sup>23</sup> Further, according to 2007 IHS figures, approximately 13% of AI/AN homes, in contrast to 0.6% of non-native homes, lack access to safe drinking water and/or safe wastewater disposal infrastructure.<sup>24</sup> In their FY 2021 budget request, IHS

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<sup>17</sup> Key Facts on Health and Health Care by Race and Ethnicity, Kaiser Family Foundation,

<https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/>

<sup>18</sup> Trends in Indian Health, Indian Health Services, <https://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp>

<sup>19</sup> A Call to Action: Eliminating Diabetes Disparities in Native Communities, American Diabetes Association, Clinical Diabetes,

[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608273/#:~:text=According%20to%20the%20U.S.%20Department,di e%20from%20diabetes%20\(3\).](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608273/#:~:text=According%20to%20the%20U.S.%20Department,di e%20from%20diabetes%20(3).)

<sup>20</sup> Among Non-Elderly Adults, Low-Income, American Indian/Alaska Native and Black Adults Have Higher Risk of Developing Serious Illness if Infected With Coronavirus, Kaiser Family Foundation, <https://www.kff.org/disparities-policy/press-release/among-non-elderly-adults-low-income-american-indian-alaska-native-and-black-adults-have-higher-risk-of-developing-serious-illness-if-infected-with-coronavirus/>

<sup>21</sup> Housing Needs of American Indians and Alaska Natives in Tribal Areas: A Report From the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs, U.S. Department of Housing and Urban Development, Office of Policy Development and Research,

<https://www.huduser.gov/portal/sites/default/files/pdf/HNAIHousingNeeds.pdf>

<sup>22</sup> Water, sanitation, hygiene, and waste management for the COVID-19 virus: interim guidance, World Health Organization, <https://www.who.int/publications-detail/water-sanitation-hygiene-and-waste-management-for-covid-19>

<sup>23</sup> Annual Report To the Congress of the United States On Sanitation Deficiency Levels for Indian Homes and Communities FY 2018, Indian Health Service, Office of Environmental Health and Engineering, Division of Sanitation Facilities Construction,

[https://www.ihs.gov/sites/newsroom/themes/responsive2017/display\\_objects/documents/Report\\_To\\_Congress\\_FY18\\_SanitationFacilitiesDeficiencies.pdf](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/Report_To_Congress_FY18_SanitationFacilitiesDeficiencies.pdf)

<sup>24</sup> Strategies for Increasing Access to Safe Drinking Water and Wastewater Treatment to American Indian and Alaska Native Homes, US Environmental Protection Agency, Indian Health Service, U.S. Department of Agriculture, and

reported that \$2.57 billion is needed to raise all IHS and tribal sanitation sites to a Deficiency Level 1 classification. It is impossible for AI/AN communities to abide by CDC's sanitation and hygiene standards in response to COVID-19 without the necessary water and sanitation infrastructure.

Further, during the COVID-19 crisis, telehealth and telemedicine are critical to providing health care services to AI/AN people. Unfortunately, rural tribal nations may be unable to provide these services due to the lack of broadband capacity or infrastructure in their area. In 2018, the Government Accountability Office (GAO) and the Federal Communications Commission (FCC) reported that only 65 percent of American Indian and Alaska Natives (AI/ANs) living on tribal lands had access to fixed broadband services compared to 92 percent of all Americans.<sup>25</sup> Further, approximately 75 percent of IHS sites are located in areas defined as 'rural' by the FCC, which pay a higher percentage of their operating budget than urban locations on Internet access.<sup>26</sup> The immediate need to access telemedicine is likely to continue after the national emergency has passed, particularly for patients in the Indian health system.

### ***Structural Funding Inequities***

These health disparities are a byproduct of the chronic underfunding of the federal government's trust and treaty responsibilities. With regard to health, the I/T/U system services over 2.2 million individuals and has been chronically underfunded at the expense of AI/AN health. In 2018, IHS health care expenditures per person were \$3,779, compared to \$9,409 for federal health care spending nationwide.<sup>27</sup>

In December 2018, the U.S. Commission on Civil Rights (USCCR) released its report titled, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* ("Broken Promises"). The Broken Promises report found that in the past 15 years, federal programs serving Indian Country continue to be underfunded and, in some ways, federal initiatives for Native Americans have regressed. With regard to health, the Commission found:

Resulting in part from the failure of the federal government to honor its trust responsibilities, vast health disparities exist between Native Americans and other populations.

Funding for the IHS and Native American health care is inequitable and unequal. IHS expenditures per capita remain well below other federal health care programs, and

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Department of Housing and Urban Development, <https://www.epa.gov/sites/production/files/2015-07/documents/meeting-the-access-goal-strategies-for-increasing-access-to-safe-drinking-water-and-wastewater-treatment-american-indian-alaska-native-villages.pdf>

<sup>25</sup> Tribal Broadband, FCC Should undertake Efforts to Better Promote Tribal Access to Spectrum, November 2019, United States Government Accountability Office, <https://www.gao.gov/assets/700/695455.pdf>

<sup>26</sup> Comments to the FCC on Actions to Accelerate Adoption and Accessibility of Broadband-Enabled Health Care Solutions and Advanced Technologies, The National Congress of American Indians and the National Indian Health Board, <https://www.nihb.org/tribalhealthreform/wp-content/uploads/2017/05/FCC-Comment-NIHB-NCAI-Joint-Recommendations.pdf>

<sup>27</sup> Reclaiming Tribal Health: a National Budget Plan to Rise Above Failed Policies and Fulfill Trust Obligations to Tribal Nations, The National Tribal Budget Formulation Workgroup, [https://www.nihb.org/docs/05042020/FINAL\\_FY22%20IHS%20Budget%20Book.pdf](https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf)

overall IHS funding covers only a fraction of Native American health care needs, including behavioral health needs to address the suicide epidemic in Indian Country.<sup>28</sup>

Regarding federal funding related to public health and socio-economic wellbeing, the Commission found that:

Federal programs designed to support the social and economic wellbeing of Native Americans remain chronically underfunded and sometimes inefficiently structured, which leaves many basic needs in the Native American community unmet and contributes to the inequities observed in Native American communities. The federal government has also failed to keep accurate, consistent, and comprehensive records of federal spending on Native American programs, making monitoring of federal spending to meet its trust responsibility difficult....<sup>29</sup>

These findings—two years prior to the COVID-19 pandemic—demonstrate that structural inequities arising from the underfunding of the federal government’s fiduciary responsibilities created the destructive conditions that led to COVID-19’s rapid and continuing advancement in tribal communities.

### **We Urge this Subcommittee to Use its Oversight and Investigatory Authority to Address Indian Country’s Recovery Needs and Ensure Immediate Access to Federal Funding**

Indian Country has experienced unquantifiable harm during this pandemic. The death of each tribal citizen has meant the loss of a part of our culture, history, and language and devastated many families where multiple members have died. Likewise, individuals that recover confront an unchartered future where they continue to lack access to basic health and living standards that are necessary to treat their conditions and mitigate future susceptibility to severe illness.

The 2018 Broken Promises Report laid out a roadmap for addressing a then existing and growing health and socio-economic crisis in tribal communities. This roadmap was effectively a “Marshall Plan” for Indian Country’s development. More than ever, a tribal Marshall Plan is needed for addressing the devastating impacts of this pandemic and the conditions that created it. I urge this Subcommittee to aid the development of this recovery plan by working with the U.S. Commission on Civil Rights to issue an updated report that evaluates the following and recommends legislative solutions:

1. How have the health and associated socio-economic disparities identified in the Broken Promises report been aggravated by the pandemic?
2. Has COVID-19 legislative responses addressed tribal response, mitigation, and recovery needs?
3. Has the Executive Branch’s response to the pandemic and implementation of COVID-19 legislation addressed AI/AN needs?

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<sup>28</sup> Broken Promises: Continued Federal Funding Shortfall for Native Americans, U.S. Commission on Civil Rights, <https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf>.

<sup>29</sup> Ibid

4. What legislative and administrative solutions—including technical fixes—could be adopted to address the disparities identified in this report?

I also urge this Subcommittee to aid Indian Country by immediately exercising its investigatory powers to address delays in federal funding that were specifically allocated by Congress for COVID response. Distribution of tribal funds have been beset with delays that have resulted from:

- failure to engage in and delays in commencing tribal consultation;
- sluggish inter-departmental coordination;
- limited communications with tribal applicants;
- creation of non-statutory barriers to accessing funds; and
- a lack of transparency in the creation of methodologies for the distribution of funds to eligible tribal recipients.

Tribal nations have experienced delays in accessing Health and Human Services, Centers for Disease Control, and Department of Homeland Security funding. Further and to date—two months after Congress passed the Coronavirus Aid, Relief, and Economic Security Act—over \$3.2 billion dollars in tribal COVID-19 funding has yet to be released by the Departments of Treasury, Education, Interior, Agriculture, and Commerce. As a result, we request that this Subcommittee exercise its investigatory power to ensure that congressional COVID-19 relief immediately reaches the AI/AN communities that Congress expressly intended to aid.

## **Conclusion**

I thank you for the opportunity to testify regarding the health impacts of COVID-19 within Indian Country. I look forward to working with this Subcommittee on bi-partisan solutions that address these disparities and ensures the United States' upholds its trust and treaty responsibilities to tribal nations and citizens.