The Impact of COVID-19 on American Indian and Alaska Native Communities: A Call for Better Relational Models

Mary J. Owen, MD, Michael A. Sundberg, MD, MPH, Jackie Dionne, BS, and Anna Wirta Kosobuski, EdD

ABOUT THE AUTHORS

Mary J. Owen is with the Center for American Indian and Minority Health, University of Minnesota Medical School, Duluth. Michael A. Sundberg is with the University of Minnesota Medical School Twin Cities, Minneapolis. Jackie Dionne is with the Minnesota Department of Health, St. Paul, MN. Anna Wirta Kosobuski is with the University of Minnesota Medical School Duluth, Duluth.

American Indian and Alaska Native (AI/AN) health outcomes improve when institutions and governments seek input from tribal leaders. In multiple instances, the historical failure to recognize the necessity of this inclusion has resulted in poor health outcomes in tribal communities; the ongoing impact of the COVID-19 pandemic serves as yet another example. The current pandemic is, however, also an opportunity for pivotal change in the way health programs interact with tribal communities. With the equal voice of tribal leaders, effective methods of consulting with tribes can be developed. Now is the time for governments and institutions to implement ongoing consultation regarding the current and long-term effects of COVID-19 on tribal communities and, in concert with tribal health leaders, to create new strategies for improved health outcomes among AI/ANs. We note the particular health system and socioeconomic effects of COVID-19 on tribal communities, and we highlight recent intergovernmental interactions—all with emphasis on the necessity of a consultative model in government– or institution–tribe interactions.

A UNIQUE DISEASE WITH A CLASSIC EFFECT

The epidemics introduced with the arrival of Europeans to the Americas, and the ensuing disease rates and death tolls on AI/AN communities, contribute to intergenerational trauma experienced in the daily lives of AI/ANs.[1] Yet, these epidemics are not just a reality of days long past, and each replay adds another layer of injury to already traumatized communities.[2]

Throughout Indian Country, many tribal members have either experienced epidemics firsthand or have heard stories passed on about affected family and community members. COVID-19 has been no exception in its magnified effect on AI/AN communities; AI/ANs in many regions are dying at a higher rate than any other population, and the disparity is alarming. As an example, since early 2020, the Minnesota Department of Health compiled weekly data comparing positive COVID-19 cumulative cases among its ethnic populations. Although age-adjusted total cases among AI/ANs remain lower than other populations in the state, AI/AN case mortality has consistently been approximately 50% higher than all other populations—including other minorities.[3] It is most likely that such a magnified effect of COVID-19 on mortality is multifactorial, and understanding the reasons for such high mortality rates requires close study of the unique health needs and resources of AI/AN communities—knowledge that usually exists and can be accessed from within the communities themselves.

STRESSED SOCIOECONOMIC AND HEALTH SYSTEMS

Mortality is not the only deleterious outcome of COVID-19. AI/AN communities are also reeling from the social, cultural, and economic consequences of sheltering in place. For thousands of years, culture and traditional practices have served as survival mechanisms for AI/AN people and communities; they are essential to healing and resilience in the direst of circumstances. The pandemic has prohibited tribal members from gathering and engaging in many community, cultural, and traditional practices, thereby excluding a fundamental element of creating and maintaining individual and collective well-being.

For most tribal communities, even in the best of circumstances, services and infrastructure are vastly underfunded. Many tribes rely on revenues generated by the gaming and tourism industries as means to supplement funding for housing; education; health care; courts and law enforcement; emergency services; roads, water, and sewer systems; and social services.[4] The pandemic has forced the loss of these integral revenue sources, which will result in significant long-term economic effects.

As happened to most clinics and hospitals, when tribal clinics limited access to care as a means to mitigate the spread of COVID-19, significant revenues were lost. However, the per patient care funding for the Indian Health Service (IHS), the primary source and system of tribal health, is less than half that of the per patient funding expenditures among major federal health care programs nationally.[5] Thus, the health impacts of COVID-19 are expected to be greater on patients receiving their care from tribal clinics, despite the best efforts of the IHS, than other patients receiving care through government-funded mechanisms. Furthermore, in 2018 fewer IHS patients reported any health insurance coverage than did the general population (22.0% compared with 8.5%), further decreasing revenues and increasing share in the burden of cost for tribal health programs and the IHS.[6,7]

CHALLENGES AND SUCCESSES

In an attempt to reduce the impacts of COVID-19, both state and federal governments offered assistance. In retrospect, we argue that major aspects of the initial federal response did not include significant input from tribal leaders and resulted in challenges in pandemic preparation in tribal communities. As a primary case in point, the federal government provided Tribal Nations with Coronavirus Aid, Relief, and Economic Security (CARES) Act and Centers for Disease Control monies. But, despite tribal leaders' requests that the health care funds be distributed via long-standing IHS mechanisms, they were distributed as noncompetitive grants.

The grant application system for funding the response in tribal communities was problematic for multiple reasons. The CARES funding grants were time consuming and effort intensive, resulting in delays as long as three months before payments reached communities. Such funding is managed like other grants, requiring building administrative management and reporting infrastructure in tribal organizations and often shifting tribal health professionals' attention away from ongoing and critical work. Additionally, it resulted in inappropriate funding scenarios. In a particularly concerning example, CARES funding specifically for AI/AN health was allocated to for-profit corporations in Alaska that do not manage tribal health—effectively creating a scenario of treating corporations as federally recognized tribes and reducing funding that would otherwise have been available for the pandemic response among tribal entities providing health services. With CARES, a greater consultative model with tribal health leaders could have saved time and money, as well as prevented a lawsuit brought by tribal leaders to modify eligibility guidelines. Indeed, modifications to better address direct funding to IHS, and extensions of CARES grant funding, were included in the provisions for the Coronavirus Response & Relief Supplemental Appropriations Act of 2021.[8]

Yet by contrast to the initial federal response through CARES to the needs of tribal communities, the Minnesota state government engaged tribal leaders early and regularly to assess tribal preparedness for COVID-19. This occurred through two different avenues. In 2018, Minnesotans elected a Native American lieutenant governor. Her presence increased state government respect for, and attention to, the needs of tribal communities. With the onset of the COVID-19 crisis, the lieutenant governor and her staff began to hold regular meetings with tribal leaders to hear their concerns about the consequence of the pandemic on their communities.

Additionally, since the early days of the pandemic, the Minnesota Department of Health has convened biweekly meetings with tribal health directors, providing updates on the status of infections and hospitalizations across the state as well as state and regional efforts to address COVID-19. This ultimately led to the state providing training for tribal community health members to perform their own contact tracing—a more effective mechanism for understanding the pandemic in tribal communities. Indeed, Tribal health directors in Minnesota report that this has resulted in a better response from community members. Although it is difficult to ascertain yet whether these efforts reduced mortality in Minnesota AI/AN populations, more accurate and available epidemiologic data provided by tribes themselves to the state would be expected to help with public health efforts and overall case reduction in tribal communities. That is, the deadly impact of COVID-19 on AI/ANs might otherwise have been worse.

CONSULTING TRIBAL HEALTH LEADERS

COVID-19 has significantly affected and continues to significantly affect tribal

communities and will likely worsen the already poor health outcomes of AI/AN communities for many years. Altering these outcomes for the better will require significant funding of AI/AN health services and infrastructure as well as continued strengthening of collaborations with state governments and the US federal government. Most importantly, improving the health status of AI/AN people will require the presence of AI/AN health leadership at the forefront of any discussions that affect their communities. AJPH

CORRESPONDENCE

Correspondence should be sent to Mary J. Owen, University of Minnesota Medical School Duluth, 182 SMed, 1035 University Dr, Duluth, MN 55812 (e-mail: mjowen@d.umn.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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CONFLICTS OF INTEREST

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