Patrice H. Kunesh
Commissioner, Administration of Native Americans
ACF Deputy Assistant Secretary for Native American Affairs
Chair, HHS Intradepartmental Council on Native American Affairs

National Rural – Tribal Health Snapshot	Rural	Urban	Tribes
Percentage of population	19.3%	80.7%	29% (Rural)
Number of physicians per 10,000 people	13.1	31.2	* Physician vacancy rates as high as 46% across IHS
Number of specialists per 100,000 people	30	263	-
Population aged 65 and older	18%	12%	10.2% (total population)

Average per capita income	$45,482	$53,657	$23,000
Adolescents who smoke	11%	5%	20.6%
Male life expectancy in years	76.2	74.1	61.5
Female life expectancy * Native women 2X more likely to die of pregnancy-related causes than White women, and experience gross disparities in pregnancy-related maternal health conditions (CDC).	81.3	79.7	69.2

Resources:

- Health Resources and Services Administration and Rural Health Information Hub: About Rural Health Care | National Rural Health Association - NRHA - NRHA
- USDA Economic Research Service: https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=77893
- National Council on Aging: The American Indian/Alaska Native Population in the U.S. (ncoa.org)
- Northwestern University Institute for Policy Research: What Drives Native American Poverty?: Institute for Policy Research - Northwestern University
- CDC Racial/Ethnic Disparities in Tobacco Product Use Among Middle and High School Students — United States, 2014–2017: https://www.cdc.gov/mmwr/volumes/67/wr/mm6734a3.htm?s_cid=mm6734a3_w
- Princeton University: Life Expectancy Drops for Native Americans Due to COVID-19 | Princeton School of Public and International Affairs
- National Council of Urban Indian Health: New Report Estimates 400,000 Native Americans Terminated from Medicaid During Unwinding - NCUIH

The Indian Health Service

Agency overview: The Indian Health Service (HIS) an agency within the Department of Health and Human Services (HHS), is responsible for providing federal health services to more than **2 million American Indians and Alaska Native people** who are members of federally-recognized tribes.

The responsibility to provide health services grew out of the special government-to-government relationship between the federal government and Native Nations dating back to 1787. Its foundation is Article I, Section 8 of the **U.S. Constitution,** and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.

The **IHS is the principal federal health care provider and health advocate** for Native people, and its goal is to raise their health status to the highest possible level.

Unique mission: to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Part of the U.S Department of Health and Human Services, **serving nearly two million American Indians and Alaska Natives** through a network of **45 state-of-the-art hospitals** and more than **293 clinics** throughout **35 states**.

IHS physicians and medical staff live and work in or near the communities they serve, experiencing unique Tribal cultures and traditions.

IHS is a rural health delivery system with a focus on primary and preventive care, along with the following specialties:

> Anesthesiology - Emergency Medicine - Family Medicine - General Practice - General Surgery - Internal Medicine - OB/GYN - Ophthalmology - Orthopedics/Surgery - Otolaryngology - Pediatrics - Podiatry - Psychiatry - Radiology - Rheumatology

Top 5 Challenges in Delivering Health Care to Rural Native People

Karina L. Walters, Ph.D., M.S.W., Director of the U.S. Department of Health and Human Services National Institute of Health Tribal Health Research Office

1. **Chronic underfunding for AI/AN healthcare.** Although some gains have been made in IHS funding in the past two years, IHS still remains woefully underfunded. For example, to match the level of care provided to federal prisoners, funding would have to nearly double. Funding would need to be even higher to match the benefits guaranteed by programs such as Medicaid.

   Because funding for Native people is at the discretion of Congress and the President, inequities emerge in contrast with mandatory funding such as for Medicare. For example, between 1980 and 2002, the Medicare spending per person grew by $5200, which stands in stark contrast appropriations for IHS per person which grew by only $1121. As a result, of chronic underfunding, tribal members have dramatically different health care reality than most U.S. citizens.

   (Mangla A, Agarwal N. Clinical Practice Issues in American Indians and Alaska Natives, May 29, 2023; StatPearls Publishing, Jan. 2024, available from: https://www.ncbi.nlm.nih.gov/books/NBK570601/)

2. **Shortage of qualified medical personnel**. Drastic shortage of qualified medical personnel, particularly medical doctors serving in rural Native communities. Physician vacancy rates were as high as 46% in 2018 across IHS regions. (The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs, JAMA, 2022; GAO-18- 580, Apr 17, 2024)

   Moreover, there are few Native physicians. As of 2021, fewer than 3000 physicians, out of 841,322, identified as American Indian or Alaska Native, according to the latest statistics from the Physician Specialty Data Report , published by the Association of American Medical Colleges.

3. **Geographic spread and remote locations coupled with inaccessible or expensive transportation.** Geographic spread as well as remote locales of some communities (e.g., Alaska) are often burdened with insufficient transportation support, the high cost of transportation, and poor access via plane or properly paved roads to medical care. Some patients delay diagnostic care until symptoms present as urgent, thus

bypassing opportunities to get early care, address medical condition, as well as keep down costs of care.

Moreover, when rural community members access care, follow-up or ongoing treatment access (e.g., dialysis, cancer care) creates enormous socio-economic burdens on patients who already may be socio-economically compromised.

Finally, geographic barriers and lack of qualified emergency response personnel in local rural communities translates to use of life/medical flights to address emergencies, thus increasing costs to care. The wait time to receive emergency care may also be delayed in remote locations as a result, thus increasing threat to loss of life in rural communities.

4. **Institutional discrimination and lack of cultural competency in health care settings.** Nearly 1 out of 4 Native people report experiencing discrimination when going to a doctor or health clinic. In fact, nearly ¼ of Native people report experiencing discrimination in clinical encounters and 15% report avoidance of seeking health care for themselves or their family members in response to anticipated discrimination.

   (Findling MG, Casey LS, Fryberg SA, Hafner S, Blendon RJ, Benson JM, Sayde JM, Miller C. Discrimination in the United States: Experiences of Native Americans. Health Serv Res. 2019 Dec;54 Suppl 2(Suppl 2):1431-1441. doi: 10.1111/1475-6773.13224. Epub 2019 Oct 27. PMID: 31657013; PMCID: PMC6864378).

5. **Inadequate broadband and internet access.** Native people also are less likely to have internet access than other populations. Telemedicine can be an important health care delivery mechanism for rural and remote health care. However, Native populations still are encumbered by spotty broad band and internet coverage.

   Given that Native people live in rural and isolated areas that often require long travel distances to health care, often accompanied by high transportation costs, telemedicine may be an important cost and life-saving approach.

   (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-among-american-indian-and-alaska-native-and-native-hawaiian-and-other-pacific-islander-people)