**Submission of the National Congress of American Indians**

**to the**

**United Nations Special Rapporteur on Indigenous Issues**

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Founded in 1944, the National Congress of American Indians is the oldest and largest representative organization serving the broad interests of American Indian and Alaska Native tribal nations and communities in the United States. 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 Indigenous self-determination.

There are over 574 Indigenous nations recognized by the United States government 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 cession of tribal nations’ lands and resources. For over two hundred years, the United States has consistently maintained a government to government relationship with American Indian and Alaska Native 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:

The Indian Health Service (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 Public Law 93-638. IHS also provides services to urban Indians (Indigenous people living away from their homelands) 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….[[1]](#endnote-1)[i]

Despite its fiduciary responsibility, the federal government has consistently neglected its legal obligations to tribal nations and citizens resulting in a 21st century health and socio-economic crisis in Indigenous communities. This existing crisis created disparities that led to American Indians and Alaska Native’s (AI/AN) vulnerability to the COVID-19 pandemic and resulted in Indigenous communities having the highest per-capita COVID-19 infection rate in the United States.[[2]](#endnote-2)[ii]

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

Infectious diseases have historically ravaged Indigenous 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 Indigenous peoples.[[3]](#endnote-3)[iii] In the 20th century, the 1918 influenza pandemic disparately impacted Indigenous communities with mortality rates four times higher than in the general population.[[4]](#endnote-4)[iv] Even among Indigenous peoples, 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.[[5]](#endnote-5)[v] 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.[[6]](#endnote-6)[vi]

Presently, the rate of infection and deaths from COVID-19 continues to grow in AI/AN communities. As of June 3, 2020, the IHS reports nearly 11,475 positive cases within the IHS, tribal, and urban Indian health care system.[[7]](#endnote-7)[vii] 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.[[8]](#endnote-8)[viii] 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, the weighted distribution of the AI/AN population is 2 percent; however, the distribution of COVID- 19 deaths is at least 21.6 percent.[[9]](#endnote-9)[ix]

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.[[10]](#endnote-10)[x] 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.[[11]](#endnote-11)[xi] Additionally, gathering national IHS data is hindered by an outdated electronic record system that has yet to be replaced.[[12]](#endnote-12)[xii]

Second, the inability to provide coronavirus testing across Indian Country has greatly hindered tribal governments’ 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.[[13]](#endnote-13)[xiii] 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 Oyate 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.[[14]](#endnote-14)[xiv]

Third, 71 percent of AI/ANs live in urban areas and utilize county and state health services.[[15]](#endnote-15)[xv] Current data collection practices by many state and local entities often omit or misclassify Indigenous populations, providing us with an inaccurate picture of 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.

## 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.[[16]](#endnote-16)[xvi] 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.[[17]](#endnote-17)[xvii] 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.[[18]](#endnote-18)[xviii] 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.[[19]](#endnote-19)[xix]

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.[[20]](#endnote-20)[xx]

Additionally, the lack of access to water and basic sanitation has been a longstanding public health challenge for Indigenous peoples in the U.S. 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.[[21]](#endnote-21)[xxi] 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.[[22]](#endnote-22)[xxii] 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. In their FY 2021 budget request, IHS 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 living on tribal lands had access to fixed broadband services compared to 92 percent of all Americans.[[23]](#endnote-23)[xxiii] 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.[[24]](#endnote-24)[xxiv]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 Indigenous health. In 2018, IHS health care expenditures per person were $3,779, compared to $9,409 for federal health care spending nationwide.[[25]](#endnote-25)[xxv]

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 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.[[26]](#endnote-26)[xxvi]

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….[[27]](#endnote-27)[xxvii]

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.

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 uncharted 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.

**Severe Economic Disruption for Indigenous Communities**

In addition to experiencing disproportionate health impacts from COVID-19, Indigenous economies have also experienced extreme disruptions. In the U.S. many tribal economies rely on the tourism and hospitality industries, both of which have been severely impacted by COVID-19 related closures. Many tribally-owned enterprises,  which provide the primary source of revenue for indigenous nations to provide governmental services to their citizens, are shuttered or have only recently begun to reopen. Without these sources of governmental revenue, Indigenous governments are furloughing employees and unable to provide education, health care, public safety, and other governmental programming to their citizens. Federal aid has not been adequate to meet the need of Indigenous nations.

While the U.S. Congress has allocated emergency relief funds for COVID response to tribal nations, the 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 Federal Emergency Management Agency 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. These delays are significantly hampering the ability of tribal nations to address the impacts of the pandemic on their citizens.

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