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Fellowship Capstone | Policy Brief

Policy Strategies to Achieving Equity in Indigenous Healthcare

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I. Executive summary

Indigenous populations in the United States experience significantly worse health and economic outcomes compared to non-Indigenous citizens. These disparities include, but are not limited to, lower life expectancy, higher rates of chronic diseases, and limited access to healthcare.

II. Overview

The history of US Indigenous populations has been characterized by land theft, forced removal, coercive bargaining, and other federal policies aimed at undermining Indigenous sovereignty and rights. As a result, Indigenous governance structures and economic markets have faced severe disruption from the early days of English colonization to the modern day.

Moreover, federal actions were not solely focused on limiting Indigenous resource access or land usage. Throughout the 19th and 20th centuries, federal policymakers emphasized assimilation in an attempt to destroy Indigenous culture by suppressing Native language learning and banning common cultural and religious traditions.

These policies were effective in their goals but disastrous to the Indigenous communities. Families were forcibly separated and children were sent to boarding schools where they would learn to not be or act Indigenous. Critical social systems, especially education, healthcare, and even law enforcement, were dismantled or severely weakened.

Today, Indigenous communities continue to navigate the psychological and societal consequences of these policies. Although later policy shifts, particularly those implemented during the New Deal and Cold War, sought to reintroduce a measure of Indigenous self-sovereignty, many of these initiatives failed due to inadequate funding and structural support. Consequently, improvements have been uneven at best, while significant disparities remain across health, education, housing, employment, and general standard of living.

A. Relevance

American Indian and Alaska Native populations continue to experience some of the highest rates of preventable disease and mortality in the United States. According to the Indian Health Service, mortality rates are especially pronounced in the following diseases: chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, chronic respiratory disease, assault and homicide, and self harm and suicide. Life expectancy is also significantly lower, with the Indian Health Service finding an Indigenous expectancy of 73 years compared to a national average of 78.5 years. These disparities constitute a public health crisis, one only

made worse by persistent gaps in care quality, housing, income, and overall wellbeing.

III. History

The US Government's relationship with Indigenous populations has been singularly focused on acquisition of Indigenous land and the forced removal, suppression, and assimilation of Indigenous people into Western society. Governmental policies were therefore aimed explicitly at weakening various forms of Indigenous power. Trade routes and agricultural resources were intentionally destroyed. For example, the US Army encouraged settlers to hunt the bison in the Great Plains as a way to counteract Comanche, Sioux, Cheyenne, and Kiowa influence in the region. When tribal land was found to contain precious resources, such as gold, silver, fertile soil, or oil, tribes were forcibly moved to reservations. The geographical isolation cut them off from contact with major industrial and communication hubs while limiting their ability to practice their belief systems, many of which were tied to ancestral lands.

By removing communities from resource-rich environments and limiting their mobility, these policies created long-term economic disadvantages and dependence on federal resources that continue to affect Native populations today, contributing to the structural disparities in income, employment, development, education, and health that persist to the present day.

IV. Policy Problem

A. Stakeholders

The primary stakeholders are Indigenous populations who often live in rural regions, reservations, or otherwise underserved areas where where access to employment opportunities, quality education, healthcare, and other forms of critical infrastructure remain limited.

However, Indigenous tribes are far from the only stakeholders either involved in or affected by Indigenous issues. Healthcare providers, insurance agencies, and federal bodies such as the Indian Health Service, as well as localized tribal clinics and regional hospitals, all play a significant role in determining outcomes for Indigenous populations.

Similarly, local communities in reservation states or states with large Indigenous communities are also stakeholders, as disparities in Indigenous health outcomes strain emergency response systems, lower workforce participation, and slow overall economic growth at the state and local levels.

B. Risks of Indifference

Ignoring disparities in Indigenous healthcare and economic outcomes would worsen already longstanding inequalities whose implications reach far beyond Indigenous communities. Without targeted interventions, preventable diseases such as diabetes, chronic liver disease, and various forms of respiratory illnesses will put stress on Indigenous, local, state, and federal care delivery systems. Many of these ancillary costs will be distributed among local carriers consumers, thus inflating cost of care in the long-term. Moreover, as

homelessness rates rise, other governance mechanisms such as law enforcement and public safety organizations will be strained.

Nonpartisan Reasoning

Because disparities in Indigenous health and economic outcomes intersect with issues of public health, economic productivity, governance at all levels, and community stability, combating these disparities is inherently nonpartisan, with significant improvements benefitting both sides of the political divide.

From a conservative economic lens, improving Indigenous healthcare and infrastructure reduces dependency on emergency governmental funding or transfer payments while simultaneously improving both workforce participation and worker productivity. In general, the healthier the workforce, the more self-sufficient and stable the overall community, reducing the need for costly state or federal oversight in the long term. Progressives, meanwhile, will see investments in Indigenous healthcare and economic development pay off through the promotion of economic equity and opportunity access for historically marginalized peoples. In the end, both parties agree that preventing illness and reducing poverty improves national productivity.

The same nonpartisan reasoning applies equally to debates over federalism. The federal government, through centuries of treaties, has longstanding legal obligations toward Indigenous nations. Conservatives may frame satisfying these commitments through policy reforms as Constitutional responsibility and governmental credibility, while progressives emphasize the importance of ensuring historical justice and protecting civil liberties. In either case, supporting the health and economic well-being of Indigenous tribes clearly supports the ideological positions of both dominant parties.

V. Tried Policy

One major policy that aimed at improving healthcare access for Native American communities such as the Chickasaw Nation, was the expansion and continued funding of the Indian Health Service. The IHS was created to fulfill the federal government's treaty obligations by providing healthcare services to Indigenous populations, especially those living in rural and underserved areas within the US. Through tribal clinics, hospitals, and healthcare programs, the policy attempted to reduce disparities in healthcare access and improve health outcomes for Native American communities. However, over the years this policy has struggled to fully meet its goals due to financial and structural limitations. For example, the Indian Health Service has remained underfunded compared to other federal healthcare systems even within the Department of Health and Human Services, resulting in doctor shortages, outdated facilities, and limited access to specialized medical care. Furthermore, many Indigenous tribes still face transportation barriers and geographic isolation due to their reservation locations, making it difficult for patients to consistently and immediately receive treatment. As a result, many Native American populations continue to experience extremely high rates of chronic disease, drug/mental health challenges, and reduced access to quality healthcare.

The Indian Self-Determination and Education Assistance Act of 1975 was another attempt to improve outcomes for Indigenous communities. In theory, this legislation granted tribes the autonomy to manage their own healthcare and educational services rather than relying entirely on slower federal bureaucracies. However, while the policy improved tribal autonomy and allowed communities greater control over local services, many tribal governments still lacked the financial resources necessary to fully implement effective healthcare systems.

VI. Policy Options

Increase Targeted Funding to the Indian Health Service

Because it relies on annual apportionments from Congress, the Indian Health Service has suffered from inconsistent funding since its formation in 1955. This policy seeks to rectify this by allocating long term grants to tribal nations in order to fund the construction and modernization tribal hospitals, increased physician enrollment through medical student loan forgiveness programs, and the expansion of mental health and addiction services on reservations. Additionally, because many tribal communities live far from major medical centers, this platform would invest heavily in the expansion of telehealth services. The key to making this policy work would be shifting the category of Indian Health Services funding from discretionary funding to mandatory spending, similar to programs like Medicare and Social Security, which cannot be easily defunded without large majorities in both houses of Congress and the support of the executive.

2. Launch Tribal Healthcare Workforce Development Programs

Another strong policy option is the creation of a federally-funded and tribally-managed workforce initiative designed to train Indigenous workers to operate in local healthcare industries. To accomplish this, the federal government would directly set aside funding for scholarships, tuition assistance, and paid medical internships, apprenticeships, and ROP placements for Indigenous students interested in pursuing careers in healthcare. To incentivize states to contribute, the federal government could tie state funding for various public goods to funding targets for tribal economic development and education. Increasing the number of tribal healthcare workers would dramatically improve the cultural competency of medicine in tribal communities, build trust between patients and providers, and alleviate longstanding worker shortages that contribute to persistent outcome disparities.

3. Expand Tribal Economic Partnerships and Investment Incentives

A third option would be to focus on reducing tribal dependency on federal support, which has historically been insufficient to meeting tribal needs. In this case, state lawmakers could collaborate with tribal leadership to offer tax breaks and other subsidies to businesses investing in any form of reservation infrastructure, whether that be education, healthcare, security, energy, transportation, or workforce development. The chief driver of this platform would be the promotion of public-private partnerships between all stakeholders involved, including not only the

tribes themselves, but also universities interested in conducting research, regional care providers, school administrators, and local businesses. This could promote long-term economic independence while increasing employment, modernizing infrastructure, and generating more stable revenue streams for tribal communities.

VII. Conclusions

This brief has explored the healthcare disparities affecting Native American communities, specifically focusing on the challenges, both historical and present day, faced by the Chickasaw Nation and other Indigenous populations in accessing quality healthcare. After examining policies that failed to resolve longstanding disparities in Indigenous communities such as the creation of the chronically underfunded Indian Health Service and the well-intentioned but unsupported Indian Self-Determination and Education Assistance Act, this brief then analyzed several policy approaches aimed at improving healthcare equity. Out of these three, the most practical and effective solution would be increasing long-term federal funding and support for tribally operated healthcare systems and infrastructure by reclassifying IHS funding as mandatory spending, as workforce development grants do not qualify for the same protections and public private partnerships would not guarantee improvements to all tribal communities. Ultimately, although significant progress has been made through tribal healthcare initiatives and organizations, there is still a long way to go in achieving equitable healthcare outcomes for all Indigenous populations in the United States.

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