HEALTH FOR ALL: ADDRESSING HEALTH EQUITY AMONG AMERICAN INDIANS + ALASKA NATIVES

By Chidi Ike

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On April 7 (tomorrow), the World Health Organization will observe its 75th anniversary and World Health Day, with this year's theme being centered around achieving health for all. It is an ambitious, yet sensible, directive that can be accomplished in part by increasing access to high-quality healthcare nationwide. A story from the Navajo Nation—a 27,000-square-mile expanse of land that extends across Utah, Arizona, and New Mexico—is proof of this.

Serving the Navajo Nation

In 2019, Tuba City Regional Health Care Corporation in Tuba City, Ariz., developed the first cancer clinic on any American Indian reservation in the United States. Lynette Bonar—a member of the Navajo Nation—serves as its chief executive officer. In an *Oncology Issues* article, Bonar shared the story of a young woman who died of cancer after refusing treatment. She was afraid that the cost of getting her to her treatment appointments would cause her children to lose their jobs. "This person died because there's no access locally for cancer," Bonar said. "How many people is this happening to?"

Prior to Tuba City Regional Health Care Corporation's American Indian reservation-dedicated cancer clinic, a local member of the Navajo Nation (or any of the other 574 federally recognized American Indian and Alaska Native tribes in the U.S.) would have to travel hundreds of miles to receive specialty care, including anti-cancer treatment. This is because the Indian Health Service (IHS), a federal agency within the Department of Health and Human Services, is responsible for providing general health services to these populations, which does not include specialty care. This reality, coupled with the socio-economic barriers these populations often face, has created a significant barrier to healthcare access.

Why Access to High-Quality Healthcare Is Necessary

One in 3 American Indians are living in poverty, and the median income of this group is $23,000 a year. Further, American Indians and Alaska Natives (AI/ANs) experience the highest rate of poverty in the country and less than 60 percent were gainfully employed in 2018, resulting in poorer health and economic outcomes. This state of economic hardship among AI/AN populations is exacerbated by an underfunded IHS.

In 2015, the per capita funding for the IHS was **$3,099, compared to $8,097** for the general American population. And according to the U.S. Government Accountability Office, IHS data show that it is, too, facing a shortage of healthcare providers, with an average vacancy rate of **25 percent** for physicians, nurses, and others. These factors contribute to the life expectancy of AI/ANs, which is 5.5 years less than every other racial group in the U.S., yet AI/AN groups also die at higher rates than any other demographic because of their lack of access to healthcare. More people in AI/AN communities are dying from preventable causes—including cancer.

AI/AN populations are often diagnosed with cancer at later stages of the disease, resulting in the **lowest survival rate** for almost all cancer types of any population in the U.S. **Studies** show that a small fraction of all AI/ANs diagnosed with cancer actually receive cancer-directed therapies, compared to non-Hispanic White populations. This is largely due to socio-economic factors, such as low incomes and rural residences, as **68 percent** of all AI/AN populations live on or near reservations and tribal lands in rural America. However, acknowledging these issues exist is only half the battle.

Bridging the Gap

Improving prevention efforts and access to early cancer screenings would play a key role in reducing the number of AI/ANs who die from cancer. For example, among **American Indians in the southwest**, colorectal cancer screening rates are lower than in the general American population. This is due to multiple factors like inadequate access to healthcare, education on cancer screenings (why it's important and at what age one should be getting screened), as well as cancer screening promotions among healthcare organizations. In addition, there is a cultural barrier that must be delicately tackled when treating these patient populations. For example, American Indians have **historically used tobacco** for spiritual and medicinal purposes; thus, lung cancer may be more prevalent. As such, community-based education initiatives must be conducted with the cultures of the targeted patient populations in mind.

There is also the issue of trust. A **study** found that newly diagnosed American Indians with cancer report higher levels of mistrust and lower levels of satisfaction with their healthcare. Most of the study's participants (62 percent) also expressed the belief that clinics and hospitals have done harmful things to patients without their knowledge in the past. Further, some participants (23 percent) reported that they previously delayed receiving medical care out of fear they may be treated disrespectfully.

Health For All

Trust is difficult to rebuild, especially against a backdrop encumbered by generational trauma. However, in pursuit of achieving health for all, bridging the health gaps that exists between American Indians and Alaska Natives is vital. This work starts by creating partnerships with these populations that is built on open communication, such as what Tuba City Regional Health Care Corporation is doing. Healthcare organizations can also develop mobile mammography and other screening programs that can be brought directly to reservations and tribal lands. Finally, the recruitment of individuals from the 574 federally recognized tribes will also be key to improving healthcare delivery and patient outcomes. But it will take people like Bonar and others, who are in positions of power and members of these communities, who can better facilitate the effort of improving cancer care delivery among American Indian and Alaska Native populations.

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