National Council of Urban Indian Health Resolution in Support of COVID-19 Resources for the Indian Health System

WHEREAS, the National Council of Urban Indian Health (NCUIH), founded in 1998, is a 501(c) (3) organization created to support the development of quality, accessible, and culturally sensitive health care programs for AI/ANs living in urban communities; and

WHEREAS, NCUIH strives to improve the health of the over 70 percent of the AI/AN population living in urban settings, supported by quality, accessible health care centers; and

WHEREAS, the National Council of Urban Indian Health (NCUIH), is the premier national representative of Urban Indian Health Programs receiving grants under Title V of the Indian Health Care Improvement Act (IHCIA) and the AI/ANs they serve; and

WHEREAS, the federal government's trust responsibility to provide AI/AN healthcare does not end at the borders of an Indian reservation, Alaska Native Village, Pueblo or Tribal lands, and Congress acknowledged during the 1987 reauthorization of the Indian Health Care Improvement Act the responsibility for the provision of health care services follows AI/AN to urban areas; and

WHEREAS, the first year of the COVID-19 Pandemic has exposed the failure of the federal government to uphold its trust and treaty obligations to American Indian and Alaska Natives (AI/AN) resulting in poor health outcomes; and

WHEREAS, according to the Centers for Disease Control and Prevention, age-adjusted rates of COVID-19 hospitalization among AI/ANs from March 1, 2020, through January 23, 2021, were 3.6 times higher than for non-Hispanic Whites;[1] and

WHEREAS, COVID-19 is killing AI/ANs at a faster rate than any other community in the United States. January 2021 was the deadliest so far in the US, with 958 recorded Native deaths – a 35% increase since December, a bigger rise than for any other group; and

WHEREAS, there is a lack of complete data on COVID-19 outcomes among AI/ANs. Available COVID-19 data already highlights significant disparities between AI/ANs and the general population; and

WHEREAS, in an August 2020 report on COVID-19 in Indian Country, the CDC acknowledged that reporting of detailed case data to CDC by states is known to be incomplete and AI/AN persons are commonly misclassified as non-AI/AN races and ethnicities in epidemiologic and administrative data sets, leading to an underestimation of AI/AN morbidity and mortality;[2] and

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[1] Centers for Disease Control and Prevention. COVID View Weekly Summary. Accessed 9/1/2020. https://www.cdc.gov/coronavirus/2019- ncov/covid-data/covidview/index.html
[2] Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1166–1169. DOI: http://dx.doi.org/10.15585/mmwr.mm6934e1

WHEREAS, Washington, D.C. is a city, not a state with federal representation, and therefore, vaccine allocations are subject to the decision of a city government and excluded from any tribal consultation or urban confer to ensure that American Indians and Alaska Natives in the area are prioritized for vaccines; and

WHEREAS, roughly 70% of Native Americans live in cities, and 41 Urban Indian Organizations serving 22 states provide care to some of those populations and most Urban Indian Organizations have received their vaccines through the Indian Health Service; and

WHEREAS, many cities, including Washington, D.C., do not have any Indian Health Care Providers (IHCPs) and therefore the American Indian and Alaska Natives serving in federal government positions and at national Native organizations located in the Washington, D.C. area are not prioritized to receive the vaccine; and

WHEREAS, there are nearly 63,000 American Indians and Alaska Natives living in the Washington, DC Metropolitan Area who do not have direct access to COVID-19 services and vaccines; and

WHEREAS, the United States average health care spending is $11,172 per person, however, Tribal and Indian Health Service (IHS) facilities receive only $4,078 per American Indian/Alaska Native (AI/AN) patient from the IHS budget and Urban Indian Organizations (UIOs) receive just $672 per AI/AN patient; and

WHEREAS, the Indian Health Service is woefully underfunded such that urban Indian health funding has never received adequate funding, which has led to the pandemic disproportionately impacting AI/ANs, including those in the Washington, DC Metropolitan Area; and

WHEREAS, it is the duty of federal government to fully fund the Indian Health Service in accordance with the recommendations set forth by the Tribal Budget Formulation Workgroup with maximum flexibility; and

WHEREAS, the diaspora of American Indians and Alaska Natives is a direct reaction to and result of the policies of the federal government, including the Indian Relocation Act of 1956 which was specifically designed to encourage American Indians and Alaska Natives to leave their Native Homelands and further assimilate into the dominant culture; and

WHEREAS, in the most recent report to Congress on the needs of Urban Indians, IHS identified 17 cities with a population of AI/AN individuals significant enough to warrant an Urban Indian Health Program. This list included Washington DC; and

WHEREAS, it is the United States Department of Health and Human Services authority to halt the furtherance of systemic racism that has cost millions of AI/AN lives; and

THEREFORE BE IT RESOLVED, the Health and Human Services and Indian Health Service must provide full resources, technical assistance and support to ensure all I/T/U facilities can administer COVID-19 vaccines to their patients, including the urban facility in the Washington, D.C. area, Baltimore and Boston Native American Lifelines; and

THEREFORE BE IT FURTHER RESOLVED, that the National Council of Urban Indian Health calls upon HHS to prioritize the vaccination of all AI/AN people by immediately convening an Emergency COVID-19 Urban Indian Task Force to create a strategy to inoculate AI/ANs living outside of the reach of the Indian health system, including the 17 cities IHS listed in its report.

CERTIFICATION

The foregoing resolution was adopted by NCUIH on February 26, 2021 with a quorum present.

Walter Murillo, President

Linda Stone, Secretary