

The Impact of Indian Health Service Funding for Type 2 Diabetes

Preventive Care Programs on Outcomes in the Navajo Nation

Anjali Chennapragada

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Introduction

American Indian and Alaska Native (AI/AN) communities have, throughout history, experienced disproportionately higher rates of numerous health problems in comparison to the general American population. This has resulted in poorer health outcomes such as life expectancy and even negative socioeconomic impacts, including poverty, homelessness, and unemployment. In order to address the particular needs of the AI/AN populations, the Indian Health Service (IHS) was established as the federal agency responsible for overseeing and directing health care services and programs in federally recognized tribes. However, the allocation of IHS funds for Indian health care across the country has been inadequate in addressing the urgent needs of these tribes.

This issue is exemplified by the prevalence of Type 2 diabetes, which is higher in AI/AN tribes than any other population in the United States. In many of these tribes, the level of IHS funding for Type 2 diabetes preventive care has been insufficient. This is an especially critical issue in the Navajo Nation, a tribe with the largest reservation in the United States, located in the Southwest. The lack of sufficient IHS funding for Type 2 diabetes preventive care within the Navajo Nation has hindered the ability of providers, community health centers, and related socioeconomic programs to address the high prevalence of Type 2 diabetes in the tribe.

The role of the federal government in tribal affairs has always been complex due to the fact that AI/AN tribes are considered sovereign powers. This necessitates the existence of a federal agency solely responsible for navigating the complex relationship between federal and tribal jurisdiction, apart from other health care agencies. For this reason, the Indian Health

Service was established in 1955 under the Department of Health and Human Services (DHHS) after many years of trying various government smaller-scale programs to address Indian health.

This paper will examine multiple forms of Type 2 diabetes preventive care in the Navajo Nation in order to assess their current effectiveness, accessibility, and utilization. This analysis will examine existing literature and data to identify any existing gaps in funding or areas requiring development for the purpose of developing policy recommendations and potential solutions.

Background

As previously mentioned, the IHS is a federal agency that operates under the Department of Health and Human Services (DHHS). This is the main agency responsible for providing health care to federally recognized AI/AN tribes. According to an issue brief by the Kaiser Family Foundation (KFF), “IHS-funded health services are provided through a network of hospitals, clinics, and health stations that are managed directly by IHS, by tribes or tribal organizations, and urban Indian health programs” (Artiga et al. 2013, 1). These services are largely limited to members and descendants of federally recognized tribes. As per the IHS Fiscal Year 2023 Budget Submission to Congress by the DHHS, the IHS provides primary health care and preventive services to 2.7 million individuals “through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations,” primarily managed by the IHS, Tribal, and urban Indian health programs (DHHS 2022, CJ-1).

Most of the funding for the IHS is allocated through congressional appropriations, in addition to reimbursements from Medicare, Medicaid, the State Children’s Health Insurance Program (CHIP), the U.S. Department of Veterans Affairs, and private insurance (Lofthouse

2022, 2). The authority for the IHS to receive payments from other federal programs sets it apart from other federal agencies. These payments are used to provide health services to IHS beneficiaries that are also enrolled in those above mentioned programs.

Although IHS funding has grown over the last decade, it has still been shown to be inadequate and comparatively less than that of other health care agencies. The summary of the FY 2023 Budget Submission states that “substantial growth in the IHS discretionary budget...has not been sufficient to address the well documented funding gaps in Indian Country” (DHHS 2022, CJ-3). Insufficient IHS funding affects all AI/AN populations and the specific health care needs of each community. The provision of health care services itself is filled with conflicts and complications that often result in disproportionately low accessibility and availability of health care as well as disparities in health outcomes within each tribal population.

One such conflict is between health services directly managed by the IHS or tribal organizations, which limit care to members and descendants of federally recognized tribes on or near reservations and urban Indian health programs, which serve a wider AI/AN group that also includes those who do not meet the eligibility criteria or service area requirement to access the IHS- or tribally-operated health care. The complication here is that there is very limited IHS funding for these urban programs and the distribution of this “has not reflected the overall demographic shift of American Indians and Alaska Natives away from reservations” (Artiga et al. 2013, 7). Therefore, the impact of IHS funding on health services for AI/AN populations is compromised because unequally prioritizes certain portions of the overall population. This perpetuates the high burden of disease and illness in tribal communities across the United States.

One of the most pressing health issues across all AI/AN communities is type 2 diabetes (T2D). According to the Centers for Disease Control and Prevention (CDC), T2D is characterized by insulin resistance which results in high blood pressure and is the most common type of diabetes, accounting for over 90% of Americans with diabetes. Whereas type 1 diabetes is caused by an autoimmune disorder most often diagnosed in children and adolescents with no known preventive measures, type 2 diabetes is typically developed over many years and can often be associated with particular lifestyle factors or comorbidities. Major risk factors include being overweight, low levels of physical activity per week, prediabetes and family history of T2D. The other important factor is that unlike type 1 diabetes, which is a lifelong disease, T2D could potentially be reversed through diet changes or weight loss, which could return blood sugar levels to normal (CDC 2022). However, the ability for maintenance or reversal of T2D can be greatly hindered by socioeconomic barriers and this often affects entire communities, particularly those that are underserved. Such is the case in the overall AI/AN population. In many tribes, individuals both on and off reservations face obstacles to accessing or utilizing preventive care which ultimately impacts the burden of T2D across the entire community. The CDC research study says that the “erosion of traditional lifeways and culturally estranged health care systems...are major drivers of diet-related health disparities” (Trevisi et al. 2020, 1).

The prevalence of T2D in AI/AN. This is double that of the non-Hispanic white population, for which the prevalence of diabetes is 7.4%. This paper is specifically focused on the Navajo Nation, the largest Indian reservation in the United States. The Navajo Nation covers over 27,000 square miles across Arizona, New Mexico, and Utah. The population of the Navajo Nation is 350,000, but the population of those who use the Navajo Area Indigenous Health Service, a regional unit of the IHS, is 247,000 people. According to a study published by the

Centers for Disease Control and Prevention (CDC), about half of the adult Navajo population is living with either T2D or prediabetes. For comparison, in Arizona, New Mexico, and Utah, the T2D prevalence in the overall adult population is approximately 10%, 12%, and 8%, respectively, which is much lower (Trevisi et al. 2020, 2).

In any population, preventive care is necessary to reduce the burden of T2D, but it is especially crucial in AI/AN communities because of the disproportionately high T2D prevalence in these tribes. Preventive care for T2D includes interventions both for adults with existing prediabetes—elevated blood sugar levels that still are not high enough to be diagnosed as T2D—and for high-risk individuals or populations. On an individual level, preventive measures include healthy lifestyle interventions and routine screenings (CDC 2022). On a larger population level, preventive care would include programs that address the social determinants of health that impact T2D prevalence in a community. Examples of these risk factors include, but are not limited to, “socioeconomic status, health literacy, the food environment and food insecurity, and neighborhood and physical environments” (NCCC 2021, 19). There are currently multiple programs on both the federal and tribal levels focused on T2D prevention and treatment in AI/AN communities. Many of these programs receive IHS funding, either through grants awarded to individual tribal health agencies or annual budget allocations by Congress. Specific programs will be further discussed in the following section.

Literature Review

Much of the existing literature on this issue focuses on T2D and/or IHS funding as it pertains to the overall AI/AN population of the United States, primarily covering issues related to epidemiology and socioeconomic factors, IHS funding or budget analyses, and existing

community or preventive care programs. The body of literature specific to the Navajo Nation, however, is much narrower. The majority of publications on this issue are focused on the larger IHS-covered population of the United States or the burden of T2D and T2D-related programs across all AI/AN tribes.

There are many publications that focus on IHS funding and budgets as well as those that evaluate whether or not current allocations are sufficient in supporting T2D preventive care programs. Federal agencies must submit an annual Congressional Justification to Congress regarding the budget for each upcoming fiscal year. In the case of the IHS, the Department of Health and Human Services submits its “Justification of Estimates for Appropriations Committees” and all of these documents, starting at Fiscal Year (FY) 2009 are available on the IHS Division of Budget Formulation webpage. The Congressional Justification for the current fiscal year, published in 2022, contains the “FY 2023 Performance Budget Submission to Congress.” The report is then divided into nine subsections. The Executive Summary includes overviews of the budget submission and the agency’s performance, as well as any changes that were made from the budget of the previous FY. This is followed by Appropriation Accounts, which contains a summary of the request. This breaks down all the services in addition to facilities-related costs. There is a specific portion dedicated to preventive services and while it is not specific to the Navajo Nation, it provides a general idea of how much weight is placed on preventive care in the budget, compared to other areas of spending (DHHS 2022, CJ-133).

However, to supplement these reports, there are also testimonies from various agencies or organizations that attest to underfunding within the IHS. Two examples, both regarding the FY 2023 budget, are National Indian Health Board’s (NIHB) testimony for the DHHS Annual Tribal Budget and Policy Consultation and IHS testimony for a hearing by the Senate Interior,

Environment, and Related Agencies Appropriations Subcommittee. In both of these testimonies, there is reference to chronic underfunding of the IHS in comparison to other federal health programs or agencies, in addition to proposals for budget provisions and funding allocations to address this (NIHB 2021; Fowler 202).

It is also important to understand how the IHS is structured on both the policy and/or administrative levels in order to contextualize the budget and funding data. This context is provided in the previously mentioned issue brief by the Kaiser Family Foundation (KFF), which “provides an overview of health coverage and care for American Indians and Alaska Natives today and the potential implications of the ACA coverage expansions” (Artiga et al. 2013, 1). It details the various components of the IHS, including its role and the scope of its services, while also identifying gaps and obstacles.

One challenge with the IHS is how complex the eligibility requirements are. There are numerous conflicts between those living on versus outside reservations, IHS/tribal health centers versus urban health centers, and IHS-covered AI/ANs with private insurance or Medicaid coverage versus those who are uninsured. The insights in the KFF brief are vital to the specific issue of this paper because even if there was an abundance of T2D preventive care programs, there is still unequal access and eligibility among the Navajo population specifically served by the IHS. This automatically compromises the effectiveness of such programs, which is especially problematic as performance is a key consideration for allocation of funding in annual IHS budgets, which get divided up between tribal jurisdictions (Artiga et al. 2013).

Similar insights are provided in a 2022 policy brief called *Increasing Funding for the Indian Health Service to Improve Native American Health Outcomes*, in which the author, Jordan

K. Lofthouse, discusses chronic underfunding of the IHS and its implications on AI/AN health outcomes. According to Lofthouse, the federal government “has allocated smaller proportions per capita to the IHS than any other federally funded healthcare program,” specifically referencing Medicare, Medicaid, and the Veterans Health Administration. This is despite the fact that the IHS has significantly lower annual spending and serves a smaller number of individuals compared to these federal providers or public insurers. The consequences of the lack of sufficient funding range from gaps in coverage as well as the diagnosis and treatment of certain health issues, particularly in rural areas (Lofthouse 2022, 2). Although the paper ultimately provides more short-term policy recommendations, it still highlights the same critical issue as the KFF brief, which is that the funding constraints in the IHS are sustaining the disproportionately poor health outcomes in AI/AN communities.

An article in the *American Journal of Public Health* (AJPH), “The Costs of Treating American Indian Adults With Diabetes Within the Indian Health Service,” uses “demographic and health service utilization data from the IHS electronic medical reporting system” to derive treatment costs, chronic condition prevalence, and service utilization for American Indians with diabetes in central Arizona (O'Connell et al. 2012, 301). The research was not specifically focused on the Navajo Nation; however, the study population all lived in the Phoenix Service Unit and under it, the Phoenix Indian Medical Center (PIMC) does serve members of the Navajo Nation. The study’s findings include calculations of utilization of medical services as well as IHS treatment costs for AI/AN adults with and without diabetes. The data is significant because it shows how much of the IHS treatment costs are used for adults with diabetes, underscoring the importance of T2D preventive care programs.

The next category of literature is work that focuses on epidemiology and surveillance. Understanding the demographic breakdown of disease prevalence is crucial in drawing comparisons between the Navajo Nation population and the overall US population. Those comparisons can be used to identify major disparities and how they impact both the effectiveness and access to preventive service as well as the level of need for funding. The aforementioned AJPH paper breaks the prevalence of diabetes in the research population by demographic, specifically age group and gender. One of the notable statistics showed that, although T2D predominantly impacted older adults in the overall US population, in the Phoenix Service Unit, participants 65 years or older only accounted for 12% of all participants. If the onset of T2D is disproportionately earlier in this population versus the general population, it emphasizes the importance of analyzing diabetes preventive care (O'Connell et al. 2012, 303).

This issue is also the focus of “Increasing Burden of Type 2 Diabetes in Navajo Youth: The SEARCH for Diabetes in Youth Study,” published in the journal *Pediatrics Diabetes*. In this publication, the authors used data from the SEARCH study for diabetes in youth, specifically from SEARCH-Navajo, which “actively surveils IHS health system databases.” The population for this study was all Navajo Nation members “under 20 years of age who were active health system users of tribally operated or IHS operated regional health facilities” and included youth type 2 diabetes (YT2D) surveillance within this population. The data confirms that there has been a growing prevalence and incidence of YT2D in the Navajo Nation and that there is a potential for this increase to continue in the future. As in the previously mentioned AJPH publication, this study is noteworthy because it shows that T2D prevalence is affecting a greater number of youth and specifically those who receive IHS care. The study says that “Effective and sustainable programs aimed at primary prevention of YT2D in Navajo may help prevent future

diabetes cases” and therefore, any improvements in funding for these programs could be greatly beneficial for the overall population (Powell et al. 2020, 815).

Another topic covered in existing literature is existing T2D preventive care programs and initiatives within AI/AN communities and their effectiveness in these communities, particularly those primarily funded or operated by the IHS. Preventive care is crucial to addressing the disproportionately high burden of T2D in AI/AN communities because, unlike treatment and management, it addresses incidence, slowing or preventing the onset of new cases by targeting high-risk populations and the factors that lead to diabetes.

A key federal initiative is the Special Diabetes Program for Indians (SDPI), through which Congress “provide[s] grants for diabetes treatment and prevention services to Indian Health Service (IHS), tribal, and urban Indian (I/T/U) health programs across the United States.” The FY 2023 Congressional Budget Justification shows how much funding was set aside for the program, as well as how the money was allocated through tribes, which is through competitive grants established by the IHS. The document also outlines the requirements that grantees are expected to follow, which include implementing a “best practices approach to diabetes treatment and prevention” and documenting the use of “corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability” (DHHS 2022, CJ-196). Because competitive grants have consistently been part of grievances brought up during Tribal consultations, this information will show whether or not the allocation method is impacting T2D interventions in tribes that have received these grants versus those that have not.

Data from multiple reports have shown that the SDPI has had success in improving T2D prevalence and related health outcomes. The National Clinical Care Commission (NCCC)

published the 2021 “Report to Congress on Leveraging Federal Programs to Prevent and Control Diabetes and Its Complications,” which was supported by DHHS. The report provides recommendations for reducing diabetes-related risks, preventing diabetes in both the general and targeted high-risk populations (NCCC 2021, 19). According to the NCCC report as well as the SDPI 2020 Report to Congress, by focusing on prevention, the IHS as of 2017 was able to reduce the prevalence of T2D in the AI/AN population “from 15.4% in 2013 to 14.6% in 2017” (61).

There are also publications that discuss local Tribal preventive care programs and approaches. A research study published in the journal *Preventing Chronic Disease* focused on an intervention known as Community Outreach and Patient Empowerment (COPE) and aimed to “identify groups for whom the intervention had the greatest effect” and took place in the Navajo Nation. This intervention utilizes Community Health Representatives, or CHRs. The CHR program in the Navajo Nation consisted of “nearly 100 CHRs who are certified nursing assistants and fluent in Navajo.” This intervention relies on a combination of CHRs, clinic-based providers, and patients. The authors utilized electronic health record (EHR) data for adults with diagnosed T2D that received care at a participating health care facility. Because the CHR program is overseen by the Navajo Department of Health which is part of the regional IHS unit, these findings show what impact preventive care strategies can have on T2D prevalence (Trevisi et al. 2020, 2).

Analysis

Because the body of literature related to IHS funding specifically for the Navajo Nation is very limited, this research involved synthesizing national IHS funding data in conjunction with

literature about epidemiology or the socioeconomic factors of T2D in the Navajo Nation. This aim of this synthesis was to (1) identify which factors of T2D prevalence in the Navajo Nation must be prioritized through preventive care programs; (2) determine how much funding is being allocated to existing programs and whether preventive care is a priority in IHS budgets; (3) evaluate how effective existing preventive care programs actually are in addressing the needs of this specific population; (4) and identify gaps in the eligibility, accessibility, and utilization of services within members of the community.

As such, the analysis required looking at both peer-reviewed and gray literature. Publications about the clinical aspects of the issue, such as epidemiology, T2D surveillance, specific risk factors, and health outcomes were most commonly found in various medical or public health journals using a database search. Research also included clinical guidance and surveillance data that was directly available on government agency or nonprofit organization sites, such as that of the Indian Health Service, the CDC, and the American Diabetes Association (ADA).

The funding component of the research relied primarily on gray literature, including the above-mentioned government budget reports and policy or issue briefs. As stated in the AJPH paper, “Although health service delivery, financing, and resource allocation are important determinants of health, little is known about health service utilization and treatment costs within IHS” (O’Connell et al. 2012, 301). Therefore, in the absence of a comprehensive body of literature examining the specific relationship between IHS funding and clinical T2D outcomes, budget and cost reports were used to evaluate how much funding is specifically allocated for preventive care and existing T2D-related programs. This was then used to contextualize separate

findings on the relationship between the utilization of specific preventive care services or programs and T2D prevalence in the Navajo Nation.

The first component of this analysis is identifying the risk factors or barriers with the greatest impact on T2D incidence in the Navajo Nation. Risk factors were primarily categorized as being either clinical or socioeconomic. However, these categories are not mutually exclusive, as socioeconomic challenges often exacerbate the onset of clinical risk factors related to chronic disease, on both an individual and societal scale. Based on the social ecological model depicted in the Annual Review publication, risk factors were categorized as individual, interpersonal, and environmental. A similar framework was used to classify the risk factors for T2D in the Navajo Nation and analyze them in the context of national-level IHS preventive care programs and initiatives (O'Connell et al. 2012, 464).

One of the most significant components of the disproportionately high T2D prevalence in the Navajo Nation is barriers to access and utilization of health care services. Of particular concern is the impact this has on utilization of primary care services. Studies have shown that there has been an increasing burden of T2D on the younger population of the Navajo Nation. Research published in the journal *Pediatric Diabetes* found that both prevalence and incidence rates of youth onset type 2 diabetes (YT2D) increased in the Navajo Nation of those below 20 years of age (O'Connell et al. 2012, 815). Additionally, in the AJPH study, findings showed that the prevalence of diabetes among participants between the ages of 35 and 54 accounted for nearly half of all participants, while prevalence of those aged 65 years and older only accounted for 12%. These findings underscore how significant of a role preventive care plays in reducing the burden of T2D in the Navajo Nation (O'Connell et al. 2012, 303).

The role of the SDPI has been pivotal in introducing better health promotion, patient education, and lifestyle interventions into many AI/AN communities and funding for the program is included in the overall annual IHS budget. For FY 2023, SDPI funding is \$147 million. However, this funding amount has decreased from FY 2022, during which SDPI received \$150 million in funding. This is because the current budget includes a mandatory sequester of 2%, which is the “legislatively mandated process of budget control consisting of automatic...spending reductions... limit federal spending” (IHS 2022, 2). Through a grant program, the SDPI currently provides funding for diabetes treatment and prevention to 301 IHS, Tribal, and Urban (I/T/U) health grant programs. In the FY 2023 budget, \$130.2 million has been allocated to SDPI grant programs, which consist of 272 Tribal and IHS grants, as well as subgrants. In contrast, only \$8.5 million has been allocated to grant programs for Urban Indian Health Programs (DHHS 2022, CJ-197).

An alternate strategy in addressing the barriers to accessing or utilizing health care services is the previously mentioned Community Outreach and Patient Empowerment (COPE) intervention, which uses Community Health Representatives (CHR). Because the Navajo Department of Health oversees the tribal CHR program, that means it operates under the regional IHS administrative unit. The findings of the research evaluating this program showed that this intervention had the greatest benefit for patients who did not have a primary care provider (PCP) and yielded greater responses in patients aged 64 years or younger (Trevisi et al. 2020, 2).

While there is little data on IHS funding specifically for the Navajo Nation CHR program, the Congressional budget does include funding for a federal CHR program. The program is first listed under the Preventive Health subsection, which indicates that there are a number of preventive services which were discontinued in the FY 2023 Budget. Among these is

the CHR program and the justification given was “ to prioritize health care services and staffing of newly constructed facilities” (DHHS 2022, CJ-133). The program has received a \$5 million increase in funding, reserved only for federal agency operations. Of this amount, \$3 million is allocated for a national evaluation of the program. The reason given for this evaluation is that a lack of national data on the role and impact of the program “has raised questions from stakeholders about the overall efficacy of the program” (DHHS 2022, CJ-152).

Discussion

Having analyzed the research question by synthesizing both federal IHS data and local Navajo Nation clinical research, there are some key areas in which policy change is needed, the first of which pertains to coverage and eligibility. One of the primary conflicts with IHS services in tribes across the country is that there are significant gaps impacting who can access IHS or Tribal health programs and services in federally recognized tribes. Frequently, health care services “provided through IHS- or tribally-operated facilities generally are limited to members or descendants of members of federally-recognized tribes...who live on or near federal reservations” (Trevisi et al. 2020, 7). There is a growing number of AI/ANs who live outside of reservations and because IHS eligibility requirements have not changed to reflect this shift, many of them are only able to access Urban Indian health programs.

The challenge with this is that Urban Indian health programs receive a very minimal percentage of IHS funding and are also ineligible for contracting health services from private providers if they are unable to meet those needs, which is an option afforded to IHS or tribally-run facilities (Trevisi et al. 2020, 6). The implications are also present in the issue of T2D preventive programs in the Navajo Nation. The two previously mentioned services, the

SDPI and CHR programs, both receive federal funding. The first conflict is that SDPI grants are competitive and therefore, subject to fluctuation. Inconsistent preventive care services will not produce the intended benefits if the funding is unreliable. Additionally, because the SDPI is subject to a mandatory 2% sequester, there will be annual reductions in the amount of funds available for these grants.

Conversely, within the Navajo Nation, the CHR program is operated by the local IHS administrative unit and therefore, has a more consistent presence in the community. The benefit with this program both locally and federally is that it falls under the mandatory funding in the budget. Mandatory funding provides “predictability that would allow IHS, tribal, and urban Indian health programs the opportunity for long-term and strategic planning.” Additionally, it cannot be subject to sequestration, unlike with SDPI funding (IHS 2022, 2). However, the predictability of mandatory fundings is compromised by the fact that the CHR program has been discontinued in the FY 2023 budget and is being scrutinized in terms of its efficacy. According to the budget, the CHR program is “over 90 percent directly operated by Tribes or Tribal organizations,” hence why most of the federal funding is reserved solely for federal operations (DHHS 2022, CJ-152).

One potential policy change to address this would be to provide mandatory funding for the SDPI program as well. This would ensure that grantees would have secure and consistent funding for their diabetes prevention and treatment programs. Because the funding allows for grantees to establish their own preventive programs, this would serve the Navajo Nation in helping to alleviate some of the coverage and eligibility gaps for the services because Urban Indian health programs would now be able to receive more equitable levels of funding. In the 2021 NIHB testimony, a recommendation was made that “the Special Diabetes Program for

Indians be permanently reauthorized and increase funding to \$250 million per year plus annual inflationary increases and authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 contracts and compacts” (NIHB 2021, 8). P.L. 93-638 refers to the self-determination law granting “Indian tribes the authority to contract with the Federal government to operate programs serving their tribal members and other eligible persons” (Bureau of Indian Affairs). Having more tribally operated programs would also strengthen the role of CHR programs, such as the one operated by the Navajo Department of Health. In doing so, the program could continue to operate and receive federal funding without being subject to doubts about whether the program has any measurable impact on the community or subsequent T2D health outcomes.

As shown in the AJPH study examining the Phoenix Service Unit, service utilization and treatment costs related to T2D make up a high portion of overall IHS costs. This is especially concerning given that the same paper indicated that average treatment costs in the study findings for adults with diabetes were 3.6 times those of American Indian adults without diabetes (O'Connell et al. 2012, 304). This not only impacts funding, but also places some financial burden on patients because of outside factors related to accessing these programs. This adds to the non-clinical factors that exacerbate T2D burden. Because these costs are already strained across all sectors of health care, both locally and nationally, diverting or increasing funding specifically for prevention would alleviate some of the strain on Navajo and IHS costs by delaying or preventing the onset of T2D. This would free up funds for programs addressing other urgent health care and socioeconomic issues in these communities.

If more of the population has access to these preventive services, it will impact the larger socioeconomic factors that are perpetuating the disproportionately high T2D prevalence in the

Navajo Nation and the resulting burden it places on the entire community as a whole. Although the IHS is not considered insurance, its purpose is to provide health care to federally recognized tribes that face stark health disparities in comparison to the general US population. However, it is clear that there are significant gaps in budget allocations that result in inadequate funding for these vital T2D prevention programs. By reevaluating the role of funding and the programs it covers, it gives both the federal agency as well as local and tribal jurisdictions the ability to ensure that all their members are able to access the benefits for which the IHS was established.

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