The population of American Indians and Alaska Natives (AIAN) in the USA, which comprise about 5 million individuals, have worse health outcomes than other Americans. Life expectancy among AIAN people is more than 4 years lower than that of the overall US population. AIAN death rates are about 50% higher than rates in the white population. More alarmingly, this disparity in mortality rates has increased in the past decade, with death rates falling in white people and increasing in AIAN people. Given these growing inequalities, the Lancet Series, America: Equity and Equality in Health, is welcomed.

As detailed in the Series papers, socioeconomic disparities have a profound role in the persistence of health disparities in the USA, and are of particular importance for the AIAN population. As Zinzi Bailey and colleagues outline, structural racism—the institutionalisation of racial discrimination in systems such as housing, education, and health care, among others—can have a profound effect on population health, health inequities, and the health and wellbeing of individuals. Indeed, the worrying inequalities among AIAN raise fundamental issues for health care systems and providers.

The social determinants of health play a prominent part in the health status of AIAN people. AIAN individuals are more likely than white people to have a family income below the poverty level (27% vs 10%), less likely to have a family member in full-time employment (70% vs 84%), and are more likely to be uninsured for health (21% vs 8%). The leading contributors to excess mortality among the AIAN population include factors directly related to these high levels of social risk, such as unintentional injury, violence, and diabetes. The direct clinical consequences of these social risk factors are clear: compared with white individuals, AIAN people have a higher prevalence of obesity, tobacco use and physical inactivity, and lower consumption of fruits and vegetables. AIAN people report a “fair or poor” health status more frequently than white people (20% vs 9%), as well as an increased burden of diabetes, hypertension, asthma, substance use disorder, and mental illness.

Providing adequate access to high-quality health care is therefore crucial. However, although AIAN populations increasingly reside in urban settings, a substantial proportion are clustered in rural and remote environments with restricted access to health care. Bailey and colleagues highlight the importance of segregation as a manifestation of structural racism, and in the case of the AIAN population, this issue has implications for the delivery of high-quality care. Bailey and colleagues highlight the importance of segregation as a manifestation of structural racism, and in the case of the AIAN population, this issue has implications for the delivery of high-quality care. AIAN people are more likely than whites to report that they have no personal doctor (28.3% vs 18.7%), and isolated communities have difficulty in accessing tertiary care for conditions such as acute myocardial infarction and renal transplantation.

The Indian Health Service (IHS), while not the only means for AIAN to receive health care, is a federal agency that provides health care to 2.2 million AIAN people who are members of federally recognised tribes through a system of hospitals and ambulatory health centres. The IHS has shown improvements in cancer prevention and chronic disease management and in the uptake of innovative health information technology, while incorporating culturally appropriate quality improvement strategies. Although the future of the Affordable Care Act (ACA), as discussed in this Series, is uncertain, the legislation has resulted in a significant decrease in the uninsured rate among

For the America: Equity and Equality in Health Series see http://www.thelancet.com/us-health
AIAN: it fell from 24.8% in 2012–13 before the ACA to 20.6% in 2014 after the ACA was implemented, with Medicaid expansion often supplementing IHS coverage.15

But major challenges for the IHS remain, especially quality of care. Less than half of primary care physicians within the IHS report adequate access to specialists, non-emergency hospital admission, and diagnostic imaging services, while only about half have adequate access to mammography.14 Thus, primary care physicians have to manage complex conditions for which they would otherwise prefer the assistance of specialists. A report by the US Government Accountability Office earlier this year found that the IHS needs to make substantial progress to improve quality of care by focusing on the incorporation of quality into governing board meetings; improving the consistency of reporting of data on quality; and improving safety event reporting.16 The IHS has responded by developing a quality framework implementation plan to provide greater oversight and consistency in its approach to delivering high-quality care.

Consistent with the conclusions of the Lancet Series, key steps are needed to substantially reduce the health inequities experienced by AIAN people. First, a public health approach to addressing the social determinants of health is needed to target the root causes and ultimate consequences of unhealthy and risky behaviours. These efforts need to engage and empower the AIAN community in culturally appropriate ways, using models such as community health workers.17 Second, the IHS requires greater resources to ensure clinicians have the tools needed to deliver high-quality care. One solution is for the IHS to partner with academic institutions to help support specialty care via telemedicine programmes and on-site physician volunteer programmes.2 However, long-term approaches include appropriation of funds and diversifying the pipeline of health professionals, in particular AIAN health professionals who will serve these communities. Third, as is already planned, the IHS should focus its efforts on ensuring a consistent and reliable approach to the delivery of high-quality care across all of its care settings for AIAN communities. While the inequities faced by AIAN are substantial, the actions required to address these are known and require us to take urgent action.

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I declare no competing interests.

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