Representative Voices: Native American Representation, Political Power, and COVID-19 in U.S. States

LAURA E. EVANS, RAYMOND FOXWORTH, GABRIEL R. SANCHEZ, CHERYL ELLENWOOD, AND CARMELA M. ROYBAL

We examine predictors of COVID-19 cases in Native nations during the early months of the pandemic. We find that where Native American representation and Native American political power in state politics were greater, COVID-19 cases on tribal lands were fewer. We expand the literatures on descriptive representation and on tribal-state relations by demonstrating consequences of powerful Native American voices in the state-house. We find that Native American voices on tribal lands are also vital. Tribal lands that had extensive networks of community-based health facilities and tribally controlled health facilities recorded fewer COVID-19 cases. The broader lesson here is that if Native nations are to protect their citizens, they need outside governments that support, not thwart. Our findings draw on unique, original quantitative analysis.

Keywords: inequality, representation, Native American, COVID-19

Native America was hit hard by the COVID-19 global pandemic. It exposed long-standing inequities in the U.S. political system, inequities that made Native communities particularly vulnerable to the virus. In previous research, we documented that federal neglect, including the inability of the federal government to live up to its trust responsibilities to Native nations, was

Laura E. Evans is an associate professor at the Evans School of Public Policy and Governance at the University of Washington. **Raymond Foxworth** (Navajo Nation) is vice president of First Nations Development Institute, a Native-led nonprofit organization in Longmont, Colorado, and a visiting scholar at the University of New Mexico for 2021–2022. **Gabriel R. Sanchez** is a professor of political science and the founding Robert Wood Johnson Foundation Endowed Chair in Health Policy at the University of New Mexico, United States. **Cheryl Ellenwood** (Nez Perce) is assistant professor in the School of Politics, Philosophy, and Public Affairs at Washington State University, United States. **Carmela M. Roybal** (Ohkay Owingeh) is an assistant research professor and executive director of the Native American Budget Policy Institute at the University of New Mexico.

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a contributing factor in the spread of COVID-19 in Native American communities. Longstanding inequities, including a lack of critical infrastructure in Native communities, led to significant illness and death across Native America (Carroll et al. 2020; Foxworth, Evans, et al. 2021; Roybal 2020). This article builds on our earlier work and examines state political factors that help us explain rates of COVID-19 across Native America.

Although the federal government has trust and treaty responsibilities to Native nations, Native nations have increasingly become active and important constituents for state legislators. Native nations engage in lobbying, sponsor candidates, promote issues, encourage tribal citizen participation, and more. Additionally, as individuals, Native people have launched campaigns to run for state political office to represent Native American and other historically marginalized constituents. These participatory mechanisms are important tools as Native people and communities engage in the political process to hold politicians accountable and to make demands on the political system—demands that have historically been ignored and minimized.

Most research on Indigenous communities during the COVID-19 pandemic has documented Native American vulnerability as a consequence of poverty (Leggat-Barr, Uchikoshi, and Goldman 2021; Chakraborty 2021). However, those analyses remain rooted in deficit frames of Native nations as passive subjects of the COVID-19 pandemic rather than as active agents mobilizing to keep their communities and cultures safe. We challenge these limited and shallow portraits of Native nations and engage the literature on representation and Native sovereignty to better understand Native nations' political responses to the COVID-19 pandemic.

Given the history of Native American social exclusion and social inequities that fueled the COVID-19 pandemic in Native American communities, we argue and find that both Native American political power within states and Native American political representation in state legislatures matter in reducing COVID-19 cases in Native communities. Those two independent and distinct pathways of Native American representation in state politics matter in a number of ways in combating social inequity, especially in times of crisis. First, where Native nations increased their political power within states, we see fewer cases of COVID-19 because Native nations' political mobilization within states increased incentives for state politicians to collaborate with and respond to Native nations' demands. That political influence of Native nations provides tribal leaders with the ability to advance the needs of Native communities in state politics. Second, the presence of Native Americans in state legislatures also has a direct impact on COVID-19 outcomes. That finding connects to the broad body of research on descriptive representation, which notes that group interests and demands may be prioritized and elevated when public officials share group identification.

We do not suggest that tribal-state relations are the only avenue through which Native nations shape their fate, of course. Our findings demonstrate that tribal control over health systems is an important factor as well. We find fewer COVID-19 cases on tribal lands that had extensive networks of community-based and tribally controlled health facilities. Those results help situate our findings on tribal-state relations in a broader context, specifically that robust exercise of tribal sovereignty keeps tribal citizens safe. That finding is significant given the history of federal and state policy that has argued that tribal sovereignty "holds tribes back" from modern life.

We connect our findings with research that highlights the structural inequalities within Native communities. We show that Native American representation combined with active state- and federal-level collaboration may further reduce inequities. Moreover, we show that the sovereignty of Native nations matters, especially in the context of the COVID-19 pandemic.

NATIVE NATIONS, HISTORICAL NEGLECT, INEQUITIES, AND COVID-19

In 2020, the United States was home to one of the world's largest outbreaks of the SARS-CoV-2 virus, commonly referred to as coronavirus disease 2019 or COVID-19. The pandemic amplified long-standing inequalities, resulting in ra-

cial and class differences in COVID-19 transmission and death rates (CDC 2020a; Raifman and Raifman 2020; James, Tervo, and Skocpol 2022, this issue). That trend was especially true in Native American communities, given stark and long-standing health and economic inequities.

Vulnerability in Native communities from epidemics and pandemics is not new. Research documents that in the 1918–1919 influenza, roughly 25 percent of Native Americans caught the flu, the highest of any racial and ethnic group, resulting in a 2 percent population loss (Kakol, Upson, and Sood 2020). The first victims of the hantavirus outbreak in the southwestern United States in 1993 were in Navajo communities. During that outbreak, news media stoked fears among non-Native people, referring to the virus as the Navajo flu (CDC 2020c; Pressley 1993). During the H1N1 outbreak in 2009, death rates for American Indian and Alaska Natives were four times greater than all other racial and ethnic groups combined in states with high Native populations (CDC 2009; Galarce, Minsky, and Viswanath 2011).

Beyond these traditionally defined health epidemics, many Indigenous scholars argue that colonization has been the most significant health epidemic, leading to the greatest loss of Indigenous life across the Americas (Estes 2020; Roybal 2020). Ninety percent of Indigenous life was lost across the Americas during the first century of European contact. Death was incited by disease, starvation, poverty, and violence. These factors continue to ravage Native communities at disproportionate rates today (Jones 2006; Newson 1993).

The coronavirus pandemic is in many ways a repeat of prior disease outbreaks on tribal lands resulting from structural inequalities fueled by generations of colonization. Long-standing inequalities made Native Americans vulnerable to COVID-19 infection and spread. Research documents that the history of colonization and policy neglect by federal and state governments compound the effects of COVID-19 in Native nations (Foxworth, Evans, et al. 2021; Rodriguez-Lonebear et al. 2020). The perpetuation of structural inequities fuels poverty, unemployment, deficient infrastructure, food insecurity, a lack of internet access, trauma, ineffective health care, and much more (Fortuna et al. 2020; Graves et al. 2020).

The Navajo Nation became the epicenter for COVID-19 in the United States. By August 2020, Native Americans nationally had 3.5 times more COVID-19 cases and hospitalization rates, five times higher than that of White Americans (CDC 2020a; Raifman and Raifman 2020). Native American leaders highlighted the lack of coordinated and effective federal response to COVID-19 on tribal lands. In Indian Country, federal relief packages were trapped in bureaucratic limbo as citizens in Native nations remained in fear of mass death (Akee et al. 2020; Cancryn 2020; Rodriguez-Lonebear et al. 2020).

The Snyder Act of 1921 and the Indian Health Care Improvement Act of 1976 codify health care as a right for Native nations (Indian Health Service 2013; U.S. Commission on Civil Rights 2003).[1] In practice, access to quality health care has been a challenge for Native American communities. The Indian Health Service (IHS) has been perpetually underfunded, and political will to improve Native American health care has been minimal (Bergman et al. 1999; Warne and Frizzell 2014). Today, the IHS is funded at only about 60 percent of need (Trahant 2018), and per capita spending averages $3,943 (Morse 2020) relative to the U.S. average of more than $11,500 (Martin et al. 2021).

Moreover, research finds that partisanship had significant impacts on the spread of COVID-19 in Native communities. Our prior work showed that, for Native nations in Republican states, the lack of response by Republican leaders was associated with more cases of COVID-19 on tribal lands. Scholars outside Native America also document the partisan effects of COVID-19. They note that conservative Americans are less likely to believe the virus is real, more likely to believe that the pandemic is blown out of proportion, and as a result less likely to take preventive measures (Perez 2020; Peters and Grynbaum 2020; Santucci 2020). Scholars also find that self-identified Republi-

1. Snyder Act, Pub. L. 67-85, 25 U.S.C. 13 (1921); Indian Health Care Improvement Act, Pub. L. 94-437, 25 U.S.C 1601 (1976).

cans were less likely to wear a mask in public to address infection rates of COVID-19, as were Americans who lived in Republican-led states (Sanchez, Dominguez, and Vargus 2020). More recent scholarship found that state partisanship influenced reopening thresholds, mask mandates, and stay-at-home orders. For example, Sarah James, Caroline Tervo, and Theda Skocpol (2022, this issue) find that Republican governors were less likely to use their emergency powers to implement mitigation strategies and implemented them for shorter periods if they chose to do so.

To be clear, tribes simply were not on the receiving end of history, and we reject deficit models of tribal governments. Tribes actively shaped their fate during the pandemic through exercising their sovereignty. Responding to community vulnerability, Native nations used their inherent right to govern within their territories to pass a variety of laws to keep their communities safe, often receiving scrutiny from state and local governments. In many instances, such policies were stricter than state policies and showed extreme caution.

In addition, tribal governments led successful vaccination campaigns. In fact, Native Americans led all racial groups in the United States in COVID-19 vaccinations through the summer of 2021 (Foxworth, Redvers, et al. 2021). Tribal vaccination strategies included incentivizing vaccination and creating partnerships with community organizations, IHS, and state governments to hold vaccination events. Many tribes converted their facilities—tribal offices, schools, casinos, urban Indian centers—into vaccination clinics and sites for drive-by and outdoor mass-vaccination events. The success of tribes' vaccination efforts was at least partially a result of their ability to determine their priorities in vaccinating their community members. Many Native American communities chose to start the vaccination process with members who were vital to the tribe, including elders who are keepers of important cultural knowledge such as language. An example is the Cherokee Nation in Oklahoma, which put fluent Cherokee-language speakers at the front of the line for vaccination due to pandemic casualties among fluent language-speakers (Brown 2021). Tribes also strategically vaccinated influential leaders from their communiies to help encourage others to become vaccinated (Hellman 2021).

Consistent with more than a century of inequities, Native Americans experienced and continue to experience the spread of COVID-19 at disproportionate rates. Native communities have also shown resilience. All the same, we know that tribal-state relations played a key role in shaping the pandemic's course, and more. More specifically, we suspect that state politics have been consequential during the pandemic. In the sections that follow, we explore whether and how Native American representation and Native nation political power played a role in stopping the spread of COVID-19 in Native communities.

DESCRIPTIVE AND SUBSTANTIVE REPRESENTATION

Our theory that the presence of Native American legislators reduces COVID-19 cases in Native communities is based on literature focused on descriptive representation. According to Suzanne Dovi (2007, 27), "Descriptive representatives are those who look like, or at least have experiences and interests similar to, the people they represent." Descriptive representation is often applied to race, ethnicity, and gender when the elected official and their constituency match on those attributes. We apply descriptive representation theory to the case of Native Americans who we believe may benefit from the presence of Native Americans in their state legislatures during the pandemic.

Descriptive representation theory suggests that having member legislators from diverse communities in legislative bodies leads to public policies benefiting members of those communities, often because they understand the needs of those constituents (Bratton and Haynie 1999; Haynie 2001; Tate 2001). Scholars interested in descriptive representation often focus their research on the presence of minority representatives in the U.S. Congress (Cameron, Epstein, and O'Halloran 1996; Canon 1999; Welch and Hibbing 1984). Another body of work explores whether descriptive representation at state and local levels of government leads to positive substantive representation for minority communities (Eisinger 1982; Kerr and

Mladenka 1994). Work at the state level demonstrates that racial and ethnic diversity in legislatures not only motivates positive policy outcomes on behalf of minority interests but also leads to the blockage of proposals that harm those communities (Filindra and Pearson-Merkowitz 2013; Preuhs 2006).

We are also drawn to work that finds a relationship between descriptive representation and trust because increased trust in Native American representatives is one of the mechanisms we believe may reduce COVID-19 outcomes in Native communities. For example, Claudine Gay (2002) argues that descriptive representation can forge bonds of trust between legislators and their constituents. Such increased trust has the potential to enhance a feeling of inclusion among those groups, which makes the "polity more democratically legitimate" in the eyes of the disadvantaged (Mansbridge 1999, 651). Although somewhat limited, the literature on the relationship between descriptive representation and perceptions of government has generally supported those theoretical arguments. For example, Susan Howell and Deborah Fagan (1988) find that African Americans represented by a Black mayor are more trusting of government than those in other areas without descriptive representation. Similarly, Gabriel Sanchez and Jason Morin (2011) find that Latino respondents with a Latino mayor are more likely to believe they and people like them can influence political outcomes.

Our analysis of the impact of Native American representation within states on COVID-19 outcomes comes at a time of increased political representation of Native Americans in state legislatures. Between the mid-1990s and 2018, the number of Native Americans in state legislatures tripled from twenty-six to eighty-one. Although the high of eighty-one in 2018 amounted only to roughly 1 percent of all state legislators across the country, the sharp increase is notable. Concurrently, Native Americans are participating in politics at greater rates and are key constituents in deciding electoral outcomes (Evans et al. 2019; Foxworth and Sanchez 2020; Sanchez, Foxworth, and Evans 2020). The growing political influence of Native Americans, we argue, enabled elected officials from Native American communities to advocate more effectively for their constituents.

Most of the research on descriptive representation focuses on women, African Americans, and Latinos. The few studies on Native American descriptive representation also highlight similar, positive, substantive outcomes from increasing representation. Native American elected officials reported that they pushed for improved service delivery to Native Americans in their jurisdiction (McCool, Olson, and Robinson 2007). Scholars note that Native legislators also work to insulate their constituents from bad policies and educate their non-Native colleagues about the unique experiences of Native Americans in their state (Schroedel and Aslanian 2017). Native American state legislators can shift dynamics in state-tribal relations, and a critical mass of Native legislators is even more beneficial (Kessler-Mata 2017; Evans 2011).

Given that trust in government has been one of the most challenging barriers for communities of color, we expect that trust in Native American legislators lowers COVID-19 rates in Native communities. Scholars illustrate that trust in government shapes health behaviors (Suhay et al. 2022, this issue; Pears and Sydnor 2022, this issue). Perhaps this pattern may be most pronounced for Native American communities given the many injustices they have endured, as discussed earlier. As Representative Ken Luttrell (Cherokee), cochair of the Oklahoma Legislature's Native American Caucus, noted recently, "The tribes rely on us to be their voice down here. In many parts of the country and in many parts of the state, many tribes feel like they have been unrepresented, nonrepresented, or not represented enough. We certainly have given them a voice and an outreach for their concerns and their issues, which is what we're here for. Not only to serve our constituents in our home district, but our fellow tribal citizens, also" (Luttrell 2021).

Given this context, public health officials recommend the use of messengers who are members of the community themselves and have relationships with Native American community members for COVID-19 information, including vaccine outreach (Urban Indian Health Institute 2021). Consequently, we expect that Native American leaders will have an indi-

rect impact on COVID-19 outcomes as messengers in addition to the more direct role they may play through protective legislation. We now lay out our theoretical expectations.

REPRESENTATION, NATIVE NATION POLITICAL POWER, AND COVID-19 IN NATIVE NATIONS

We argue that representation is an important factor in ensuring that the needs of racial and ethnic minority communities are served. Two distinct kinds of representation mattered for Native American communities during the COVID-19 pandemic: descriptive representation and tribal political power within states. Each played an important role in reducing the spread of COVID-19 rates in Native American communities.

We know that representation remains core to the quality of any democracy, especially for historically marginalized groups. Citizens elect representatives, and the quality of citizen representation affects citizens' political efficacy, engagement, participation, knowledge, and overall confidence in government (Hayes and Hibbing 2017; Wolak and Juenke 2021). During the pandemic, Black and Latino representatives spoke out to bring additional attention and resources to their respective communities hard hit by COVID-19 (Alford 2020; Bevington 2020). The calls from Black political officials intensified when inequities were compounded by ongoing police violence that led to a wave of protests across the United States. Similarly, Latino calls for government action were even more pronounced when news spread about the eventual humanitarian crisis at the U.S.-Mexico border.

During the COVID-19 pandemic, descriptive representation was important because racial and ethnic minority groups neglected by the political system were looking for trustworthy information. In the early days of the pandemic, information was often slow, and significant contradictions between public health experts and the Trump White House were frequent. In this context, increasing legislator activism on behalf of local communities can overcome feelings of alienation—including distrust and cynicism (Pantoja and Segura 2003).

Native American legislators at all levels operated much as their Black and Latino colleagues did during the COVID-19 pandemic. Because Native communities have endured long histories of political neglect and experienced significant death and illness from the COVID-19 pandemic, Native leaders developed tactics both to communicate with their constituents and force urgent, coordinated responses from federal, state, and other governments. Native American representatives disseminated important public health and other information on the COVID-19 pandemic to their constituents and Native communities through social media, local media in Native communities, and more. They also took important steps to advocate for increased government relief and responses to their hard-hit communities (Armas 2020).

Native leaders, with the weight of their nations behind them, mobilized quickly to demand state policy responses to the COVID-19 pandemic. For example, in New Mexico, the Pueblo, Apache, and Navajo Nations coordinated early with states for testing, case tracking, tribal border closings, and demands for a federal response (Romancito 2020). In, for example, Montana and South Dakota, Native legislators emphasized publicly the importance of tribal border closings (Groves 2020).

Given the level of response from Native American legislators, we expect that COVID-19 cases will be lower in Native communities in states with more Native American legislators. We believe that descriptive representation of Native Americans within state legislatures is important in reducing COVID-19 rates in Native American communities because these legislators are both trusted sources of information and advocates in demanding response and aid for Native nations.

Native Nation Political Power Within States

Although we expect descriptive representation is associated with fewer cases of COVID-19 in Native communities, we do not believe this was the only representational pathway to ensuring the safety of Native communities. Leaders of Native nations also mobilized quickly during the pandemic to ensure that Native nations were not forgotten in COVID-19 response strategies at the federal, state, and local levels of

government (Acee 2020; Becenti 2020). For example, Pueblo, Apache, and Navajo Nations coordinated early with the state of New Mexico for testing, case tracking, tribal border closings and demands for federal response (Romancito 2020).

The political power of Native nations within states has grown over time. As Native nations increased their interactions with state governments in recent decades, they sought greater influence in state politics. Forced interaction between tribes and states in the modern era increased after the passage of the Indian Gaming Regulatory Act of 1988,[2] whereby the federal government devolved important powers over Indian gaming to states. At roughly the same time was a generalized movement to devolve federal power to states for social welfare programs such as Temporary Aid to Needy Families, foster care, and others. This movement also forced greater interaction between states and Native nation governments (Cornell and Taylor 2000; Corntassel and Witmer 2008).

Consequently, Native nations became increasingly involved in state politics to advance their interests. Native nations use traditional political strategies such as candidate endorsement, campaign donations, and lobbying to ensure that their voices are heard. Some research identifies lobbying as a tactic Native nations use to exert political influence in states (Boehmke and Witmer 2020; Foxworth, Liu, and Sokhey 2015; Witmer, Johnson, and Boehmke 2014). In sum, we believe that the political power of Native nations within states is associated with lower COVID-19 spread in Native communities. As Native nation power within state politics has grown, so have incentives for politicians—both Native and non-Native—to keep this important constituency in mind in designing and deploying policy responses.

Most often, the level of tribal financial contributions made to political candidates within states is a proxy for understanding Native nations' political power and mobilization within states. Consistent with this established empirical strategy, we expect less incidence of COVID-19 in Native communities in states where Native nations give larger financial political contributions. In states where Native nations give more, state leaders will have greater incentive to coordinate with or respond to Native nations' concerns during the COVID-19 pandemic. We discuss our research design and results in the sections that follow.

RESEARCH DESIGN

We build on earlier work that finds that both long-standing neglect and marginalization have a significant impact on COVID-19 rates in Native communities (Foxworth, Evans, et al. 2021; Rodriguez-Lonebear et al. 2020). We use these findings to understand how state legislators and Native nations' political power in state politics are associated with COVID-19 rates in Native communities.

Our dependent variable is a count of positive COVID-19 cases in Native nations gathered and confirmed by Indian Country Today. We use positive COVID-19 case counts through June 11, 2020. We use this as a cut-point because we are interested in examining how representation may have affected the spread of COVID-19 during the early days of the pandemic. Moreover, this cut-point aligns with the full distribution of Coronavirus Aid, Relief, and Economic Security Act (CARES) funding for federally recognized tribes. At this point, tribes had federal relief dollars to shift toward spending more time and money on tribal policymaking.

We believe this is a plausible cut-point for identifying the early phase of the COVID-19 pandemic on tribal lands. By June 11, the outbreak had been spreading in Native nations for three months. During that time, tribes struggled to secure federal assistance for their COVID-19 responses. In May, the Department of Treasury distributed only half of the CARES funding that Congress allocated to tribes.

We test state-level factors and control for community-level factors across 333 Native communities in the lower forty-eight United States. We include in our dataset all tribal governments with reservations or Tribal Statistical Areas designated in the Census Bureau's American Community Survey (ACS). Our sample

2. Indian Gaming Regulatory Act, Pub. L. No. 100-497, 102 Stat. 2467 (1988).

includes only tribes with residential housing on tribal lands. For some tribes with a very small land base, tribal lands are used for administrative offices and public facilities, and tribal members live off tribal lands. We exclude Indigenous communities in Alaska and Hawaii because data for these communities were not included in early iterations of the Indian Country Today dataset (Rodriguez-Lonebear et al. 2020).

We use a negative binomial regression, which is ideal given that we are working with count data. Our measure is a tribe-state dyad to account for tribes that cross state boundaries. This is an important nuance to our design because several tribes, including the Navajo Nation, have lands that span multiple states. If a tribe in our dataset crosses state boundaries, we code it as part of two dyads. In the average observation, sixty-one tribal members contracted COVID-19.

Case Counts: Data Erasure and Indigenous Data Sovereignty

We know that federal policy affects Native well-being in real and measurable ways, and the COVID-19 pandemic exacerbated that. Federal interactions with Native nations also affect the availability (or rather absence) of data on Native American communities. Critical scholarship is growing on Indigenous erasure—where Indigenous peoples are systematically overlooked, intentionally excluded, Othered as a footnote, or treated as an Asterisk Nation* (Hudson et al. 2020; National Congress of American Indians 2012). The lack of intentionality in collecting Indigenous data results in huge disparities in the availability of timely and accurate data on Indigenous peoples and communities, especially relative to other ethnic-racial groups. This lack of data is pervasive, and the data available for research have unfortunately often been weaponized (Walter and Andersen 2013), necessitating the need for Indigenous peoples to govern their own data (Rainie et al. 2017; Taylor and Kukutai 2016).

This context for understanding Indigenous data (or absence of) is important because in the face of such exclusion, Native nations have had to respond to data needs with innovative solutions, including during the COVID-19 health pandemic. During the early days of the pandemic, collecting data on all racial and ethnic groups was a challenge, including for Native American communities. Without data, tribes struggled with responding locally and advocating for federal and state action.

To address this gap, Indian Country Today, housed at Arizona State University, developed a website and Google form to gather crowdsourced tribal data of COVID-19 cases and deaths in Indian Country (Indian Country Today 2020). According to the website, data were "confirmed by tribes, tribal health clinics, urban Indian programs, the Indian Health Service, state public health agencies, or the Centers for Disease Control and Prevention," gathered from Native nations' public release of information, and supplemented and verified by news reports. These data represent an innovative and comprehensive grassroots effort to combat the absence of standardized Native American COVID-19 case data.[3]

Other peer-reviewed, scholarly publications use these data to understand the causes and effects of the pandemic in Native American communities (Carroll et al. 2020; Foxworth, Evans, et al. 2021; Rodriguez-Lonebear et al. 2020). Moreover, Indian Country Today's impressive data and methods were later used to create the Tribal Land COVID-19 Database, a joint project of Indian Country Today, the Coronavirus Resource Center, and the Center for American Indian Health, the second two at Johns Hopkins University (for more, see Weeks 2021).

Key State Covariates

Native American state legislators. To test whether descriptive representation affected COVID-19 rates in Native American communities, we use a count measure of total number of Native American state representatives and senators in 2020. This data was collected by Indian Country

3. Indian Country Today is one of the oldest, best-known Indigenous media outlets in the United States and beyond. It has taken the lead in collecting other data to combat erasure of Native Americans. Other studies using these data include Desi Rodriguez-Lonebear and colleagues (2020) and Laura Evans and colleagues (2019).

Today (Evans et al. 2019) and the voter mobilization organization Native Vote. In 2018, a record number of Native Americans ran for political office, which we believe was consequential in combating the spread of COVID-19 in Native America.

Native nations' campaign contributions in state politics. To understand whether Native nations' political power was a significant factor in facilitating greater collaboration and responses from state governments, we use Native nations' financial contributions in state politics in 2018 or 2019, whichever year is higher. We took this data from Followthemoney.org. We use financial contributions from Native nations themselves only, not from tribal businesses or enterprises, such as casinos. Contributions per state ranged widely. Tribes donated $0 in Alabama, Colorado, Connecticut, Delaware, Georgia, Iowa, Idaho, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, Nevada, Rhode Island, South Carolina, South Dakota, Texas, Virginia, and Wisconsin. At the top end of the distribution, tribes donated $17,457,682 in California and $8,569,016 in Florida.

Partisanship of state governor. President Trump consistently downplayed the dangers of COVID-19, disparaged public health policies that can reduce the spread of the disease, encouraged his supporters to defy health and safety regulations, and pressured Republican governors to avoid using their powers to protect public health. We expect that these behaviors endangered Native Americans. We identify whether a state's governor was a Republican. Governors have a great deal of discretion over powers they can use—or not use—to contain a pandemic. Across our dataset, 29 percent of observations are in states with a Republican governor.

State COVID-19 rates. We expect that nearby or adjacent states' COVID-19 rates will affect the tribes' COVID-19 rates. Accordingly, we include the number of cases per hundred thousand people by June 11 in each state (CDC 2020b). For the average observation, state cases were 469 per hundred thousand residents.

State population. We include two state population measures taken from the American Community Survey (ACS) 5-Year estimates (2014–2018): total state population and total American Indian–Alaska Native state population.

Tribal health systems. We use data from the Indian Health Service that identify all health facilities on tribal lands, the type of services they provide, and the management structure of the facility. We accessed the dataset in Spring 2020. In some cases, the name of a health facility indicates its location. In all cases, IHS provides the physical address for facilities. We mapped facility location when the name was ambiguous. We exclude from our analysis specialized facilities such as dental clinics and substance abuse treatment centers.

Most health facilities on tribal lands are relatively small sites for primary care and community engagement. Such facilities may be important locations for health education. Does it make a difference for COVID cases if a wider network for community interaction is in place? We include a calculation of the density of health facilities on tribal lands: the number of facilities divided by the tribe's land base. We expect that more locations for health system contact can improve health outcomes.

Tribal health system control. We consider control over the health system on tribal lands. Some health facilities are fully under IHS control, but the majority are not. Tribes exercise control over health facilities in three main ways and may blend the strategies. They may provide health services fully independently. They may receive grants from IHS and forgo IHS direct delivery of care using either self-government compacts or Pub. L. 93-638 contracts. Tribes do not need to be fully in or out of IHS operations. If they choose, they may have some facilities run by IHS and some facilities that they manage.

Do tribes have fewer COVID cases if they run their health-care systems? We expect that they do, because tribally controlled facilities may be able to more swiftly adapt to community needs. We calculate tribes' degree of control over their health systems by tallying the number of health facilities that a tribe operates fully independently or via IHS' compacts and contracts and dividing that by the total number of facilities on tribal lands. For this analysis, our sample is limited to tribes that have health facilities on their lands.

Community Control Variables

Water and language. Desi Rodriguez-Lonebear and colleagues (2020) note that COVID-19 cases were more likely in areas with a higher proportion of homes lacking indoor plumbing, and COVID-19 cases were less likely in communities with higher rates of English-only language. The association between these two factors and COVID-19 outcomes motivates inclusion of these measures in our model. We use the percentage of Native American households in Native nations with complete plumbing and the percentage of households that speak only English. For the average observation in our dataset, 95 percent of households have plumbing. For the average observation, 77 percent of households speak only English at home. These data come from the ACS 5-Year estimates (2014–2018).

Non–Native American visitors. Research identifies that when non-Native visitors from nearby populations sidestep tribal sovereignty, ignoring tribal mandates restricting travel to their communities, increases in COVID-19 rates occur (Florey 2020). Building on this work, we expect that visitors from nearby populations will increase tribes' COVID-19 rates. As one indicator of nontribal members visiting tribal lands, we include the size of tribal casinos. We think casino size is a sound proxy for one reason that individuals visit tribal lands. We know that the presence of Native casinos is usually combined with other draws for non-Native tourists. Casino revenues are proprietary information and not available publicly, but other indicators on the scale of casino operations are accessible. Laura Evans and her colleagues (2020) compiled the square footage of all tribally owned casinos; we include their compilation in this article with their permission.[4] For the average observation, tribal casinos covered 66,891 square feet.

For the average observation, 55 percent of people living within the tribe's lands are American Indian or Alaska Native. Many tribal lands are what are known as *checkerboarded*, meaning private parcels of land owned by non–Native Americans within the outer boundaries of a reservation. In large part, tribal governments do not have authority over these parcels. Checkerboarding is a product of federal assimilation policy: "a mighty pulverizing engine to break up the tribal mass," to use Theodore Roosevelt's words. Today, checkerboarding results in an array of jurisdictional complexities (Wilkins and Stark 2017). Given that checkerboarded lands are harder to govern overall, we expect poorer health outcomes where more non–Native Americans live on tribal lands.

Community demographic controls. Native nations are not a monolith; their social and economic circumstances vary greatly. We include a variety of indicators of social and economic conditions on tribal land, drawn from the ACS. Specifically, we control for Native American population, age, and income by reservation.

Additional Controls

Measurement controls. We include two measures to account for possible underreporting of cases on some tribal lands. One indicator is whether the tribe is part of a health policy network more closely attached to Indian Country Today. Perhaps tribes near Indian Country Today are more likely to know about this crowdsourced dataset and spread word in their professional networks. Indian Country Today is headquartered in Phoenix, and therefore we control for whether a tribe is a member of the Phoenix Indian Health Board. The Phoenix Indian Health Board is a key organization connecting tribal health professionals in the Southwest. Twelve percent of observations are from members of the Phoenix Indian Health Board.

Another indicator is whether a tribal government is recognized by a state government, but not the federal government. State-recognized tribes have less access to national networks of tribal health professionals facilitated by federal agencies. Because state-recognized tribes are less networked, they may be less aware of the crowdsourced dataset. ACS notes whether a tribe is state or federally recognized. Ten percent of observations are of state-recognized tribes.

RESULTS

We test our expectations with a negative binomial regression and present the results in table

4. See National Indian Gaming Association, http://indiangaming.com/home/ (accessed July 11, 2022).

1 and model A. The coefficient on Republican governors is significant and positive, indicating that in states with Republican governors, COVID-19 cases in Native communities were higher. This finding is consistent with our research highlighting the partisan effects of COVID-19 spread in Native communities (Foxworth, Evans, et al. 2021). Turning attention to the representational linkages to COVID-19 spread in Native communities, both the number of Native American state legislators and the size of tribal campaign contributions are negatively associated with COVID-19 cases in Native communities, and both effects are statistically significant. In general, as the number of Native American legislators increases, COVID-19 cases decline. Similarly, the greater the size of tribal campaign contributions in states, the lower the number of COVID-19 cases during the early days of the pandemic.

In addition to representation, tribal health facilities in Native communities also affect COVID-19 cases. We find that the density of tribal health facilities is statistically significant and associated with COVID cases on tribal lands. As the density of tribal health facilities increases, the number of COVID-19 cases in Native communities during the early days of the pandemic decreases. In table 2, we include a measure capturing the extent to which tribes control health facilities in their communities. We include this measure in model B because it is highly correlated with the density of tribal health facilities. In sum, tribal control over health facilities has a negative, statistically significant association with COVID cases on tribal lands. Generally, the density of tribal health-care facilities and greater tribal control of local health-care systems are associated with better health outcomes for Native American people in reservation communities.

Consistent with previous studies (Foxworth, Evans, et al. 2021; Rodriguez-Lonebear et al. 2020), the greater the number of primary English speakers is negatively associated with COVID-19 cases in Native communities, and larger reservation population size is associated with increased COVID-19 cases. Finally, tribal casinos, which are our proxy for the likelihood of having non-Native travel on tribal lands (such as tourism), are associated with increased COVID-19 cases. These findings are consistent across both our models. In model B, more state contextual factors including size of Native American population and state COVID-19 cases are positively associated with greater COVID cases in Native communities. Our two measures for connections to data collectors are associated with greater COVID-19 cases in Native communities.

As we suspected, both Native American representation and political power, as well as the presence and tribal control of tribal health facilities, led to fewer COVID-19 cases. We considered a variety of robustness checks and found the results were stable. We included in the analysis the number of seats in the state legislature. We included data on state-level errors in racial classification of medical patients. We replaced the party identification of governors with the majority party in the state legislature. This approach required us to drop observations from two states from our analysis: Nebraska, where state legislators do not declare a party affiliation, and Minnesota, where party control of the legislature was split in this time period. In this robustness check, although the effect of Republican-controlled legislatures is statistically insignificant, the effects are stable from tribal campaign contributions, Native legislators, and health-care systems on tribal lands. We stick with the party of governors as the measure of state party politics in our main model because it allows a larger sample size and many of the immediate responses to the pandemic were in the hands of chief executives. Because the party of governor and of the majority in the legislature are highly correlated, we do not include both measures in the main model.

Substantive Effects

In table 2, we translate regression coefficients into substantive effects for our key significant independent variables to illustrate the importance of our findings. We note the percentage decrease in COVID-19 cases if the condition existed holding all other variables at their means. All variables in table 2 note significant changes in COVID-19 cases in Native communities attributed to our key independent variables. As noted in table 2, having a Democratic governor

Table 1. Native American Representation, Political Power, and COVID-19 Cases Across Native Nations by June 11, 2020

	Model A (Health-Care Facility Density)	Model B (Tribal Control of Health Facilities)
Republican governor in state	1.27**	1.46**
	(0.60)	(0.66)
Number of Native American state legislators	−0.23**	−0.26**
	(0.10)	(0.12)
Tribal government campaign contributions in state elections (in thousands)	−.00030***	−.00037***
	(0.00011)	(0.00014)
Density of health-care facilities on tribal lands	−0.20***	−0.18**
	(0.077)	(0.070)
Tribal control of health-care systems (if at least one health-care facility on tribal lands)		−1.26**
		(0.60)
Population in state (in hundred thousands)	−0.00061	−0.0016
	(0.0054)	(0.0057)
Native American population in state (in hundred thousands)	0.54	0.49**
	(0.51)	(0.54)
Cases per hundred thousand in state by June 11	−0.0012	−0.0019**
	(0.00067)	(0.00073)
Percent of households on tribe's lands with plumbing	−4.16	−4.17
	(4.05)	(3.86)
Percent of households on tribe's lands that speak English only	−5.87***	−5.96***
	(0.97)	(1.01)
Total population on tribe's lands (in thousands)	0.017***	0.013**
	(0.0055)	(0.0056)
Median age on tribe's lands	−0.044	0.0059
	(0.036)	(0.039)
Median household income on tribe's lands (in thousands)	0.013	0.0050
	(0.023)	(0.023)
Percent American Indian or Alaska Native on tribe's lands	−1.81*	−2.08
	(1.28)	(1.32)
Tribal casinos: indicator of non-Native travel on tribal lands. ln(1+casino ft^2)	0.24***	0.24***
	(0.042)	(0.047)
Tribe in Phoenix Indian Health Board: stronger connections to data collectors	−1.10	−1.76*
	(0.87)	(0.92)
State-recognized tribe: weaker network connections to data collectors	2.96***	(a)
	(1.02)	
Constant	10.44**	10.90**
	(4.98)	(4.74)
Number of observations	*N*=331	*N*=263

Source: Authors' tabulation.

Notes: Negative binomial regression. Robust standard errors in parentheses.

(a) Omitted because of collinearity.

* $p < .10$; ** $p < .05$; *** $p < .01$

Table 2. Estimated Change in Number of COVID-19 Cases by June 11, 2020, for a Native Nation

Democratic governor in state, rather than Republican	decreases by 77 percent
Number of Native American state legislators increases by 1 standard deviation	decreases by 77 percent
Tribal government campaign contributions in state elections increase by 1 standard deviation	decreases by 79 percent
Density of health-care facilities on tribal lands increases by 1 standard deviation	decreases by 89 percent
Tribal control of health-care systems increases by 1 standard deviation	decreases by 39 percent
Number of observations	263

Source: Authors' tabulation.

decreased cases by 77 percent across Native nations in our sample. A one standard deviation increase in the number of Native American state legislators decreased COVID-19 cases by 63 percent. Similarly, a standard deviation increase in tribal government campaign contributions (our proxy for Native nation political power) decreased COVID-19 cases by 79 percent. We see similar high decreases in COVID-19 cases in Native communities by density of health-care facilities on tribal lands and if tribal lands have a tribally controlled health-care facility. One standard deviation increase in health-care facility density on tribal lands decreased COVID-19 cases by 89 percent. A single standard deviation increase in tribal control of health-care systems decreased COVID-19 cases by 39 percent.

These substantive changes highlight the significance of Native American representation, political power, and health-care system access and control on the health and well-being of Native Americans in Native communities. Native American representation, gaming contributions (our proxy for Native American political power), and Native community health-care facility control all decreased COVID-19 cases significantly during the early days of the pandemic.

DISCUSSION

Most existing studies of Native nations during the COVID-19 pandemic highlight their vulnerability and the extreme inequities present in Native communities. Although important, these discussions do not examine the diverse response strategies and tools Native people and nations deployed. Our analysis connects COVID-19 infection rates to social science theories of representation and finds that Native American representational linkages affected rates of COVID-19 spread across Native communities.

During the early days of the pandemic, when the federal response was slow and uncoordinated, Native nations and representatives mobilized to ensure that Native people were not forgotten in the development of response strategies. These findings highlight that the political power of Native people, both state representative and Native nation political power, were important in protecting the health and safety of Native people and bringing much-needed relief to Native nations in response to COVID-19. The effects of state-level Native American political power are an important scholarly consideration for how the voices, concerns, and demands of Native people are represented within states and how Native representatives push for substantive change for their constituents. After all, as Kouslaa Kessler-Mata (2017, 59) writes, "What counts as a reasonable justification for taking a particular course of action may look quite different from the perspectives of Native and non-Native communities." Further, we illustrate that the pathways through which Native political influence occurs are multifaceted, and our work affirms prior findings on descriptive representation.

We also identify unique features of Native politics. Native nations follow dual mechanisms to shape health outcomes—representation and sovereign action—and the two complement each other. We find fewer COVID-19

cases when tribal health systems have a dense network of community-based health centers and when Native nations exercise more control over health-care facilities. These findings bring context and nuance to our analysis of tribal-state relations. Native nations are not well served by an either-or framework under which they somehow choose between managing their own affairs or engaging with state governments. Instead, Native nations can benefit if they exercise sovereignty over their health systems and also have mechanisms to ensure that states support, not thwart, their inherent rights to sovereignty and self-determination.

In 1928, Lewis Meriam presumed that Native peoples were a threat to the health of non-Native communities when he wrote, "the advent of white civilization has forced on the Indians new problems of health and sanitation that they, unaided, can no more solve than can a few city individuals solve municipal problems. The presence of their villages in close proximity to white settlements make the health and sanitary conditions in those villages public questions of concern to the entire section" (88). We are well past the moment when we should flip the script. As we write, Native nations are exemplars for the administration of COVID-19 vaccines: multiple Native nations achieved vaccination rates over 90 percent. We encourage further exploration of how Native leaders cope with the reality that the health and sanitary practices of state governments are their concern as well.

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