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

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Abstract:
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, there were fewer COVID-19 cases on tribal lands. We expand the literatures on descriptive representation and on tribal-state relations by demonstrating consequences of powerful Native American voices in the statehouse. We find that Native American voices on tribal lands are vital, too. There were fewer COVID-19 cases on tribal lands that had extensive networks of community-based health facilities and tribally-controlled health facilities. There is a broader lesson here: 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 pandemic. The global pandemic exposed longstanding inequities in our political system making Native communities particularly vulnerable to the virus. In our previous research, we document that federal neglect, including the inability of the federal government to live up to its responsibilities to Native nations, was a contributing factor in the spread of COVID-19 in Native communities. Longstanding inequities, including the lack of critical infrastructure in Native communities led to significant illness and death in Native communities (Carroll et al. 2020; Foxworth et al. 2021; Rodriguez-Lonebear et al. 2020; Roybal 2020).

This paper builds on our earlier work and examines state political factors that help us explain rates of COVID-19 across Native America. Though the federal government has trust and treaty responsibilities to Native nations, Native nations have increasingly become active and important constituents for state legislators in state politics. Native nations engage in lobbying activities, sponsor candidates, promote issues, encourage tribal citizen participation and more. Moreover, as individuals, Native people have started to run for state political office as a means to represent Native American and other historically marginalized constituents within state politics.

We argue and find that both Native American political power within states and Native American representation matter in reducing COVID-19 cases in Native communities. We examine these two independent and distinct pathways of Native American representation in state politics. First, where Native nations have increased their political power within states, we see fewer cases of COVID-19. This is because Native nations' political mobilization within states has increased incentives for state politicians to collaborate with and respond to Native nation demands. This growth in political influence has provided Native American legislators with the ability to advance the needs of the communities they represent more powerfully. Second, the

presence of Native Americans in state legislatures has both a direct impact on COVID-19 outcomes through legislative action.

We do not suggest that tribal-state relations are the only avenue through which Native nations shape their own 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 health facilities and tribally-controlled health facilities. These results help situate our findings on tribal-state relations in a broader context: robust exercise of tribal sovereignty keeps tribal citizens safe.

We connect our findings with previous research that highlights the structural inequalities within Native communities. We suspect that increased Native American representation combined with active state and federal level collaboration may further reduce inequities.

I. 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 (COVID-19). The global COVID-19 pandemic amplified longstanding inequalities in all aspects of American life resulting in racial and class differences in COVID-19 transmission and death rates (CDC 2020a, 2020b; Hatcher 2020; Moore 2020; Raifman and Raifman 2020; James, Tervo, and Skocpol 2021). Native American communities across the U.S. were disproportionately affected by COVID-19 because of the stark and longstanding health and economic inequities that have existed in these communities.

Unfortunately, health pandemics and epidemics are not new for Native communities. Research has documented that in 1918-1919, during the influenza outbreak, 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). Again, in 1993, during the hantavirus outbreak in the southwestern U.S., the first victims were Navajo. During this outbreak, news media stigmatized and stroked fears among non-Native people referring to the virus as the "Navajo flu" (CDC 2020b; Pressley 1993). Once again in 2009, during the H1N1 outbreak, death rates for American Indian and Alaska Natives were fouWr 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 have argued that colonization has been the most significant health epidemic leading to the greatest loss of Indigenous life across the Americas (Estes 2020; Kubik, Bourassa, and Hampton 2009; Sherwood 2013; 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, and extreme poverty, all factors that continue to ravage Native communities at disproportionate rates today (Jones 2006; Newson 1993; Snow and Lanphear 1988).

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

The Navajo Nation became the epicenter for COVID-19 in the US and by August 2020 it was reported that Native Americans nationally had 3.5 more COVID-19 cases than White Americans and hospitalization rates five times that of White Americans (CDC 2020; Raifman and Raifman 2020). During the early days of the pandemic, Native American leaders from across the nation went on media tours to highlight the lack of coordinated and effective federal response to COVID-19 on tribal lands. The general federal response to the COVID-19 pandemic lacked clear direction and leadership nationally and the same was true for Indian Country as 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).

This despite the fact that the right to quality healthcare is a treaty right for Native nations, codified in the Snyder Act of 1921 and Indian Health Care Improvement Act of 1976 (Indian Health Service 2013; U.S. Commission on Civil Rights 2003). But in practice, access to quality healthcare has been a challenge for Native American communities. The Indian Health Service (IHS) has been perpetually underfunded and there has been little political will to change policy for better Native American healthcare (Bergman et al. 1999; Warne and Frizzell 2014). Today, the IHS is only funded at about 60 percent of need (Trahant 2018), with per capita spending averaging $3,943 (HHS Division News 2020) compared to U.S average per capita health spending totaling over $11,500 (Martin et al. 2021).

Moreover, research has also found that partisanship had significant effects on the spread of COVID-19 in Native communities. Our prior work shows that for Native nations with lands in Republican states, the lack of response by Republican leaders is associated with greater cases of COVID-19 on tribal lands. The partisan effects of COVID-19 have been documented by other scholars outside of Native America. These scholars have noted that conservative Americans are

less likely to believe that the virus is real, more likely to believe that the pandemic is blown out of proportion, and as a result not take preventative measures to slow its spread (Perez 2020; Peters and Grynbaum 2020; Santucci 2020). Scholars have also found that self-identified Republicans were less likely to wear a mask in public to address infection rates of COVID-19, as are Americans who live in Republican-led states (Sanchez, Dominguez, and Vargus 2020). More recent scholarship finds that state partisanship influenced the implementation of reopening thresholds, mask mandates, and the length of stay-at-home orders (James, Tervo, and Skocpol, forthcoming). James, Tervo, and Skocpol (forthcoming) find Republican governors were less likely to use their emergency powers to implement mitigation strategies, and if they did implement such strategies, they did it for shorter periods of time.

We are not suggesting that tribes were simply on the receiving end of history and we reject deficit models of tribal governments. Tribes have actively shaped their fate during the pandemic by exercising their sovereignty. As a result of community vulnerability and their inherent right to govern within their territories, Native nations passed a variety of laws to keep their communities safe, often receiving scrutiny by state and local governments. In many instances, these policies were stricter than state policies and showed extreme caution as various jurisdictions began to reopen in the summer of 2020.

In addition, tribal governments have led successful vaccination campaigns across the country. In fact, Native Americans led all groups in the U.S. in vaccination through the summer of 2021 (Foxworth et al. Forthcoming). Vaccination strategies employed by tribes, included incentivizing vaccination, and partnerships with community organizations, IHS, and state governments to hold vaccination events. Many tribes converted community buildings and facilities—tribal offices, schools, casinos, Urban Indian Centers—into vaccination clinics,

including sites for drive-by and outdoor mass vaccination events. The success of these vaccination efforts by tribes was at least partially a result of the ability for tribes to determine their own priorities in vaccination of 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 like language. For example, the Cherokee Nation in Oklahoma who put fluent Cherokee language speakers at the front for vaccination due to casualties through the pandemic to fluent language speakers (Brown, 2021). Tribes also strategically vaccinated influential leaders from their community to help encourage others to become vaccinated (Hellman, 2021).

With over a century of inequities, Native Americans experienced and continue to experience the spread of COVID-19 at disproportionate rates. But they have also showed resilience, leading in rates of vaccination. All the same, we know that tribal-state relations have shaped the pandemic's course and more specifically suspect that state politics have been consequential during the pandemic. In the sections below, we are interested in further exploring if and how Native American representation and Native nation political power may have played a role in stopping the spread of COVID-19 in Native communities.

II. Descriptive and Substantive Representation

Our theory, that the presence of Native American legislators reduces COVID-19 cases in Native communities, is based on the deep literature focused on descriptive representation. According to Suzanne Dovi, "descriptive representatives are those who look like, or at least have experiences and interests similar to, the people they represent" (2007, 27). Descriptive representation is often applied to race, ethnicity, and gender where a match between the elected official and their constituency is made based on these descriptive 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 members from diverse communities in legislative bodies lead to public policies beneficial to members from those communities, often through legislation sponsored by those descriptive representatives who understand the needs of those constituents (Bratton and Haynie 1999a; Haynie 2001; Tate 2001). We find descriptive evidence that Native American legislators were active in legislation during the COVID-19 health pandemic to help address the many challenges this population faced. Beyond substantive policy outcomes, scholars have also noted that descriptive representation leads to other positive outcomes, including increasing the representation of different points of view and interests in legislative bodies (Phillips, 1998; Mansbridge, 1999).

Scholars interested in descriptive representation often focus their research on the presence of minority representatives in the US Congress, the branch of the federal government that is in theory intended to provide the public with representation given the relative connection voters have with their member of Congress (Bratton and Haynie 1999b; Cameron, Epstein, and Sharyn O'Halloran 1996; Canon 1999; Tate 2003; Welch and Hibbing 1984). However, there is also a body of work that has explored whether descriptive representation at state and local levels of government leads to positive substantive representation for minority communities (Bratton 2006; Eisinger 1982; Kerr and Mladenka 1994; Stein 1986). This work at the state level has demonstrated that racial and ethnic diversity in legislatures not only motivates positive policy outcomes on behalf of minority interests but also has led to the blockage of proposals that are harmful or restrictive to those communities (Filindra and Pearson-Merkowitz 2013; Haynie 2001; Preuhs 2006).

We are particularly drawn to the work that has found a relationship between descriptive representation and trust, as increased trust is one of the mechanisms that we believe may influence 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. This increased trust has the potential to enhance a feeling of inclusion among these groups, which makes the "polity more democratically legitimate" in the eyes of the disadvantaged (Mansbridge, 1999: 651). This is an important normative outcome given the long histories of political marginalization many groups have faced in the United States. Though somewhat limited, the literature focusing on the empirical relationship between descriptive representation and perceptions of government has generally supported these theoretical arguments. For example, Susan E. Howell and Deborah Fagan (1988) find that African Americans in New Orleans represented by a Black mayor are much more trusting of government than those in other areas without descriptive representation. Similarly, Gabriel R. Sanchez and Jason L. Morin (2011) found that Latino respondents who live in a city with a Latino mayor are more likely to believe that they and people like them can have an influence on political outcomes.

Our analysis of the impact of Native American representation at the state level on COVID-19 outcomes comes at a time of a rise in political representation of Native Americans. More specifically, between the mid-1990s and 2018, the number of Native Americans tripled from twenty-six to eighty-one. Although the high of eighty-one in 2018 only amounts to roughly one percent of all legislators across the country, this sharp increase in representation of Native Americans within state legislatures is notable. The linkage between Native representatives and Native citizens has also become important because 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 across the country 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 have also highlighted similar positive substantive outcomes from increasing representation. For example, qualitative interviews with Native American elected officials indicate that these officials pushed for improved service delivery to Native Americans in their jurisdiction, often citing the importance of providing a voice for Native Americans (McCool, Olson, and Robinson 2007). Interviews with Native American legislators in South Dakota reveal that these descriptive representatives may not always be successful in their efforts to promote positive legislation on behalf of Native American communities, but they often help insulate their constituents from bad policies that could harm their Native American constituents and inform their non-Native colleagues about the unique experiences of Native Americans in the state (Schroedel and Aslanian 2017). Scholars find that a single Native American state legislator can shift dynamics in state-tribal relations, and a critical mass of Native legislators is even more beneficial (Kessler-Mata 2017, Evans 2011).

Trust in government has been one of the most significant drivers to COVID-19 outreach and one of the most challenging barriers for communities of color. Scholars have illustrated the role of trust in government is shaping health behaviors (Suhay et al., forthcoming; Pears and Sydnor, forthcoming). Arguably, this pattern may most pronounced for Native American communities, due to the many injustices they have endured due at the hands of the federal

government (some discussed above). As Rep. Ken Luttrell (Cherokee), co-chair 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, non-represented, 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, the utilization of messengers who have relationships with Native American community members and who are members of the community themselves has been strongly recommended for COVID-19 vaccine outreach (Urban Indian Health Institute 2021). Consequently, we expect that Native American leaders will have an indirect impact on COVID-19 outcomes as messengers, in addition to the more direct role they may play through the passage of protective legislation. We lay out our theoretical expectations in the section below.

III. 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 during times of crisis. Representation was especially important during the COVID-19 pandemic for Native American communities. We argue that two kinds of representation mattered for Native American communities during the COVID-19 pandemic: descriptive representation and tribal political power within states. Both of these kinds of representation are distinct and each played important roles in reducing the spread of COVID-19 rates in Native American communities.

We know that representation remains core to ensuring the quality of any democracy, especially for historically excluded and marginalized groups. Representatives are elected by citizens and the quality of citizen representation has an effect on citizens' political efficacy, engagement, participation, knowledge and overall confidence in government (Hayes and Hibbing

2017; Pantoja and Segura 2003; Wolak and Juenke 2021). Representation and its associated outcomes are even more important during times of crisis.

During times of crisis, representatives have additional roles to ensure the safety and care of the communities they serve. During the pandemic, we saw black and Latino representatives across the U.S. speaking out to bring additional attention and resources to their respective communities who were hard hit by COVD-19 (Alford 2020; Bevington 2020). The calls by black political officials intensified when inequities were compounded by ongoing police violence against black people which led to a wave of black protests across the U.S. 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 also important because citizens, especially racial and ethnic minority groups who have been neglected or excluded from the political system, were looking for trustworthy information. During the early days of the pandemic, information was often slow and there were large contradictions in information about the coronavirus between public health experts and the Trump White House. 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 similarly to their lack and Latino colleagues during the COVID-19 pandemic. Since Native communities have suffered long histories of political neglect and were experiencing significant death and illness because of the COVID-19 pandemic, Native leaders had to develop tactics both to communicate with their constituents and to bring much needed attention to force urgent, coordinated responses by federal, state, and other governments. Native American representatives disseminated important

public health and other information to their constituents and Native communities on the COVID-19 pandemic. This accrued through social media, local media in Native communities, and more. They also took important steps to advocate for increased government relief and response 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, Pueblo, Apache and Navajo nations coordinated early with states for testing, case tracking, tribal border closings and to demand federal response (Romancito 2020). In Montana and South Dakota, Native legislators emphasized publicly the importance of tribal border closings (Groves 2020).

Given this level of political activity and response by Native American legislators, we expect there to be a strong relationship between the presence of Native American legislators in states and the spread of COVID-19 in Native communities. *More specifically, we expect that COVID-19 cases will be lower in Native communities located 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

Though we expect that 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). The political power of Native nations within states has increased over time. As Native nations have had to increase their interactions with state and other governments, Native nations have increased their influence within state politics as contributors to political campaigns, sponsors of community initiatives, and champions of issues within states that lead to better policy outcomes for Native people and the broader public.

Forced interaction between tribes and states in the modern era increased after the passage of the Indian Gaming Regulatory Act (1988). This Act forced the devolution of power from the federal government to state governments on issues related to Indian gaming. At roughly the same time, there was a generalized movement to devolve federal power to states for social welfare programs like Temporary Aid to Needy Families, foster care, and others. This movement forced greater interaction between states and Native nation governments (Cornell and Taylor 2000; Corntassel and Witmer 2008).

Hence, Native nations across the U.S. have become increasingly involved in state and local politics to advance their interests. Native nations have used traditional political strategies, like candidate endorsement and lobbying, to ensure their voices are heard and interests are met within state politics. Previous research has identified lobbying as a tactic used by Native nations to exert political power and influence state policy outcomes (Boehmke and Witmer 2003, 2011, 2020; Evans 2011; 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.

Most often, the level of tribal financial contributions made to political candidates within states has been used as a proxy to understand Native nation political power and mobilization

within states. Consistent with this established empirical strategy, *we expect that in states where Native nations give larger financial political contributions, there will be less incidence of COVID-19 in Native communities.* In states where Native nations give more, state leaders will have greater incentive to coordinate with and/or respond to Native nation concerns during the COVID-19 pandemic. We discuss our research design and results in the next sections.

IV. Research Design

We build on earlier work that finds that both longstanding neglect and marginalization have a significant impact on COVID-19 rates in Native communities (Foxworth et al. 2021; Rodriguez-Lonebear et al. 2020). We use these established findings to understand how state legislators and Native nations' political power in state politics have an effect on COVID-19 rates in Native communities. We want to understand effects on Native American health and calls to action of Native representatives during the COVID-19 pandemic.

In our regression analysis, the 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 the 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 were able to shift towards 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 11th, the outbreak had been spreading in Native nations for three months. During that time, tribes were struggling to secure federal assistance for their

COVID-19 responses. In May, the Department of Treasury (DoT) distributed only half of the CARES funding that Congress had allocated to tribes.

We test state-level factors and control for community-level factors that explain COVID-19 cases across 333 Native communities in the lower 48 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 only includes 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 of tribal lands. We do exclude Indigenous communities in Alaska and Hawaii because data for these communities was 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, as several tribes including the Navajo Nation have lands that span multiple states. If a tribe in our dataset crosses state boundaries, it is coded as part of two dyads. In the average observation, 61 tribal members had contracted COVID-19.

COVID-19 Case Counts in Native America: Data Erasure and Indigenous Data Sovereignty

We know that federal policy has impacted Native wellbeing in real and measurable ways and this is exacerbated during the COVID-19 pandemic. But federal interactions with Native nations also affect the availability (or rather absence) of data on Native American communities. There is growing critical scholarship on Indigenous erasure – where Indigenous Peoples are systematically overlooked, intentionally excluded, and "Othered" as a footnote, or treated as an "Asterisk Nation*" (Hudson et al. 2020; National Congress of American Indians 2012). The lack

of intentionality to collect Indigenous data has led to huge disparities in the availability of timely and accurate data on Indigenous peoples and communities, especially compared to other ethnic/racial groups. This lack of data is pervasive, and the data available for research has 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. This includes during the COVID-19 health pandemic. During the early days of the pandemic, data on all racial and ethnic groups was a challenge, including for Native American communities. Without data, tribes were struggling to respond locally as well as to advocate 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 *Indian Country Today* website, data was "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." Not all data was crowd-sourced, as data was also gathered from the public release of information by Native nations. Furthermore, data was supplemented and verified by news reports. This data serves as an innovative and comprehensive grassroots effort to combat the absence of standardized Native American COVID-19 case data.[1]

[1] *Indian Country Today* is one of the oldest, best-known Indigenous media outlets in the U.S. and beyond. *Indian Country Today* has taken the lead in collecting other data to combat the absence of data on Native Americans in the U.S. Other published literature using this data include Rodriquez-Lonebear et al. 2020 and Evans et al. 2019.

Key State Covariates

Native American State Legislators: To test if descriptive representation had an effect on 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 Today* (Evans et al. 2019) and the voter mobilization organization Native Vote. In 2018, a record number of Native Americans ran for political office and we believe this was consequential in combating the spread of COVID-19 in Native America.

Native Nations' Campaign Contributions in State Politics: To understand if Native nations' political power was a significant factor in facilitating greater collaboration and response by state governments, we use level of financial contributions made by Native nations in state politics in 2018 or 2019, whichever year is higher. This data was taken from followthemoney.org. We only use financial contributions directly from Native nations themselves, not tribal businesses or enterprises like 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 in $17,457,682 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 utilizing their powers to protect public health. We expect that these behaviors endanger 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 COVID-19 rates will affect the tribes' COVID-19 rates. Accordingly, we include the number of cases per 100,000 by June 11th in each state (CDC 2020c). For the average observation, state cases were 469 per 100,000 residents.

State Population: We include two state population measures taken from the American Community Survey 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 (IHS) that identifies 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; the most recent version is available at https://www.ihs.gov/findhealthcare/. 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 there is a wider network for community interaction? 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. There are three main ways tribes exercise control over health facilities, and they may blend these strategies. Tribes may provide health services fully independently. Tribes may receive grants from IHS, and forgo IHS direct delivery of care, through two avenues: self-government compacts and PL 93-638 contracts. Note that tribes do not have to be fully in or out of IHS operations. If tribes 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: Rodriguez-Lonebear et al. (2020) noted 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 where greater rates of English-only language are present. 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 American Community Survey 5-year estimates (2014-2018).

Non-Native American visitors: Previous research has identified 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 non-tribal 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. Evans et al. (2020) compiled the square footage of all tribally-owned casinos, available from the National Indian Gaming Association at http://indiangaming.com/home/ and we include their compilation in this paper with their permission. 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 "checkerboarded," meaning there are 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 COVID-19 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 that are in close proximity to *Indian Country Today* are more likely to know about this crowd-sourced dataset and spread word in their professional networks. *Indian Country Today* is headquartered in Phoenix, so 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 that are facilitated by federal agencies. Because state-recognized tribes are less networked, perhaps they are less aware of the crowd-sourced dataset. ACS notes whether a tribe is state or federally recognized. Ten percent of observations are of state-recognized tribes.

V. Results

We model our expectations with a negative binomial regression and results are presented in Table 1. As noted in Model A within the table, the coefficient on Republican governor is significant and positive, indicating that where a Republican is governor, COVID-19 cases in Native communities were higher. Both the number of Native American state legislators and the

size of tribal campaign contributions have negative effects on COVID-19 cases in Native communities, and both effects are statistically significant. In parallel, we find that the density of tribal health facilities and the extent of tribal control over health facilities have negative, statistically significant effects on COVID cases on tribal lands. As we suspected, both Native American representation and political power, as well as the presence and tribal control of tribal health facilities, lead to fewer COVID-19 cases.

Table 1: # of COVID-19 Cases Across Native Nations by June 11, 2020

	Model A	**Model B**
Republican governor in state	1.27**	1.46**
	(.60)	(.66)
Number of Native American state legislators	-.23**	-.26**
	(.10)	(.12)
Tribal government campaign contributions in state elections (in thousands)	-.00030***	-.00037***
	(.00011)	(.00014)
Density of health care facilities on tribal lands	-.20***	-.18**
	(.077)	(.070)
Tribal control of health care systems (if there is at least one health care facility on tribal lands)		-1.26**
		(.60)
Population in state (in hundred thousands)	-.00061	-.0016
	(.0054)	(.0057)
Native American population in state (in hundred thousands)	.54	.49**
	(.51)	(.54)
Cases per 100K in state by June 11	-.0012	-.0019**
	(.00067)	(.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***
	(.97)	(1.01)
Total population on tribe's lands (in thousands)	.017***	.013**
	(.0055)	(.0056)
Median age on tribe's lands	-.044	.0059
	(.036)	(.039)
Median household income on tribe's lands (in thousands)	.013	.0050
	(.023)	(.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 $ft^{2)}$	.24*** (.042)	.24*** (.047)
Tribe in Phoenix Indian Health Board: stronger connections to data collectors	-1.10 (.87)	-1.76* (.92)
State-recognized tribe: weaker network connections to data collectors	2.96*** (1.02)	*(a)*
Constant	10.44** (4.98)	10.90** (4.74)
Number of observations	N=331	N=263

Notes: Negative binomial regression. Robust standard errors in parentheses. $^{*}p < 0.10$, $^{**}p < 0.05$, $^{***}p < 0.01$. *(a)* Omitted because of collinearity

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 ID 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, while 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 because many of the immediate responses to the pandemic in the hands of chief executives. Because party of governor and of the majority in the legislature are highly correlated, we do not include both measures in the main model.

Discussion

During the early days of the pandemic, when the federal response was slow and uncoordinated, Native nations and representatives mobilized to ensure Native people were not forgotten in the development of response strategies. Our findings highlight that the political

power of Native people, both representational power and Native nation political power, were important in protecting the health and safety of Native people and bringing much needed relief to Native nations for COVID-19 response. 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 wrote, "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," (2017, 59). We test the effect of Native American descriptive representation in state legislatures on the health of Native peoples during the early stages of the COVID-19 pandemic. Further, we illustrate the pathways through which Native political influence occurs. Our work affirms prior findings on descriptive representation.

Also, we identify unique features of Native politics. Native nations follow dual mechanisms to shape health outcomes—descriptive 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 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, where they somehow choose between managing their own affairs or engaging with state governments. Rather, Native nations can benefit if they exercise sovereignty over their health systems and also have mechanisms to ensure that states support, not thwart, self-determination.

In 1928, Lewis Meriam presumed that Native peoples were a threat to the health of non-Native communities when he wrote, "[t]he 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 have been exemplars for the administration of COVID-19 vaccines: multiple Native nations have 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, too.

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