

“American Diagnosis” podcast

Season 4 Episode 12: Indigenous and Invisible in the Big City

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TRANSCRIPT

Céline Gounder: Gloria Curtis was an Ojibwe woman who moved to Minneapolis in the 1960s, but she got sick. She had infectious hepatitis. Gloria got so ill she had to be hospitalized, but the experience became a nightmare.

Advocates for Gloria told journalist Bill Moyers in 1973 that Gloria received poor care. They alleged it was because she was Indigenous. They told Moyers Gloria didn’t trust the staff and said they even ignored her request for toilet paper at one point.

The story went that Gloria stabilized and was eventually sent home, but her condition got worse. She needed more care, but her experience in the hospital was so bad, she refused to go back. Finally, she was admitted to another hospital. Not long after, though, Gloria died.

Richard Wright: It’s very sad, very sad.

Céline Gounder: Richard Wright was living in Minneapolis at the time. He’s a member of the Leech Lake Band of Ojibwe in northern Minnesota. Richard saw the community's response to Gloria's death.

Richard Wright: It was an outrage reaction.

Céline Gounder: Richard regularly went to community meetings about issues facing Indigenous people across the region.

Richard Wright: And that's when I started to find out more about Gloria

Céline Gounder: Richard didn't know Gloria personally, but he worked in a clinic for years. He says he knew many Indigenous people who faced discrimination when they needed health care.

Richard Wright: And I think that it had happened with such high incidence that the American Indian people said, “This has gotta stop. You know what, we're gonna start our own clinic. We're gonna start our own medical facility.” And they did.

Céline Gounder: That clinic would become the Indian Health Board of Minneapolis. It opened in 1971. Richard worked there for decades as a substance use counselor. Today, he provides spiritual guidance to Indigenous patients who come into the clinic for mental health services.

The Indian Health Board caters to Indigenous people living in the Twin Cities, but it's not part of the Indian Health Service, the government agency responsible for providing health care to Indigenous people; it's a nonprofit health center. It gets federal funding to fill gaps in care for urban Indigenous people, in particular.

While enrolled members of federally recognized tribes can access the Indian Health Service or tribally run health care on their reservations, Indigenous people who live in cities can find themselves without access to the care they're entitled to. And that's a lot of people. Approximately 70% of Indigenous people in the United States live in urban areas.

[“American Diagnosis” theme begins.]

In this episode, we'll look back on the reasons why many Indigenous people left their reservations for the city.

Douglas Miller: There was an urban relocation program in the mid-20th century, supported by the federal government, to move Native American peoples from reservation or rural Indian Country to major metropolises.

Céline Gounder: When Indigenous people arrived, there was little support — including the health care guaranteed to them in treaties.

Esther Lucero: Even though we're living in urban areas now, that doesn't mean that our benefits should leave us.

Céline Gounder: Indigenous urban health providers started to open their doors around the country, but the battle for health care resources continued as some politicians were looking to cut back.

Patrick Rock: They came into the mindset that it doesn't make sense for the federal government to continue on with a budget for urban Indian health. So, I think that put our community on edge. Like, “Are we gonna lose our clinic?”

Céline Gounder: I'm Dr. Céline Gounder; this is “American Diagnosis.”

[“American Diagnosis” theme fades.]

Céline Gounder: Richard Wright grew up on Leech Lake Reservation in northern Minnesota. The area was remote.

Richard Wright: The island that I grew up on, it was so inaccessible that the mail was delivered by boat.

Céline Gounder: Growing up in rural Minnesota, Richard says, life flowed with the seasons. Fishing one part of the year, harvesting wild rice in others.

Richard Wright: But there was no steady employment where they would go to work and earn a paycheck. And then the Bureau of Indian Affairs announced that Relocation Act.

Céline Gounder: After World War II, the Bureau of Indian Affairs started pushing Indigenous people to move to cities. Richard's mother, father, and several of his siblings moved to Chicago in the early 1950s. His dad got a job as a truck driver.

Richard remembers one day when his family came back to the reservation for a visit.

Richard Wright: He put his paycheck on the table. It was \$112, and that's when he made a week. And that would've been 1955 or so. That was huge money back then.

Céline Gounder: This was the dream the Bureau of Indian Affairs promoted. A new, more prosperous life for Indigenous people in America's cities.

Douglas Miller: They stuck these posters up around reservation agency windows and they showed these families, like, living the high life in Chicago and Denver and L.A. and so forth. And look what you're gonna get if you come do this.

My name is Douglas K. Miller and I am an associate professor of Native American history at Oklahoma State University.

Céline Gounder: Douglas studies Indigenous urban migration. He says that after World War II, the federal government was looking to cut costs.

Douglas Miller: And one area where federal officials thought they should cut money is to the Bureau of Indian Affairs and to Native American people. And they used this term at the time: They want to, quote-unquote, "get out of the Indian business."

Céline Gounder: The thinking at the time was if Indigenous people moved to cities and assimilated, the federal government could cut costs by no longer needing to provide services and entitlements enshrined in its treaty obligations to Indigenous people.

This period came to be known as the Termination Era. Congress sought to end the special relationship between the government and tribes. Along the way, the policy erased some Indigenous rights. Some tribes lost sovereignty over criminal and civil court cases. Reservation land was forfeit, and some tribes lost their federal recognition entirely.

In his research on the government's relocation program, Douglas found letters Indigenous people wrote to the Bureau of Indian Affairs.

Douglas Miller: So in these letters Native people wrote, they would often describe how desperate their situation really was. They would say things like: "Please get me out of Oklahoma. I have nothing here." They would talk about that they're cold, they're hungry. Yeah, I remember one letter that a woman very ... in a very detailed description, talks about exactly how far she has to haul water up to her house each morning and, just, how burdensome it is.

Céline Gounder: Douglas says people looking to relocate most commonly wrote about work.

Douglas Miller: "I want a job. I wanna support my family. I fought in World War II. I proved myself. I can do things. I have skills. I wanna work, I wanna work."

Céline Gounder: Early iterations of the program could be as basic as a one-way bus ticket and short-term housing assistance. Douglas says, after the first years, the program became more involved.

Douglas Miller: So not only are they gonna help you get an apartment and sort of get set up somewhere, they're actually gonna get you into a welding program, or a hairdressing program. Those were the really popular occupations.

Céline Gounder: For some, the program was a path to a new life. But the influx of Indigenous people into cities created new problems the bureau did not properly plan for.

Douglas Miller: Native people who moved to Chicago, Los Angeles, Dallas, Salt Lake City, San Jose needed health care like anyone else, and they would go to the local health care clinics and be told there that "we can't serve you. You get that stuff for free on the reservation. Like, what are you doing here?"

Céline Gounder: In the 19th century, when tribes signed treaties turning over land to the United States, the federal government agreed to provide services, like health care, to Indigenous people.

That care has been historically underfunded, but it was available on reservations through the Indian Health Service or, later, tribally run clinics. There was nothing like this waiting for Indigenous people once they started moving to cities en masse.

Douglas Miller: Native people would go to the BIA office in the city and were asking them for health care. And BIA officials in these offices started to realize they had a major problem with the program.

Céline Gounder: The only option some of these transplants had was to travel back to their reservation for health care. But people from tribes in Minnesota may have been sent as far away as Los Angeles. And if someone was able to decide to make the trip back, there was no guarantee they'd be seen at the clinic back home either.

Douglas Miller: "No, that's all being paid for by the relocation program, go back to Chicago." And they couldn't find health care in any direction.

[Music fades.]

Céline Gounder: City life brought other challenges, too.

Douglas Miller: They could rarely find a city that had enough housing or enough jobs at the same time.

Céline Gounder: Families faced discrimination in housing, employment, and hospitals. Richard Wright's family, who moved to Chicago in the 1950s, ran into their own troubles. Richard says his father started to drink.

Richard Wright: He'd come home Monday morning and he'd be broke. You know, I think a lot of times they just got evicted and eventually my mother would put all her kids on a train and just come back to the reservation alone.

[Dreary music begins in the background.]

Céline Gounder: Richard says the family left Chicago for Minneapolis, and eventually returned to the Leech Lake Reservation.

[Dreary music continues.]

Douglas Miller: The program was mismanaged, was poorly conceived, was underfunded.

Céline Gounder: Douglas Miller, the historian, says after roughly 20 years the relocation program started to run out of steam.

Douglas Miller: By the '70s, most people are really hip to what it entails. You know, they're much more knowledgeable about what the program can and cannot do.

So, the major shift, I would say, from 1972 onward is that the federal government just stopped investing in trying to encourage Native people to do this.

Céline Gounder: The bureau's program accounts for some of the mass movement of Indigenous people toward cities, but not nearly all of it.

Douglas Miller: How else do you explain New York, for example? New York City today has the highest per capita Native American population in the country.

Céline Gounder: New York City was never an official BIA relocation site. Neither was Minneapolis, but Indigenous people continued to move to these and other cities for work, family, and school.

Douglas Miller: Native American peoples, like people throughout human history, have always migrated. They've always been mobile people for their own purposes, with the health of their tribal communities in mind and their own possible futures in mind.

[Calming classical music plays.]

Céline Gounder: When we come back, we'll hear what health disparities persist for urban Indigenous people, and how some clinics have found innovative solutions to providing care in the city.

[Calming classical music continues and fades.]

Céline Gounder: As the urban relocation program faded in the late 1960s, a renewed Indigenous civil rights movement was rising. Indigenous people who had moved to cities were organizing.

Esther Lucero: And they really fought to have our programs established to get health care, to get education, to get housing — like, all of those things that were important.

Céline Gounder: This is Esther Lucero.

Esther Lucero: Yá'át'ééh, everybody. My name is Esther Lucero and I'm Diné on my mom's side and Latina on my dad's side, and I have the privilege of serving as the president and CEO for the Seattle Indian Health Board.

Céline Gounder: Activists started occupying federal property to demand services and land. One of the highest profile protests took place on Alcatraz Island.

Richard Oakes: The Native Americans reclaimed this land known as Alcatraz Island in the name of all American Indians by right of discovery.

Esther Lucero: They took over Alcatraz and demanded these rights and benefits.

Richard Oakes: Since the San Francisco Indian Center burnt down, there is no place for Indians to assemble and carry on our tribal life here in the white man's city. Therefore we plan to develop, on this island, several Indian institutes. We feel this claim is just and proper and that this land should rightfully be granted to us for as long as the river shall run and the sun shall shine. Signed, Indians of all tribes. Nov. 19, 1969, San Francisco, California.

Esther Lucero: So simultaneously you think about the American Indian movement and you think about leaders like Bernie Whitebear.

Bernie Whitebear: There are over 3,000 Indian families in Greater Seattle amounting to approximately 12,000 persons. The vast majority are at or below a poverty level of \$1,200 per year.

Esther Lucero: So there was a takeover at Fort Lawton where they demanded these benefits. And it was from that time period that all of the organizations here serving Native folks in Seattle were birthed.

Céline Gounder: In response to the lack of services and discrimination, urban clinic started to open up across the U.S. with a focus on Indigenous people's needs.

Bernie Whitebear, who helped lead the occupation of Fort Lawton in Washington state, would go on to be the first executive director of the Seattle Indian Health Board, which Esther leads today.

Esther Lucero: So the reason people come to us is because the way we survived in urban areas, was we began to share our cultural experiences. We shared our cultural practices. We bonded together in social justice movements, and so sometimes people come to us to speak their language or to just see another Native face. You know, to get some reprieve from the racism that we all experience, even myself, who's in a very privileged position, experience on a daily basis. So, you know, we are much more than a community health center or place that provides direct service. We are a home away from home and that makes a difference to everybody.

[Bouncing music plays and fades.]

Céline Gounder: Urban Indigenous providers also bring cultural competency.

Patrick Rock: Your ceremonial needs may not even be addressed if you were seen at another health care facility, or you may even be looked at like you're crazy, right?

My name is Patrick Rock, R-o-c-k. I'm a family physician as well as CEO of the Indian Health Board. My tribal affiliation is the Leech Lake Band of Ojibwe.

Céline Gounder: Patrick has been working at the Indian Health Board of Minneapolis since 1997. He says care that respects a person's spiritual or cultural beliefs distinguishes their clinic from others.

Patrick Rock: That's where people want to go. They don't want something that's been cleansed of any mention of traditional health care. And so people here, when they come see me, I ask them, “Do you go through ceremony? What ceremonies do you go through? If your tribe or your ceremony includes fasting, what do you need to think about as far as insulin is concerned?”

Céline Gounder: Growing up in rural Minnesota, Patrick got his health care from the Indian Health Service. As an undergraduate, he volunteered for his tribe's ambulance service. Later, he was a medical resident in Minneapolis. He says serving in the city was different.

Patrick Rock: My mind was blown. I was surprised of, really, the depth of the need that I was encountering during my rotation here.

Céline Gounder: Urban Indigenous health providers like those in Minneapolis and Seattle have been around since the 1970s, but Indigenous people have to navigate a complex system to get the care they're entitled to.

[Soft guitar music plays in the background.]

Céline Gounder: Patrick still remembers one patient who seemed to be falling through the cracks: a middle-aged Indigenous man who worked as a mechanic. He initially came in complaining of a rash.

Patrick Rock: And so further questioning of that rash, you know, got down to, “Yeah, I'm having a lot of swelling in my hands.”

Céline Gounder: Patrick diagnosed it as psoriatic arthritis. It's treatable, but Patrick knew the mechanic would need a specialist, a rheumatologist. But the Indian Health Board didn't have one on staff, and they couldn't get him the drugs he needed.

Patrick Rock: We didn't have a pharmacy. We would have to rely on pharmacy companies giving us medications free of charge.

Céline Gounder: This mechanic was facing the same gap in coverage as other Indigenous people who moved to the city 50 years ago. He didn't have insurance, and there was no Indian Health Service clinic in the city.

Patrick Rock: We, as urbans, did not have, and still don't have, ability to send a person out to rheumatology and get that paid for because we don't have contract health services dollars.

Céline Gounder: Contract health services. This is how the Indian Health Service or tribes provide care when a service or specialist, like a rheumatologist, is not available in the system. In that case, those services can be found elsewhere, then reimbursed by IHS. But urban Indian health providers like Patrick's aren't part of that system. Patrick says this would have gone differently if the mechanic had been diagnosed on tribal land.

Patrick Rock: The tribe or the IHS would've paid for that visit to the rheumatologist. Medications would've been filled through the hospital.

Céline Gounder: The mechanic did eventually make it to a rheumatologist, but Patrick says the patient couldn't afford it and stopped going.

Patrick Rock: The last follow-up that I got from him was he was gonna continue to try to work and he subsequently never came back. Which is also upsetting because it ... I felt, like, I say, I felt helpless in that sense. My hands were tied and the system's hands were tied.

[Music fades.]

Esther Lucero: Yes, all of those things happen.

Céline Gounder: Esther Lucero again.

Esther Lucero: You know, anything from, “Well, I just don't access the service” to “I'll take partial service” and “Oh, I'll wait, you know, for a long time or try to find a way to get back home to get access to a specialty provider.” So yeah, I wish it was more seamless. I really do, but it isn't.

Céline Gounder: Esther says access to care like that mechanic needed is based on what tribe he belonged to, what services would've been available on his reservation, and how well resourced the urban clinic was.

Esther Lucero: So it really depends on where you are and who you are.

Céline Gounder: Esther says this patchwork system impacts health.

Esther Lucero: There's a reason when you look at health disparities that, you know, Native folks are at the top of many of them: diabetes, substance use, even accidents, right? Heart disease. And I do think that that's partially because of disjointed systems.

Céline Gounder: One of the problems when it comes to caring for Indigenous people in cities is knowing who's living there in the first place. Esther says the Seattle Indian Health Board serves

people from more than 370 different tribal nations, but census data often misses Indigenous people altogether or misidentifies them.

Esther Lucero: So for example, you know, I said that I'm Latina and I'm Diné, right? If I check that Hispanic box, then suddenly I'm moved into a completely different category and it dismisses my Native identity completely.

Céline Gounder: This erasure can hide public health crises in plain sight. Esther says they saw this when they were investigating the epidemic of missing and murdered Indigenous women.

Esther Lucero: We found that there are some police systems in some states that only count Black or white and nothing else, right? Or we knew that they used initials. Like, for example, here in the city of Seattle where they used the letter "N" to signify Negro and Native American. So how can you tease out that data?

Céline Gounder: This history of inaccurate data on Indigenous people in urban areas led the Seattle Indian Health Board to create the Urban Indian Health Institute. It's a tribal epidemiology center.

Esther Lucero: Tribal epidemiology centers were founded to actually scrub data, you know, like from the CDC, or state entities, or county entities to tell a true story about our people. So let's use covid as an example.

Céline Gounder: Data played a key role here. Early on in the covid pandemic, when vaccine supplies were low, the Centers of Disease Control and Prevention was recommending that people 70 years and older get priority for vaccines.

Esther Lucero: You know, we took a look at our data. Quite frankly, our people are not living that long. And so we started at 50 and older. So we vaccinated our elders. We vaccinated our language keepers because we know preserving our languages is really key. We vaccinated our traditional healers and our knowledge keepers, right? That was very important.

[Soft instrumental music plays.]

Céline Gounder: The scope of health care services for Indigenous people in cities has expanded greatly since the 1970s. But even so, Esther says, the system is underfunded.

Esther Lucero: There are not enough resources, right? So you know, this idea that we have this whole pie ... we don't have a whole pie. So we are always saying we have to increase funding overall.

Céline Gounder: Patrick Rock with the Indian Health Board in Minneapolis offers the same message.

Patrick Rock: The Indian Health Service is underfunded. Period. But if you live within that system where a lot of Native people live in urban centers, and IHS has a 1% urban Indian health line-item budget. And so there's an incongruity, right?

Céline Gounder: Even that 1% of the Indian Health Service budget has come under threat. President George W. Bush's administration proposed cutting all funding for urban Indigenous health care in its 2007 budget.

Patrick Rock: That put our community on edge. Like, are we gonna lose our clinic?

Céline Gounder: Urban Indigenous clinics across the country were able to rally support. In the end, federal funding wasn't eliminated. But Esther Lucero says that moment looms large in their minds.

Esther Lucero: Let's just be honest, federal government doesn't like to put out money. They sometimes consider us a burden — often consider us a burden. I find that very frustrating because the reason we have these benefits or we have access to these resources is because 90% of our land — right? — was transferred to this new system. And so for me, it's like a prepaid benefit. And I wish the general population understood that. It's not part of some, like, welfare system, right? This is something that we've earned.

[Music fades.]

Céline Gounder: This is Dr. Céline Gounder. This episode is the last of Season 4 of *American Diagnosis*. Thank you for listening.

Our hope is that we've shown the strength and resiliency of Indigenous people. The team shared stories of lost and reclaimed foodways, holding outsiders accountable for violence against Native people, and Indigenous physicians reimagining what health care looks like.

Esther Lucero: I think our story is one of strength, where folks said we're just not gonna take that.

Céline Gounder: The fight for equity continues. Last month, the Centers for Disease Control and Prevention reported that life expectancy in the United States took a nosedive during the pandemic. American Indians and Alaska Natives saw the biggest drop: nearly seven years — more than any other group.

Esther Lucero: The issue wasn't covid. The issue was lack of resources, right? And a lack of response to meet the needs of American Indian/Alaska Native communities in a time when we are supposed to be receiving services that are equal to the value of the land that we gave up.

Céline Gounder: Throughout this season, we mapped the ways that colonization and Manifest Destiny have been engines for sickness and death for Indigenous people in this country. We heard from Native leaders who showed us how unfulfilled promises led to underfunded health care. Stories of boarding schools, land loss, and relocation. Those policies and forces severed Indigenous people from their traditions and knowledge.

Esther Lucero: So basically we're just recovering from, you know, colonization, and the silos that are created, and institutional impact.

Céline Gounder: Understanding history is part of recognizing the social determinants that can hurt health. Without that grounding, Esther says, when a crisis like the covid pandemic shows up, there's no context for public health statistics, and people are left ill and dying with root causes the medical system does not understand.

Esther Lucero: That's a conversation we need to continue to have. Because I think when you put out data like that, when people say, "Oh, there's still a problem" — right? But no, the system is still a problem. And I wanna make sure that we always direct our attention to that, and the times that we are able to act on our own, with our own resources and our own strategies, we've been the most effective.

[Music fades to silence and "American Diagnosis" theme begins.]

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This episode of "American Diagnosis" was produced by Zach Dyer and me. It was engineered by Jim Briggs. Additional reporting from Taylor Cook.

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I'm Dr. Céline Gounder. Thanks for listening to “American Diagnosis.”

[“American Diagnosis” theme fades to silence.]