The pandemic's impact on the Native American population

Watch the AMA's daily COVID-19 update, with insights from AMA leaders and experts about the pandemic.

Featured topic and speakers

AMA Chief Experience Officer Todd Unger speaks with AMA Chief Health Equity Officer Aletha Maybank, MD, MPH; Donald Warne, MD, associate dean of diversity, equity and inclusion and director, Indians Into Medicine (INMED) and public health programs, University of North Dakota; and Siobhan Wescott, MD, MPH, assistant director of INMED, on updates regarding COVID-19 including the impact of COVID-19 on Native Americans and the unique challenges physicians face in caring for this population.

Chicago is home to the USA's third largest urban community of Native Americans.

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Transcript

Unger: Hello. This is the American Medical Association's COVID-19 Update. Today we're discussing the impact of COVID-19 on Native Americans and the unique challenges physicians face in caring for this vulnerable population.

I'm joined today by Dr. Aletha Maybank, AMA's chief health equity officer in New York. Dr. Donald Warne, associate dean of diversity, equity and inclusion and director of the Indians Into Medicine, or INMED, and Public Health Programs at the University of North Dakota in Grand Forks, North Dakota, Dr. Siobhan Westcott, assistant director of INMED and assistant professor, Family and Community Medicine at the University of North Dakota, also in Grand Forks, North Dakota.

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I'm Todd Unger, AMA's chief experience officer in Chicago, which is home to the country's third largest urban community of Native Americans, a community who still practices its heritage and traditions. We acknowledge that the land where we live and work is the traditional homelands of the Council of the Three Fires—the Odawa, the Ojibwe, and the Pottawatomie nations.

Dr. Maybank, let's start with you. Talk a little bit about health equity and from that perspective, what underlying disparities are causing the Native American population to feel the impact of COVID-19 more profoundly?

Dr. Maybank: Thanks Todd. Thanks for the acknowledgement as well. So I think what is really elevated for me in the last couple of weeks, in the last week or so, there's been a lot of attention in the media as it relates to the impact of COVID, especially to communities of colors and those racially marginalized, but especially for black communities across the country. But what we're clear about, and the data shows us, and the stories that people tell us also let us know, that it's not just the black communities that are being impacted. And this is kind of the narrative and the story that has happened historically, that communities have been made vulnerable, and they've also been made invisible. And so our data systems and the way that data is collected has not been consistent in how we collect race and ethnicity data across the country.

There are places that don't even collect Native American data, and what's happening in the Native American community, nor do they disclose it either. So there are many, I guess barriers and realities of how we are understanding, and not really, fully understanding what's happening in all communities, and especially among Native American communities. I mean we know the health in terms of the underlying conditions exist, and they exist at greater rates, but there are so many other structural, historical contexts that put people at greater risk and have made communities vulnerable, and especially the Native American community.

Unger: Dr. Warne, your thoughts?

Dr. Warne: Yeah, I would agree with those statements, and one of the challenges is that we've had longstanding underfunding of the Indian Health Service and Indian Health System. And we combine an underfunded health system, a lack of public health infrastructure with a great deal of poverty within our populations. So our ability to respond to a pandemic, or really any type of public health emergency, is limited from both impoverished individuals and impoverished systems. And unfortunately, we're seeing in some of our communities some bad outcomes from this particular pandemic.

Unger: Dr. Westcott, any thoughts there?

Dr. Westcott: Certainly another underlying issue that we have to think about is comorbidities. There's higher disparities in chronic diseases which can make people more vulnerable to COVID and have a

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worse outcome with it. And so these are longstanding problems. I also think that our communities are resilient and creative, and we're seeing some truly amazing ways that people are coming together, but we have a lot of obstacles in our way.

Unger: Dr. Westcott, in addition to the comorbidities, can you talk a little bit about the role of tribal practices and cultural norms, and how that plays out in terms of adherence to social distancing guidelines or other public health strategies within this population?

Dr. Westcott: Well, like a lot of populations, it's not a nuclear family. And that the old joke is for the Navajo family, it's parents, children, grandparents and their anthropologist. Quite a bit of closeness and even sometimes living in the same quarters, which may or may not have running water. So washing your hands all the time, distancing from elders, from square one that can be very difficult. So it's tough. I mean, you just—that's the way they live, and rearranging everything in their entire way of life because of the pandemic is difficult.

Unger: Dr. Warne?

Dr. Warne: Yeah, I would agree with those statements. In addition, for many of our tribal cultures, a firm handshake is actually a sign of respect, and we're having to operate in many ways outside of some of our typical cultural norms, and trying to convince our very traditional people to not shake hands is a challenge in and of itself. And that's across other cultures as well.

I think it's also important to acknowledge that there's not a single American Indian and Alaskan Native culture. There's hundreds of cultures. So when we're working with populations, we need to recognize that diversity, even within American Indian and Alaskan Native populations. And I would just encourage physicians and public health professionals working in these communities to get a better understanding of the cultural norms and develop strategies to try to ensure that we're promoting as much safe behavior as possible.

Dr. Maybank: Okay.

Unger: We've talked a little bit about the why, relative to underlying conditions. Can you give me a little bit of the data element about the actual impact on Native Americans? We're seeing pretty significant differences. Can you talk about that?

Dr. Warne: Sure. If we're thinking about some of the numbers, we have some of our populations, unfortunately like Navajo nation, that's really been decimated by COVID-19. When we look at the numbers nationally, we have a lot of different datasets that we have to look at, and Indian Health Service does collect data in terms of the numbers of people tested and the numbers of people positive.

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So, so far to date we've had about 27,000 tests through the Indian Health System and of that number about 3,000 positives. The challenge is that that collects all of the Federal Indian Health Service data, but many tribes actually operate their own health systems. And we also have urban American Indian health facilities and their reporting to that database is voluntary. So I would say that we're really underestimating the prevalence of COVID-19 based on some of the data challenges of the multiple data sets that we have to work with.

Dr. Maybank: I'll quickly add, it's a similar story to kind of what we're hearing about the public health infrastructure overall, is that the Indian Health Service has been severely under resourced in terms of just capital and funding, but also in physicians that are present. My understanding is that there's about a 20% to 25% vacancy rate of physicians within the Indian Health Service. So those present tremendous barriers in terms of people's access to health care, but also just access to what is needed to have an infrastructure of which you can make healthy choices and decisions for your life.

Dr. Warne: Yeah, and I think one thing that's not very well understood is that American Indians are the only population that's actually born with a legal right to health services. And that's based on treaties in which our tribes exchanged land and natural resources for various social services, including housing, education and health care. So that's why there's a Bureau of Indian Affairs. That's why there's an Indian Health Service. And Indian Health Service is a part of the United States Public Health Service. Unfortunately, due to underfunding, we invest relatively little in public health, and what little money there is available is focused on medical care. So we've created a circumstance in which our populations are a tremendous risk for things like a pandemic.

Dr. Westcott: Ironically the Indian Health Service was created in those treaties to mainly manage epidemics. So quarantine could be done safely and that there would be physicians and other medical care provided.

Unger: Dr. Wescott, from a physician perspective, I mean you've talked about some of the challenges already, but are there other unique challenges of treating patients in tribal communities right now?

Dr. Westcott: Well, I think there's not enough testing, and that's true throughout the nation. And there's also, there was already a shortage of health care providers at every level, including physicians within the Indian Health Service. And so with unfortunately high rates of chronic disease, those aren't being managed well right now. So I think in short amount of time we're going to see worsening of comorbidities because of the lack of availability of care, or fear of going into the health clinic or the hospital because you might catch COVID.

Unger: Are you experiencing some of the same kind of challenges around PPE that we're seeing in the kind of urban hotspots?

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Dr. Westcott: Absolutely. And this is where the ingenuity and the ubiquitousness, of mainly Indian women who can sew, to save anyone's life who are literally coming in and having parties where they sew: PPE gowns, masks, everything for their staff.

Unger: Dr. Warne, we've talked about telemedicine with a lot of other physicians. Is this a solution that you see working for you?

Dr. Warne: I think there's a real opportunity to expand telemedicine, and fortunately with the CARES Act, there's a billion dollars set aside for Indian Health Service and Indian health programming. And it does include a significant amount to support telehealth activities. And in our tribal communities, particularly in the Northern Plains where Dr. Westcott and I are working, most of the tribal communities don't have hospitals, and if they do have a hospital, they do not have an intensive care unit. And certainly a shortage of those types of high level of services.

So we need both telemedicine to provide specialty care around this type of a crisis. In addition, we have to have good referral processes to the private sector.

And quite often there are—there have been challenges historically in terms of IHS and private sector working collaboratively to adequately treat diseases. And clearly this is such a complex circumstance where we have to maximize and leverage all the resources available. And I think telemedicine will have a powerful role, potentially, in addressing the crisis. In addition, we also have to have those referral processes because we don't always have the ventilators and the ICU staff in our communities.

Unger: Dr. Maybank, what is the AMA Center for Health Equity doing to support Native American physicians now?

Dr. Maybank: Well, I think one of the—I guess, for me—very important and meaningful parts are making sure that we're in close communication. We have several conversations with Dr. Westcott and a few others, and I understand they're very busy in their schedule, but have been just very grateful for their graciousness for us to talk directly with the physicians themselves so that we understand what is happening, and then we find ways to translate that into action. So we're doing lots of advocacy as it relates to race and ethnicity data collection. We have the op-ed, we have the letter that we sent to HHS in partnership with APIP.

So that work we continue to do, we continue to work on getting legislation, and we did have recent legislation introduced that we helped support of actually putting funding to the public health infrastructure, which would be inclusive of the Indian Health Service, to collect race and ethnicity data. So somewhere up to $50 million to go towards that. So we'll see what happens, and the movement on that.

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And then also just creating space in terms of online space, the best that we can. So to hear the voices of those physicians, of what is happening within their communities and neighborhoods. We are hosting the Prioritizing Equity series, and we are planning having one in the very near future that will be focused on Native American physicians as well as their health.

Unger: Dr. Warne, Dr. Westcott, any final thoughts regarding what you see as most critical to support Native American people to have an opportunity to achieve optimal health during this pandemic and beyond?

Dr. Warne: I think there's a real basis of lack of public health infrastructure, and that's going to be an ongoing problem, and it leads to high risk for a once in a century pandemic, but it also leads to high risk for excess chronic disease and other challenges. So I think we need to recognize that in many ways the American Indian population has been neglected in terms of health needs and investments. And I'm hoping that if there's any silver lining, perhaps we can shine a brighter light on the needs of indigenous people right here in the United States and recognizing that we have been inadequate in those investments.

Dr. Westcott: And I would add, so really we need to train native people in public health. And we have an American Indian specialization here at UND in our MPH program. And previously at NDSU, for instance, one of our graduates was Ruth Buffalo, who is the first native woman elected to the North Dakota state legislature. And we just started a PhD in indigenous health, the first in the world, really, specifically for public health. But I'd like to take just this last moment to say thank you to everyone in the Indian Health Service or a tribal 638 facility who are caring for our population. We are so eternally grateful to you. You're ensuring the health of this generation, and seven generations to come, and we thank you.

Unger: Indeed. And thank you, Dr. Maybank, Dr. Warne and Dr. Wescott for being here today. That's it for today's COVID-19 update. We'll be back tomorrow with another segment.

In the meantime, for updated resources on COVID-19 go to ama-assn.org/covid-19. Thanks for being with us here today.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.

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