Invisible Tribes: Urban Indians and Their Health in a Changing World

EXECUTIVE SUMMARY

A Report Issued by the Urban Indian Health Commission
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This report was produced by the Urban Indian Health Commission, a select group of leaders convened by the Robert Wood Johnson Foundation and the Seattle Indian Health Board's Urban Indian Health Institute to examine health care issues facing urban American Indians and Alaska Natives.

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This logo was designed by Roger Fernandez for the Urban Indian Health Commission. The front structure is a Northwest Coast plank house and it symbolizes the home, which is what the Urban Indian Health Organizations are to many urban Indians. The buildings and the teepee in the background remind us of the changing landscape urban Indians face in today's world.

The term "tribe" is often associated with American Indians today. We chose to use the term tribe in the title of this report not to imply that urban Indians are a tribe, but that Indians living in cities are forming communities to help them maintain their native customs and cultures. The pan-Indian nature of urban Indian communities speaks strongly to the vitality of American Indian tribal communities today, and the desires on the part of Indian people everywhere to assure that their cultures are preserved.

EXECUTIVE SUMMARY

During the last 30 years, more than 1 million American Indians and Alaska Natives have moved to metropolitan areas. These original inhabitants of the United States have left reservations and other areas, some by choice and some by force. This change in lifestyle has left many in dire circumstances and poor health. To many in the United States, this population is invisible, leaving an important problem unnoticed: the health of nearly 67 percent of the nation's 4.1 million self-identified American Indians and Alaska Natives.

This report focuses on and highlights this segment of our nation's population that many do not understand very well. Aside from the valiant, heroic efforts of our nation's urban Indian health care programs, American health care and America's leaders largely ignore these people. We know from the RAND national report card on quality that overall the quality of American health care remains mediocre for everyone. However, we also know that racial and ethnic minorities, including American Indians and Alaska Natives, are at an even greater risk of receiving mediocre or even poor quality care. Other than the few urban Indian health care programs sprinkled across the country, large-scale efforts to reduce these disparities in care often overlook the urban Indian population. The current urban Indian programs cannot do this job alone. So, although the federal government and various organizations have attempted to address this problem, there remains much to be done—and urgently—as urban Indians struggle to get the health care they deserve.

BACKGROUND

Today, nearly seven out of every 10 American Indians and Alaska Natives—2.8 million—live in or near cities, and that number is growing. Some urban Indians are members of the 562 federally recognized tribes and are thus entitled to certain federal health care benefits, with the bulk of these services provided only on reservations, making access difficult for those in cities. Others are members of the 109 tribes that the government "terminated" in the 1950s. Without this federally recognized status, members of these tribes do not qualify for federal Indian health aid provided by the IHS or tribally run hospitals and clinics. Legislation enacted and treaties signed during the last century guaranteed health care for American Indians and Alaska Natives, but for the most part, recent policies have stripped many of them of their rights to health care when they move to cities. Today's urban Indians are mostly the products of failed federal government policies that facilitated the urbanization of Indians, and the lack of sufficient aid to assure success with this transition has placed them at greater health risk. Competition for scarce resources further limits financial help to address the health problems faced by urban Indians.

Decades ago, tribes exchanged their land and its vast resources for federal promises of a better life and better health, but the government has not delivered on its promises. As a result, the health of urban Indians has suffered, especially compared to other Americans' health.

Today, there is no national, uniform policy regarding urban Indian health, and current federal executive policy aims to eliminate funding for urban Indian health within the Indian Health Service.

THE FINDINGS

Urban Indians face several challenges when trying to access quality health care. According to one study, they face time constraints, transportation issues, distrust of government programs and the cost of traveling to receive government-provided health care. (Kaiser Family Foundation, 2004) Additionally, many of those seeking treatment at urban clinics are poor and uninsured, and Medicaid covers only part of their care.

A large proportion of urban Indians is living in or near poverty and thus faces multiple barriers to obtaining care. Half of all non-elderly American Indians and Alaska Natives are poor or near-poor, with family incomes below 200 percent of the federal poverty level. More than 25 percent of American Indians and Alaska Natives are eligible for Medicaid, yet only 17 percent report that they are covered by it or another public program. American Indians and Alaska Natives do not apply

for Medicaid for a variety of reasons, many of which could be addressed and resolved through greater awareness and an increased focus on this population's needs.

Urban Indians are much more likely to seek health care from urban Indian health organizations (UIHOs) than from non-Indian clinics. However, with only 1 percent of the Indian health budget allocated to urban programs and with this 1 percent under threat of elimination, these Indian-operated clinics must struggle to obtain and maintain the funding, resources and infrastructure needed to serve the growing urban Indian population. The vast majority of American Indians and Alaska Natives living in cities are ineligible for or unable to utilize health services offered through the Indian Health Service or tribes, so the urban Indian health organizations are a key lifeline for this group.

An additional challenge in addressing the needs of this population is the lack of data. Although federal, state and local public health institutions collect some urban Indian public health data, these data are rarely disaggregated, separately analyzed or reported. Existing data are replete with problems, including racial misclassification on official documents, inattentiveness on the part of public officials to collect data on urban Indians, small cell size in official studies that limits the use of officially collected data, inadequate numbers to allow for scientifically sound analysis, and a general lack of standardization and attention to data collection on urban Indians as a whole. Since many decisions about public support are based on data, those with little or no data can easily be overlooked.

Although public and private health institutions continue to struggle to collect data on the health care of American Indians and Alaska Natives, profiles of specific diseases that plague this population have emerged. Depression, diabetes and cardiovascular disease deserve special attention due to their alarming presence and frequent coexistence in this population.

These three diseases are closely linked as risk factors and co-morbidities in the American Indian and Alaska Native population. It is common for an urban Indian to suffer from more than one of these diseases, which interact with, amplify and perpetuate one another. Many of the underlying causes, markers and barriers to treatment of these diseases are also shared—at above-average rates—by other diseases and afflictions suffered by American Indians and Alaska Natives.

Depression

Researchers have collected little data on depression among urban Indians, although some studies have indicated that up to 30 percent of all American Indian and Alaska Native adults suffer from depression (SAMSHA, 1999) and there is a strong reason to believe the proportion may be even greater among those living in cities. Few urban Indian health organizations have sufficient funding to create useful and sustainable mental health programs. Few can afford to employ a mental health professional or manage the cost of additional space to treat patients in private. Many of their clients lack health insurance, and those who are insured might have policies imposing strict limits on mental health coverage.

National aggregate data, however, can offer an idea of the magnitude and distribution of depression among urban Indians. The data show that at the national level, American Indians and Alaska Natives suffer disproportionately from depression and substance abuse and, with the exception of private psychiatric hospitals, are overly represented in in-patient care relative to Caucasians. (OMH Web site, 2007) More than one-third of Indian Health Services patient-care contacts in 2006 were related to mental health, alcoholism or substance abuse.

In treating these patients, it is important for health care professionals to understand this population's culture and history. With few American Indian or Alaska Native health professionals, and with many primary caregivers lacking sufficient mental health training, urban Indians are not, in most cases, receiving adequate mental health care. To effectively treat urban Indians, health care professionals must understand, accept and work with urban Indians' unique cultural and historical perspectives.

Diabetes

Compared to the general U.S. population, American Indians and Alaska Natives have a higher prevalence of diabetes, a greater mortality rate from diabetes and an earlier age of diabetes onset.

An estimated 15 percent of American Indians and Alaska Natives age 20 years or older who receive care from the Indian Health Service have type 2 diabetes. (CDC, 2005) This prevalence exceeds that of the nation as a whole (9.6 percent), as well as that of many other racial groups. A study of two urban Indian health clinics found that diabetes was among the top five reasons for health care visits. (Taylor, 1988) Diabetes kills roughly four times as many American Indians and Alaska Natives as it does members of the U.S. population at large. (IHS, 2000) In general, people are more likely to develop type 2 diabetes and die from its complications as they grow older (CDC, 2005), a pattern that is even more pronounced among American Indians and Alaska Natives. (IHS, 2000)

Between 1990 and 1999, diabetes was the fifth leading cause of death for American Indians and Alaska Natives living in counties served by urban Indian health organizations. Among this population, the diabetes death rate was 32 per 100,000 and significantly higher than that of the general urban population. In addition, between 1990 and 1999 diabetes-related mortality increased at a faster rate among American Indians and Alaska Natives than among the general urban population. (Urban Indian Health Institute, 2004)

A special initiative was started in 1999 to address diabetes among American Indians. Through improvements in education, prevention and treatment, the initiative has not only raised awareness, but it has likely prevented deaths and disabilities among patients. Urban Indian health organizations are a part of this initiative and have been successful in reaching urban Indians. Preliminary data for the period 2000 to 2005 show significant improvements in most urban areas. This initiative proves the value of targeted interventions and the ability of community-based organizations to better serve hard-to-reach populations like urban American Indians and Alaska Natives. But with many urban Indians already afflicted with diabetes, more steps must be taken.

Cardiovascular Disease

Cardiovascular disease is the leading cause of death among American Indians and Alaska Natives. It kills more American Indians and Alaska Natives age 45 and older than cancer, diabetes and unintentional injuries—their second, third and fourth leading causes of death—combined. (IHS, Trends in Indian Health, 2000-2001) Diabetes raises the risk of stroke. The American Indian and Alaska Native stroke-related death rate due to diabetes is more than triple that of the general population. (Galloway, 2002) Perhaps even more troubling, obesity, physical inactivity and high blood pressure—all risk factors for cardiovascular disease—are growing problems among American Indian and Alaska Native youth.

Studies show that contrary to trends among other U.S. racial and ethnic groups, cardiovascular disease rates continued to rise among American Indians. (Howard et al., 1999) Up to 25 percent of American Indian men ages 45 to 74 have signs of heart disease. (Ali et al., 2001) New cases of coronary heart disease (chest pain and/or heart attack) among American Indians are nearly twice that of the general population. (Howard, et al., 1999)

Studies show that coronary heart disease, high blood pressure and stroke are disproportionately prevalent among American Indians and Alaska Natives. (AHA Statistics Committee and Stroke Statistics Subcommittee, 2007) They have substantially higher rates of coronary heart disease than whites and many other racial and ethnic groups. (Galloway, 2005)

Heart disease, like diabetes, is an expensive and time-consuming condition to treat. Often, heart disease accompanies diabetes, making treatment even more complicated and expensive. For urban Indians, access to both diagnostic tests and specialized cardiac care cannot be assured due to poverty, lack of insurance and the limitations of urban Indian health organization services. The current UIHO network is an incomplete system offering only preventative and primary health care, which limits the ability of urban Indians to receive adequate and timely treatment of cardiovascular problems.

CONCLUSIONS AND RECOMMENDATIONS

These findings illustrate the depths of the urban Indian health crisis. Decades of neglect have placed urban Indians at greater risk of unnecessary death and disability. Although the United States continues to work to address racial and ethnic disparities in health care, American Indians and Alaska Natives

living in this country's cities have been mostly invisible in these strategies. Special attention must be paid to make sure they are included in future initiatives. Without informed dialogue and targeted action, the health of urban Indians will continue to decline. To that end, the Urban Indian Health Commission offers the following recommendations.

- **Demographics:** Although federal Indian policy favors resources for Indian tribes and those living on Indian reservations, shifts in populations and findings from health disparities research confirm that public and private sector efforts to improve health care quality and reduce disparities must assist and recognize Indians living cities.
- **Best Practices to Improve the Quality of Care and Reduce Disparities:** Build upon and implement interventions for improving urban Indian health care; expand the information technology capacity of Urban Indian Health Organizations (UIHOs) and others who provide care for urban American Indians to help improve clinical performance and serve as a platform for data collection; establish and support initiatives like the Special Diabetes Program for Indians for other conditions, such as cardiovascular disease, depression and other major health problems; help clinical systems employ tools like the Chronic Care Model, where applicable; and implement culturally specific best practice prevention interventions, such as the use of traditional healers, talking circles and community events, where applicable.
- **Data for Performance Measurement, Public Reporting, Quality Improvement and Research:** Ensure that urban American Indians and Alaska Natives are included in all data collection efforts to improve health care quality such as regional quality improvement collaboratives, regional and national private health plan initiatives and others so that this work measures the quality of care provided to urban American Indians and Alaska Natives, stratifies those measures by American Indian and Alaska Native race and ethnicity, and reports those stratified measures publicly; engage municipal, local, state and federal health officials to ensure that data on the urban Indian population are indeed available; examine new approaches to small population research that would meet scientific rigor and the needs of urban American Indians and Alaska Native people; support increased research activity by and for the urban American Indian and Alaska Native people; and consider the development of urban American Indian and Alaska Native Centers of Excellence.
- **Culturally Competent Quality Care:** Expand the number of Native health professionals by working with local colleges, universities and trade institutions to support Native students; encourage UIHOs to serve as training sites and facilitate collaborative relationships to support this educational role; and support the integration of traditional medicine in health care delivery.
- **Access to Quality Care and Health Services:** Provide technical assistance in building partnerships with local health providers for greater health service access; improve access to public and private health insurance to assure proper uses of health care when needed; educate health officials and policy-makers about the effects of eligibility requirements on insurance enrollment; and help reduce misunderstandings and perceived barriers for urban Indians.
- **Policy and Funding:** Support the Urban Indian Health Program through the Indian Health Service; include urban American Indians and Alaska Natives in national programs dealing with health disparities and minority health initiatives; and encourage efforts to enhance public and private partnerships that can help urban Indians build health access and service capacity.

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