

Health Issues Facing the State's American Indian Populations

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According to 2003 Census estimates, approximately 108,000 North Carolina residents identify themselves as American Indians/Alaska Natives, representing about 1.2% of the state's population.¹ The state's American Indian population is largely represented by eight recognized tribal groups (Coharie, Eastern Band of Cherokee, Haliwa Saponi, Lumbee, Meherrin, Occaneechi Band of Saponi Nation, Sappony, Waccamaw Siouan) and four American Indian Urban Centers (Cumberland County Association for Indian People, Guilford Native American Association, Metrolina Native American Association, Triangle Native American Society).² North Carolina represents the largest state concentration of American Indians east of the Mississippi River.

Limited information available from research studies and publicly available data sources indicate that significant disparities exist for many health conditions in American Indian communities. For example, the prevalence of diabetes and other cardiovascular disease risk factors are substantially higher for North Carolina American Indians compared to whites.³⁻⁵ Diabetes-related complications, such as lower-extremity amputation and end-stage renal disease, have been reported to be three and six times higher, respectively, among the Eastern Band of Cherokee Indians compared to the rate for United State whites.⁶⁻⁷ The diabetes death rate for North Carolina American Indians is three times higher, and the death rates for stroke and heart disease are at least 25% higher, than the rates for non-Hispanic whites.⁸ Other health concerns, such as unintentional

injuries and homicides, are dramatically higher for American Indians compared to whites.⁸ These conditions lead to higher rates of premature mortality; the average years of potential life lost per death (YPLL) in North Carolina is 22.2 for American Indians, compared to 15.2 for whites and 20.5 for African Americans.⁹

Disparities in Health Are Linked to Socio-economic Status

These disparities are believed to be reflective to a large extent of the significant socio-economic burden in many American Indian communities. Nearly one-quarter of North Carolina American Indians live below the poverty level, and rates of unemployment are at least two to three times higher in this population compared to whites.¹⁰ About three-quarters of American Indians in the state have a high school education or less, compared to 56% of whites.⁸

Access to healthcare is a major concern in American Indian communities. Only one of the eight tribal groups in the state, the Eastern Band of Cherokee Indians, is authorized to provide healthcare through the Indian Health Service (IHS). However, barriers such as limited resources and inadequate transportation for many tribal members still exist that limit effective appropriation of healthcare. Statewide, American Indians are twice as likely to report that they have no healthcare coverage, and to report they

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were unable to see a doctor in the past year due to costs. Approximately 38% of pregnant American Indian women do not access prenatal care during the first trimester, compared to 18.4% for whites and 21.8% overall.¹¹ Inadequate healthcare among North Carolina American Indians is likely due, in addition to the high rates of poverty in these communities, to other barriers. For example, nearly 70% of North Carolina American Indians live in rural communities,⁸ where access to high-quality healthcare may be difficult. Cultural factors may also contribute to reluctance by American Indians to access the available healthcare system.

Limited Data

Much is still unknown about the health and healthcare of American Indians in North Carolina. One of the more significant gaps in our understanding is the limited information on the health of American Indian children. Maternal risk factors are very high among American Indian mothers, and the infant mortality rate for American Indian children is higher than the state rate. The asthma hospitalization rate for American Indian children in 1997 was reported to be nearly three times the rate for white children.⁸ There is no information currently available on Type II diabetes among American Indian adolescents. This condition is documented as being on the increase among ethnic minority adolescents in general, and among American Indian adolescents in particular.¹² Data on chronic disease risk factors among American Indian children, such as obesity, physical inactivity, harmful tobacco use, and inadequate diet, are not readily available.

Another gap in our understanding of American Indian health in North Carolina is the lack of tribal-specific data. The eight recognized tribal groups in the state are divided not only by geography, but also by unique elements in culture and history. Much of the data on health and healthcare among North Carolina American Indians comes from one tribe, or is not segmented by tribal group, which limits our ability to interpret this information for every tribe. Some tribes are relatively small, and some do not have organized tribal rolls, making research efforts difficult in these communities.

Cultural Differences

Culture is a significant but often overlooked contributor to health and healthcare in the United States. Culture can influence lifestyle behaviors, attitudes toward health, living arrangements, and receipt of healthcare. The extent to which culture, relative to other factors, such as socio-economic status, contributes to the observed disparities among American Indians in North Carolina is not well understood. Similarly, little is known about whether

racism influences health, health behaviors, and healthcare for North Carolina American Indians.

North Carolina Commission on Indian Affairs

The North Carolina Commission on Indian Affairs, created in 1971 by the North Carolina General Assembly, has been instrumental in advocating for issues related to American Indian health. The Commission was instrumental in organizing three statewide American Indian Summits since 2001. The goals of these conferences have been to raise awareness of the health needs of American Indians, develop and implement healthcare best practices guidelines, and to develop networking opportunities for healthcare providers and organizations interested in healthcare. The Health Committee of the Commission has also been instrumental in identifying and participating in research and health priorities for American Indian communities. These priorities include an initiative to provide diabetes education in American Indian churches and anti-smoking cessation efforts targeting American Indian youth.¹³

American Indian Health Task Force

The American Indian Health Task Force has been developed as a collaboration between the North Carolina Department of Health and Human Services, the Office of Minority Health and Health Disparities, and the North Carolina Commission on Indian Affairs. The Task Force was initially convened in July 2004. The Task Force is represented by a diverse group of healthcare providers, administrators, and academicians from across the state and from various American Indian tribes. This Task Force is charged with developing recommendations to address the health disparities of North Carolina's American Indian population. This Task Force is examining issues related to the availability of health-related data, sovereignty and governmental issues, and access to prevention and care services.

Conclusion

Despite substantial gaps in our understanding, the existing information available point to significant health disparities for North Carolina American Indians. Chronic diseases such as diabetes and cardiovascular diseases, and other concerns such as unintentional injury and homicide, contribute substantially to these disparities. The causes of these disparities are more than likely multi-faceted, but our understanding of these factors is limited. On-going efforts in the state involving numerous agencies will hopefully address these gaps and reduce the health burden in this population. **NCMJ**

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**Caregivers
Don't Need
To Do This Alone!**

- Significant increase in the number of persons providing care to a friend or family member age 60 or older from 2000 to 2003
- Over 25% of adult North Carolinians now provide care to an older friend or relative
- Almost half of those receiving care are reported to have memory loss or dementia

Many people need the support of others who are in similar situations or perhaps the support of a professional. They may need education on caregiving issues. Caregivers may need respite or a "time-out" from their caregiving duties. Seeking information on what services are available and assistance to help connect with these services can be an important first step.

North Carolina Family Caregiver Support Program
<http://www.dhhs.state.nc.us/aging>