Native American Children Also Live in Our Communities

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ABSTRACT

Increasing urbanization of Native Americans will bring community health practitioners into contact with a patient population that has potentially different cultural orientations and with individuals in difficult general health and living conditions. Pediatric providers will be faced with a population of youngsters, a greater percentage of whom will have disabilities than the general pediatric population. The challenge will be to meet the "usual" oral health needs of community youngsters—family members whose heritage and culture may be quite different from those of the practitioner and staff. (*J Dent Child*. 2005;72:39-42)

KEYWORDS: NATIVE AMERICANS, ACCESS TO CARE, DEMOGRAPHICS

NUMBER AND RESIDENCE

One million, four hundred thousand children (under 18 years old) were identified as American Indians and Alaskan Natives in the 2000 Census.[1] Approximately 29% of all Native American children lived on the 619 reservations and in Alaskan Native Villages. The largest of these lands, the Navajo reservation, overlaps the boundaries of 3 states (Arizona, New Mexico, and Utah) and is about the size of the State of West Virginia. In 2000, there were 73,000 Native American children living on this reservation.

The Lumbee American Indian Statistical Area in North Carolina (with about 20,000 children) was the only reservation east of the Mississippi. Almost 70% of American Indian children live in states west of the Mississippi River. (Note: The Census enumeration was more complex in 2000 than in earlier decades). Respondents were instructed to mark all races that applied to indicate their racial identity. Historically, Native Americans have had high rates of intermarriage with other groups, mostly whites and African Americans. Also, a relatively larger number of Native American children identified with multiple groups. The number of Native Americans that reported only one race was 840,000 individuals.[1]

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NATIVE AMERICAN CHILDREN BY STATE

The residence of Native American children (including children of single or racial combinations) range from almost 1,000 in the District of Columbia and nearly 2,000 in Delaware and Vermont, to more than:

1. 25,000 children in Alaska, Colorado, Florida, Michigan, Minnesota, Montana, Oregon, South Dakota, and Wisconsin;
2. 50,000 children in New York, Texas, and Washington;
3. 100,000 children in Arizona and Oklahoma;
4. 200,000 children in California.[1]

NATIVE AMERICAN CHILDREN BY CITY

Only 8 cities with large numbers of Native American children are located east of the Mississippi River. Among the country's largest cities, the number of American Indian child residents range from:

1. approximately 1,500 in San Francisco and Boston;
2. between 2,000 and 5,000 in 26 cities;
3. more than 10,000 in Anchorage, Alaska, more than 12,000 in Phoenix, Ariz, almost 16,000 in Los Angeles, and more than 27,000 in New York City.

NATIVE AMERICAN CHILDREN BY COUNTY

While most counties have few Native American children, 25 counties have relatively large numbers of these child residents, including:

1. more than 7,000 in the following counties: Pierce, WA, Bronx, NY, and Fresno, CA;
2. between 8,000 and 10,000 in the following counties: Queens, NY, Harris, TX, Bernalillo, NM, and King, WA;

3. more than 25,000 in 4 counties: Apache, Navajo, and Maricopa in Arizona, and McKinley, NM;
4. almost 44,000 in Los Angeles County, CA.[1]

In effect, 71% of all American Indian and Alaskan Native children do not live in reservations or native villages, but rather in general population communities throughout the country. In 2000, almost two thirds (65%) of Native Americans lived in metropolitan areas.[2]

SOCIAL AND HEALTH STATISTICS

A series of government reports provide a general perspective of the social and health demographics of Native American families. For example, in the late 1990s, compared to the general population, a greater proportion of Native Americans:

1. had fair or poor health (24% vs 15%);
2. were obese (34% vs 19%);
3. smoked (32% vs 22%);
4. lacked leisure time physical activity (33% vs 28%);
5. binged drank (consumed 5 or more alcoholic drinks on one occasion; males=24% vs 22%; females=9% vs 7%).[3]

Compared to other minority populations, (in 2001-2002), Native American males and females reported a greater prevalence of obesity, smoking, cardiovascular diseases, high cholesterol, hypertension, and diabetes. (Note: an exception was a greater prevalence of high cholesterol and hypertension reported by female black respondents.[4])

In addition, available information on death certificates provides general information on some health and social factors during an individual's life. For example—compared to the general population—for Native Americans living in Indian Health Service areas, the death rate related to:

1. alcoholism was 627% greater;
2. tuberculosis was 533% greater;
3. diabetes mellitus was 249% greater;
4. accidents were 204% greater;
5. suicide was 72% greater;
6. pneumonia and influenza was 71% greater;
7. homicide was 63% greater.[5]

AVAILABILITY OF HEALTH SERVICES

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing health services to federally recognized American Indian and Alaskan Native tribal governments. The IHS is the primary source of health services for 55% of the estimated 2.4 million Indian people. The majority of the population served by the IHS lives on or near reservations in some of the most remote and poverty stricken areas of the country. Urban Indian health programs provide limited services to more than 150,000 Indians living in 34 cities. The IHS provides services in a network of care facilities in 35 states through 49 hospitals, 214 health centers, 280 health stations, satellite clinics, and Alaska village clinics operated by the IHS and tribes.[6] However, "... access to dental care is limited because of a dental workforce crisis: approximately 22% of the dentist positions in the IHS are vacant."[7]

In particular, Native Americans have "... less health insurance coverage and worse access and utilization (of health services) than whites. Over half of low-income uninsured (Native Americans) did not have access to the IHS."[8] In 2000, compared to the general population, Native Americans had a significantly lower physician visit rate (118 visits per 100 persons vs 370 visits per 100 persons).[9] (Note: limited information is available regarding the general and oral health status of the Native Americans not served by the IHS.[10])

CHILDREN LIVING IN POVERTY

In 2000, 17% of US children were living below the federal poverty threshold. The proportion of Native American children living in poverty was greater than the national average in 22 of the 23 major American Indian and Alaskan Native tribes and tribal groups (only the children in the Aleut had a lower poverty rate–13%). The child poverty rate was 40% or more in 6 Native American tribes, reaching 48% in the Tohono-O'Odam tribe (almost triple the national average; Table 1).

Nationally, 38% of the children lived in low-income families (those with incomes below 200% of the national average). In each Native American tribe (except the Aleut tribe), a greater percentage of children lived in low-income families. The proportion of children living in low-income families was more than 70% in Apache, Navajo, and Sioux tribes, and approximately 80% in Cheyenne and Tohono O'Odham tribes (Table 1).

HIGH SCHOOL DROPOUTS

In 2000, 10% of US teenagers between 16 to 19 years old had dropped out of high school. Compared to the national average, a greater percentage of teenagers in 20 of 23 tribes and tribal groups were high school dropouts, including youngsters in 5 tribes with double or almost triple the national rate (highest for the Cheyenne tribe–27%; Table 1).

CHILDREN WITH DISABILITIES

The Census Bureau reported that in 2000, 6% of US children between 5 to 15 years old (approximately 2.6 million children in nonresidential facilities) had 1 or more disabilities. Twenty-one thousand American Indian and Alaskan Native children with disabilities were included in this total.[1] The proportion of children with disabilities was greater than the national average in 19 of the 23 major American Indian and Alaska tribes and tribal groups (highest for the Iroquois, 11%, and Blackfoot, 15%). The number of children with disabilities ranged to highs of 3,580 Navajo and 4,549 Cherokee youngsters (Table 1).

ORAL HEALTH

Substantial unmet dental needs have been identified among Native Americans:

1. 78% of children aged 2 to 4 years had a history of dental decay[7];
2. approximately 4 times as many American Indian preschool-age children experienced dental disease, compared to all US children in this age group;
3. while 70% of US preschool children had a dental visit, only about one quarter of American Indian children had an annual visit;

Table 1. Selected Profile Demographics of Major Grouping of American Indian and Alaskan Native Children in the 2000 Census[1,9]

	<18 ys living in poverty	<18 ys in low income family	16-19 ys high school dropout	5-15 years with 1 or more disabilities	
				Proportion	No.
Total US child population	17%	38%	10%	6%	2.6 million*
Tribes and tribal groupings†					
Athabaskan	20	54	14	6	206
Aleut	13	34	9	6	172
Apache	41	74	15	8	981
Blackfoot	26	64	21	15	829
Cherokee	22	51	13	10	4,549
Cheyenne	43	80	27	7	164
Chickasaw	22	45	16	8	321
Chippewa	30	58	18	8	1,918
Choctaw	23	51	11	7	1,271
Comanche	20	58	13	9	153
Creek	25	52	10	8	666
Eskimo	23	55	16	4	461
Iroquois	22	52	20	10	900
Lumbee	25	57	17	8	803
Navajo	41	72	15	5	3,580
Potawatomi	17	38	10	6	218
Pueblo	33	64	18	5	571
Puget Sound Salish	27	60	10	6	210
Seminole	35	62	12	9	227
Sioux	47	74	19	7	2,067
Tlingit-Haida	19	49	5	6	205
Tohono O'Odham	48	80	19	8	364
Yaqui	41	68	18	6	230
Total no. of children with disabilities by tribes and tribal groupings					21,066

**Children in nonresidential care facilities.*
†Data for respondents who selected only 1 tribe or tribal grouping.

4. caries experience in 6- to 8-year-olds is approximately 2 times higher than for all US children. Significant differences exist in dental caries experienced in adolescent American Indian children and US children[10,11] (Table 2);

As for Native American adults:

1. 68% of adults and 56% of the elderly had untreated dental decay;
2. 54% of adults (35 to 44 years) and 84% of the elderly had periodontal disease.[7]

Table 2. Proportion of Children With Untreated Dental Decay (1988–1994, 1999)[12,13]

	2-4 ys	6-8 ys	15 ys
American Indian or Alaskan Native (IHS areas*—1999)	67%	69%	67%
Total US child population (1988-1994)	16%	29%	20%

**Indian Health Service areas.*

NEEDY NATIVE AMERICAN CHILDREN IN OUR COMMUNITIES

Many of the nearly two thirds of American Indians living in metropolitan areas lack needed health services. For example, California is now home to more American Indians than any other state[14] and "... urban American Indians, California's fastest-growing ethnic group, overwhelmingly lack medical insurance and lack the access to health services that other

ethnic groups often have ..."[15] Nearly 45% of urban American Indians "... lacked health insurance, limiting the number of physician visits and encouraging postponement of medical attention for children."[15]

In addition:

1. IHS health services available on reservations are nearly nonexistent in urban areas where most California American Indians live, often in poverty. Approximately 20% of California urban American Indians live in poverty.
2. "Urban Indians also fear being looked down upon for participating in public health programs and confronting health workers who are ignorant of American Indian culture."[15]

CONCLUSIONS

The swelling urbanization of Native Americans[16] will increasingly bring community health practitioners into contact with a patient population that has potentially significant different cultural orientations as well as individuals in difficult general health and living conditions. Furthermore, pediatric providers will be faced with a growing population of youngsters, a greater percentage of whom will have disabilities than the general pediatric population. The challenge will be to meet the "usual" oral health needs of community youngsters—family members whose heritage and culture may be quite different from that of the practitioner and staff.

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