Beyond Socioeconomic Factors to Health Equity for Urban American Indians and Alaska Natives

Urban Indian Health Institute
A Division of the Seattle Indian Health Board

INTRODUCTION

American Indians and Alaska Natives (AI/ANs) living in urban areas continue to struggle with high disease rates and health risks despite national efforts to address health disparities. Urban AI/ANs also have high rates of poverty and unemployment, and low rates of education and health insurance. However little is known about the impact of these socioeconomic factors on health indicators for this population.

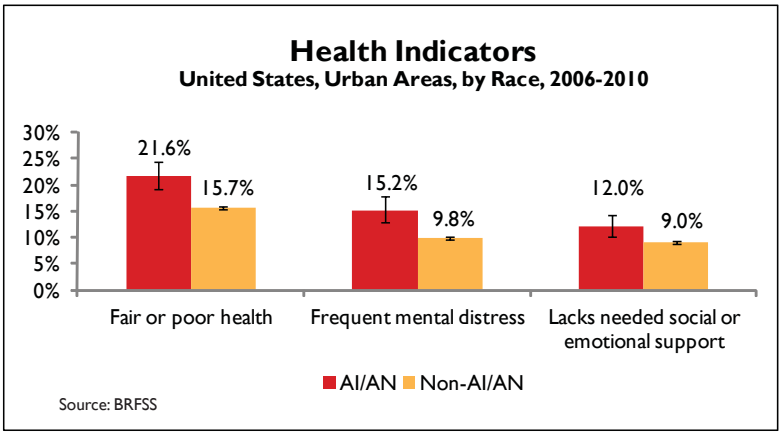
This fact sheet includes select findings from a study of health indicators among urban AI/ANs including mental distress, social support and overall self-reported health status, and the impact of poverty, education, employment and health insurance on these factors. A comprehensive report of study findings will be forthcoming.

STUDY QUESTION

How much do socioeconomic factors impact rates of mental distress, social support and overall self-reported health status for urban AI/ANs compared to non-AI/ANs?

STUDY RESULTS

Urban AI/ANs have higher rates of reported fair or poor health, frequent mental distress and gaps in needed social and emotional support compared with non-AI/ANs (See graph). Similar to the national picture, the urban AI/AN sample examined is also younger, has higher rates of poverty and unemployment, and lower rates of health insurance and education than the non-AI/AN sample.



IMPACT OF SOCIOECONOMIC FACTORS

Looking at these health indicators among people of the same age, sex and marital status:

- Disparities remain for mental distress and fair/poor health between urban AI/ANs and non-AI/ANs with the same health insurance status.
- Although the disparity is less, rates of mental distress remain 39% higher for urban AI/ANs with the same poverty, education and employment status as non-AI/ANs.

CONCLUSIONS

Study results indicate that factors beyond socioeconomic status (SES) as measured in these data may play a significant role in the health of urban AI/ANs. Examples like job opportunity, educational quality, neighborhood and long-term wealth would provide a more comprehensive picture. However, removing SES barriers alone may not alleviate the inequities seen in rates of mental distress. In addition to discrimination and chronic stress, shown to impact health disparities, the unique cultural and historical experience of urban AI/ANs should be considered by health care professionals, program providers and policy-makers in efforts to address health inequities in this population.

STRATEGIES FOR ACHIEVING HEALTH EQUITY AMONG URBAN AI/ANs

- Understand and incorporate the unique health and social needs of urban AI/ANs into allocation of funds, training, programming and care.
- Increase funding to urban Indian health organizations, which provide more than healthcare to AI/ANs living in cities nationwide by offering connection to community and culture (More information on back page).
- Improve data for urban AI/ANs by including community at all levels of research, planning sufficient sample size in national surveys, and examining contextual factors that impact health disparities.

FACT SHEET: BEYOND SOCIOECONOMIC FACTORS FOR MORE INFORMATION VISIT WWW.UIHI.ORG

STUDY DESCRIPTION

A sample of 291,090 adults from 2006 – 2010 were drawn from the Behavioral Risk Factor Surveillance System (BRFSS); a nationally representative household-based telephone survey conducted by the Centers for Disease Control and Prevention. More about BRFSS may be found at www.cdc.gov/brfss. The urban areas analyzed included 96 counties from 19 states, which are served by one of 34 Title V urban Indian health organizations (UIHO) for which national BRFSS data were available. American Indians and Alaska Natives in our study include anyone who reported AI/AN as their only race or the race that best describes them. There were a total of 3,342 AI/AN and 287,748 non-AI/AN respondents from the selected urban areas. Socioeconomic factors examined included poverty, education and employment together and separately health insurance.

REFERENCES

Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010. Accessed by UIHI April 2012.

Urban Indian Health Commission. Invisible Tribes: Urban Indians and Their Health in a Changing World. Seattle: Urban Indian Health Commission, 2007.

Williams DR, Mohammed SA. Discrimination and Racial Disparities in Health: Evidence and Needed Research. Journal of Behavioral Medicine, 32(1): 20-47, 2009.

URBAN INDIAN HEALTH ORGANIZATIONS (UIHO)

UIHO are not-for-profit community health centers established through Title V of the Indian Health Care Improvement Act and receive funding through the Indian Health Service. Through a network of 34 organizations, UIHO play a fundamental role in providing culturally appropriate clinical, outreach and referral services to urban AI/AN communities, nationwide. UIHO provide either direct or referral services to AI/ANs living in 100 select urban counties in 19 states across the country.

To learn more about UIHO visit the UIHI webpage:
http://www.uihi.org/urban-indian-health-organization-profiles/

URBAN INDIAN HEALTH INSTITUTE (UIHI)

One of 11 tribal epidemiology centers, the UIHI focuses on the nationwide urban AI/AN population while the other 10 serve tribes regionally. The mission of UIHI is to support the health and well-being of urban Indian communities through information, scientific inquiry, and technology. UIHI staff work on multiple, ongoing research projects serving the network of UIHO and urban AI/ ANs. nationwide. To learn more about the work of the UIHI, visit our website: www.uihi.org

CONTACT US

We welcome your feedback, questions, thoughts and suggestions. Please contact at info@uihi.org or 206-812-3030.