Health Behavior and Health Needs of Urban Indians in Minneapolis

WILLY De GEYNDT, PhD

IN A SPECIAL message sent to Congress in July 1970 (*1*), President Nixon described the Indians as "the most deprived and most isolated minority group in our nation" (*1a*). Because this study focuses on the health behavior and health needs of urbanized Indians, I quote the passage of the President's message which deals with this problem (*1b*):

> . . . Indians living in urban areas have often lost out on the opportunity to participate in other programs designed for disadvantaged groups. . . . The biggest barrier faced by those Federal, State, and local programs which are trying to serve urban Indians is the difficulty of locating and identifying them. Lost in the anonymity of the city, often cut off from family and friends, many urban Indians are slow to establish new community ties. Many drift from neighborhood to neighborhood; many shuttle back and forth between reservations and urban areas. Language and cultural differences compound these problems.

Minneapolis has been called "Minnesota's largest reservation" and has the second or third largest urban concentration of American Indians in the country. In this study, carried out in January 1971, my consultant and I examined and analyzed the behavior, attitudes, needs, and preferences toward health and health care services delivery of the Minneapolis Indians. The specific objectives of the study were to (*a*) collect demographic and socioeconomic information, (*b*) trace the Indians' mobility patterns, (*c*) describe the patterns of use of medical and dental care, (*d*) identify the major social problems as perceived by Indians, and (*e*) probe the Indians' attitudes about health clinics and financing of health services.

To accomplish these objectives, we made a survey using a structured questionnaire and a multistage sampling technique. The questionnaire was developed with advice and direction from an Indian consultant, and three Indian women conducted the interviews.

The total sample consisted of 291 households. Of these, 225 respondents representing 77.3 percent of the households were interviewed; 47 (16.2 percent) had changed addresses and could not be located, and 19 spokesmen from 6.5 percent of the households were unwilling to be interviewed. The analysis of the results of the survey was structured according to socioeconomic factors, patterns of mobility, patterns of health care utilization, social problems, and attitudes about health care services.

Socioeconomic Factors

One hundred and twelve households, or 49.8 percent, received support from a welfare program. Two welfare programs supported 105 of the 112 households, namely, Aid to Families with Dependent Children (92 households) and relief or general

Dr. De Geyndt is executive vice president, Minnesota Systems Research, Inc., Minneapolis, and assistant professor, program in hospital and health care administration, School of Public Health, University of Minnesota. Tearsheet requests to Minnesota Systems Research, Inc., 2412 University Ave., SE., Minneapolis, Minn. 55414.

assistance (13 households). Three households received Old Age Assistance, one was supported by Aid to the Disabled, and one by Aid to the Blind. In 96 households no man 21 years of age or over was present.

Following the advice of the Indian consultant, questions dealing with employment status, household income, and home ownership were asked only of spokesmen for the 113 households which did not receive welfare support. In 103 (91.1 percent) of these 113 households, at least one person was employed at the time of the interview. Employment, however, included both full- and part-time employment, and of the 103 household spokesmen who reported employment, only 58 reported full-time, year-round work, and an additional 17 reported both full- and part-time work.

Cumulatively, 27.4 percent had a yearly income of $3,000 or less, 38.9 percent had $4,000 or less, 50.4 percent had $5,000 or less, and 64.5 percent had $6,000 or less. Twenty-eight households of the 113, or 24.75 percent, earned more than $6,000 per year, and 12 (or 10.6 percent) refused to report their income. If it is assumed that persons who do not report their incomes are most frequently in the low income category, at least one-third of those households which did not receive support from a welfare program had yearly incomes of less than $3,000.

A cross tabulation of income compared with employment showed that the 101 spokesmen who reported on income were essentially the same as the 103 spokesmen who reported that at least one person in the household was employed. Stated differently, the households with no one employed at the time of the interview were those with respondents who did not report their income. Only 17 (15 percent) of the 113 nonwelfare households owned their home, and the others rented their dwelling.

The mean number of years of school completed by all persons in a household who were 18 years of age or over was 10.14 years. The median number was 9.89 years. The relationship between low income, unemployment, low educational level, and almost no home ownership is obvious.

The median number of persons living in the same dwelling was 2.85 for the 225 respondents, and 105 (46.7 percent) of all households included children who attended school. The average family size for the nation is 3.66. Thus, the average Indian household in Minneapolis was smaller than the national average.

Each respondent was asked whether he or she had a car available during the day. Only 29 percent answered "Yes," and 71 percent answered "No." This question was asked because the availability of private transportation may affect the accessibility to health care. These two variables are linked in a subsequent section on patterns of use of medical and dental care.

We also wanted to know whether the respondent had a driver's license; that is, even if a car were available during the day, whether the person at home during the day would be able to use it. Of all respondents, 66 percent did not have a driver's license, and 34 percent did. Linking the availability of a car and the possession of a driver's license, we noted that 10 of the 65 respondents who had a car available during the day did not have a driver's license (15 percent). Thus, the majority of the respondents did not have the use of a car during the day and, of those who did, 15 percent did not have a driver's license.

To the question whether anyone who lived in the same dwelling had health insurance or health coverage of any kind, 50.2 percent responded "Yes," and 49.8 percent answered "No." However, it was equally important to know how many persons were covered by health insurance in each household. In 29.2 percent of the households in which a resident had health insurance only one person was covered, and in 16.8 percent two persons were covered. The median number of persons covered by health insurance in a household was 1.89.

The 113 households that carried health insurance were covered by group insurance at work (41.6 percent), medical assistance programs (37.2 percent), Blue Cross-Blue Shield (14.2 percent), and by other programs (7.1 percent). Of the 103 households with at least one employed person, 59 (57.3 percent) were covered by health insurance. Of 112 respondents who reported receiving welfare support, 61 (54.5 percent) were not covered by health insurance.

Mobility Patterns

Mobility patterns in this study refer to (*a*) moving from one dwelling to another within Minneapolis, (*b*) length of residence in Minneapolis, and (*c*) leaving Minneapolis to live in one's hometown for at least seven successive days during the past year. Thus, we tried to estimate the magnitude of movement within the city and the movement of Indians to their hometown for short periods.

The median period that the 225 interviewees had lived at their current address the day of the interview was 1.11 years. At least one of four households had lived in their present living quarters for less than 6 months. These findings indicated that urban Indians moved within the city approximately once a year.

Does a relationship exist between length of residence in the same dwelling and income? Keeping in mind that income information was obtained only from 113 persons who are not supported by a welfare program, we learned that households living in the same dwelling less than 6 months had a median yearly income of $3,143. For those who lived in the same house or apartment for 6 months to 1 year, the yearly median income was $4,000; for residents of 1 to 2 years, $5,500; for residents of 2 to 5 years, $5,400; for those who had lived for more than 5 years in the same dwelling, the median income was $6,750. The overall yearly median income was $4,500.

These results suggested a positive relationship between income and length of time in the same residence, that is, the shorter period of residence, the lower the household income was likely to be. For households receiving support from welfare programs, the median length of residence in the same dwelling was lower than for the employed group, that is 11.64 months.

The median length of residence in Minneapolis for all interviewees was 8.95 years. Only 4 percent of the respondents had lived in Minneapolis for 1 year or less.

The welfare group differed only slightly from the nonwelfare group. Those on welfare lived in Minneapolis an average of 8.8 years; those not on welfare 9.48 years. A positive relationship existed between median income and length of residence in Minneapolis: the longer the residents had lived in Minneapolis, the higher the household income was likely to be.

It was commonly believed that one cultural pattern of the urbanized Indians in Minneapolis was going to their hometown for brief periods. The interviewers inquired whether anyone in the household who was over 18 years of age had visited his hometown during the past year for a period of a week or more. The question was asked to (*a*) estimate the magnitude of mobility between the city and the hometown and (*b*) study the impact of this mobility, if any, on the continuity of health care.

Of the persons interviewed, 32 percent stated that a member of the household over 18 years of age had gone to a hometown during the past year for 1 week or more. Thus, even though the time period stipulated was short, only one-third answered the question affirmatively. An analysis of this subset of 32 percent shows no substantial difference from the rest of the sample, except that the subset had lived in Minneapolis for a median period of 7.38 years as compared with 8.95 years for the total sample.

The Indian consultant and I had hypothesized greater mobility of the urbanized Indian than the study verified. We were surprised to learn that 72.5 percent of the sample had lived in Minneapolis more than 5 years and that only one-third of the households indicated some relationship to the reservation. Even the once a year change of address within the city had been believed to be higher, although in absolute terms moving annually is indicative of social, economic, and cultural problems.

Health Care Utilization Patterns

Use of health care services focused on medical care, including obstetrical and dental services. In 83.1 percent of the 225 households someone received medical treatment during the past year. If the nonrespondents are omitted, the percentage for all respondents was 88.21 percent. Thus, in nine of 10 households someone had received medical care during the previous year. It must be stressed that this refers to persons living in the respondent's household and does not mean that nine of 10 Indians received medical care in the past year.

In almost all instances this care was received in the Twin Cities area (91.6 percent). Only 18 respondents reported that someone in the household had received medical care outside this area.

The primary sources of care were the Hennepin County General Hospital emergency room and outpatient department (40.4 percent). The second most important source of care was a private clinic or a physician's office (21.8 percent), closely followed by the "other " category (19.1 percent). The other category included Public Health Service clinics, Pilot City Health Center (a neighborhood health center), and other governmental health care facilities. The fourth source of care reported (16.4 percent) was the emergency room or outpatient department of other hospitals. The remaining 2.2 percent did not answer this question.

These findings can be summarized as follows.

In approximately one of five households the most recent medical care was received in a private clinic or physician's office, in three of five households it was obtained in emergency rooms or outpatient departments, and one of five households went to government-supported clinics or health centers.

We hypothesized that the availability of a car during the day may affect the utilization pattern of sources of care. Household members to whom a car was available during the day went more frequently to a private clinic or a physician's office for medical care (27.7 percent) than persons without the use of a car (19.5 percent). Those with a car went less frequently to an emergency room or an outpatient department (50.77 percent) in contrast to 59.12 percent for those without a car.

The use of government-supported clinics and health centers remained the same. The rank of sources of care in terms of their relative importance remained the same. However, a significant shift occurred in the absolute importance of the two major sources of care, dependent upon the availability of private transportation during the day. More private clinic or physician's office visits and fewer emergency room or outpatient department visits were made when private transportation was available during the day.

Maternity Care

Seven of 10 households reported that someone living there had had a baby (161 or 71.6 percent). Three of 161 expectant mothers did not receive care during pregnancy. Of the 158 women who received prenatal care, 95 percent received it in the locality of their residence before pregnancy and 5 percent did not.

All mothers received care during the delivery: 88.5 percent received prenatal and obstetrical care in the locality of their residence before pregnancy, 7 percent were not delivered where they lived before pregnancy and received prenatal care, and 3.8 percent gave birth in the same locality where they received their prenatal care but did not live before pregnancy. The maternity care patterns can be summarized as (*a*) almost all pregnant women received at least some prenatal care, (*b*) all received medical care during delivery, and (*c*) generally prenatal and obstetrical care were obtained in the same city or town.

Dental Care

The interviewees were asked when was the last time anyone in the household had received dental care. The nonresponse rate was higher for this question than for any other in the questionnaire (15.1 percent). Excluding nonrespondents, in three of five households (60.2 percent) someone had received dental care in 1970, approximately one of six (16.2 percent) in 1969, and slightly more than one in five in 1968 or before (21.5 percent). Four respondents (2.1 percent) stated that no one in their household had ever received dental care. Thus, in one of four households no one had received dental care in the past 2 years.

What type of dental work was performed for persons who received dental care? The most prevalent type among this population was tooth extractions (29.7 percent) closely followed by tooth filling (29.2 percent). If the percentage of the combination "extracted and filled" (5.2 percent) is added to these two figures, two of three visits to a dentist are for tooth extraction or tooth filling. The third most frequent type of dental work is lumped under "other" (26.4 percent) and includes crown and bridge work, X-rays, checkups, orthodontics, and dentures. These three types of dental work account for nine of 10 dental visits (90.6 percent).

The type of dental care described by the respondents is different from the national figures on dental visits by type of service, which show that 12.3 percent of all dental visits were for tooth extractions and 29.7 percent for tooth fillings (*2*).

Table 1. Ranking of five problem areas by welfare and employment status

Problem areas	Total sample		Welfare group		Employed group	
	Number	Percent	Number	Percent	Number	Percent
Housing	76	36.7	37	34.6	39	39.0
Clothing	63	30.4	32	29.9	31	31.0
Food	38	18.4	24	22.4	14	14.0
Medical care	22	10.6	9	8.4	13	13.0
Education	8	3.9	5	4.7	3	3.0
Total	207	100	107	100	100	100

For white persons the percentages are 11.1 for extractions and 30.3 for tooth fillings and for nonwhite persons 29.7 percent for extractions and 21.2 percent for tooth fillings.

Social Problems

The interviewees were asked to rank five problem areas in terms of their perceived importance and priority. Of 225 households surveyed, 207 respondents ranked the five listed problem areas, six indicated a nonlisted area as ranking first, five stated that they had no problems, and seven did not wish to answer the question. The problem areas ranked first are housing (33.8 percent), clothing (28 percent), food (16.9 percent), medical care (9.8 percent), and education (3.6 percent).

Do Indians who receive welfare support rank these five problems differently than Indians who are employed? Table 1 compares the ranking of the total sample with the welfare group and with the employed group. Only the first choice or the most pressing problem is tabulated. The order of the five problem areas is identical for the total sample, the welfare group, and the employed group; that is, each group ranked each problem area in the same order of importance. Some minor differences appear between the employed and the welfare groups with respect to the percentages for each problem, especially for food.

Although the ranking of problems by the employed group follows the same pattern as for the welfare group and for the total sample, this is no longer true when the employed group is analyzed with respect to its income level. Table 2 lists the problems which were ranked first by the employed group according to yearly income. Housing is ranked first in three income levels and in the "income not reported" category. In three income levels housing is tied for first place with food, or clothing, or education. Clothing comes first in the $3,000 to $5,000 category and is tied with medical care in the more than $8,000 category.

Table 2. Problem areas ranked first by income level

Yearly income	Problem areas ranked first
Less than $1,000	Housing
$1,000–$1,999	Housing, food
$2,000–$2,999	Housing
$3,000–$3,999	Clothing
$4,000–$4,999	
$5,000–$5,999	Housing, clothing
$6,000–$6 999	Housing
$7,000- $7,999	Housing, education
$8,000 or more	Clothing, medical care

The question was asked: "Does anyone living here need a job?" All interviewees responded, and 70 (31.1 percent) answered the question affirmatively. Because 112 of the 225 households received welfare support, one might have expected a larger number of positive answers to this question.

There are several reasons for the relatively few positive answers. The major reason probably is that the regulations of the welfare system offer no incentive to seek a job. Finding a job means losing welfare benefits and especially health insurance. (Only 57.3 percent of those employed are covered by health insurance.) A second reason may be that the unemployed are not actively seeking a job because no jobs are available because of the state of the economy. In addition, Indians are excluded from certain jobs, and lack of specific skills often disqualifies them for others. Third, one welfare program, Aid to Families with Dependent children, accounts for 83.1 percent of the welfare support. In most such cases no man lives in the household, and the mother takes care of the children. Fourth, some Indians hold seasonal jobs and will say they do not need a job when they are temporarily unemployed.

In answer to the question, "Do you have money to pay for medical care?," 191 (84.9 percent) of the respondents said "No," 10 (4.4 percent said "Yes," 22 (98 percent) answered "Sometimes," and two interviewees declined to respond. Taking the subset of households in which someone needs a job, the percentage of households that have no money for medical care rises to 92.75 percent. Overall, at least eight of 10 households do not have money for medical care. In the ranking of the five problem areas, medical care was ranked first by only one in 10 households, which indicates a low priority for medical care except in a crisis.

In 7.6 percent of the households someone was judged by the respondent to need the services of a physician at the time of the interview, and in 92 percent of the households no one needed to see a physician. The question about dental care drew a different response, and in almost eight of 10 households (77.3 percent) someone was judged to need dental care. If the current need for dental care is compared with the last time dental care was received, in 52.3 percent of the households in which dental care was needed someone received it in 1970, 13.2 percent in 1969, and 18.4 per-

cent in 1968 or before. The others did not report their last dental visit. With respect to school problems for health reasons, one out of three households with children attending school reported school difficulties resulting from health problems such as "bad hearing" or "bad eyesight."

Attitudes About Health Care Services

The interviewees were presented with a number of hypothetical situations to determine their attitudes about places and facilities where they would go for medical care and about paying for the services received. We compared responses to the hypothetical situation questions with actual behavior reflected in response to previous questions.

Except for two persons, all respondents, or 99.1 percent, would seek emergency care in the Twin Cities area. This compares with 91.6 percent who received their most recent medical care in the Minneapolis-St. Paul area; however, the 91.6 percent does not refer only to emergency medical care, and therefore the two answers are not really comparable.

To which health care facility would the respondents go for emergency medical care? The primary source of care would be the emergency room of Hennepin County General Hospital for six respondents in 10 (60.4 percent). In second place as a source of care were the private clinic or the physician's office (17.8 percent) and emergency rooms of other hospitals (17.8 percent). Last, 4 percent would go either to Pilot City Health Center, to a Public Health Service clinic, or to another government health care facility. Combining the first and the third sources of care, 77.7 percent would go to an emergency room of a hospital for emergency medical care.

For emergency medical care 99.1 percent of the respondents said that they would seek it in the Twin Cities, but for future nonemergency medical care the percentage dropped to 88.4 percent. One person did not answer the question, and 11.1 percent stated that they would seek this type of care outside Minneapolis and St. Paul. As mentioned earlier, 91.6 percent received their most recent medical care in the Twin Cities.

The facility where nonemergency medical care would be sought most frequently is the emergency room or the outpatient department of Hennepin County General Hospital, for 41.3 percent of the respondents. This proportion compares with 60.4 percent for emergency care in a hypothetical situation and with 40.4 percent for actual behavior evident from place most recent care was received. Excluding the persons who did not respond to these questions, the percentages are 44.3 for nonemergency medical care, 60.7 for emergency medical care, and 41.4 for actual care received.

The percentages for actual behavior and expressed attitudes are close. Two of five respondents receive ambulatory medical care at Hennepin County General Hospital and two of five would go there. The hypothetical situation presented to them does not in reality allow a choice. First, other sources of care are not available, accessible, or acceptable to many respondents and therefore are not mentioned. Second, some respondents may not have been aware of other sources of care.

The second-ranked facility where nonemergency medical care would be sought was the private clinic or the physician's office (24 percent). Actual behavior indicated that 21.8 percent of the households had received their most recent medical care from that source, and 17.8 percent would go there for emergency medical care. Excluding the nonrespondents, the differences increased slightly and indicated that one of four respondents would seek nonemergency medical care at a private clinic or a physician's office.

The emergency room or outpatient department of hospitals other than Hennepin County General Hospital would be used by 18.2 percent for nonemergency care. This percentage of preferred use was approximately the same for emergency care and source of the most recent care received. Combining the first and the third sources of care, one can conclude that (*a*) three of five respondents would go to an emergency room or an outpatient department of a hospital for nonemergency care, (*b*) the proportion is the same when compared with actual behavior, and (*c*) four of five respondents would use these two sources of care for emergency reasons.

The fourth source of care groups Public Health Service clinics, Pilot City Health Center, and other governmental health care facilities. One of 10 respondents (9.8 percent) would use these sources for nonemergency care, whereas only 4 percent would use them for emergency care. In reality, 19.1 percent of the respondents indicated that they had used these sources for the most recent medical care they had received.

In summation, (*a*) respondents would use gency rooms and outpatient departments of hospitals in approximately the same proportion as actual current use, (*b*) the private clinic or the

physician's office would be used slightly more often for nonemergency care than presently used, and (*c*) the "other" sources of care would be used much less frequently than present usage patterns indicate.

The question was asked: "Would you go to a health care clinic if a lot of Indian people work there?" All interviewees responded, and 84.9 percent answered "Yes," 5.8 percent said "No," and 9.3 percent gave a qualified yes. The persons who gave a qualified affirmative answer were concerned about such factors as quality of care and spectrum of services available. This group may represent the more sophisticated segment of the sample in terms of medical care. Adding the conditional yesses to the yes answer, 94.2 percent of the respondents said members of their households would like a health care clinic with Indian employees. Also, the vast majority (84.4 percent) would prefer free care, and 10.7 percent would prefer to pay a small fee. This clearly indicates that urbanized Indians in Minneapolis prefer a health care clinic with Indian employees where no payment would be required.

Conclusion

The findings of the study lend support to the President's assertion that the American Indians are "the most deprived and most isolated minority group in our nation." Efforts to meet the health needs of the Indian population must be coordinated with efforts to solve other social problems, especially housing, employment, and education. More than one-third of the study sample cited housing as the most important social problem.

The Public Health Service should reexamine its role and its responsibility with respect to urbanized Indians and provide a coordinative mechanism insuring continuity of health care between the reservation and the urban setting, even if this mobility—as proved in this study—is minimal. From the point of view of the recipient of health care, the interviewees indicated a definite preference—which should be carried out—for an Indian health clinic where health care services would be provided free of charge.

More Indians should be involved in controlling their own programs, and an Indian health center could be the focal point for coordinating all programs attempting to raise the standard of living and to improve the economic and social condition of the American Indians. An Indian-controlled health program is in the process of becoming a reality because of a grant awarded to the Minneapolis American Indian Health Board by the Indian Health Service, Health Services and Mental Health Administration. The grant proposal was supported by the findings of this study. The Federal grant will be used to begin a health outreach program and will establish the first urban Indian health project in the country. The program will be supervised by a 24-member all-Indian board of directors.

REFERENCES

(*1*) U.S. Congressional Record—House: The American Indians—Message from the President of the United States (H. Doc. No. 91–363). Vol. 116, pt. 17, 91st Cong., 2d sess. U.S. Government Printing Office, Washington, D.C., pp. 23131–23136; (*a*) 23131; (*b*) 23134.

(*2*) National Center for Health Statistics: Number and percent distribution of dental visits, by type of service, color, and age, United States, 1971. Unpublished.