

**LONG TERM CARE AND HEALTH NEEDS OF
AMERICA'S NATIVE AMERICAN ELDERS**

PART I

Testimony submitted to the Senate Committee on Indian Affairs

by

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July 10, 2002

TESTIMONY

Mr. Chairman, and Honored Members of the Committee, I am honored for the opportunity to speak on behalf of my elders. My name is Leander McDonald, my mother is an Arikara from the Three Affiliated Tribes, and my father is a Dakota from the Spirit Lake Nation, both reservations are located in North Dakota. I am a research analyst at the National Resource Center on Native American Aging (NRCNAA). The Resource Center is located in the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Established in 1993 with funding from the Administration on Aging, the Resource Center has a mission of providing research, training, and technical assistance to the nation's Native American Elders.

Today we will be presenting new findings about prevalence of chronic disease, their effect on functional limitations, and differences in life expectancy for Native American populations from a nationwide elder's needs assessment project called Conducting Local Assessments: Locating the Needs of Elders. The project entails conducting a survey on reservations that voluntarily participate in this project, and allows for comparison of elders on reservations with their national counterparts. The results from the research not only provide us with new information about Native elders, but also gives each tribe data they can use to help guide them in developing long-term care infrastructure for their communities. The data has been used by a number of tribal communities in their planning efforts, program development, and grant application primarily directed at addressing the need for long-term care services within their communities. To date, we have 83 tribes with 8,560 respondents. Two additional tribes are being processed this week, and will be added to the aggregate file upon completion.

KEY FINDINGS

Life expectancy and Health Status

With that background on the study, let me share with you a picture of elder health and long-term care needs based on our results. Life expectancies for Native Americans and Alaskan

Natives are low relative to the general population. In addition to important differences between Natives and the general population, it is also very important to note that there is substantial variation across Native American and Alaskan Native tribes in life expectancy across the Indian Health Service areas. Average life expectancy ranges from a low of 64.3 years of age in the Aberdeen Area to a high of 76.3 years in the California Area, a difference of 12 years (Table 1). Life expectancy for the general population is 76.9 years (NCHS, 2000).

Table 1

Life Expectancy at Birth, ages 55, 65 and 75 by IHS Area

IHS Area	At Birth	At Age 55	At Age 65	At Age 75
Aberdeen	64.3	18.9	13.2	8.5
Bemidji	65.7	18.7	12.7	10.1
Billings	67.0	20.2	13.9	8.9
Alaska	68.0	21.3	14.7	9.2
Tucson	68.4	22.2	15.8	10.0
Phoenix	69.8	22.6	16.1	10.6
Portland	71.7	23.1	16.0	10.1
Navajo	71.9	24.9	17.7	11.7
Nashville	72.2	22.8	16.3	10.5
Albuquerque	72.7	25.4	19.6	12.2
Oklahoma	74.2	25.7	18.2	13.1
California	76.3	26.9	19.4	13.3
All Indians	71.1	23.5	16.7	11.2

Earlier this year, I attended the high school graduation at the Spirit Lake Reservation, and watched as grandparents congratulated their grandchildren in accomplishing a major goal. When I graduated from high school in 1981, I had one grandmother still living at age 77, she died two years later. My other grandmother died during childbirth at age 37, with my two grandfathers

dying both from heart attacks, one at age 62 and the other at age 64. So, while the number of Native elders living to be old is increasing, old age is still rare on the reservation.

Chronic Disease

While quantity of life is an important indicator of health for the general population health, the health status of the aged is also an important focus. As populations including Native Americans age, there is a likelihood of developing chronic illness like arthritis or heart disease, which can impact both life span and quality of life. For example, the Native elders are 19.5% more likely than the general population to experience arthritis (Figure 1). Similarly, Native American elders were 48.7% more likely to experience congestive heart failure, 17.7% more likely to report high blood pressure, 17.5% more likely to have experienced a stroke, 44.3% more likely to report asthma, and 173% more likely to be afflicted with diabetes. Only cataracts were reportedly higher in the general population. So, the Native elder is sicker from chronic disease, but is at least able to see a little better than their U.S. general counterparts.

Figure 1. Arthritis

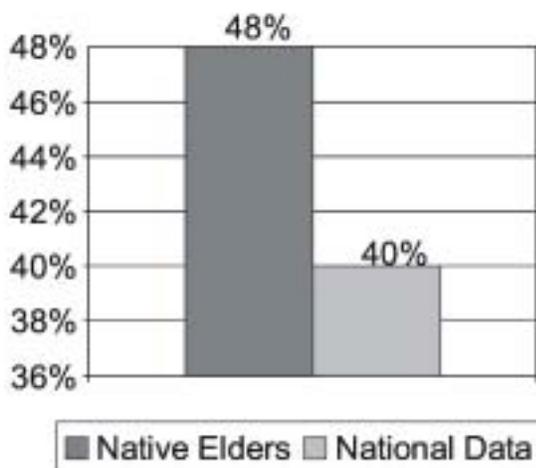


Figure 2. Congestive Heart Failure

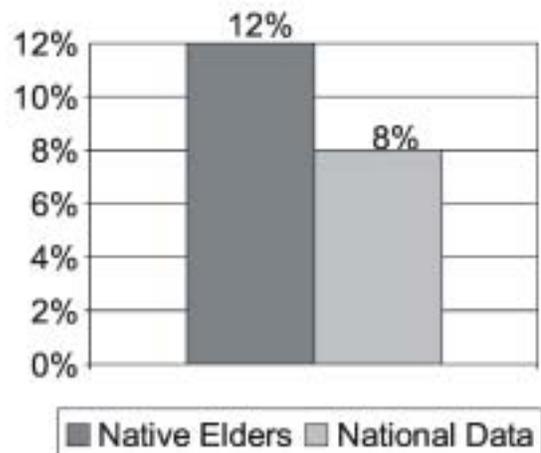


Figure 3. High Blood Pressure

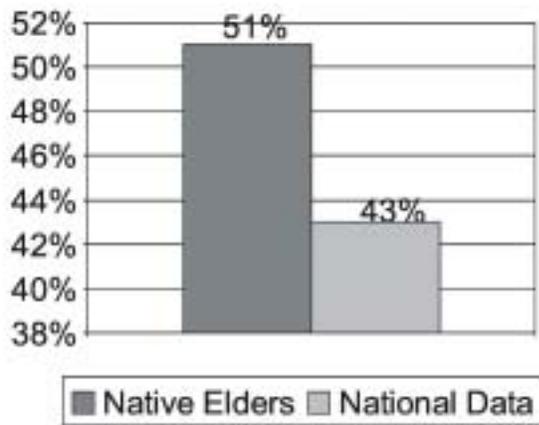


Figure 4. Stroke

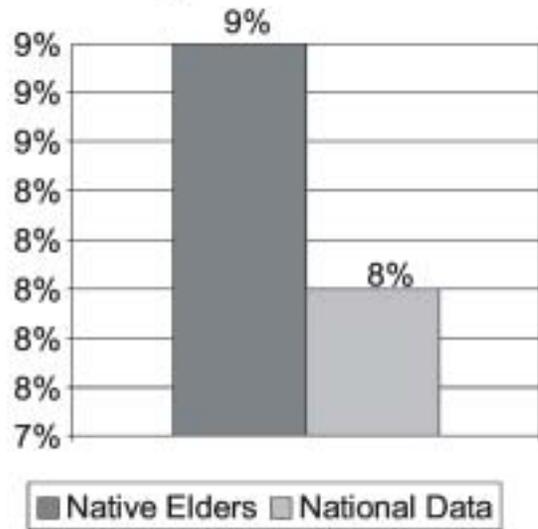


Figure 5. Asthma

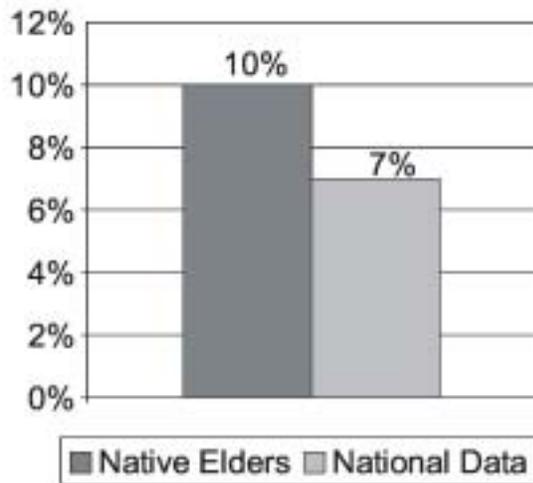
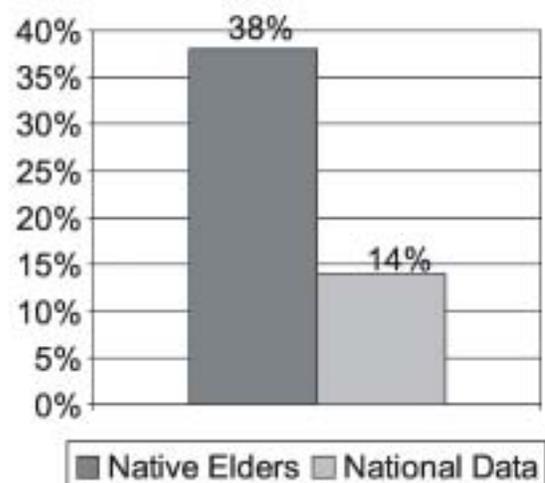


Figure 6. Diabetes



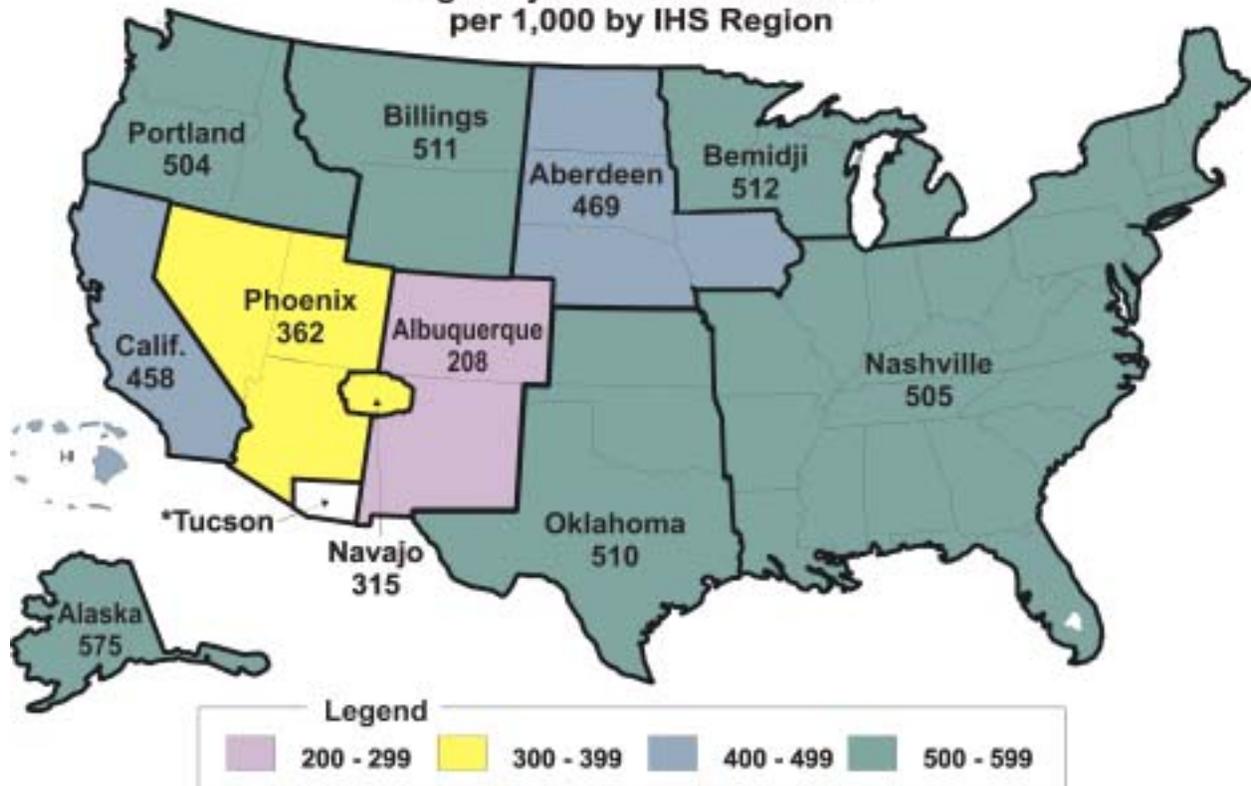
Our data, as seen in Figures 1 through 6, suggest that chronic disease rates are higher among Native American elders in spite of their shorter life expectancy. These findings suggest that the disparate health conditions of the Native elder are the result of other factors such as life style, socio-economic status, and access to timely and adequate care. Furthermore these findings, and the prevalence of chronic disease, like life expectancy, varies across Native American and Alaskan Native tribes.

When the regional chronic disease rates of Native American and Alaskan Native elders are compared, we see apparent differences between the areas.

- Arthritis rates reported in the survey tended to be low in the arid southwest and high elsewhere (Figure 7).
- The same pattern holds for congestive heart disease (Figure 8).
- High Blood Pressure tends to be reported at higher levels in the east and south (Figure 9).
Asthma rates again appear lowest in the arid southwest (Figure 10).
- Diabetes, while high generally, produced lower rates for Alaska and the highest rates in the Phoenix area (Figure 11).
- Persons reporting having experienced a stroke were lowest in the Navajo and Phoenix areas, followed by the northcentral and northwest areas (Figure 12) .

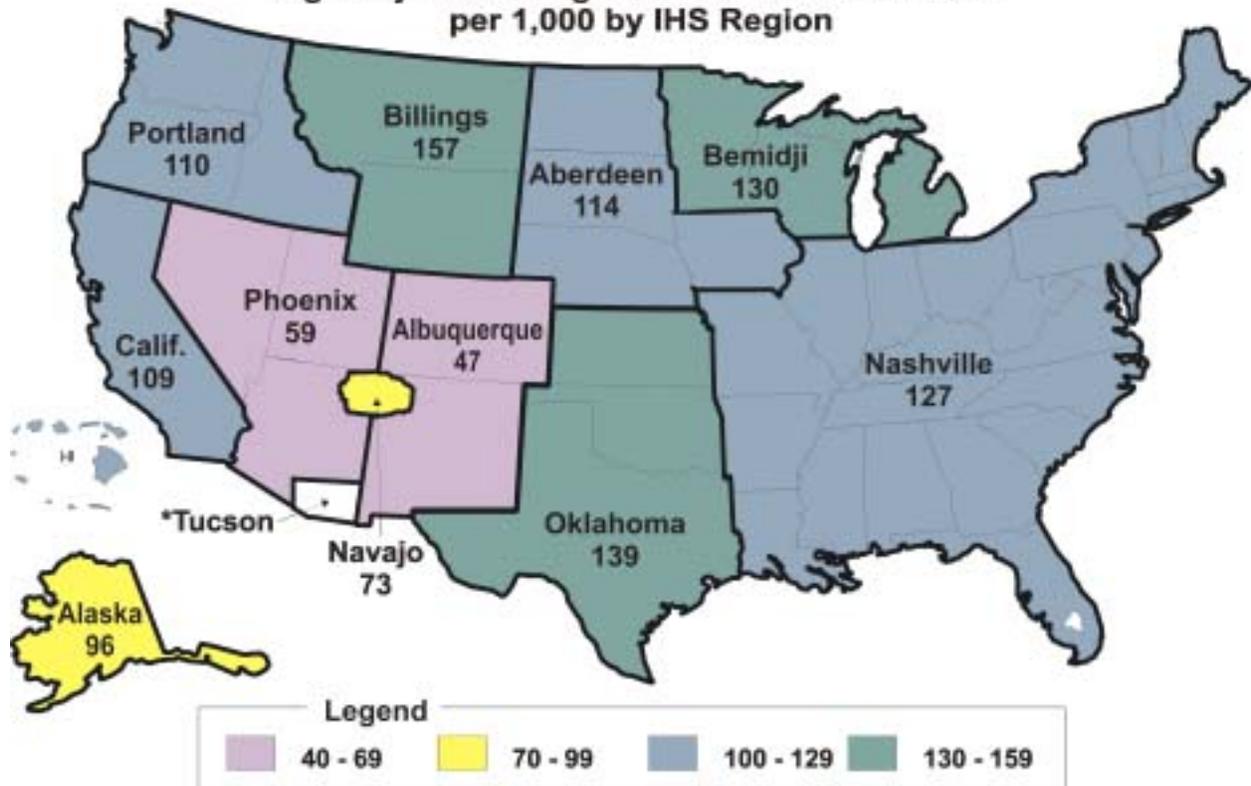
Keep in mind that these represent people who have been diagnosed with stroke and survived. The areas with the lowest life expectancies tended to also report lower rates of stroke victims in their survey data. We believe these lower or average rates of chronic disease to be the result of lower life expectancy rather than being indicative of better health status. Chronically ill elders in these regions have shorter life spans, resulting in regional chronic disease rates that are lower. In a sense, only the strong and healthy survive to be elders, which in turn affects the chronic disease rates in the Midwest and Alaskan regions.

**Figure 7. Native Elders 55 and Over
Age Adjusted Arthritis Rates
per 1,000 by IHS Region**



Source: NRCNAA Needs Assessment Data, UND Center for Rural Health.
* No data are available.

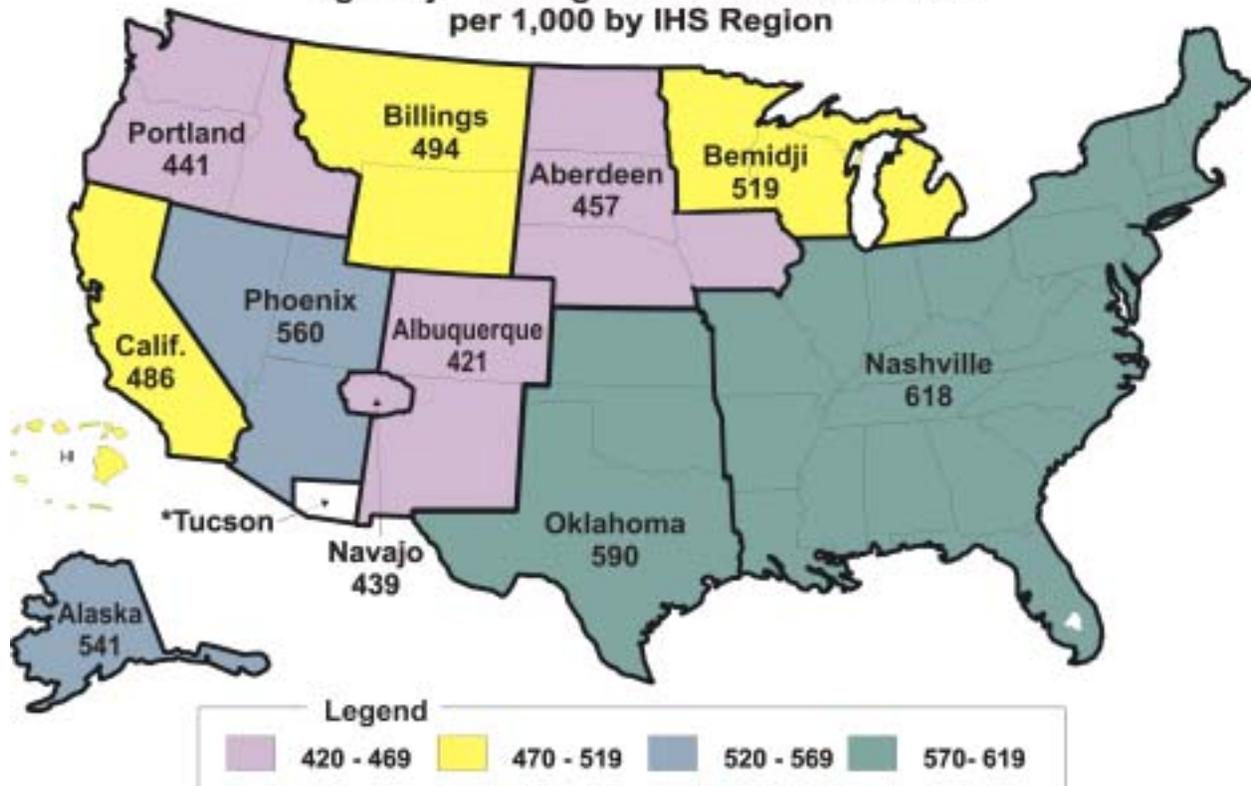
**Figure 8. Native Elders 55 and Over
Age Adjusted Congestive Heart Failure Rates
per 1,000 by IHS Region**



Source: NRCNAA Needs Assessment Data, UND Center for Rural Health.

* No data are available.

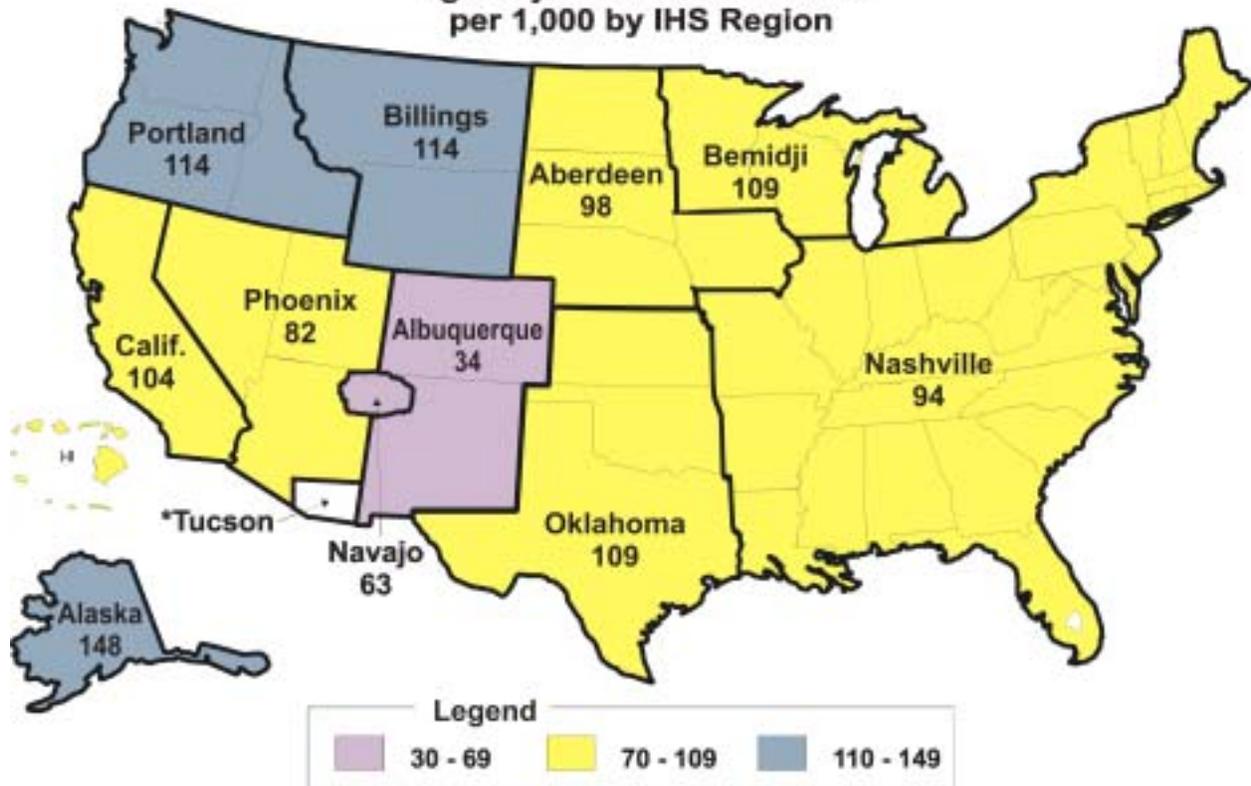
**Figure 9. Native Elders 55 and Over
Age Adjusted High Blood Pressure Rates
per 1,000 by IHS Region**



Source: NRCNAA Needs Assessment Data, UND Center for Rural Health.

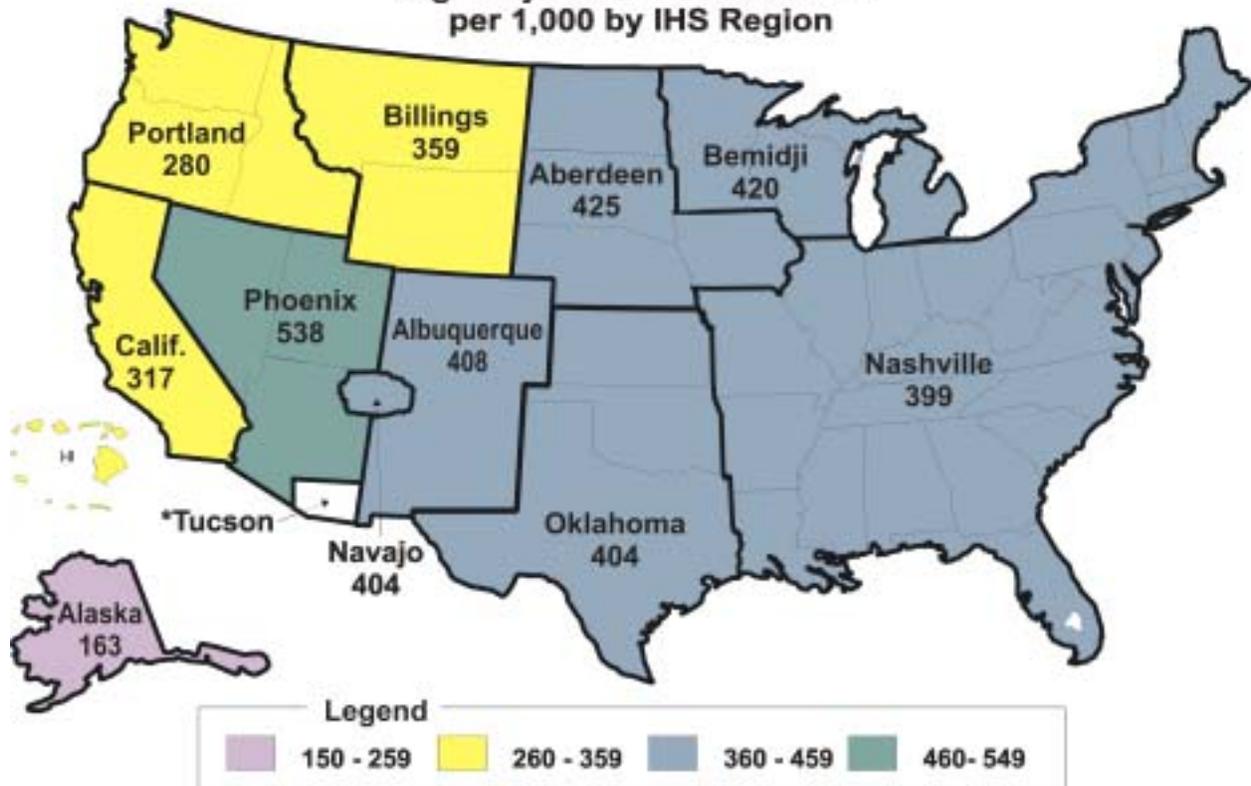
* No data are available.

**Figure 10. Native Elders 55 and Over
Age Adjusted Asthma Rates
per 1,000 by IHS Region**



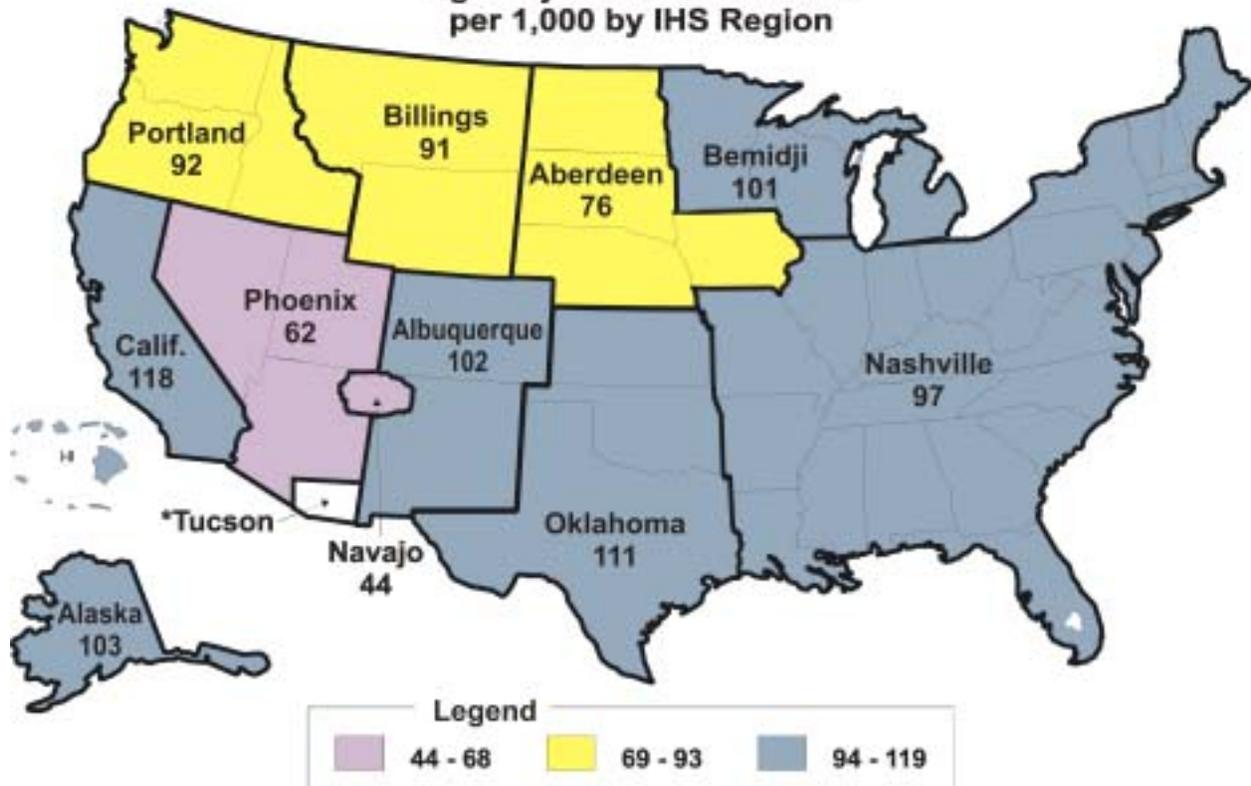
Source: NRCNAA Needs Assessment Data, UND Center for Rural Health.
* No data are available.

**Figure 11. Native Elders 55 and Over
Age Adjusted Diabetes Rates
per 1,000 by IHS Region**



Source: NRCNAA Needs Assessment Data, UND Center for Rural Health.
* No data are available.

**Figure 12. Native Elders 55 and Over
Age Adjusted Stroke Rates
per 1,000 by IHS Region**



Source: NRCNAA Needs Assessment Data, UND Center for Rural Health.

* No data are available.

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PART II

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July 10, 2002

TESTIMONY

Mr. Chairman, and Honored Members of the Committee, I am also honored and grateful for the opportunity to speak. I serve as the Director of Research at the National Resource Center on Native American Aging (NRCNAA) and have worked in close collaboration with Mr. McDonald throughout this project. My comments are an extension of those just presented by Mr. McDonald and will deal with the issue of increasing numbers of Native Americans with functional limitations reflecting a growth in the need for long term care services. I will also comment on strategies for decreasing the number of individuals with functional limitations.

FINDINGS

Functional Limitations

Chronic disease varies widely with some people minimally affected while others have significant levels of disability. The level of disability is related to functional limitations in the population, and is used as criteria for admission to nursing homes, assisted living and to community based long term care programs. Nearly all definitions of functional disability use information about “activities of daily living” (ADLs) and “Instrumental activities of daily living” (IADLs). Examples of ADLs include difficulties such as eating and walking with IADLs focusing on limitations like cooking and shopping.

A Classification of Functional Limitations

When ADLs and IADLs are combined, people can be classified into four levels of need. The associated care requirements can be identified as ranging from no long-term care services needed to home and community based care, to assisted living support and to skilled nursing care (see Table 1). Using these categories, we are able to estimate the numbers of people at these

different levels of need and determine the need for different levels of long term care services.

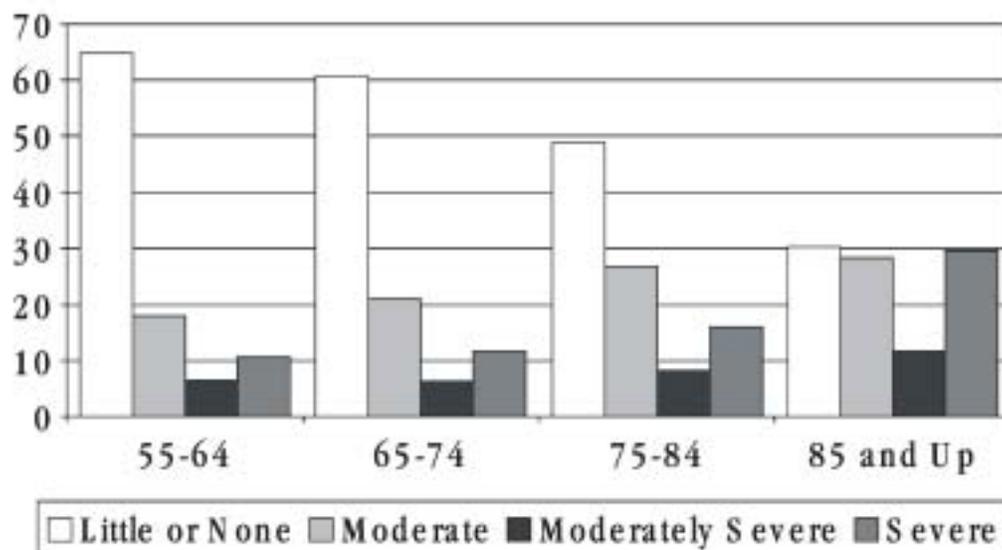
Table 1

Functional Limitation Categories

Categories	Limitations
Little or none	No ADL limitations, up to one IADL limitation
Moderate	One ADL limitation alone or in combination with fewer than 2 IADLS
Moderately Severe	2 ADL limitations
Severe	3 or more ADL limitations

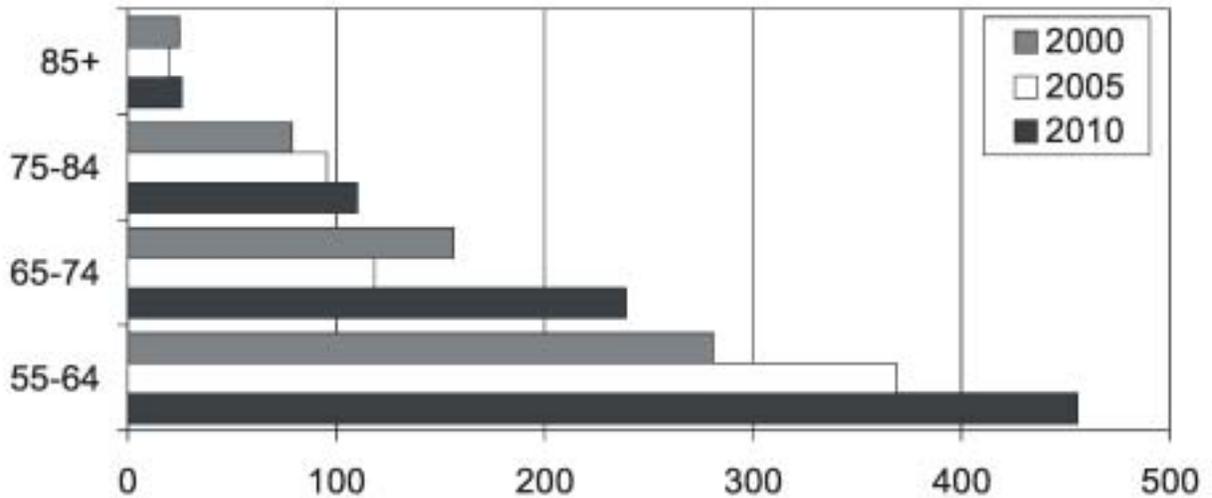
The prevalence of functional limitations increases with age and the severity of limitations also increases with age. Figure 1 contains the data from our surveys regarding functional limitation rates for Native American Elders. It is clear that the rates for all levels from Moderate to Severe increase with age and that they do so most dramatically in the oldest cohorts.

**Figure 1. Functional Limitation Rates by Age:
Native American Elders 2000**



As the population ages, there will be an increased need for long term care services. The numbers of people classified as elders in the Native American population is about to explode with the arrival of those born during the baby boom (Figure 2). When one combines the population data with the measure of functional limitation, a picture of the growth in need for long term care is generated (see Figure 3). The most dramatic growth will occur as a result of the large numbers present in the baby boom cohorts. In the next decade, this growth will expand the population of “young old”, and barring any change, will increase the need for moderate levels of care consistent with home and community based services at a rate greater than other

Figure 2. Population Changes by Age: 2000 to 2010

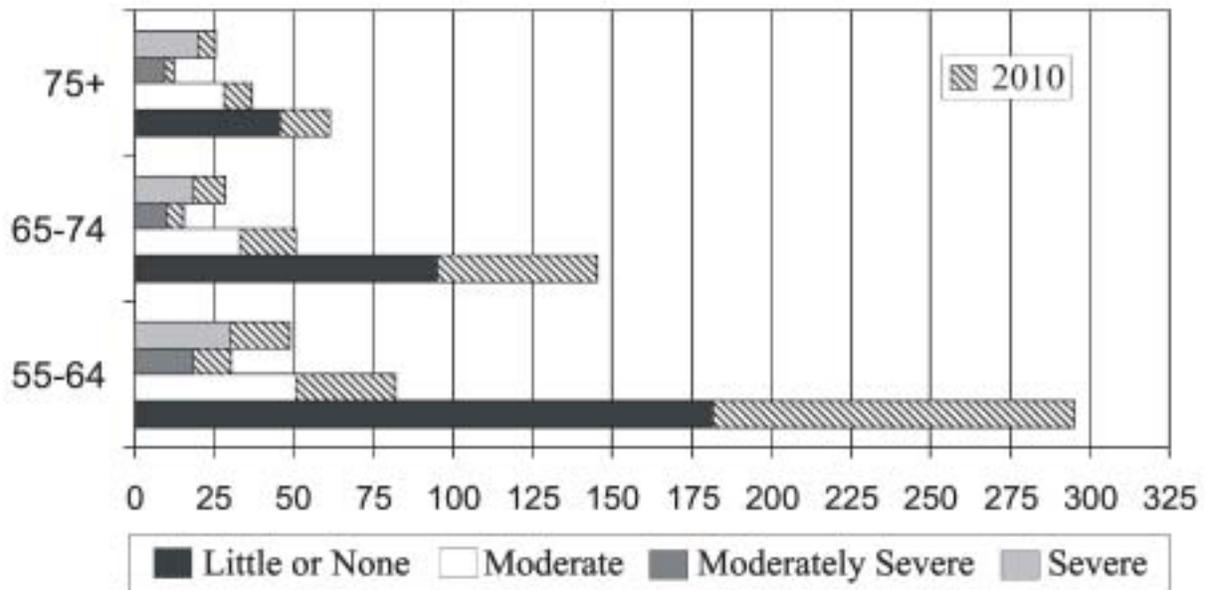


cohorts.

Life expectancy for Native American Elders has been growing rapidly and should be

expected to grow in the future. Population projections developed using IHS life tables and Census data show that as of year 2000, the nation has approximately 218,000 Native American Elders with functional limitations of a moderate or greater level. As the population ages, the number of elders with functional limitations will grow assuming the same rates of disability are continued. By 2010, as shown in Figure 3, we can expect an 51% increase or approximately 329,000 Native elders to have functional limitations of moderate or more severe levels. The

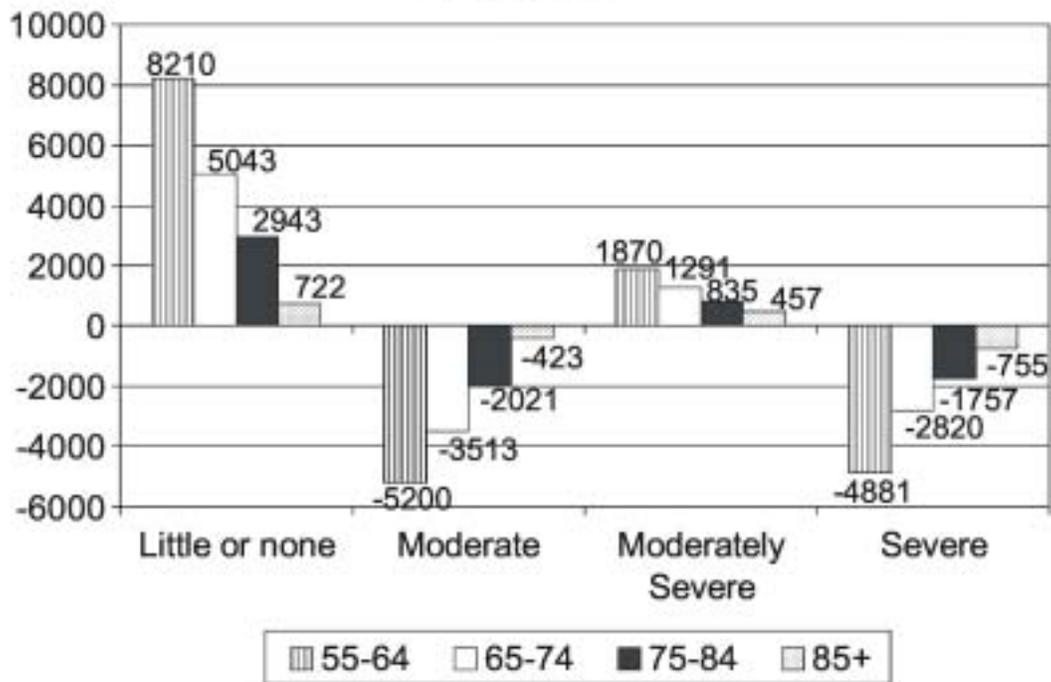
Figure 3. Population with Functional Limitations by Age: 2000 and 2010



large numbers of people becoming elders and early ages of onset for many chronic diseases that produce functional limitations creates a conservative estimate of growth in functional limitations to the end of the decade.

The health and vitality of future elders depends on healthy lifestyles including good diets, regular exercise and refraining from drinking and smoking. If people take care of themselves, they can reduce the need for long term care services. Access to preventive and other health services is important for delaying onset of illness as well as effectively treating diseases. If we reduce only 10% of Native American and Alaskan Natives limitations, we would see a significant decrease in demand for long term care services. Figure 4 presents the changes in numbers of people with each level of limitation that would occur with a 10% across the board reduction in functional limitations that could occur with improved health promotion and access to state of the art health care.

Figure 4. A Model of Changes in the Population with Functional Limitations by 2010 with a 10% Reduction



RECOMMENDATIONS

Based on our study findings we have recommendations that we believe merit your consideration.

First, given the increase in life expectancy and the increase in the Native elder population, we recommend the following.

1. An initiative to develop intervention and health promotion models that lead to improved outcomes for Native Americans and Alaskan Natives as they enter their elder years.

While promoting health behavior is relevant to individuals across the life span, an intense focus on our current cohort of “young elders” can influence health care status and related new demand for more expensive care. These health promotion efforts must incorporate elements of each unique culture.

2. Long term care services, ranging from home care to assisted living to skilled nursing care are largely unavailable in local communities for Native Americans living on reservations.

Leaving one’s community, family and friends to reside in non-native and occasionally hostile assisted living, or nursing home environment is clearly not adequate. Since there are no nursing homes on the reservation in North Dakota for example, the elders are usually sent to the border towns for skilled nursing home facilities when they need care. In addition to being in a strange environment, unfortunately, we are well aware of cases where Native American elders are met with hostility by non Native Americans in those environments. A locally accessible array of long term care services will be needed for this aging population. Tribes should be allowed and supported to integrate local cultures into their long term care solutions experimenting with models that are tailored in terms of both the types of care that work best, and the means by which local communities can

realistically produce the care required. Also, simplifying the process of creating long term care options and assisting reservation communities in developing local responses acceptable to federal and state agencies would greatly help.

3. Increased support for targeted research on Native American aging and related educational and capacity building programs is essential to help fill gaps in information and help tribes anticipate emerging health care needs. Many questions remain to be addressed. One cannot show a difference in health care problems and then speak to need without developing a way of monitoring change. One also cannot assume that the trends of the nation will be echoed in the Native American population.

SUMMARY

In closing, I would like to leave with three points of importance to the Native American and Alaskan Native people. The first point is the need to reduce chronic diseases and functional limitations, so our Nation's Native American elders might have a better quality of life, thus increasing access to care, and reducing the demand for health services. The second is to eliminate disparities across tribes, and between Native American elders and the general population, increase life expectancy, which can be partly remedied if the first point is resolved. The last point goes back to the tribes who have completed the needs assessment. In a huge majority of these tribes, we see the data being used for planning and the building of long term care infrastructure where there is none. Therefore, the last point is to address the shortages or lack of long-term care options in Indian Country.

Thank you for allowing us to come and testify about the needs of the Nation's Native elders, we would be happy to answer any questions.