The Impact of the Social Detriments of Health on the Southwestern Native American Population.

Audrey B. Blondin

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1. Introduction and Overview of Southwestern Native American Populations

The World Health Organization defines the social detriments of health as the conditions in which people are born, grow, live, work and age. All of these conditions are shaped by the distribution of money, power and resources at the global, national and local levels. 1 (see Appendix 1)

These social circumstances create societal stratification and are responsible for health inequities among different groups of people based on social and economic class, gender and ethnicity. In addition, these various social determinants of health involve multiple interactions which can impact health and access to health care, education, employment opportunities, income levels, food resources, stress and substance abuse among these different groups.2

Societal determinants of health include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care. Addressing social determinants of health is important for improving health and reducing longstanding disparities in health and health care.3

Research shows that health outcomes are driven by an array of factors, including underlying genetics, health, behaviors, social and environmental factors, and health care, While there is currently no consensus in the research on the magnitude of the relative contributions o each of these factors to health, studies suggest that health behaviors, such as smoking, diet, and exercise, and social and economic factors are the primary drivers of health outcomes, and social and economic factors can shape individual’s health behaviors. Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages.3

Efforts to improve health in the U.S. have traditionally looked to the health care system as the key driver of health and health outcomes. However, there has been increased recognition that improving health and achieving health equity will require broader approaches that address social, economic, and environmental factors that influence health.3

The racial group known as American Indian includes people having origins in any of the original peoples of North America, South America and Central America, who maintain tribal affiliation or community attachment. As of 2017, there were an estimated 5.6 million people who were classified as American Indian alone or in combination with one or more other races. This racial group comprises 1.7 percent of the total U.S. population and also includes the Alaskan Native population.

The 2010 Census reveals that 78 percent of them live outside of tribal statistical areas. 22 percent of American Indians live on reservations or other trust lands. 60 percent of American Indians live in metropolitan areas, this is the lowest metropolitan percentage of any racial group. Currently there are 573 federally recognized American Indian tribes, and more than 100 state recognized tribes.4

The term “Indian” originated with Christopher Columbus. He thought that he had reached the East Indies when he landed in America and therefore named the inhabitants Indians.5

Native Americans were greatly affected by the European colonization of the Americas, which began in 1492, and their population declined precipitously mainly due to introduced diseases as well as warfare, including biological warfare, territorial confiscation and slavery. After its creation, the United States, as part of its policy of settler colonialism, waged war and perpetrated massacres against many Native American peoples, removed them from their ancestral lands, and subjected them to one-sided treaties and to discriminatory government policies into the 20th century. Since the 1960s, Native American self-determination movements have resulted in changes to the lives of Native Americans, though there are still many issues faced by Native Americans today.6 (see Appendix 2)7

The Southwest American Indian region encompasses Arizona, New Mexico, the southern portion of Colorado and New Mexico.8 The five major tribes from the Southwest are the Apache, Hopi, Navajo, Pueblo and Zuni. Most of these Southwest Indians lived in villages and farming was their main occupation.9

The Navajo Indians of the Southwest have the largest Indian reservation in the U.S. It covers over seventeen million acres in New Mexico, Utah and Arizona and is larger than some U.S. states.8

The Native American population rose by 1.1 million, or 26.7 percent, between the 2000 and 2010 census. That’s much faster than the general population growth of 9.7 percent. By 2050, the Native population is expected to increase by more than three million. Given that the median age of the Native American population is 29, eight years younger than the general population, the indigenous population is in a prime position to expand. Eight Native American tribes have at least 100,000 members.10

Native Americans experience continued disparities in health, disability and longevity, and rank lower in socioeconomic and health indicators than their white counterparts. Their life expectancy lags three to four years behind that of the general U.S. population. White adults ages 65 and older represent 14.4 percent of the U.S. white population, but only 7.1 percent of the American Indian population.11

They have higher mortality rates than other Americans for a number of conditions, including chronic liver disease and cirrhosis (368 percent higher), diabetes mellitus (177 percent higher), unintentional injuries (138 percent higher), assault and homicide (82 percent higher), intentional self-harm and suicide (65 percent higher), and chronic lower respiratory diseases (59 percent higher). There were 22 percent of seniors reporting a depressed mood much of the time during a past year, compared to 11.7 percent of whites. Only 49.5 percent of Native Americans ages 50 and older were in compliance with colorectal cancer screenings, compared to 59.8 percent of whites. Approximately 23 percent of Native Americans lack health insurance coverage.11

Many social, economic and political injustices continue to affect the Native American populations in significant ways. In addition, health disparities are inherently tied to the historical and sociopolitical paths experienced by the Native Americans over the past five centuries.

II. Specific Social Detriments of Health (SDOH)

We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. We also know that differences in health are striking in communities with poor SDOH, such as unstable housing, low income, unsafe neighborhoods, or substandard eduction. Healthy People 2020 highlights the importance of addressing DSOH by including “create social and physical environments that promote good health for all” as one of the four overarching goals for the decade.12

1. Geography and Historical Trauma

The nation’s indigenous people had a population of nearly 10 million before European settlers explored America and their numbers began to fall rapidly shortly thereafter due to war and diseases brought by the settlers. Native Americans faced centuries of persecution and discrimination, losing their land and resources and being forced onto reservations that lacked the soil and natural resources needed to build and sustain their communities. Today, Native Americans still face threats from federal and state governments related to land-use and resource extraction. Native Americans have the highest poverty rate of any major racial group, with one in four people living below the poverty line.13

Today there are only 52 million acres left from the original American Indian homeland of the about 6.1 billion acres that form North America and this trust land is mostly of inferior quality: the BIA took an investigation about the erosion on American Indian tribes land and considered the state of 12 million acres crucially, 17 million gravely, 24 million gently affected as to that. So for many Native Americans there is no possibility to make a living by farming without the use of chemicals and in some reservations commercial hunting and fishing are prohibited.

Furthermore the lack of infrastructure (e.g., often no electricity, telephones or Internet connectivity) makes life difficult in the reservations and these drawbacks and the insufficient or partly missing links to the traffic system keep most foreign industry from installing sites in the reservations. The bad conditions complicate the foundation of American Indian businesses like casinos and tourism for some tribes, too, because they are not within easy reach from the next big city and the potential customers.

The government in the 1990s promised high financial and economic rewards to the tribes who would agree to the storage of toxic and radioactive waste on their reservation land for several decades. Many American Indians, particularly those in the Southwest, were tempted by the money and were not aware of the consequences for their health, their environment and life base, which makes the barriers to the reservations’ development even more unbearable.14

American Indian and Alaska Native (AI/AN) populations living in rural counties face socioeconomic challenges. The most obvious of these is poverty at both the individual and the community level. More than a quarter (28.8%) of AI/AN rural residents experience household poverty; this is more than twice the proportion among white rural residents. In addition, more than half of rural AI/An residents (60.9%) live in counties that fall into the worst quartile for poverty.15

In addition, many Native American communities face difficulties as a result of unresolved historical trauma. Historical trauma is the term used to describe traumatic events which have caused catastrophic upheaval across a community. The term was first used by Dr. Maria Yellow Horse Braveheart in the 1980s to enable understanding of which Native Americans are not living fulfilled lives.16

According to Dr. Maria Yellow Horse Braveheart, historical trauma is the “cumulative emotional and psychological wounding over one’s lifetime and from generation to generation following loss of lives, land and vital aspects of culture.”17

For Native American Indians this “cumulative” wounding extends back over 500 years, manifesting in detrimental and debilitating effects that persist from generation to generation.

The symptoms and long-term effects of historical trauma include but are not limited to:

* Unresolved emotional trauma
* Depression
* High morality rates
* High levels of drug and alcohol abuse
* Child abuse
* Domestic violence16

Studies suggest that daily thoughts about loss, stress, grief, discrimination, and cultural displacement are part of the lives of many Native Americans. Generations of Native Americans live under the shadow of history, and this causes enormous stress on the body and mind. 17

1. Wealth, Income, Poverty

Native Americans, particularly those living in the Southwest, remain one of the United States’ most economically disadvantaged populations. About one in four American Indians (26.4%) lived in poverty. In contrast, about one in 10 non-Hispanic whites (11%) lived in poverty. Not surprisingly, the Native American population is a relatively low-wealth population. In 2000, Native Americans’ median wealth was equal to only 8.7 percent of the median wealth amount all Americans. For most Americans, a home is a key source of wealth. Native Americans, however, have a significantly lower homeownership rate than whites, and the homes they do own tend to be worth much less than those of whites.18

The median household income for American Indians is $45,448.00, as compared to $65,845.00 for non-Hispanic white households. 30.5 percent of American Indians and Alaska Natives age 16 and over work in management and professional occupations, in comparison to 42.9 percent of whites. Also, 21.9 percent of this racial group live at the poverty level, as compared to 9.6 percent of non-Hispanic whites in 2017.4

Mobility significantly affects future success. In many rural communities, where poverty has been persistent and multi-generational for many individuals, low perceptions of mobility mean people feel as though they do not have control over their own lives. Ultimately, this feeling of a lack of control induces toxic stress and leads people to engage in risky behaviors – both of which can lead to a variety of poor health outcomes.19

AI/AN individuals mare more likely to live in remote, socially, and economically disadvantaged areas facing higher poverty, lower wages, unemployment, and lower standards of education. The social, economic, and political inequalities among AI/AN populations are associated with chronic stress which has been associated with risky behaviors, chronic diseases, and adverse health outcomes. County of residence is associated with several health-risk behaviors and health outcomes including life expectancy. Recent reports show that the gap in life expectancy has been widening between low- and high-risk counties.

The AI rural population is concentrated in counties falling in the highest quartile for poverty. Among AI rural residents, 60.9% lived in high-poverty counties versus 46.0% of their white peers. Similarly, the USDA has designated 558 counties as “persistent child poverty” counties in which 20% or more of children have lived below the poverty line in each Census since 1980. Across rural America, 558 counties are labeled persistent child poverty counties; 28.2% of the rural population lives in these areas. Again, racial disparities are marked. More than half of AI residents (52.7%) live in persistent child poverty counties versus 20.9% of white residents.

Rural residents generally engage more in high-risk health behaviors and are more likely to report their health as poor. Prior research has found that AI population overall experiences a higher prevalence of poor health status, risky behaviors such as tobacco use and binge drinking, obesity, substance abuse, mental health conditions, suicide, road traffic accidents and teenage pregnancy.20

Community poverty translates into a shortage of healthcare resources. AI rural residents are more likely than their white peers to live in countries that are health professional shortage areas. This situation is not fully alleviated by AI access to HIS facilities and providers. Persons receiving care from the HIS are considered medically uninsured as there is no standard benefit that must be provided. Absence of standards is perceived to allow for historic underfunding of this service. Other options for providing access to care, such as Medicaid, vary regionally and in addition, multiple states are considering or have acquired a waiver allowing the imposition of work requirements on adult Medicaid beneficiaries which may be difficult to meet in counties that have high levels of unemployment.20

Poverty is closely associated with adverse health outcomes and health risk behaviors including a sedentary lifestyle, unhealthy diet, and smoking. Higher unemployment, lower earnings, and living in isolation are major contributors to poverty in AI households. A markedly higher proportion of rural AI residents (28.8%) lived below the federal poverty line in 2016 than did their rural white peers. Poverty rates were also high among urban AI residents (24.6%). Of note, the prevalence of poverty is higher among rural AI populations than among rural African American residents (24.1%) or rural Hispanic residents (21.3%). AI persons constitute the poorest minority group within the rural U.S.20

1. Education

In 2017, 82.8% of American Indians alone or in combination had at least a high school diploma, as compared to 92.9% of non-Hispanic whites. 19.6% of American Indians age 25 and over had a least a bachelor’s degree, in comparison to 35.8% of non-Hispanic whites. 6.8% of American Indians held an advanced graduate or professional degree, as compared to 13.8% of the non-Hispanic white population.4

The AI rural population falls behind the white population in educational attainment. A higher proportion of rural AI (19.7%) than rural white residents (10.4%) had less than a high school education in 2016. High school completion values for urban AI adults were similar with 20.4% lacking a high school diploma. At the other end of the educational spectrum, a smaller percentage of rural AI adults (44.5%) than rural white adults (54.7%) have a college education or better.20

American Indian communities today live with a legacy of cultural trauma as a result of centuries of dispossession at the hands of the U.S. government and its policies and practices intentionally designed to break apart culture, communities, family and identity. Many of the disparities experienced by American Indian children highlighted above are, at a minimum, exacerbated by educational disparities and may in fact be causally related to the problems students experience in the educational system, especially insofar as they are driven by poor health literacy and health behavior.21

Historically, educational institutions have not played a positive role in American Indian communities; they have participated in removing American Indian children from their families and communities, forbidden the use of American Indian languages and cultural practices, and been a part of larger efforts to undermine tribal life ways and practices through the assimilation of children into the larger society. It is, therefore, not surprising that American Indian children have often faired poorly in primary and secondary educational settings, with high absenteeism and dropout rates and low achievement and parental involvement.21

90% of American Indian students attend public school. The state of education in our nation’s K-123 schools for Native students is distressing. Native students perform two to three grated levels below their white peers in reading and mathematics. They are 237 percent more likely to drop out of school and 207 percent more likely to be expelled than white students. For every 100 American Indian/Alaska Native kindergartners, only seven will earn a bachelor’s degree, compared to 34 out of every 100 white kindergartners.22

One contributing factor this this achievement gap is that most American Indian students are not prepared to learn when they walk through the doors of their school. In addition, the effects of poor economic conditions in many Indian communities add to the challenges facing families and schools. Low-income homes, lack of adequate health care, and other factors create challenges that add to the achievement gap.22

1. Employment, Labor Market and Conditions

Many Native American communities are economically depressed and their jobless rates are high.

Many American Indian communities are impoverished, with some tries reporting unemployment as high as 85%. Existing jobs are found mainly within the tribal government, Bureau of Indian Affairs, state social services, the school systems, and the Indian Health Service (HIS) Hospital. Additionally, years of failed government policies have left reservation economies with limited economic opportunity. The government placed reservations in areas away from fertile land, population centers, water supplies and other vital resources, compounding economic challenges with geographic isolation.

* Native Americans have the lowest employment rate of any racial or ethnic group in the United States
* In the poorest Native counties, only about one-third of men in Native American communities have full-time, year-round employment.25

For rural residents without access to or the ability to drive a private car, a lack of reliable transportation options provides significant barriers for people to travel to work, doctor’s offices, and grocery stores – all of which likely have negative effects on health outcomes. In rural areas, just 32 percent of counties have full access to public transportation services with another 28 percent having only partial access. A lack of transportation options presents particular challenges in rural areas where distances to social and health services are often greater than in urban areas.19

1. Housing, Environment, Climate Change

Southwest Native Americans traditionally lived in Adobe homes. These houses had many levels in them and were made from clay and straw bricks. They were cemented together with adobe. Adobe homes housed one family, but the homes were connected together so many families lived next door to each other. These homes were good in warm dry climates for tribes that did not move around to hunt and gather.23

However, the southwest region is shifting into a drier pattern as wet weather systems have become rarer, scientists recently reported in *Geophysical Research Letters*. And researchers reported last year that the western United States could face a megadrought by the end of the century. But an even bigger problem is that as temperatures rise, more precipitation is falling as rain instead of snow. Normally winter precipitation builds snowpack in the Rockies that feeds streams in warmer months when rain is scarce. When the snowpack is smaller than average, there can be less water available. New patterns in storms and extreme weather can result in catastrophic flooding – water that is not useful. And rising temperatures also means that more of that water is lost to evaporation, leaving even less for people to use.

Already these conditions are affecting Native American tribes in different ways. A loss of soil moisture on Navajo lands in northeastern Arizona, for instance, caused sand dunes to inundate homes. And the Hualapai of Arizona had to sell much of their livestock during the most recent drought.

While these problems face everyone in the Southwest, Native American communities have unique vulnerabilities. One of these is a complex system of land ownership. These   
“checkerboard lands” – where patches of land may be owned by tribes, individual tribal members or non-Native Americans – it can be difficult to know who has authority to act and make decisions about land and water.

In addition, many Native American lands have been divided up into parcels that now, generations after they were established, have dozens of heirs that all have interest in the land. Decision-making becomes inefficient, and it can be impossible to manage the land’s resources sustainably.24

1. Health Disparities and Services

The Indian Health Service (IHS) was established on July 1, 1955, a year after the transfer of Native American health services from the Bureau of Indian Affairs (BIA) to the pUblic Health Service. It is responsible for providing health care under historical treaty agreements between the federal government and tribes. The HIS operates a comprehensive health service delivery system for approximately 2.2 million American Indians. Typically, this urban clientele has less accessibility to hospitals, health clinics or contract health services provided by the HIS and tribal health programs. Studies on urban American Indian populations have documented a frequency of poor health and limited health care options for this group.4

Since 1972, HIS has embarked upon a series of initiatives to fund health-related activities in off-reservations settings, which make health care services accessible to urban American Indians. Currently, the HIS funds 41 urban Indian health organizations, which operate at sites located in cities throughout the United States. Approximately 70 percent of American Indians live in urban areas and are eligible to utilize this program. The programs administer medical services, dental services, community services, alcohol and drug use prevention, education and treatment, HIV and sexually transmitted disease education and prevention services, mental health services, nutrition education and counseling services, pharmacy services, health education, optometry services, social services and health care.

American Indians frequently contend with issues that prevent them from receiving quality medical care. These include cultural barriers, geographic isolation, inadequate sewage disposal and low income.4

In 2017, 51.3% of American Indians alone or in combination had private health insurance coverage. 43.2% of American Indians relied on Medicaid or public coverage, and 14.9% of American Indians had no health insurance coverage. This compares to non-Hispanic whites by 75.4%, 33.7% and 5.9%, respectively.

According to Census Bureau projections, the 2015 life expectancies at birth for American Indians are 77.5 years, with 80.3 years for women, and 74.7 years for men. For non-Hispanic whites the projected life expectancies are 79.8 years, with 82.0 years from women, and 77.5 years for men.4

The HIS has historically been inadequately funded. Federal funding only provides for 54% of needed services. Recent estimates show increased patient use despite proposed funding cuts. What’s more, the majority of American Indians live in urban settings with very limited access to IHS facilities.

As a result, many American Indian patients receive health care that may be inadequate or of minimal quality. Others must wait a long time for urgently needed care. These experiences have collectively led to a distrust of institutions, including health care centers. Many will avoid or delay necessary screenings and care.26

American Indians are at a greater risk than the general population of dying from cancer, accidents, diabetes, homicide or suicide. These disparities are shaped by social inequality, historical trauma and discrimination. Most American Indians live in chronic poverty, with limited access to health care, adequate housing, quality education and adequate law enforcement services.

Early exposure to traumatic events and losses, including sexual and domestic violence, are common for many American Indians. This childhood trauma can translate to a lower quality of life and a wide variety of poor health outcomes.26

Disparities in health have existed among American Indian populations since the time of first contact 500 years ago, and they continue to occur across a broad spectrum of disease categories and for all ages. Historically, our understanding of health disparities within the American Indian population has been limited because of the lack of adequate data; our understanding of the health disparities experienced by American Indian children in particular has been especially so. The literature on American Indian children’s health is relatively small, oftentimes dated, and characterized by descriptive studies of small regional samples, partly because of difficulties in sampling he small, isolated, diverse, and culturally distinct groups that form this population.21

Across the developmental spectrum American Indian children also experience physical health-related disparities relative to their non-Native peers. Data documents rates of inadequate prenatal care and post-neonatal death among American Indian infants that were two to three times those of white infants and a post-neonatal death rate roughly twice that of both the U.S. all-races and white races (4.8 deaths per 1000 live births versus 2.7 and 2.2, respectively).21

Similar national data from the United States indicated that American Indian youth had an overall two times greater injury-related death rate than the U.S. average. Relative to white youth, they experienced greater injury-related death in all injury categories and exceeded both black and white children for injury-related deaths due to motor vehicle accidents, pedestrian events and suicide. These data highlighted the involvement of alcohol in all injury-related deaths among American Indian youth.21

Additional physical health disparities emerge for American Indian children beginning in early childhood and continuing throughout development. Of particular note are childhood obesity and overweight and childhood dental disease. In national studies, American Indian children are twice as likely to be overweight and three times as likely to be obese, with rates of both growing by 4% since the mid-1990s.21

American Indian youth also experience higher rates of mental health disorders relative to their peers. Conduct and oppositional defiant disorder, anxiety disorders, and separation anxiety were most common diagnoses. The suicide rate is three to six times higher among American Indians than their non-Native peers and indeed represents one of the greatest health disparities faced by young American Indian youth today.21

From the 16th century through the early 20th century, no fewer than 93 confirmed epidemics and pandemics – all of which can be attributed to European contagions – decimated the American Indian population. Native American populations in the American Southwest plummeted by a staggering 90 percent or more. Causes of death included influenza, smallpox, whooping cough, scarlet fever and typhus. Many died because their immune systems had never been exposed to European diseases and were unable to fight them off.

American Indians continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease.28

The American Indians have long experienced lower health status when compared with other Americans. Lower life expectancy and disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These challenging conditions lead to poor health outcomes.28

Differences in access to across the Southwestern Native American population occur for a number of reasons resulting in large healthcare disparities, particularly in groups unable to access care provided by the Indian Health Service. Lack of health insurance or inadequate insurance plans limit the amount of services available to them as well as the number of providers they can use. They are less likely to be able to visit the same doctor on a regular basis and tend to rely more on clinics and emergency rooms. Without a regular healthcare source, people have more difficulty obtaining their prescriptions and attending necessary appointments.29

Structural barriers include lack of transport to healthcare providers, inability to obtain convenient appointment times and lengthy waiting room times. All of these factors reduce the likelihood of a person successfully making and keeping their healthcare appointment. In rural areas, the number of health care practitioners and diagnostic facilities are often inadequate. Native Americans living in more rural areas area more likely to experience transport problems or suffer from a lack of mobility, factors that can impact their access to health care, as well as not having access to the internet, where these individuals are also less likely to benefit from the valuable health information that can now be found on the interest.2

1. Strategies for Future Improvement

There are a number of strategies that can be used to address the possibility for future improvement as related to the impact of the social detriments of health on the Southwestern Native American population. Efforts to improve maternal and child health access are an important part of improving health disparities facing the Southwestern Native American population. Closing the gap of the uninsured and improving access to providers will have large, long-term positive effects on lessening these ongoing health disparities.30

Improving the quality of education and providing high-quality early childhood education can have long-term positive impacts on educational attainment and achievement, which in turn leads to better employment opportunities and access to health insurance and health care providers. Increasing the number and size of tribal programs supporting higher education helps tribes to develop the human capital necessary for their economic development. They also potentially provide role models and mentors to encourage others to pursue higher education. The more highly educated adults there are in a community, the more children will aspire to be highly educated when they become adults, resulting in more and better health care outcomes for all involved.30

The fact that Native Americans have lower odds of being employed even after controlling for age, education, state of residence, reservation residence, urbanicity, marital status, disability status and other factors leaves open the possibility that Native Americans may face racial discrimination in the labor market. Investigating the role that racial discrimination plays for Native American job applicants, along with improvements in the collection of tribal labor market data will help to improve employment rates for Southwestern Native American which in turn provide for better and more positive health care outcomes for the employees and their families.30

Supporting strong Southwestern Native American self-determination and leadership will also help to lessen the impacts of health disparities among the population.

Researchers have found that strong and culturally appropriate tribal leadership is associated with higher employment rates, which in turn leads to better and more appropriate health care access and outcomes. In their analysis, tribes governed by a chief executive or a legislature, typically a parliamentary tribal council, had better employment outcomes than tribes governed by a general council. The researchers also found that for the tribal government to be effective, it needed to be based on the cultural traditions of the tribe and not simply on forms that were at one time imposed by the federal government.30

Increasing the number of, and strengthening Native American community development financial institutions contributes to the establishment and expansion of Native-owned businesses and the creation and retention of jobs which again leads to better and more access to health care. More and stronger Native American community development financial instructors would also help to facilitate economic self-determination through health-building and entrepreneurship, lessening the economic disparities which in turn lessen the health, social and disparities among these Southwestern Native American communities.30

Underserved people can populations continue to bear the burden of hidden costs and historical trauma associated with declining health status. The social determinants of health are a reminder that the sum total of the nation’s health is more than what is spent on health care, but the total of what happens on the job, in the home, and throughout a community. Moreover, recommendations encourage the department to build a more generative approach that works across sectors to address the multi-dimensional health and socioeconomic challenges of individuals and families, including:

* Reconciling diverse perspectives and defining a shared vision and goals
* Accessing the needs of the community, identifying gaps and potential interventions and prioritizing actions to achieve shared goals
* Allocating resources and creating the information systems and capability to access performance and implement rapid cycle changes.

All help to create an opportunity for rural hospitals and health care providers to play a significant role in improving the health of their communities in coordination with human service and workforce support organizations.

Disparities will require more knowledge about native histories, cultures, and values – knowledge that can help us increase the cultural competence of providers and services, and tailor relevant programs. Such knowledge can also support social policy that expands services and facilitates economic parity for native populations.11

“Health in All Policies” is an approach that incorporates health considerations into decision making across sectors and policy areas. A Health in All Policies approach identifies the ways in which decisions in multiple sectors affect health, and how improved health can support the goals of these multiple sectors. It engages diverse partners and stakeholders to work together to promote health, equity, and sustainability, and simultaneously advance other goals such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, and improved educational attainment. States and localities are utilizing the Health in All Policies approach through task forces and workgroups focused on bringing together leaders across agencies and the community to collaborate and prioritize a focus on health and health equity.3

1. Conclusion

The Federal Government is responsible for managing Indian affairs for the benefit of all Indians and has failed miserably across the board. As a result, Native American Reservations are among the poorest communities in the United States as our government keeps Native Americans in poverty. Across the broad spectrum of the social detriments of public health, including health and access to health care, education, employment opportunities and jobs, transportation, housing and food resources, in each and every instance Southwestern American Indians have less rights and opportunities and suffer more inequities and inequalities than any other group of persons of color here in the United States.

For over 500 years our government has forced an oppressive and minority status on Native Americans that continues to this day. From the time they are born, to where and how they grow, live, work and age, Native Americans face often insurmountable barriers to improved living conditions and generational advancement, unlike any other American ethnic group. Underlying this doctrine is the notion that tribes are not capable of owning or managing their lands. The government is the legal owner of all land and assets in Indian Country and is required to manage them for the benefit of the Indians.

But because Indians do not generally own their land or homes on reservations, they cannot mortgage their assets for loans like other Americans. This makes it incredibly difficult to start a business in Indian Country. Even tribes with valuable resources remain locked in poverty. Their resources amount to “dead capital” – unable to generate growth for tribal communities.

Chief Justice John Marshall set Native Americans on the path to poverty in 1831 when he characterized the relationship between Indians and the government as “resembling that of ward to his guardian.” With these words Marshall established the federal trust doctrine, which assigns the government as a trustee of Indian affairs which continues to this day. (Appendix 2)31

Reservations contain valuable natural resources worth nearly $11.5 trillion. Historically, tribes had little or no control over their energy resources. Royalties were set by the Bureau of Indian Affairs, but the agency consistently undervalued Indian resources. A federal commission concluded in 1977 that leases negotiated on behalf of Indians were “among the poorest agreements ever made.”31

As long as tribes are denied the right to control their own resources, they will continue to remain locked in poverty and dependence. This is yet another example of the way in which the social determinants of health contribute to the negative impact that money, power and resources have over the Southwestern Native American population.

In addition, this population suffers from significant health disparities, including nutrition-related chronic diseases such as diabetes and heart disease and continue to experience some of the worst health conditions in the United States. This is all related to the unique aspects facing the Native American population impacting these social determinants of health including forced displacement, poverty, inadequate and inferior medical care, food deserts, crumbling and non-existent infrastructure, accident and suicidal deaths and a general over-all poorer and less safe existence compared to almost all other Americans.

Because disparities in health status parallel disparities in wealth and power and because of the unique aspects of control of our Federal government over the Southwestern American Indian population, decisions addressing these disparities often involve decisions to deploy or withhold economic and political resources. Policy makers have had to balance Indian health with other priorities and obligations of the Federal government, including land acquisitions, military needs and resource development.11

Despite these attempts to prioritize existing and competing responsibilities among governmental entities and the Southwestern Native American population, these ongoing disparities in health status clearly continue to occur due to the disparities in wealth and power that have existed since the time of colonization. Because of historical relocation from traditional lands and livelihoods and, in some cases, continued marginalization from mainstream society, native people may experience a cumulative disadvantage. This means that fewer opportunities for education lead to fewer opportunities for living-wage jobs, which lead to lower family incomes, and so on across generations. As noted earlier, Native Americans have a lower socioeconomic position compared to whites in the United States.11

In addition, many challenges remain to address social determinants of health, and new directions pursued by the Trump Administration could limit resources and initiatives focused on these efforts. The Trump Administration is pursuing a range of new policies and policy changes, including enforcing and expanding work requirements associated with public programs and reducing funding for prevention and public health. These changes may limit individuals’ access to assistance programs to address health and other needs and reduce resources available to address social determinants of health.3 All of this will continue to impose a widening gap of disparities in all aspects of life of the Southwestern Native American population, forcing them to remain impoverished and unwell for generations to come.

Only if and when ongoing attempts to improve interventions begin to succeed will these disparities in health status between the Southwestern Native American population and the general United States population ever have any hope of being equalized and eradicated.

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