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Learning How To Heal: An Analysis of the History, Policy, and Framework of Indian Health Care

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LEARNING HOW TO HEAL: AN ANALYSIS OF THE HISTORY, POLICY, AND FRAMEWORK OF INDIAN HEALTH CARE

Betty Pfefferbaum, Rennard Strickland, Everett R. Rhoades, Rose L. Pfefferbaum*

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*"[Her doctor] did not know how to heal an illness, only how to cut it out More to herself . . . she added, He did not know my clan, my family, my history. How could he possibly know how to heal me?"***

The former Cherokee Chief Wilma Mankiller wrote those words in her 1985 short story, "Keeping Pace with the Rest of the World." In that highly

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**WILMA MANKILLER & MICHAEL WALLIS, MANKILLER: A CHIEF AND HER PEOPLE 232-33 (1993).

autobiographical piece of fiction, Mankiller records the reactions of Ahniwake, "a kind of Cherokee 'everywoman' who found herself at the mercy of the American system of medicine after a lifetime of turning to traditional Cherokee doctors in her ailments." As Mankiller personally concludes of her own long and troubled medical history: "My rage came mainly from the frustration caused by the way I feel about Western medicine, the way it generally dehumanizes patients."

There is probably no better case study of what Mankiller calls "this issue of cultural clashes" than the historic struggle to provide health care to Native peoples. This essay focuses upon the history, policy and framework of Indian health. In ways too often ignored by historians and anthropologists, the divergent approaches to medicine and the treatment of illness may be the ultimate distinguishing colonial symbol. Disease, rather than war, was the ultimate destroyer of much of traditional tribal life and nations. More than half of Chief Mankiller's own Cherokee people died in the early smallpox plagues which their priestly doctors were unable to treat. Furthermore, those failures undermined their pre-contact theocracy and opened the way for new tribal leaders, governments and laws. Yet, through it all many of the old and traditional ways of healing survived. Modern Western medicine is now exploring and often adopting both the humanity and the procedures of the Native ways of healing.

I. Introduction

The federal government's relationship with the Native peoples has always been ambivalent, often marked by simultaneous aggression and paternalism. No completely settled policy has ever defined the relationship between the federal government and Indian tribes. Instead the interaction has often been guided by what Commodore Francis Leupp, a turn-of-the-century administrator called "only a vague sense of obligation".¹ This has resulted in marked fluctuations and inconsistent policies that have left successive generations of policy makers at uncertain odds with previous ones. Indian policy has been further described as "a great patchwork quilt" pieced together with fragments of faded, long abandoned programs and bright, new policies cut from shiny, new cloth.²

1. FRANCIS E. LEUPP, *THE INDIAN AND HIS PROBLEM*, at viii (1910).

2. Rennard Strickland, *Genocide-at-Law: An Historic and Contemporary View of the Native American Experience*, 34 U. KAN. L. REV. 713 (1986); Rennard Strickland, *The Absurd Ballet of American Indian Policy or American Indian Struggling with Ape on Tropical Landscape*, 31 ME. L. REV. 213 (1979); Rennard Strickland, *Indian Law and Policy: The Historian's Viewpoint*, 54 WASH. L. REV. 475 (1978-79); Rennard Strickland, *Inventing the American Indian Doll: Observations of an Indian Lawyer About Law and Native Americans*, 5 VA. L. SCH. REP. 6 (1981); Rennard Strickland, *SAVAGE SINNERS AND REDSKINNED REDEEMERS: REFLECTIONS ON INDIAN LAW, LIFE, CULTURE AND ART* (1996).

The government's obligation to provide Indian health care is deeply rooted in several historical bases, especially in treaties and federal legislation. While both broad responsibility and specific obligations have been delineated, there has too often been insufficient funding, producing long periods of inadequate care.

Dramatic changes have occurred over the more than two centuries since the signing of the earliest treaties; these changes are reflected in and result from, attitudes about disease, the science of medicine, and the government's role in the provision of health care. All these have directly influenced the development and implementation of Indian health policy. An understanding of Indian health policy requires, in addition to understanding federal-Indian relationships, an appreciation of the following: The history of health care and policy for society at large, the organization and administration of health care delivery, the mechanisms for funding, the evolving concept of health care, the changing demands for care, and health care manpower requirements. These issues, as they pertain to Indian health, are addressed in this (and a forthcoming) article.

II. New Diseases and Minimal Intervention: Pre-Nineteenth Century

Archaeological and historical evidence dating from pre-Columbian times suggests health problems of Native Americans similar to those of all mankind. Skeletal remains, surviving art, and health tradition demonstrate the occurrence of arthritis, anemia, malnutrition, dental problems, birth defects, and certain infectious diseases. Such evidence, unfortunately, does not permit a complete picture of Indian health status prior to European contact. Nonetheless, it is clear that pre-contact North American Indians had quite remarkably healthy lifestyles, including exceptional diets and sustaining natural exercise. Modern man could learn much from the Native natural and traditional wisdom. Much more is known about the devastating consequences of European-introduced infectious diseases such as measles, cholera, pertussis, diphtheria, and smallpox. Epidemics decimated entire tribes, playing a significant role in the ultimate subjugation of Native peoples.³ Worldwide, contagious diseases were a more serious problem in areas where large numbers of people resided and worked. Indians had little or no immunity to the diseases brought by Europeans and little was known about contagion and infection control.

Prior to the nineteenth century, the government's role in health care was minimal not only for Indians but for society at large. In the late eighteenth century, the federal government simultaneously warred with and saw itself as protector of Indian people.⁴ Two images of the Indian emerged in the white

3. Everett R. Rhoades et al., *Health on the Reservation*, in *ENCYCLOPEDIA BRITANNICA, INC., 1994 MEDICAL AND HEALTH ANNUAL* 96-119 (1994).

4. SPECIAL COMM. ON INVESTIGATIONS, SENATE SELECT COMM. ON INDIAN AFFAIRS, REPORT OF THE SPECIAL COMMITTEE, S. Rep. No. 216, 101st Cong., 1st Sess. 31-33 (1989) [hereinafter REPORT OF THE SPECIAL COMMITTEE].

man's mind — "noble savage" and "ignoble savage," but generally savage in either view. The Indian was often portrayed as different, dependent, and too often culturally, if not spiritually, inferior.⁵ The major concerns involving the federal government and Indian tribes focused upon land, trade, and treaties. There was no organized focus or articulated health policy and no expectation that the government would or even could address health matters. The absence of an articulated Indian health policy mirrored the absence of government involvement in health care in general.

III. Government Intervention: Nineteenth Century

Developments in Indian health care and policy in the nineteenth century must be understood within the context of broader Indian-White relations and evolving national perspectives on health. As westward expansion continued, Indians were seen as a barrier to America's destiny. The Jacksonian policy of removal of Indians gave way to a reservation system at mid-century and eventually to a system of allotments of land to individuals as part of efforts to "civilize" Indians.⁶ During this period, policy changes occurred against a backdrop of often sincere efforts to "civilize" and "assimilate" Native peoples as the only available alternative to probable extinction.

Throughout the nineteenth century, new sciences brought new knowledge of health and medical needs. Stimulated by rapid urbanization, an understanding of the relationship between sanitary conditions and disease was gradually formulated. Great Britain's Public Health Act of 1848 provided a foundation for public intervention in combating and preventing contagious diseases.⁷ Growing acceptance of public involvement resulted in the establishment of boards and commissions to regulate and maintain sanitary conditions in large cities. Enforcement of sanitary regulations was considered so important in some cities that health inspectors worked under the direction of the local police department.⁸ The first large hospitals opened in the mid-1800s.⁹

Early in the nineteenth century, the federal government assumed increased responsibility for certain Indian affairs. Administrative functions assigned to the War Department included modest provisions for health care. During the early 1800s, health care efforts were aimed at preventing the spread of

5. FRANCIS P. PRUCHA, *THE GREAT FATHER: THE UNITED STATES GOVERNMENT AND THE AMERICAN INDIANS* 2-3 (abr. ed. 1984).

6. S. LYMAN TYLER, *A HISTORY OF INDIAN POLICY* 7 (1973).

7. INSTITUTE OF MEDICINE STAFF, *THE FUTURE OF PUBLIC HEALTH* 60 (1988).

8. MILTON I. ROEMER, *AN INTRODUCTION TO THE U.S. HEALTH CARE SYSTEM* 50 (1986) [hereinafter ROEMER, INTRODUCTION].

9. Paul R. Torrens, *Historical Evolution and Overview of Health Services in the United States*, in *INTRODUCTION TO HEALTH SERVICES* 3 (Stephen J. Williams & Paul R. Torrens eds., 1988).

contagious diseases such as smallpox. Services were provided to Indians often with an eye towards the value to the non-Indian communities.¹⁰ With responsibility assigned to the War Department, it is not surprising that attention focused primarily on Indians residing in the vicinity of military posts.

In 1819, Congress appropriated \$10,000 to be distributed to missionary societies to "civilize" Indians; some of these missionary societies provided elementary health services.¹¹ The first congressional appropriation explicitly providing for Indian health care was not made until 1832; \$12,000 was designated to hire physicians and provide vaccinations. Increasingly, treaty agreements provided for medical services and supplies in exchange for land and promises to remain on reservations,¹² establishing a precedent for the creation of a separate system of health care for Indians.¹³ While some treaties specified time limits of from five to twenty years, the government frequently provided services beyond such treaty dates.¹⁴

In 1849, the Indian medical service was transferred from military to civilian control when the Bureau of Indian Affairs (BIA) was transferred from the War Department to the Department of the Interior.¹⁵ A Division of Education and Medicine was established in 1873 to centralize administrative control and coordinate medical services. The medical section of the Division was discontinued in 1877 because of inadequate funding.¹⁶

Health care for Indians during the latter half of the nineteenth century, was provided largely through religious and philanthropic groups.¹⁷ Again largely in keeping with general conditions, physicians in the Indian medical service were not required to have medical degrees until 1878. By 1891, doctors were also required to pass competitive examinations.¹⁸ Nurses, often members of

10. AMERICAN INDIAN POL'Y REVIEW COMM'N, REPORT ON INDIAN HEALTH: TASK FORCE SIX 28 (1976) [hereinafter TASK FORCE SIX REPORT]; COMMISSION ON THE RIGHTS, LIBERTIES, AND RESPONSIBILITIES OF THE AM. INDIAN, THE INDIAN AMERICA'S UNFINISHED BUSINESS 160 (1966) [hereinafter INDIAN AMERICA'S UNFINISHED BUSINESS] (compiled by William A. Brophy and Sophie D. Aberle).

11. U.S. PUB. HEALTH SERV., HEALTH SERVICES FOR AMERICAN INDIANS 86-97 (1957).

12. INDIAN AMERICA'S UNFINISHED BUSINESS, *supra* note 10, at 159-60.

13. WILLIAM SHONICK, GOVERNMENT AND HEALTH SERVICES: GOVERNMENT'S ROLE IN THE DEVELOPMENT OF UNITED STATES HEALTH SERVICES 1930-1980, at 162 (1995).

14. U.S. PUB. HEALTH SERV., *supra* note 11, at 86-87.

15. TASK FORCE SIX REPORT, *supra* note 10, at 29; FELIX S. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 697 (Rennard S. Strickland et al. eds., 1982) [hereinafter COHEN 1982 ED.]; HOUSE SUBCOMM. ON HEALTH & THE ENVIRONMENT, COMM. ON ENERGY & COMMERCE, INDIAN HEALTH CARE: AN OVERVIEW OF THE FEDERAL GOVERNMENT'S ROLE (Comm. Print 1984) [hereinafter INDIAN HEALTH CARE].

16. U.S. PUB. HEALTH SERV., *supra* note 11, at 87-88.

17. TASK FORCE SIX REPORT, *supra* note 10.

18. U.S. PUB. HEALTH SERV., *supra* note 11, at 88.

religious organizations who volunteered their services,¹⁹ did not appear on the staff of the BIA until the 1890s.

While the number of health care providers for Indian people increased, services remained inadequate to meet the need. Early medical services were largely directed towards school children. An Indian service hospital was established in 1882 in conjunction with an off-reservation school and by 1888, two more Indian service hospitals were in operation.²⁰ Some reservations, however, remained with no medical services whatsoever. Even where physicians and services were available, materials, medicine, and equipment were generally in short supply to health care facilities; inadequate transportation was also a major obstacle in the provision of care.²¹

The sometimes unfortunate intrusion of unexpected consequences upon otherwise well-meaning intentions is illustrated in education efforts. The value of education in providing Indians the means of earning a livelihood in the advancing American society was recognized by Indians and non-Indians alike. How to accomplish this with the small numbers of a dispersed population raised logistic questions of which a boarding school seemed to be a reasonable and feasible alternative. Although the boarding school system is often condemned for its role in the "civilization" of Indians, critics have not offered a satisfactory substitute for this means of educating Indian children. Unfortunately, the assemblage of young individuals fostered local epidemics, a situation that modern installations, such as colleges and military induction centers, still sometimes face. It was especially important in the 1800s, a period when mechanisms of contagion and disease transmission were not well understood. Although some authors indicate that conditions in the schools were extremely unsatisfactory, there is also some evidence that the general health of students in school was better than that of those remaining in the camps.²² The Report of the Commissioner of Indian Affairs for 1877 states:

Soon after the Indians returned from the chase in April, wrote Agent John D. Miles from the Cheyenne and Arapaho Agency August 18, 1877, "measles broke out in epidemic form, and notwithstanding the faithful and unceasing care and medical attention of our worthy agency physician, L.A.E. Hodge, the 'badge of mourning' is worn by the heads of almost every lodge in the two tribes." Seventy-four of the 113 school children were down with measles at one time and the agent, doctor, and teachers converted the school building into a hospital. Thanks to the care they received every child was saved. In this we gained a very

19. Torrens, *supra* note 9, at 8.

20. TYLER, *supra* note 6, at 90.

21. U.S. PUB. HEALTH SERV., *supra* note 11, at 87.

22. Fordyce Grinnell, *Indian Questions from a Medical Standpoint*, 29 CINCINNATI LANCET & OBSERVER 157 (1878).

important point with the camp Indians, demonstrating the advantage of our manner of treatment over theirs, and the superiority of warm houses over that of the damp lodge in sickness. One family of five children were all taken of except one, who was in school"²³

In any case, concern about conditions in the schools such as crowding, faulty ventilation, and the belief that schools could not offer proper isolation brought national attention to the inadequacies of the Indian medical service: pay was low and the staff was often poorly trained, uninterested, and even incompetent; equipment and medicine were inadequate; and esprit de corps was almost entirely lacking.²⁴ The 1898 Commissioner's Report announced the formation of a society of physicians, the Indian Medical Association,²⁵ but Commissioner of Indian Affairs William A. Jones (1897-1904) discouraged its activities, and any enthusiasm that might have led to a more effective Indian medical service dissipated.²⁶

Health education and preventive measures became part of BIA policy in the late 1800s. The duties of BIA physicians, according to an 1889 BIA report, included health education during school, home visits, and sanitary inspection of school and agency buildings. Field workers, the predecessors of public health nurses, provided health education and emergency nursing services. Unfortunately, few field workers were actually employed; only twenty-one were on staff by 1900,²⁷ and their usefulness was limited by lack of specialized training.²⁸

In 1880, the BIA operated four hospitals and employed seventy-seven physicians,²⁹ comparing not unfavorably with the availability of hospitalization in the dominant culture. Treatment in the home was preferred; hospitals were used almost exclusively for the treatment of the poor or those with contagious diseases.³⁰ Reasons given for the establishment of hospitals to treat Indians included living conditions that made treatment outside of hospitals useless or even dangerous, the need to limit the spread of contagious diseases and to protect Indian schools, and the hope of decreasing the influence of traditional medicine men.³¹

23. DEPARTMENT OF THE INTERIOR, REPORT OF THE COMMISSIONERS OF INDIAN AFFAIRS (1898).

24. PRUCHA, *supra* note 5, at 844.

25. DEPARTMENT OF THE INTERIOR, *supra* note 23, at 340.

26. PRUCHA, *supra* note 5, at 844.

27. SHONICK, *supra* note 13, at 163.

28. U.S. PUB. HEALTH SERV., *supra* note 11, at 87.

29. INDIAN AMERICA'S UNFINISHED BUSINESS, *supra* note 10, at 160.

30. Milton I. Roemer, *Resistance to Innovation: The Case of the Community Health Center*, in 78 AM. J. PUB. HEALTH 1234, 1238-39 (1988).

31. U.S. PUB. HEALTH SERV., *supra* note 11, at 87.

Toward the close of the nineteenth century, Commissioner Thomas J. Morgan (1889-1893) proposed the establishment of hospitals at every agency and boarding school.³² The "clash" of divergent civilizations was also reflected in the fundamental difference between traditional Indian people with their own highly developed treatments and the often strange and foreign treatments of government physicians. Although the relation between medicine man and physicians was considerably more complex than usually portrayed, Indians often reacted to "foreign" medicine with fear and hostility.³³ Many government physicians made little attempt to understand or analyze the Indian's own historically rich and highly successful traditional medicine. Medicine men were accused of actively preventing school attendance³⁴ and their practices were often declared offenses punishable by imprisonment.³⁵

While the health care needs of individual Indian people and Indian tribes varied, federal policy throughout the latter part of the nineteenth century continued to be burdened with the contradictory concept of Indians as both members of sovereign nations and wards of the federal government.³⁶ With the Indian Appropriation Act of 1871,³⁷ treaty making with Indian tribes was discontinued. However, the plenary powers earlier vested in the Congress continued and the federal government continued to carry out its Indian responsibilities largely through the legislative process. The dilemma of Indian sovereignty continued with the U.S. Supreme Court finding that the Fourteenth Amendment to the Constitution (adopted in 1868) continued the exclusion of Indians from citizenship.³⁸ So, while the Indian Appropriation Act did not invalidate previously ratified treaties, it was a step that recognized continued weakening of tribal autonomy.³⁹

Further erosion of tribal autonomy, and individual and collective traditional institutions, customs, and leadership, came with the General Allotment Act of 1887.⁴⁰ This act was part of the continuing effort to "civilize" Indians by providing for individual land ownership. The Act also provided for United States (and, via the Fourteenth Amendment, state) citizenship to allottees.⁴¹ Supported by the Indian Rights Association, the Lake Mohonk Conference,

32. PRUCHA, *supra* note 5, at 842.

33. U.S. PUB. HEALTH SERV., *supra* note 11, at 88.

34. U.S. Dep't of the Interior, *Report of the Commissioner of Indian Affairs*, in DOCUMENTS OF UNITED STATES INDIAN POLICY 160 (Francis P. Prucha ed., 2d ed. 1990) [hereinafter DOCUMENTS].

35. Thomas J. Morgan, *Rules for Indian Courts*, in DOCUMENTS, *supra* note 34, at 186-87.

36. SHONICK, *supra* note 13, at 172.

37. Ch. 120, 16 Stat. 544.

38. *Elk v. Wilkins*, 112 U.S. 94, 102 (1884).

39. Donald J. Berthrong, *Nineteenth-Century United States Governmental Agencies*, in 4 HANDBOOK OF NORTH AMERICAN INDIANS 260-61 (Wilcomb E. Washburn ed., 1988).

40. Ch. 119, 24 Stat. 388 (codified as amended at 25 U.S.C. § 349 (1994)).

41. § 1, 24 Stat. at 388.

missionary boards, and the Board of Indian Commissioners,⁴² the Allotment Act was premised on the concept of private property, education, and farming as a livelihood. The underlying principle of much policy at this time was that Indians were destined for assimilation,⁴³ an inevitability recognized by many Indians and non-Indians.

The end of the nineteenth century was a low point in Indian history: the size of many, but not all, Indian tribes was decreasing dramatically; tribes were widely dispersed and often isolated;⁴⁴ and public programs continued to be underfunded, inadequate, and unprepared to meet the needs of a diverse and unappreciated people.

In contrast to efforts to provide some degree of systematic health care to Indians, much of the nineteenth century health care was rudimentary and unorganized for society at large. Individuals were generally left to their own resources or to charitable organizations for their health care.⁴⁵ Health workers had minimal training. There was no comprehensive needs assessment or planning, little cultural sensitivity in the provision of care, and no systematic mechanism for funding, though some public funds were available. By the end of the nineteenth century, however, an organized structure for the provision of health care was emerging and a clear precedent for federal involvement was being established.⁴⁶

IV. Health as a Priority: Early Twentieth Century

Health care changed quickly and dramatically in the early twentieth century. The application of science to medicine was leading to important new discoveries. Hospitalization became central to health care delivery⁴⁷ and federal activities in public health expanded rapidly.⁴⁸ By 1910, public health offices were established at local and state levels. Health departments, even in small towns, appointed physician health officers who had legal authority to enforce sanitation and infectious disease regulations.⁴⁹ Medical education and professional licensing underwent reform. Nonetheless, while health care delivery was evolving toward more formalized care, this occurred without a thoughtful, broadly debated public policy.⁵⁰ Health care for those who could not afford to pay was still generally provided through charitable organizations,

42. TYLER, *supra* note 6, at 95.

43. Berthrong, *supra* note 39, at 260-63.

44. Philleo Nash, *Twentieth-Century United States Government Agencies*, in 4 HANDBOOK OF NORTH AMERICAN INDIANS, *supra* note 39, at 264.

45. Torrens, *supra* note 9, at 15.

46. U.S. PUB. HEALTH SERV., *supra* note 11, at 86.

47. Torrens, *supra* note 9, at 9.

48. INSTITUTE OF MEDICINE STAFF, *supra* note 7, at 66.

49. ROEMER, INTRODUCTION, *supra* note 8, at 52.

50. Philip R. Lee & A.E. Benjamin, Jr., *Health Policy and the Politics of Health Care*, in INTRODUCTION TO HEALTH SERVICES, *supra* note 9, at 467.

with public provision of services only when necessary. It would take the Great Depression and World War II to create an environment in which health care would become part of the public policy agenda and be provided through large-scale public programs. The Depression was important because it shook people's belief in the ability of individuals to control all aspects of their lives, and World War II was important because it demonstrated large-scale government provision of services based on right rather than charity.⁵¹

The federal government's role in Indian health care remained minimal. Except for agency and school physicians on reservations, little systematic attention was paid to Indian health care until 1904.⁵² The health crisis in Indian schools, exacerbated by conflicting goals regarding school enrollment and medical care, was of increasing concern. The problem was officially addressed in 1903 when Indian school agents and superintendents were instructed to enroll only healthy children; hygiene, overcrowding, and ventilation became priority concerns.⁵³

Commissioner William A. Jones (1897-1904) attempted a comprehensive survey of health in Indian schools and on reservations. The 1904 Commissioner's Report noted that tuberculosis was widespread and related to failure to disinfect tubercular sputum; there was inadequate sanitation, a lack of cleanliness, improper food preparation, overcrowded school dormitories, inadequate medical attention, and alcohol use.⁵⁴ The Report acknowledged improper medical attention, but laid blame on Indians themselves and their lack of confidence in the treatment provided. Jones concluded that adequate treatment was impossible because of the Indians' "ignorance and superstition."⁵⁵

In 1910, Commissioner Francis Ellington Leupp (1905-1909) reaffirmed that the ultimate policy goal was to integrate the Indian into the larger society.⁵⁶ According to Leupp, education was the vehicle for change. He promoted the charitable aspect of schools and considered the availability of medical assistance at schools an incentive for Indian parents to enroll their children. Only at the end of his administration did Leupp begin to express concern for health problems.⁵⁷ His efforts were tempered by his belief that it was extremely difficult to change Indian ways.⁵⁸ In 1908, Leupp appointed a special committee to review the problem of contagious diseases at schools. He

51. Torrens, *supra* note 9, at 12.

52. PRUCHA, *supra* note 5, at 842.

53. *Id.* at 845.

54. U.S. DEP'T OF THE INTERIOR, REPORT OF THE COMMISSIONER OF INDIAN AFFAIRS 32-36 (1904).

55. *Id.* at 35.

56. LEUPP, *supra* note 1, at 343.

57. PRUCHA, *supra* note 5, at 847.

58. U.S. DEP'T OF THE INTERIOR, REPORT OF THE COMMISSIONERS OF INDIAN AFFAIRS 26 (1908).

also designated agency and school doctors as "health officers" with authority to direct and enforce sanitation efforts.⁵⁹

In 1908, the first chief medical supervisor of the Indian service was appointed.⁶⁰ The tuberculosis sanatoria established to treat Indian children gradually expanded to include care for adults.⁶¹ When confronted with the possibility of establishing a tuberculosis sanatorium in the southwest, Leupp rejected the idea in favor of sanatoria on or near reservations and schools.⁶²

Health was a priority for Commissioner Robert Grosvenor Valentine (1909-1912), who believed that serious health conditions hindered assimilation efforts and that infection was likely to spread to neighboring communities.⁶³ Contemporary surveys and reports confirm the serious problems associated with infectious disease, unsanitary conditions, overcrowding, and inadequate incentives for health care providers.⁶⁴ Valentine initiated a national campaign to conquer trachoma and implemented a program of health education.⁶⁵ His campaign to increase funding for both prevention and treatment of disease was only partially successful. Valentine also pioneered in the hiring of Indians.⁶⁶

Concerned about contagious diseases, Congress began to make separate appropriations for the prevention and treatment of diseases among Indian tribes. Prior to 1911, when Congress appropriated \$40,000 to provide general health services to Indians, expenditures for Indian health care were financed entirely with miscellaneous funds.

In 1912, President William Howard Taft supplied Congress with survey results indicating an alarming prevalence of tuberculosis and trachoma in schools and on reservations and requested an appropriation of \$253,000 for medical care for Indians. Though Congress did not grant the entire request, the President's message served to increase public awareness of the continuing serious medical conditions among Indians.⁶⁷ Health became an issue in the government's Indian policy, and some progress was being made as a result of various strenuous health campaigns undertaken by Commissioner Cato Sells (1913-1921).⁶⁸ Congressional appropriations for Indian health care were \$200,000 in 1914, \$300,000 in 1915 and in 1916, and \$350,000 in 1917. Far

59. *Id.*; PRUCHA, *supra* note 5, at 848.

60. COHEN 1982 ED., *supra* note 15, at 697.

61. U.S. PUB. HEALTH SERV., *supra* note 11, at 86-97.

62. LEUPP, *supra* note 1, at 355-57.

63. D.T. Putney, *Robert Grosvenor Valentine 1909-1912*, in COMMISSIONERS OF INDIAN AFFAIRS 1824-1977, at 233-34 (Robert M. Kvasnicka & Herman J. Viola eds., 1979) [hereinafter COMMISSIONERS OF INDIAN AFFAIRS].

64. PRUCHA, *supra* note 5, at 850-52.

65. James E. Officer, *The Indian Service and Its Evolution*, in THE AGGRESSIONS OF CIVILIZATION 59, 65-74 (Sandra L. Cadwalader & Vine Deloria eds., 1984).

66. Putney, *supra* note 63, at 234.

67. TYLER, *supra* note 6, at 107-08; PRUCHA, *supra* note 5, at 850.

68. PRUCHA, *supra* note 5, at 852-54.

short of what was needed, these separate appropriations for health care were augmented with miscellaneous funds.⁶⁹ With the advent of World War I, however, efforts were curtailed; the Indian medical service staff was cut drastically⁷⁰ and there was little or no new construction or repairs of plant and equipment.⁷¹ It was not until the 1920s that Indian health needs received serious public attention.⁷²

As early as 1919, recommendations for transferring the Indian medical service to the Public Health Service (PHS), to be directed by the surgeon general, were considered. Though the PHS was highly regarded, the BIA opposed the move, arguing that health should not be separated from educational and social efforts. The surgeon general also opposed the move, claiming he was overwhelmed caring for disabled veterans. Despite initial support from the House Committee on Indian Affairs, Congress did not transfer the service.⁷³

The concept of a "right" to health care was being recognized in Indian policy. Increases in funding and the developing organizational structure reinforced the idea. Public health practices were evident in attention to sanitation and living conditions and the use of survey and statistical methodology, but the efforts were largely ineffective because preventive public health measures were not emphasized.⁷⁴

V. *The Beginnings of Public Health Practices: 1921 to 1954*

Formal structure gradually emerged along with those for the general population. The Snyder Act of 1921 provided basic authorization for Indian health care.⁷⁵ The Indian Citizenship Act of 1924 provided for the naturalization of noncitizen Indians born within U.S. territory.⁷⁶ Consequently, as U.S. citizens, Indians became citizens of the state of residence and eligible for all benefits of United States citizens.

The Snyder Act consolidated previous enactments, authorized the federal involvement in Indian programs including health, and affirmed administrative responsibility for Indian programs to the BIA under the supervision of the Secretary of the Interior.⁷⁷ The Act specifically authorized the BIA to "direct,

69. PRUCHA, *supra* note 5, at 850-52; U.S. DEPT OF THE INTERIOR, HANDBOOK OF FEDERAL INDIAN LAW 243 (1958 ed.) [hereinafter COHEN 1958 ED.] (revision of Felix Cohen's *Handbook of Federal Indian Law*); U.S. PUB. HEALTH SERV., *supra* note 11, at 88.

70. PRUCHA, *supra* note 5, at 854.

71. TYLER, *supra* note 6, at 109.

72. PRUCHA, *supra* note 5, at 852-59.

73. *Id.* at 860-63; U.S. PUB. HEALTH SERV., *supra* note 11, at 94.

74. PRUCHA, *supra* note 5, at 852-57.

75. Snyder Act, ch. 115, 42 Stat. 208 (codified as amended at 25 U.S.C. § 13 (1994)); *see* TASK FORCE SIX REPORT, *supra* note 10, at 123.

76. Indian Citizenship Act of 1924, ch. 233, 43 Stat. 253 (repealed 1952); *see* COHEN 1982 ED., *supra* note 15, at 143.

77. Officer, *supra* note 65, at 68-71.

supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians" for among other things "relief of distress and conservation of health."⁷⁸ The Act, however, established only discretionary programs rather than entitlement to specific services.⁷⁹ It did not adequately define eligibility,⁸⁰ nor did it identify levels or goals for funding. Programs remained under the general direction of Congress.

When the BIA was reorganized under Commissioner Charles Henry Burke (1921-1929), a health division was created with a chief medical supervisor who had direct access to the commissioner, and with medical directors (physicians who were commissioned officers in the PHS) who were assigned to four medical districts.⁸¹ Nonetheless, salaries remained low, turnover was high,⁸² and many of the professionals who joined the service were marginally qualified.⁸³ Public health nurses were not added until 1924.⁸⁴ In 1926, officers from the PHS assumed positions in the Indian health program. While this practice continued through the 1940s, responsibility for administration remained with the BIA.⁸⁵

Lewis Meriam's monumental two-year study of Indian conditions, published in 1928 as *The Problem of Indian Administration*, included a description of impoverishment and poor health among Indians along with a detailed review of Indian health and the government's role in providing care. Meriam described school conditions in which children received deficient diets and insufficient medical care, the faculty was ill-prepared, the curriculum was rigid, and discipline was restrictive.⁸⁶ With respect to the medical service, the Meriam Report documented low salaries, incompetent staff, inadequate facilities, and minimal preventive medicine. Specifically, the report called for additional staffing to address tuberculosis, trachoma, infant welfare and maternity, venereal diseases, and hospital and sanatorium management. Other new positions were requested including public health nurse and field positions such as home demonstration agents and social case workers.⁸⁷

78. Snyder Act, § 1, 42 Stat. at 208.

79. Everett R. Rhoades et al., *The Organization of Health Services for Indian People*, 102 PUB. HEALTH REP. 348, 352-56 (1987).

80. TASK FORCE SIX REPORT, *supra* note 10, at 123.

81. U.S. PUB. HEALTH SERV., *supra* note 11, at 90.

82. Officer, *supra* note 65, at 69.

83. Lawrence C. Kelly, *Charles Henry Burke 1921-1929*, in COMMISSIONERS OF INDIAN AFFAIRS, *supra* note 63, at 251, 253.

84. U.S. PUB. HEALTH SERV., *supra* note 11, at 90.

85. NATIONAL INDIAN HEALTH BD. & AM. INDIAN TECH. SERV., *THE INDIAN HEALTH SERVICE'S IMPLEMENTATION OF THE INDIAN SELF-DETERMINATION PROCESS 4-6* (1984) [hereinafter NATIONAL INDIAN HEALTH BD.].

86. LEWIS MERIAM, BROOKINGS INST., *THE PROBLEM OF INDIAN ADMINISTRATION 11-14* (1928).

87. *Id.* at 9-11, 189-345.

The Meriam Report offered considerable insight into the relationship between the races. It advocated respect for the rights — not just property rights — of the Indian and viewed education as a vehicle in all efforts.⁸⁸ The report called for prevention and public health, increased manpower and incentives for workers, efficient operations, data-based information gathering to guide planning and policy, and Indian self-determination.⁸⁹

Commissioner Charles James Rhoads (1929-1933) endorsed the Meriam Report and under his administration, appropriations for education, health, and welfare increased.⁹⁰ The first preventive medicine program, which emphasized maternal and infant care, was established.⁹¹ Cooperation between the BIA and the PHS increased; personnel and facilities were improved; collection and tabulation of vital statistics were afforded more attention; and federal-state cooperation in seeking solutions to the problems of Indian health progressed.⁹²

In the last half of this century, federal involvement in health care has dramatically increased as evidenced by the establishment of agencies such as the National Institutes of Health and the Centers for Disease Control. The Social Security Act⁹³ established federal grant-in-aid programs to states for establishing public health services and training. Expansion of state activity accompanied growth in federal activity; the cooperative relationship between federal and state activity also grew, eventually resulting in shared responsibility ultimately formalized through programs such as Medicaid.⁹⁴

Based on the premise that services to Indians could better be provided by states than by the federal government,⁹⁵ the Johnson-O'Malley Act⁹⁶ allowed states, other political subdivisions, and private entities to provide for Indian health, education, and welfare through contracts and grants.⁹⁷ The Johnson-O'Malley Act was a response to criticism in the Meriam Report that Indian Bureau standards were inferior to those of state agencies.⁹⁸ Under Johnson-O'Malley, Indians receive services through local entities used by other citizens rather than through special federal programs operated specifically for Indians. Perceived as intending to shift responsibility for Indian services to states, full implementation of the Johnson-O'Malley Act was limited by the fact that it was

88. *Id.* at 22.

89. *Id.*

90. Lawrence C. Kelly, *Charles James Rhoads 1929-1933*, in COMMISSIONERS OF INDIAN AFFAIRS, *supra* note 63, at 263-71.

91. Officer, *supra* note 65, at 69.

92. TYLER, *supra* note 6, at 121.

93. Ch. 531, 49 Stat. 620 (1935) (codified as amended in scattered sections of 42 U.S.C.).

94. Lee & Benjamin, *supra* note 50, at 476.

95. Nash, *supra* note 44, at 268.

96. Ch. 147, 48 Stat. 596 (1934) (codified as amended at 25 U.S.C. §§ 452-457 (1994)).

97. § 1, 48 Stat. at 596; see NATIONAL INDIAN HEALTH BD., *supra* note 85, at 4-6; U.S. PUB. HEALTH SERV., *supra* note 11, at 92.

98. COHEN 1958 ED., *supra* note 69, at 83.

enacted during the Great Depression, a time when states were unable to assume additional financial responsibilities.⁹⁹ The Depression and World War II resulted in an increased federal role in the provision of human services, higher costs, and a decreased willingness and ability of states to provide services to Indians.¹⁰⁰

The Meriam Report, which generally supported the shift of service provision from the federal government to states (and local communities), was influential in the development of the Indian Reorganization Act (IRA).¹⁰¹ The IRA, part of President Franklin D. Roosevelt's "New Deal" legislation, reversed the trend toward weakening tribal governments by establishing economic development programs and encouraging the formation of federally recognized tribal governments on a voluntary basis. The IRA began the rejuvenation of Indian communities and provided the foundation for tribal self-governance.¹⁰²

The New Deal era produced considerable improvement in federal health services for Indians. Appropriations for Indian health increased from \$3,486,085 in 1935 to \$4,011,620 in 1936. By 1936, 160 full-time and 76 part-time physicians, 378 staff nurses, 105 field nurses, 13 full-time and 13 part-time dentists, and more than 600 other professionals provided health services. A total of ninety-one hospitals and sanatoria were in operation with a total capacity of 3743 beds, 109 cribs, and 267 bassinets.¹⁰³

Although the death rate of Indians decreased from 35.6 per thousand in 1911 to 15.1 per thousand in 1936,¹⁰⁴ poor health continued among Indians largely as a result of inadequate housing, poor diets, unsanitary water supplies, and generally poor economic conditions.

The Second World War had a profound effect on Native peoples; 65,000 Indians left reservations to join the armed forces or to work in war-related industries. Many returned to underdeveloped reservations with limited job opportunities. Some sought to resume their traditional roles. Others preferred to practice new trades learned as part of their war experiences. Still others sought to take advantage of the educational opportunities afforded by the G.I. Bill.¹⁰⁵ The war experience increased the schism between those who favored assimilation and those who favored tribal autonomy. This was reflected in the debate over compensated termination as opposed to government support for developing tribal governance.¹⁰⁶

99. SHONICK, *supra* note 13, at 165.

100. Nash, *supra* note 44, at 268.

101. Ch. 576, 48 Stat. 984 (1934) (codified as amended at 25 U.S.C. §§ 461-476 (1994)).

102. Nash, *supra* note 44, at 265; SHONICK, *supra* note 13, at 165.

103. U.S. DEPT OF THE INTERIOR, REPORT OF THE COMMISSIONER OF INDIAN AFFAIRS 174-79 (1936).

104. *Id.*

105. TYLER, *supra* note 6, at 155; SHONICK, *supra* note 13, at 165.

106. SHONICK, *supra* note 13, at 165.

As in the private sector, wartime budget demands and a shortage of medical personnel interfered with provision of Indian health services during the Second World War.¹⁰⁷ After the war, ambulatory care facilities became more common and health centers were established to replace some older Indian hospitals. Typically staffed with physicians, health centers provided outpatient and public health services. The Doctor-Dentist Draft Law¹⁰⁸ permitted physicians and dentists to meet their draft obligations by serving in the Public Health Service; the number in the Indian program quadrupled in a single year.¹⁰⁹ Nonetheless, medical staffing for Indian health care remained inadequate due to low salaries, excessive clinical assignments, isolation from other professionals, substandard living quarters, little hope of advancement, and a shortage of modern equipment.¹¹⁰

Two important issues in the provision of Indian health care surfaced during this period: establishment of eligibility criteria and fees for service. Initially, decisions regarding eligibility for care were left to individual agency superintendents or physicians. In time, the BIA confined services to "ward" Indians. By the late 1930s, Bureau regulations specified that all Indians belonging to a recognized tribe, descendants of Indians who lived on a reservation, and all other persons of at least one-half Indian blood were entitled to services.¹¹¹ In 1938, Congress authorized the collection of fees for medical (as well as certain other) services from Indians who were able to pay. Discretion in levying charges was left to BIA staff, and the legislation was not extensively implemented.¹¹² As in previous decades, problems included too little emphasis on prevention and public health, limited funding, inadequate staffing, and insufficient Indian participation in planning and implementation.

VI. Official Transfer to the Public Health Service: 1955

The establishment of the Department of Health, Education, and Welfare (HEW) in 1953 further strengthened the federal government's involvement in health care and ushered in significant changes in the nation's health care delivery system. National health policy concerns emerging during the 1950s, 1960s, and 1970s included: registration and approval of medications, financial assistance for professional education, care for the elderly and the poor, and acknowledgment of some inherent rights to health care.¹¹³

Indian termination policy began with the aim of reversing federal Indian policy by eliminating Native programs. Whatever the motivations for

107. Officer, *supra* note 65, at 69; PRUCHA, *supra* note 5, at 984-85.

108. Ch. 939, 64 Stat. 826 (1950).

109. U.S. PUB. HEALTH SERV., *supra* note 11, at 90.

110. *Id.*

111. *Id.* at 93.

112. *Id.*

113. Lee & Benjamin, *supra* note 50, at 468-76.

termination — acquisition of Native land and resources, elimination of favoritism toward Indians, assimilation of Indians into the mainstream,¹¹⁴ or response to continued condemnation of existing programs — the result was severe budget cuts and the identification of tribes for whom federal government responsibility could be eliminated.¹¹⁵

Although its antecedents were much older, termination began officially in 1947 when Congress directed the BIA to identify criteria that would indicate tribal readiness to become part of the mainstream, relinquishing their status as Indians and the protections associated with their trust relationship. Termination became official congressional policy in 1953 with the adoption of House Concurrent Resolution 108.¹¹⁶ The position of the federal government was left ambiguous, however, because concurrent resolutions are advisory rather than statutory; they are binding on Congress but not on the executive branch.¹¹⁷

The history of Indian-White relations has been characterized by tension inherent between the competing objectives of termination, integration, and assimilation on the one hand, and tribal autonomy and self-rule on the other. This tension, a continuation of the 200-year-old sovereignty/ward dilemma, continues to influence public policy and the provision of health services. Indeed, it is useful to view development of health services to Indians in terms of the continuing conflict between integration and autonomy.¹¹⁸ Under the BIA, health services for Indians grew slowly but steadily from the early 1900s until World War II; in fact, prior to 1940 the BIA rarely placed Indians in community hospitals. After 1940, there was a gradual move toward reliance on local community health resources. More than thirty Indian hospitals and sanatoria were closed in seventeen states.

Greater reliance on community health resources, which occurred in part because of the limited staff at Indian hospitals and the increased availability of community hospitals, was buttressed by policy in 1952 calling for the closure of Indian facilities when appropriate non-Indian facilities were available. By 1955, the BIA had contracts for the care of Indians with eighty-seven non-Indian hospitals (sixty-five general community hospitals, seventeen tuberculosis hospitals and five mental health hospitals). The BIA was also paying on a fee-for-service basis for care for Indians at more than 180 non-Indian hospitals.¹¹⁹ The BIA did, however, increase its capacity for providing ambulatory care after World War II by establishing health centers which, to some extent, replaced hospitals. These health centers resembled the field stations (though better

114. SHONICK, *supra* note 13, at 165-66.

115. COHEN 1982 ED., *supra* note 15, at 153-59.

116. H.R. Con. Res. 108, 67 U.S. Stat. B132 (1953).

117. Nash, *supra* note 44, at 270-71.

118. SHONICK, *supra* note 13, at 166.

119. U.S. PUB. HEALTH SERV., *supra* note 11, at 89.

staffed and equipped) that had traditionally provided outpatient and public health services in outlying locations.¹²⁰

Decentralization of BIA functions had been discussed as early as the 1920s.¹²¹ There was a serious, albeit unsuccessful, attempt to transfer Indian health services to the PHS in 1919. The next such attempt, both serious and unsuccessful, occurred in the 1930s when it was argued that the transfer was needed to improve standards and staff morale. Commissioner John Collier (1933-1945) did not support the transfer,¹²² even though he recommended decentralization as an interim stage in the move toward tribal self-governance. This interim stage would involve transfer of some BIA functions to other federal agencies specializing in those particular functions and decentralization in the provision of services to state, local, and tribal governments.¹²³ For others, decentralization of BIA functions was part of a termination sentiment. It provided a mechanism for decreasing the role of the BIA and curtailing specialized services to Indians.¹²⁴

Legislation¹²⁵ transferring the Indian medical service from the BIA to the PHS within HEW was passed in 1954, with the transfer to be completed by July 1, 1955. What is now the Indian Health Service (IHS) was created in 1955 as a special branch of the PHS.¹²⁶ While the provision of Indian health care had been supervised by personnel from the PHS since 1926, the PHS did not assume legal responsibility for Indian health care until 1955.

Reasons other than those associated with termination justified the transfer of responsibility for Indian health care to the PHS. The PHS had better professional and technical resources, was better able to attract professional staff, and could provide direct medical supervision of the Indian health program. The PHS also might be more successful in obtaining appropriations and in effecting state and local cooperation in the provision of Indian health care.¹²⁷ The transfer of Indian health care to the PHS eventually resulted in increased funding, greater access to care, and better care overall, though not for all.

Support for the transfer was not unanimous. HEW argued that the transfer would not solve Indian health problems.¹²⁸ There was concern about separating health from other BIA programs in terms of the administration and

120. *Id.*

121. *Id.* at 93.

122. *Id.* at 94.

123. SHONICK, *supra* note 13, at 167; COHEN 1982 ED., *supra* note 15, at 150-51.

124. SHONICK, *supra* note 13, at 165-68.

125. Transfer Act of Aug. 5, 1954, ch. 658, 68 Stat. 674 (codified as amended at 42 U.S.C. §§ 2001-2005 (1988)).

126. COHEN 1982 ED., *supra* note 15, at 698; TYLER, *supra* note 6, at 181.

127. PRUCHA, *supra* note 5, at 1068-74; U.S. PUB. HEALTH SERV., *supra* note 11, at 86-97.

128. U.S. PUB. HEALTH SERV., *supra* note 11, at 95.

delivery of services.¹²⁹ Some Indian groups worried that transfer would mean a decline in service and closure of small hospitals thereby requiring greater patient travel for care.¹³⁰ While in previous years the BIA had objected to the transfer, it was eventually supported by Commissioner Glenn L. Emmons (1953-1961) who considered health, along with education and economic development, to be the three highest priorities for Indians.¹³¹

Despite the transfer, the Department of the Interior maintained control of expenditures for new hospitals. In an effort to integrate Indians into facilities used by others and in order to save money, the Department of the Interior refused to authorize the building of new hospitals. This resulted in serious shortages of services in some areas with sizeable Indian populations. Furthermore, unexpended dollars designated for hospital construction created a budget surplus which resulted in proposals for budget cuts in Indian health. The Indian Health Facilities Act was passed to grant funds to communities to construct hospitals to serve Indians and non-Indians alike.¹³² This Act authorized the IHS to contribute funds to construct community hospitals when Indians would be better served by such hospitals than by PHS facilities.¹³³

When Congress transferred the medical service from the BIA to the PHS, four major functions were identified: (1) provision of training and technical assistance; (2) coordination of available health resources through federal, state, and local programs for the benefit of Indian people; (3) federal advocacy for Indian health; and (4) provision of comprehensive health services, including hospital and ambulatory medical care and preventive, rehabilitative, and environmental services.¹³⁴ The transfer legislation did not define eligibility for health care or establish charges for care.¹³⁵

VII. Indian Self-determination: The 1970s

By the 1970s, health care and health policy had become critical issues for the nation as a whole. Many policy decisions were guided by the interests of the medical profession. President Richard M. Nixon favored private rather than public solutions to the country's health problems. During his administration, federal programs were cut and much federal funding was transferred to state and local governments.¹³⁶ However, for Indians, this period was marked by

129. *Id.* at 96.

130. LARRY W. BURT, *TRIBALISM IN CRISIS FEDERAL INDIAN POLICY 1953-1961*, at 54-55 (1982).

131. Paul K. Ourada, *Glenn L. Emmons 1953-61*, in *COMMISSIONERS OF INDIAN AFFAIRS*, *supra* note 63, at 301-10.

132. Indian Health Facilities Act, Pub. L. No. 85-151, 71 Stat. 370 (1957); *see* BURT, *supra* note 130, at 91-92.

133. § 2, 71 Stat. at 371; *see* SHONICK, *supra* note 13, at 171.

134. TASK FORCE SIX REPORT, *supra* note 10, at 85.

135. U.S. PUB. HEALTH SERV., *supra* note 11, at 95.

136. Lee & Benjamin, *supra* note 50, at 276.

two important pieces of legislation: The Indian Self-Determination and Education Assistance Act¹³⁷ and the Indian Health Care Improvement Act.¹³⁸

The Indian Self-Determination Act provided a mechanism for transferring programs traditionally administered by the BIA and the IHS to tribal governments.¹³⁹ The act was based on the assumption that federal domination of Indian service programs had hindered rather than assisted the progress of Indian people. This was purported to have resulted from deprivation of meaningful opportunities to develop leadership skills, precluding Indians from self-government, and denial of an "effective voice." The act acknowledged that Indians desired control of relationships among themselves and with non-Indian governments. It also affirmed the federal government's commitment to maintain its relationship with Indian tribes and to provide opportunities for "maximum Indian participation" in programs under the IHS.¹⁴⁰

In the two decades following transfer to the PHS, the number of individuals served by the IHS increased: hospital admissions in both IHS and contract hospitals doubled, and there was a five-fold increase in the number of outpatient visits.¹⁴¹ Unfortunately, there was no statutory mechanism to assure funding, congressional appropriations were arbitrary, and the budget process failed to respond to the increased numbers of individuals served and the high rate of inflation in contract services, services purchased from non-IHS providers.¹⁴² Furthermore, the budget for contract services provided for only about half of the services needed.¹⁴³

The goals of providing quality health care and assisting tribes in the management of their own programs were sometimes in conflict. Personnel were in short supply and turnover was great.¹⁴⁴ Career development, incentives, and rewards received little attention; accountability needed to be improved.¹⁴⁵ Programs which were inadequately funded when administered by the federal government continued to be inadequately funded when transferred to tribes for their administration.

In 1976, the *Task Force Six Report* was submitted to the American Indian Policy Review Commission.¹⁴⁶ This report on Indian health revealed less than satisfactory progress due, in large part, to two recurrent problems —

137. Pub. L. No. 93-638, 88 Stat. 2206 (codified in scattered sections of 5 U.S.C. and 25 U.S.C.).

138. Pub. L. No. 94-437, 90 Stat. 1400 (codified in scattered sections of 25 U.S.C.).

139. Indian Self-Determination Act, § 25, 88 Stat. at §§ 1-2; Officer, *supra* note 65, at 68-71.

140. Indian Self-Determination Act, § 25, 88 Stat. at §§ 1-2.

141. TASK FORCE SIX REPORT, *supra* note 10, at 88-94.

142. *Id.* at 94-102.

143. *Id.* at 105-13.

144. *Id.* at 114-17.

145. *Id.* at 94-102.

146. *Id.*

insufficient funding and the need for various modifications in programs.¹⁴⁷ The report noted that Congress viewed the IHS as a supplementary service "residual" to other federal and state health programs and provided limited funding. States and counties, on the other hand, viewed the IHS as the primary provider of Indian health care.¹⁴⁸ Confusion arising from these conflicting views interfered with service delivery, despite the fact that HEW had issued an interpretation in 1968 stating that Indians were eligible for state medical services as well as federal services.¹⁴⁹

Another report to the American Indian Policy Review Commission, the *Task Force Eight Report*, addressed the problems of nonreservation Indians, identifying the need for additional facilities, personnel, medicine, and information. Because most Indian health care facilities were located on reservations, Indians residing in cities or nonreservation areas had little access to care. Some Indians were hesitant to utilize non-Indian facilities in their areas. Non-Indian facilities were often unwilling to treat Indians because of uncertainty about reimbursement. These facilities frequently referred Indians to Indian facilities, usually at some distance, which meant that Indians often did not receive care until their health problems became critical. Other problems related to urban and nonreservation Indian health included lack of basic information about the Indian population and its specific health needs, failure to educate health personnel about Indian health problems, and insufficient employment of Indians in existing facilities.¹⁵⁰

Many of the recommendations contained in the *Task Force Six* and *Task Force Eight* reports remain pertinent today. IHS goals must be realistic. Funding should continue to be examined and modified in accordance with increased need. Services for Indians residing off, as well as on, reservations should be addressed.¹⁵¹

VIII. *The Indian Health Care Improvement Act of 1976*

The Indian Health Care Improvement Act of 1976¹⁵² articulated an ambitious goal: to provide "the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy."¹⁵³ This Declaration of Policy in the Act represents the first legislative statement of a goal for federal Indian health programs and a

147. *Id.* at 85-87.

148. *Id.* at 85.

149. COHEN 1982 ED., *supra* note 15, at 700.

150. AM. INDIAN POL'Y REVIEW COMM'N, URBAN AND RURAL NON-RESERVATION INDIANS: TASK FORCE EIGHT (1976).

151. TASK FORCE SIX REPORT, *supra* note 10, at 121-26.

152. Pub. L. No. 94-437, 90 Stat. 1400 (codified in scattered sections of 25 U.S.C.).

153. *Id.* § 3, 90 Stat. at 1401.

requirement for the provision of resources.¹⁵⁴ While the Snyder Act of 1921 is the primary statute authorizing Indian health programs, it only committed the government to "such money as Congress may from time to time appropriate for . . . relief of distress and conservation of health."¹⁵⁵

The Indian Health Care Improvement Act was comprehensive in scope and authorized a number of programs that serve as models for public health care and national health planning. A primary objective of the Act was to raise the health status of Indians, over a seven-year period, to a level comparable to that of the general U.S. population.¹⁵⁶ The act authorized funds for Indian health care to address needs not met under existing programs and to establish specific new programs.¹⁵⁷ It sought maximum participation of Indians in planning and managing services and allowed tribes to assume authority for the direction of IHS programs.¹⁵⁸ The act authorized a scholarship program for training Indian students in the health professions in exchange for service within the IHS, tribes, or Indian communities.¹⁵⁹ It also authorized services for Indians residing in urban areas, including the establishment of urban health centers, and amended the Social Security Act to permit reimbursement by Medicare and Medicaid for covered services provided by the IHS.¹⁶⁰ Improved care associated with the Act has resulted in improved morbidity and mortality statistics for Indians.

Many Indians who qualify for Medicaid and Medicare use IHS services instead. The federal government's acknowledgment that Indians have dual entitlements resulting from their status as citizens and from treaty rights means that Indians should be allowed to fully utilize federal and state programs for which they qualify, without reimbursement by the IHS; they should also receive IHS services. In practice, however, these entitlements are often challenged giving rise to questions of responsibility.

IX. New Roles, Persistent Problems: The 1980s to the Present

The IHS self-determination program has sought to strengthen tribal governments as well as to deliver services under the administration of tribal governments. The IHS position in regard to self-determination, often in conflict with the Office of Management and Budget, is that true self determination does not mean simply turning the program over to the tribes but means tribes have the full and unfettered right to choose their own mechanism for health care

154. TASK FORCE SIX REPORT, *supra* note 10, at 35.

155. Snyder Act, § 1, 42 Stat. at 208-09, *quoted in* TASK FORCE SIX REPORT, *supra* note 10, at 33.

156. Indian Health Care Improvement Act, § 3, 90 Stat. at 1401.

157. *Id.* § 2, 90 Stat. at 1400.

158. *Id.* § 3, 90 Stat. at 1401.

159. *Id.* § 2, 90 Stat. at 1400.

160. *Id.*

whether that care is provided by the tribe itself or by the IHS. Tribal responses have varied greatly. Contracts are the most common method for transferring IHS health programs to tribal governments, though certain transfers may also be accomplished through grants. Contract and grant activities with tribes increased dramatically, from \$17.4 million in 1975 to \$194 million in 1984, and to \$762 million by fiscal year 1994.¹⁶¹ The major concerns associated with the IHS self-determination program are adequacy of funding, IHS contract administration policies, and the extent of IHS control.¹⁶²

In 1984, IHS implementation of the Indian Self-Determination process was evaluated and found to be effective in engaging tribes in planning and operating health care delivery. The degree of success varied from site to site. Health care planning was not emphasized at most study sites. With respect to the contracting process, delays and frustration in dealing with government bureaucracy and communication problems were identified as were the need for central support, increased technical assistance, and monitoring.¹⁶³

The Indian Health Care Improvement Act of 1976 was amended in 1992,¹⁶⁴ reaffirming the nation's responsibility and legal obligation to assure the highest possible health status for Indians. The amendments specified health objectives for the year 2000, identifying sixty-one status objectives. Manpower issues were addressed with stated objectives increasing the proportion of all academic degrees in the health, allied health, and associated health professions awarded to Indians. While the amendments authorize and reauthorize programs that could help ensure the desired outcomes, appropriations are unlikely to be sufficient to ensure their accomplishment.

In December 1987, in the Omnibus Appropriations Act for fiscal year 1988, Congress provided \$1 million for planning for self-governance for ten tribes and instructed the BIA to begin the planning process. Congress amended the Indian Self-Determination Act by passage of Public Law 100-472,¹⁶⁵ which authorized the BIA to enter into compacts with Indian tribes.¹⁶⁶ The first negotiations were with seven tribes, considered to be the "first tier." Public Law 100-472 provided for self-governance to be a demonstration project for five years; however, there is little evidence that self-governance has been treated as a demonstration project, and it is unlikely that tribes intended for it to terminate in five years. The Tribal Self-Governance Demonstration Project

161. INDIAN HEALTH SERVICE, TRENDS IN INDIAN HEALTH — 1995 (1996).

162. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, INDIAN HEALTH CARE OTA-H-290 (1986).

163. NATIONAL INDIAN HEALTH BD., *supra* note 85, at 26-27.

164. Indian Health Care Improvement Act of 1992, Pub. L. No. §152-573, 106 Stat. 4526.

165. Indian Self-Determination Act Amendments of Oct. 5, 1988, Pub. L. No. 100-472, 102 Stat. 2288.

166. *Id.* § 201, 102 Stat. at 2288.

Act,¹⁶⁷ signed into law in December 1991, extended the period of demonstration for three years (until 1996) and increased the number of participating tribes to thirty.¹⁶⁸ In addition, the appropriations act for fiscal year 1992 directed the IHS to begin the process of compacting through self-governance. To support the belief that the program was never seriously intended as a demonstration project, the Congress established self-governance for BIA programs as permanent in the Indian Self-Determination Act Amendments of 1994,¹⁶⁹ enacted in October 1994.

The 1992 amendments to the Indian Health Care Improvement Act also reauthorized and amended Title III of the Indian Self-Determination Act,¹⁷⁰ to provide for tribal self-governance demonstration projects through the IHS. The 1992 amendments authorized the Secretary of Health and Human Services to negotiate and implement a Compact of Self-Governance and Annual Funding Agreement with those tribes participating in demonstration projects and authorized appropriations as necessary to carry out the projects.¹⁷¹

Self-determination and self-governance in health care have met with mixed response from tribes. Some tribes have been enthusiastic in taking over management of major components of their health care. Some tribes have moved rapidly into the more flexible self-governance mode. Other tribes, however, have been reluctant to participate, electing instead to continue receiving health care from the IHS. While reasons for continued full participation in the IHS system vary among tribes, it would appear that some tribes are relatively satisfied with the IHS. Some tribes recognize that they lack sufficient experience in delivering health care services. Others fear an adverse effect of local tribal politics on their own health care. Still others consider funding for tribal programs to be insufficient. Some fear that self-determination and self-governance will lead to dissolution of the IHS and, with it, dissolution of federal responsibility for Indian health care. It is of interest that even with the impressive movement toward self-governance, the Congress in Public Law 100-472 was careful to preserve the trust responsibility of the federal government, thus continuing the inherent contradiction in the federal-Indian relationship.

The federal appropriation for the IHS for fiscal year 1996 was \$1.984 billion, a very modest increase from the fiscal year 1995 appropriation of \$1.963 billion. Currently, the IHS provides health services directly, through tribes under both self-determination and self-governance, and through contract with private and other public providers. As of 1994, the IHS directly operated forty hospitals and 119 ambulatory facilities of various sizes. Tribes operated

167. Pub. L. No. 102-184, 105 Stat. 1278 (1991).

168. *Id.* § 3, 105 Stat. at 1287.

169. Pub. L. No. 103-413, 108 Stat. 4272.

170. Indian Health Care Improvement Act of 1992 § 3(A), 106 Stat at 4526.

171. *Id.*

an additional nine hospitals and 342 ambulatory care clinics. More complicated ambulatory and inpatient care is available from the private sector with reimbursement through the IHS. In fiscal year 1995, the IHS spent approximately \$362.5 million to purchase such care. An unknown amount of Indian health care is also provided through other federal, state and local governments, private insurance, and personal expense.

While most Indians once lived on or near reservations, this is no longer the case. The latest census figures show that more than one-half live in urban areas, less than a quarter live on reservations, and the remainder live in rural areas (often legally defined as "Indian country"). For the most part, the IHS serves Indians on or near reservations or in rural areas, though there are IHS hospitals in Phoenix, Albuquerque, and Anchorage. It is common for Indians to return to their home area to receive health care services at IHS facilities rather than utilize non-Indian facilities.¹⁷² Relatively little is known about the health status or health care utilization practices of urban Indians.

The health status of Indians has improved markedly since the IHS was transferred to the PHS in 1955.¹⁷³ These improvements are thought to be related to advances in sanitation and housing, emphasis on prevention, greater familiarity with health issues, better access to funds, and more efficient management by the PHS. The tremendous gains must be weighed against continuing deficiencies and problems. Unfortunately, a 1989 Special Committee on Investigations identified "severely limited medical resources" on reservations, significant delays in treatment, problems recruiting and retaining medical professionals, inappropriate use of funds, and administrative mismanagement.¹⁷⁴ While many of the findings of the Special Committee are questionable and many a matter of judgment, there were, and continue to be, severe limitations in medical resources, delays in treatment, and problems in recruiting and retaining medical professionals. Clearly, much remains to be done.

X. Conclusion

The development of general public health policy in this country has been slow and has followed the pattern of other industrialized countries. Three stages in the development of health policy have been identified: (1) public apathy and reliance on charity; (2) public provision of services when not adequately provided by the private sector; and (3) replacement of private and charitable programs by public services and public financing.¹⁷⁵ Public health efforts reflect a balancing of scientific knowledge and social values. These

172. Timothy L. Taylor, *Health Problems and Use of Services at Two Urban Indian Clinics*, 103 PUB. HEALTH REP. 88 (1988).

173. OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 162.

174. REPORT OF THE SPECIAL COMMITTEE, *supra* note 4, at 153-61.

175. Lee & Benjamin, *supra* note 50, at 465.

values, as well as political factors, account for the differential treatment and status of Indians as compared to the general population.

Except for care of the military and the merchant marine, the federal government had a minimal role in health care until after the Civil War.¹⁷⁶ Indian health care, however, was provided through federal programs, sometimes in conjunction with private and state entities. Early federal programs for Indians were relatively well organized. They were initiated largely to curb the spread of infectious diseases and, while the motivation may have been self-serving, Indians benefitted.¹⁷⁷ As medicine modernized during the twentieth century, applications to Indian health care did not keep pace. Appropriations have always been insufficient and both World Wars were accompanied by decreases in funding.

Not until Indian health care was transferred to the PHS in 1955 did Indian health status improve significantly. Subsequent legislation, including the development of innovative public health programs, has greatly enhanced the IHS. In the meantime, health care has become a major national issue with attention focused on efficiency and access to care. The Indian population must benefit from improvements in quality, better access to services, and enhanced services — and at a level and pace at least equal to that of the general population.

Throughout the history of federal-Indian relations, the contradiction inherent in federal responsibilities compared to tribal sovereignty continues to dominate, and sometimes confuse, policy development and implementation. The current acceleration towards tribal sovereignty through self-governance continues in this mode. Absent from most public deliberations about self-governance has been any substantial consideration of health status or clarification of the role of the IHS. Such debate and clarification is vitally needed and can only come from the Congress with its unique position in regard to Indian affairs.

As the debate on the theory and practice of Indian health care continues, it is important to remember tribal peoples and the tribes themselves. Too often, as Wilma Mankiller so eloquently reminds us, doctors do "not know how to heal an illness, only how to cut it out . . ." Western medicine must humanize itself and rise above the bureaucracy if it is to learn how to heal in ways that reach deep into the soul.

176. *Id.* at 465-66.

177. U.S. PUB. HEALTH SERV., *supra* note 11, at 86-87.

APPENDIX:

A HISTORICAL CHRONOLOGY (Pre-Contact to Present)

- Pre 19th Century Contagious diseases were the major health problem. Before the nineteenth century, government's role in the health care of Indians and society at large was minimal.
- Early 19th Century The relationship between sanitation and disease and the effects of urbanization and crowding on health were recognized. Health care efforts were aimed at preventing the spread of contagious diseases.
- 1803 The federal government became officially involved with Indian health care and assigned responsibility for it to the War Department.
- 1819 Federal legislation provided for annual appropriations of \$10,000 to religious groups which provided medical services.
- 1832 The government appropriated \$12,000 to hire physicians and provide vaccinations.
- 1848 The Public Health Act of 1848 provided a foundation for public intervention in combating and preventing contagious disease.
- 1849 The Indian medical service was transferred from military to civilian control when the BIA was transferred from the War Department to the Department of the Interior.
- Late 19th Century U.S. health care delivery became institutionalized, and the first large hospitals opened.
- 1871 With passage of the Indian Appropriation Act, Indian tribes ceased to be considered independent nations for the purpose of treaty negotiations.
- 1873 The Division of Education and Medicine was established.
- 1877 The medical division was discontinued because of inadequate funding.
- 1880 The BIA operated four hospitals and employed seventy-seven physicians.

- 1880s Commissioner Thomas J. Morgan called for hospitals at every agency and boarding school.
- 1887 The General Allotment or Dawes Act sought to break up tribal landholdings into individual homesteads. The Act granted US (and, via the Fourteenth Amendment, state) citizenship to allottees.
- 1891 Doctors in the Indian service were required to pass competitive examinations and possess medical degrees.
- 1898 The Indian Medical Association was formed but activities were discouraged.
- Early 20th Century The scientific method was introduced and applied to health care.
- 1901 Congress conferred citizenship on all Indians in the Indian Territory.
- 1903 Indian schools were instructed to enroll only healthy children. Attention to hygiene, overcrowding, and ventilation became a priority in schools after a long period of high morbidity and mortality due to infectious diseases like tuberculosis and trachoma.
- 1904 Commissioner William A. Jones undertook a comprehensive survey of health in schools and on reservations. The Commissioner's Report concluded that tuberculosis was widespread and related to problems of inadequate sanitation, infection control, and medical attention. The report criticized Indians for their lack of confidence in treatments provided.
- 1908 Commissioner Francis Ellington Leupp appointed a special committee to address the problem of contagious diseases at schools and designated agency and school doctors as "health officers" with authority to direct and enforce sanitation efforts. The first chief medical supervisor of the Indian service was appointed, but funding for health services did not follow until 1910.
- 1910 Public health offices were established at local and state levels.

- 1910-1912 Commissioner Robert Grosvenor Valentine conducted a national effort to conquer trachoma. A campaign to increase funding for prevention and treatment of disease was only partially successful. Valentine encouraged the hiring of Indians for positions dealing with Indian health.
- 1911 Congress appropriated \$40,000 for Indian health care.
- 1912 President William Howard Taft delivered a Special Message to Congress on Indian health, raising public awareness of the serious medical conditions among Indians. He requested an appropriation of \$253,000 for medical care for Indians; the request was only partially funded.
- 1914 Congress appropriated \$200,000 for Indian health care.
- 1915 Congress appropriated \$300,000 for Indian health care.
- 1916 Congress appropriated \$300,000 for Indian health care.
- 1917 Congress appropriated \$350,000 for Indian health care.
- World War I Staffing in the Indian medical service was cut drastically, and there was little new construction or repairs of plant and equipment.
- 1919 Recommendations for transferring the Indian medical services to the PHS were not followed. The BIA opposed the transfer, arguing that health should not be separated from educational and societal efforts.
- 1921 The Snyder Act was passed, consolidating various previous acts and defining the scope of federal Indian programs. Administrative responsibility for Indian programs was assigned to the BIA. The Act established a discretionary program, it did not adequately define eligibility for services, and it did not identify levels or goals for funding.
- 1921-1929 The BIA was reorganized under Commissioner Charles Henry Burke. A health division was created with a chief medical supervisor who had direct access to the commissioner, and medical directors were assigned to four medical districts. Substantial numbers of the professionals who joined the service were poorly qualified; salaries were low and turnover was high.

- 1924 Public health nurses were added to the medical service.
- The Citizenship Act of 1924 provided for the naturalization of noncitizen Indians born within US territory.
- 1926 Officers from the PHS assumed positions in the Indian health program though primary responsibility for administration remained with the BIA.
- 1928 Lewis Meriam's study, *The Problem of Indian Administration*, was published. Meriam described the impoverished living conditions and poor health of Indians, documenting low salaries, incompetent staff, inadequate facilities, and minimal preventive medicine. He called for public health and preventive measures, recommending additional staffing, efficient operations, and data-based information gathering to guide planning and policy. Meriam also recognized the importance of Indian self-determination.
- 1929-1933 Commissioner Charles James Rhoads endorsed the Meriam report, and under his administration, appropriations for education, health, and welfare increased. The first preventive medicine program, emphasizing maternal and infant health, was established.
- 1934 The Johnson-O'Malley Act was passed, allowing states, other political subdivisions, and private entities to provide for the health, education, and welfare of Indians through contracts and grants.
- The Indian Reorganization Act, passed as part of President Franklin D. Roosevelt's New Deal legislation, provided the foundation for tribal self-governance.
- 1935 The Social Security Act was passed. In addition to providing retirement benefits, the Act established federal grant-in-aid programs for states to establish public health services and training.
- Congress appropriated \$3,486,085 for Indian health care.
- 1936 Congress appropriated \$4,011,620 for Indian health care. There were ninety-one hospitals and sanatoria in operation. The Indian death rate decreased to 15.1 per thousand.
- 1938 Congress authorized the collection of fees for medical (as well as certain other) services from Indians who were able to pay. There

was considerable discretion in levying charges and the legislation was not extensively implemented.

- World War II** Approximately 65,000 Indians left reservations to participate in the armed forces and war-related industries.
- Budget decreases and shortages of medical personnel hampered the provision of medical services.
- Mid-1940s** The movement for Indian termination began with the aim of eliminating Indian tribes as well as special programs for Indians.
- 1951** BIA program objectives called for a standard of living for Indians comparable to that of other Americans and the step-by-step transfer of BIA functions to Indians themselves or to other appropriate government agencies.
- 1952** The BIA established a Division of Program to work with individual tribes to accomplish the Bureau's 1951 objectives (see 1951 above).
- Congress authorized the extension of state jurisdiction over reservations in a number of states.
- 1953** The Department of Health, Education, and Welfare was established, assuring the federal government's involvement in health care and ushering in significant changes in the nation's health care delivery system.
- House Concurrent Resolution 108 was passed, officially launching a campaign to terminate the federal government's involvement in Indian affairs.
- 1955** The IHS was transferred to the PHS. Four major functions were identified: training and technical assistance; coordinating available health resources through federal, state, and local programs; advocating for Indian health; and providing comprehensive health services. Eligibility for care and charges were not addressed in the transfer legislation.
- 1957** The Indian Health Facilities Act of 1957 was passed, granting funds to communities to construct hospitals to serve Indians and non-Indians. The Act authorized the IHS to contribute funds to

construct community hospitals when Indians would be better served by such hospitals than by PHS facilities.

- 1959 The Indian Sanitation Facilities Act was enacted, providing authority and funding for the development of safe water and waste disposal in Indian communities.
- 1962 Benefits of the Manpower Development and Training Act were made available to Indians.
- 1965 Congress passed legislation to provide health care for the elderly (Medicare) and the poor (Medicaid).
- 1968 President Lyndon B. Johnson delivered a Special Message to the Congress on "The Forgotten American." The President called for the establishment of a National Council on Indian Opportunity whose purposes would include encouraging all government agencies to make their services available to Indians. President Johnson also suggested that the concept of "termination" should be replaced by Indian "self-determination."
- Presidential candidate Richard M. Nixon spoke out against termination, noting that American society should allow many different cultures to flourish in harmony.
- 1970 In a Special Message to Congress on Indian Affairs, President Richard M. Nixon called for the US to break decisively with the past and create conditions for a new era in which the future of Indians would be determined by Indian acts and Indian decisions.
- 1970s Health care and health policies became critical issues for the nation as a whole. President Nixon favored private rather than public solutions and during his administration, federal programs were reduced and funds were transferred to state and local governments.
- 1975 The Indian Self-Determination Act was passed, providing a mechanism for transferring programs traditionally administered by the BIA and IHS to tribal governments.
- 1976 Task Force Six, a national study, examined the IHS and made recommendations to the American Indian Policy Review Commission. The study revealed insufficient funding and poor management. The Task Force called for more realistic goals; services to Indians both on and off reservations; provision of a

basic health package; and an evaluation of the structure and level of funding, with modifications to reflect increased needs.

Task Force Eight addressed the problems of nonreservation Indians.

The Indian Health Care Improvement Act was passed with the goal of providing the highest possible health status to Indians. The Act sought to engage Indians in planning and managing services, and it authorized a scholarship program to train Indian students in the health professions in exchange for service in the IHS, tribes, or Indian communities. Comprehensive in scope, the Act authorized a number of programs that serve as models for public health care and national health planning.

- 1986 The IHS operated forty-five hospitals with 1988 beds, sixty-five health centers, and more than 200 other clinics. Tribes operated ix hospitals, sixty-two health centers, and over 200 other clinics. An additional 1000 beds were available through contract services.
- 1988 Indian Health Service granted agency status within the Public Health Service.
- 1988-1989 Only thirty-one Indian men and thirty Indian women received medical degrees; seven men and six women received dental degrees; and one man and one woman received pharmacy degrees.
- 1990 Conservative estimates placed Indian mortality rates at a level 25% greater than the general population.
- 1991 The federal appropriation for the IHS for fiscal year 1991 was \$1.4 billion.
- 1992 Amendments to the Indian Health Care Improvement Act reaffirmed the government's responsibility and legal obligation to assure the highest possible health status for Indians.
- 1993 The IHS directly operated forty-one hospitals and 114 ambulatory facilities, and tribes operated eight hospitals and 347 ambulatory clinics.
- 1995 The federal appropriation for the IHS for fiscal year 1995 was \$1.9 billion.

