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## Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices

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# PROVIDING FOR THE HEALTH CARE NEEDS OF NATIVE AMERICANS: POLICY, PROGRAMS, PROCEDURES, AND PRACTICES

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

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### *Prologue*

From the very first contacts between the Old and the New World, European doctors recognized that the Indians held the key to the world's most sophisticated pharmacy. Medicine in most of the world at that time had not yet risen far above witchcraft and alchemy. In Europe, physicians talked about the balance of body humors as they attached living leeches to the patient in order to suck out the "bad blood." Moslem doctors burned their patients with hot charcoals, and physicians in the Orient prescribed elaborate potions of dragon bones . . . . By contrast the Indians of America had refined a complex set of active drugs that produced physiological . . . effects in the patient. This cornucopia of new pharmaceutical agents became the basis for modern medicine and pharmacology.

[T]he Indian cures and medicines . . . circled the world and . . . fully integrated into cultures on every continent. The medicines became so taken for granted that it was easy to forget that they had not always been there and that they had not been discovered or invented by Old World doctors.

In addition to employing the sophisticated medicine chest . . . , native doctors also understood and practiced many medical arts, some of which were still unknown in the Old World. One of the most unusual of these was the brain surgery or trephining performed by surgeons in varied Indian civilizations.

— Jack Weatherford<sup>1</sup>

A study of the history of health care and medical systems reveals a startling fact. Modern scientific medicine has deep roots into the

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1. JACK WEATHERFORD, *INDIAN GIVERS: HOW THE INDIANS OF THE AMERICAS TRANSFORMED THE WORLD* 183-84, 187, 193 (1988). See generally *id.* at 175-96 (ch. 10, "The Indian Healer").

traditional civilizations of the American continents. Not only are contemporary students of natural health, exercise, and fitness finding answers in traditional Native ways, but we are beginning to acknowledge that the patterns of treatment of many modern physicians are mirrored in the ways of the earliest healers. Jack Weatherford, in his classic study *Indian Givers: How the Indians of the Americas Transformed the World*, summarizes the impact.

The essay which follows explores the policies, programs, procedures, and practices with which the United States replaced the traditional Native health care systems. The traditional systems were tragically destroyed by conquest, genocide, and the inability of the precontact system to deal with postcontact players. Weatherford concludes that "despite the sophistication of American medicine when the European arrived, the healers succumbed to the onslaught of Old World diseases. Never in human history have so many new and virulent diseases hit any one people all at one time."

The authors earlier analyzed the Indian health care system in a historic and legal context. This essay explores more broadly the operation of the Indian health care system considering five major areas: (1) the prevailing climate; (2) the responsibility for care; (3) the Indian health service structures, capacity, and delivery; (4) the Indian health service resource allocation process; and (5) access, eligibility, and rationing.

### *I. The Prevailing Climate*

#### *A. Introduction*

American Indians and Alaska Natives — as America's original peoples — hold a distinct legal, social, cultural, and historical position. As a result of negotiated treaties, agreements, legislative enactments, and compacts, many Native peoples, but by no means all, are entitled to services of the federal government by virtue of their membership in sovereign Indian nations. As citizens of local, state, and federal governments, Indian people are equally entitled to rights and privileges granted to all other citizens of these respective governmental entities. The rights that accrue by membership in sovereign Indian nations cannot be used to deny any rights, privileges, or services available to them as members of non-Indian governmental units. In this sense, tribal member Indians possess *dual entitlement* to services. Other social, cultural, and genetic factors, along with the impact of white settlements upon the livelihood and culture of tribes, distinguish Native Americans from the general U.S. population. Destruction of traditional civilization, along with poverty and disease that followed, and subsequent treaty-based agreements, created a fundamental government responsibility for provision of health, and other, services to Indians.<sup>2</sup>

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2. AMERICAN INDIAN POL'Y REVIEW COMM'N, REPORT ON INDIAN HEALTH: TASK FORCE

Despite the establishment of a legal foundation for the public provision of Indian health services — a process that began early in the nineteenth century — the health of Indians has not yet been secured. Despite remarkable progress in recent decades, the health status of Indians remains below that of other U.S. citizens with respect to virtually all health measures. Furthermore, the Indian health care delivery system that has developed gradually over two centuries is threatened by budget constraints at all levels of government, a growing perception that Indians are beneficiaries of significant economic gains as a result of business enterprises such as gaming, and a precipitous rush to dismantle the program through the otherwise attractive doctrines of tribal self-determination and self-governance. Therefore, there remains much to be done if the health of Indian people is to be secured into the next millennium.

Persistent problems associated with responsibility for care, infrastructure, resource allocation, and the distribution of services derive from a number of sources and reflect the history of Indian-White relations in this country. This has been characterized by tension between the competing objectives of termination, integration, and assimilation on the one hand, and tribal autonomy and self-rule on the other.<sup>3</sup> Unfortunately, current economic and political considerations at the federal level threaten to exacerbate rather than ameliorate long standing problems in the provision of health services to Native Americans.

Ongoing health care reform efforts — public and private, deliberate and inadvertent — promise to affect virtually every aspect of the health care industry. For whatever reason, consideration of Indian health care has been striking in its absence from the national debate. Health care for Indians will, nonetheless, be severely impacted by changes — good and bad — that come about in the context of reform.

### *B. Historical Foundations*

Before the nineteenth century, when the major health problems were contagious diseases, there was minimal government involvement in health care. Largely as a result of recognition of the relationship between sanitation and disease in the early nineteenth century, government began to assume a greater role in preventing the spread of disease. The Public Health Act of 1848 established the legal foundation for public intervention in combating and preventing contagious disease.

Attention to Indian health increased gradually throughout the nineteenth century, with responsibility for health matters initially assigned to the War

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SIX 33 (1976) [hereinafter TASK FORCE SIX REPORT].

3. Betty Pfefferbaum et al., *Learning How To Heal: An Analysis of the History, Policy, and Framework of Indian Health Care*, 20 AM. INDIAN L. REV. 365, 381 (1995-96).

Department in 1803 and transferred with the Bureau of Indian Affairs (BIA) to the Department of Interior in 1849. By the end of the nineteenth century, health care for the nation as a whole was becoming institutionalized, large hospitals were opening, and standards for the practice of medicine were being established;<sup>4</sup> an organized structure for the delivery of health care was emerging along with clear precedent for federal involvement in the provision of care.<sup>5</sup> For Indians, some public dollars were appropriated to hire physicians and provide vaccinations, and the BIA operated a limited number of hospitals.

The early twentieth century brought dramatic changes in health care with the application of science to medicine and with increased attention to public health at federal, state, and local levels. Information regarding the health status of Indians along with limited congressional appropriations for Indian health care were available early in the century, preceding enactment of the Snyder Act<sup>6</sup> in 1921. The Snyder Act provided basic authorization for Indian health care, for the first time formulating broad Indian health policy.<sup>7</sup> The Act authorized regular congressional appropriations "for relief of distress and conservation of health . . . of Indians throughout the United States."<sup>8</sup> General in nature, this language was actually part of that year's appropriation bill. The failure of Congress to deal explicitly with issues such as rights and responsibilities, in the Snyder Act as well as in subsequent legislation, has resulted in continued unresolved disputes, deficiencies, and charges of paternalism.<sup>9</sup>

Responsibility for Indian health care was transferred in 1955 from the BIA to the Public Health Service (PHS), which at the time was a division of the Department of Health, Education, and Welfare (HEW) and which until quite recently was an operating division of the Department of Health and Human Services (DHHS). In addition to fulfilling other functions, the transfer legislation called for the PHS to serve as principal federal advocate for Indian health and to provide comprehensive health services. The Indian Health Service (IHS), within the PHS, has been the agency most directly responsible for Indian health care. A recent reorganization of DHHS has made the position of the PHS organizationally ambiguous. The IHS, along with other previous Agencies of the PHS, are now operating divisions reporting directly to the DHHS Secretary.<sup>10</sup>

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4. Paul R. Torrens, *Historical Evolution and Overview of Health Services in the United States*, in INTRODUCTION TO HEALTH SERVICES 3-12 (Stephen J. Williams & Paul R. Torrens eds., 1988).

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

6. Ch. 115, 42 Stat. 208 (codified as amended at 25 U.S.C. § 13 (1994)).

7. TASK FORCE SIX REPORT, *supra* note 2, at 33.

8. *Id.* at 33; Snyder Act, § 1, 42 Stat. at 208.

9. TASK FORCE SIX REPORT, *supra* note 2, at 34.

10. Office of the Secretary, Statement of Organization, Functions, and Delegations of

Federal responsibility for Indian health care was strongly reaffirmed by the Indian Health Care Improvement Act (IHCIA) of 1976<sup>11</sup> and its 1992 amendments.<sup>12</sup> Comprehensive in scope, the IHCIA acknowledged the government's "special responsibilities and legal obligations to the American Indian people"<sup>13</sup> and 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".<sup>14</sup> The IHCIA authorized the appropriation of specific funds to eliminate deficiencies in care, but continued the discretionary status of the IHS established in the Snyder Act, rather than establishing an entitlement to specific services, and did not identify levels or goals for funding. The 1992 amendments did, however, specify measurable health objectives for Indians to be met by the year 2000.<sup>15</sup>

The Indian Self-Determination and Education Assistance Act of 1975,<sup>16</sup> buttressed by subsequent amendments, provided a mechanism for transferring programs traditionally administered by the BIA and the IHS to tribal governments. Tribes have become increasingly interested and involved in assuming control over health care programs, but generally lack sufficient capital (human and physical, as well as financial) to effectively and efficiently assume full responsibility for the provision of care. Neutral with respect to self-determination and self-governance, the IHS provides services through tribes as well as directly through IHS facilities and personnel and through contracts with other non-IHS providers.

### *C. Indicators of Indian Health*

The IHS service population is that population residing in certain counties in the thirty-five reservation states thought to most closely represent those who are eligible to receive services from the IHS.<sup>17</sup> It is a projection made from the decennial census (composed of those who are

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Authority, 60 Fed. Reg. 56,605, 56,605-06 (Dep't of Health & Human Servs. 1995) [hereinafter Statement of Organization].

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

12. Indian Health Care Improvement Act of 1992, Pub. L. No. 102-573, 106 Stat. 4526.

13. Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (codified at 25 U.S.C. § 1602(a) (1994)).

14. *Id.*

15. *Id.*

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

17. Alabama, Alaska, Arizona, California, Colorado, Connecticut, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. Unpublished Data, Demographics Statistics Team, Div. of Community & Envtl. Health Servs., Indian Health Serv., Rockville, Md. (Jan. 3, 1997).

self-identified) and, therefore, includes a certain number, thought to be negligible for planning purposes, of Indians not eligible for IHS services. This population numbers approximately 1.43 million.<sup>18</sup> Excluding the impact of newly recognized tribes, the service population is increasing at a rate of approximately 2.1% per year.<sup>19</sup> It is younger than the U.S. All Races population, with a median age of 24.2 years for Indians compared with a median age of 32.9 years for U.S. All Races.<sup>20</sup> A total of 33% of the Indian population is younger than fifteen years, as compared to 22% for U.S. All Races; 6% of the Indian population is older than sixty-four years, as compared to 13% for U.S. All Races.<sup>21</sup> Indians have lower incomes than the general U.S. population, with a median household income of \$19,897 compared to \$30,056 for the U.S. All Races population; 31.6% of Indians live below the poverty level as compared to 13.1% for the U.S. All Races population.<sup>22</sup> According to the 1990 Census, Indians are also less educated than U.S. All Races population; 65.3% of Indians (age twenty-five and older) have at least a high school education as compared to 75.2% for the U.S. All Races population.<sup>23</sup>

There is general agreement that Indian people have experienced substantial improvement in health status since transfer of Indian health services from the BIA to the PHS in 1955. Subsequent legislation and the development of innovative public health programs have resulted in a unique and substantially successful program. Nonetheless, Native Americans still have significantly higher morbidity and mortality rates for a number of diseases and conditions compared to the general population. For example, the age-adjusted mortality rate (all causes) for Indians (1991-1993) is 17.8% higher than for U.S. All Races (1992) and 24.4% higher than for Whites (1992).<sup>24</sup> Underreporting of Indian ethnicity on death certificates is a not uncommon problem. It is especially prominent in the California, Oklahoma, and Portland Areas. When these three Areas are excluded, the age-adjusted mortality rate (all causes) for Indians (1991-1993) is 43% higher than the U.S. rate. The age-adjusted mortality rate for Indians residing in the Aberdeen Area, the Area with the highest rate, is more than twice the U.S. rate.<sup>25</sup>

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18. INDIAN HEALTH SERV., U.S. DEP'T OF HEALTH & HUMAN SERVS., TRENDS IN INDIAN HEALTH 4 (1996) [hereinafter IHS, TRENDS].

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.* at 5.

23. INDIAN HEALTH SERV., U.S. DEP'T OF HEALTH & HUMAN SERVS., REGIONAL DIFFERENCES IN INDIAN HEALTH 4 (1996) [hereinafter IHS, REGIONAL DIFFERENCES].

24. IHS, TRENDS, *supra* note 18, at 57 tbl. 4.11.

25. IHS, REGIONAL DIFFERENCES, *supra* note 23, at 5.



The two leading causes of death for the IHS service population (1991-1993) are diseases of the heart and malignant neoplasms, as is the case for the U.S. All Races population (1992). Indian deaths (1991-1993) from chronic liver disease, tuberculosis, accidents, diabetes mellitus, pneumonia and influenza, suicide, and homicide are substantially higher than those for U.S. All Races (1992).<sup>26</sup>

The birth rate for Indians (1991-1993) is 26.6 per 1000 population, which is 67% higher than the birth rate for U.S. All Races (1992).<sup>27</sup> The maternal mortality rate for Indians is 6.9 per 100,000 live births, a decrease of 75% over an nineteen-year period.<sup>28</sup> The Indian infant mortality rate decreased 60% over the same nineteen-year period to 8.8 per 1000 live births.<sup>29</sup>

Relatively little is known about the health status or health care utilization practices of urban Indians. One recent study found considerable disparities between the health of urban Native Americans and that of urban Whites in the state of Washington. Compared with urban Whites, urban Native American mortality rates were higher in every age group except the elderly, with differences greatest for injury- and alcohol-related deaths. The overall age-adjusted mortality rate for urban Native Americans was higher than the rate for urban Whites, but lower than the rate for urban African Americans and for rural Native peoples. No consistent pattern emerged from a systematic comparison of health status indicators between urban and rural Native Americans. While Native American mortality rates tended to be higher within the rural counties than within the urban area, most of this difference was explained by higher rates of the four leading causes of death (heart disease, cancer, injury, and cerebrovascular disease) among rural Native peoples as compared with their urban counterparts. There was a significant decade-long increase in the infant mortality rate for urban Native Americans, but not for other populations studied.<sup>30</sup>

## II. Responsibility for Care

### A. The Unique Case of Native Americans

Indians are citizens of the United States and residents of the states in which they live; most are also members of tribes. While historically Indian tribal affiliation and U.S. citizenship were in some cases considered incompatible, their consonance is now well established legally. Unfor-

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26. IHS, TRENDS, *supra* note 18, at 57 tbl. 4.11.

27. *Id.* at 35 tbl. 3.1.

28. *Id.* at 39 tbl. 3.6.

29. *Id.* at 40 tbl. 3.7.

30. David C. Grossman et al., *Health Status of Urban American Indians and Alaska Natives: A Population-Based Study*, 271 JAMA 845, 848-50 (1994).

unately, opponents of Indian rights have continued to cite this dual status of Indians as a rationale for denial of certain rights and benefits to Indians people.<sup>31</sup> The unique government-to-government relationship in which tribes, like the U.S. government, function as sovereign nations distinguishes Indians from other U.S. citizens. As citizens, Indians are entitled to benefits available to other citizens; they are also entitled to benefits derived from treaties, specific statutes, and court decisions.

A fundamental government duty to provide services to Indians originates from "the destruction of Indian civilization and the poverty and disease that followed in its wake."<sup>32</sup> Federal responsibility emanates from a variety of sources, including specific treaties in which land and other resources were ceded by Indians in exchange for promises of health and other services. To the extent that the government has provided health services for Indians in conjunction with treaties in which land was ceded, Indian health care represents a prepaid health plan<sup>33</sup> — quite likely the first example of such a concept.

While there is general acceptance of a federal obligation to provide health services to Indians, that obligation is ill-defined with respect to specific rights and responsibilities. Though Congress has made regular appropriations for Indian health services in recent decades, courts have thus far ruled that benefits are provided voluntarily rather than in response to the federal government's trust responsibility for Indian tribes. In *Gila River Pima-Maricopa Indian Community v. United States*,<sup>34</sup> the U.S. Court of Claims found that the government's trust responsibility cannot in itself be the basis of a claim against the government nor does it constitute a legal entitlement to benefits.

Furthermore, the U.S. Supreme Court let stand a Ninth Circuit decision that appropriations do not really belong to Indians; rather they belong to the public.<sup>35</sup> Such interpretations — juxtaposed with legislation that requires the federal government to provide "the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy"<sup>36</sup> — demonstrate the often

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31. FELIX S. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 639-40 (Rennard S. Strickland et al. eds., 1982) [hereinafter COHEN 1982 ED.].

32. TASK FORCE SIX REPORT, *supra* note 2, at 33.

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

34. *Gila River Pima-Maricopa Indian Community v. United States*, 427 F.2d 1194, 1198 (Ct. Cl. 1970), *cert. denied*, 400 U.S. 819 (1970).

35. *Scholder v. United States*, 428 F.2d 1123 (9th Cir. 1970), *cert. denied*, 400 U.S. 942 (1970).

36. Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (codified at 25 U.S.C. § 1602 (1994)).

experienced discordance between good intentions and actual legal, administrative, and economic conditions. This discordance is undoubtedly one of the most important contributors to continued frustration, disappointment, and resentment amongst Native Peoples.

Services for Indians are potentially affected by the outcome of any national election. The proposed transfer of numerous federal programs to states via block grants and limitations on the growth of federal spending threaten the structure and financing of the IHS. Current proposals to consolidate federal programs and block grant them to states make no provisions for Indian programs. If block grants materialize and if grants do not go directly to tribes, the federal government's trust relationship with Indians will become a sham far greater than the empty promises that have resulted from budgetary restrictions.<sup>37</sup>

The federal government has attempted to fulfill its responsibility for Indian health care by establishing the IHS as a separate system of health care while also making Indians eligible for those health services for which they qualify as U.S. citizens and state residents. However, continued support for the IHS implies a level of public commitment and security beyond that which actually exists. Clearly, the IHS cannot meet all of the health care needs of Native peoples; its ability to meet the greater portion of those needs is limited by severe budget constraints. Furthermore, service delivery continues to be hindered by questions of responsibility, even though such questions have been addressed repeatedly.

### *B. The IHS Mandate*

The government's role in the provision of health care is at once both obvious and obscure, characterized by multi-billion-dollar expenditures, unfunded mandates, and a complicated tangle of responsibilities. Health care reform has been part of the public policy agenda for years and now vies for center stage. Reform is made more difficult by the intricate relationships between and among service providers, the growth of specialty services and sophisticated technology, the extensive and problematic penetration of economics into ethics, and a plethora of new terminology and acronyms. The need for reform has been exacerbated by decision making based increasingly on considerations of cost rather than care and by deliberate efforts on the part of responsible parties to shift the burden of responsibility onto other entities, whether they be programs, providers, or individuals.

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37. Stephen J. Kunitz, *The History and Politics of US Health Care Policy for American Indians and Alaskan Natives*, 86 AM. J. PUB. HEALTH 1464, 1470-71 (1996).

The health care system has become a convoluted labyrinth, perplexing professionals as well as clients. Ironically, Indians have something of an advantage in this increasingly complicated maze by having a known and recognizable source of care through the IHS. They are entitled to certain health services for which they qualify as U.S. citizens and state residents. As a result of treaty provisions and a long legislative history, many Indians are also entitled to certain additional health services provided by the federal government. These additional federal services are provided, for the most part, by the IHS. Unfortunately, the IHS has not escaped the effects of cost shifting and insufficient funding — the effects of which, not surprisingly, interfere with attempts of the IHS to fulfill its mission as articulated by congressional action and further interpreted by the courts.

The transfer of responsibility for Indian health services from the BIA to the PHS<sup>38</sup> resulted in the creation of a Division of Indian Health<sup>39</sup> within the PHS.<sup>40</sup> Four major functions were identified as part of the transfer legislation: (1) to provide training and technical assistance; (2) to coordinate available health resources through federal, state, and local programs for the benefit of Indians; (3) to serve as the primary federal advocate for Indian health; and (4) to provide comprehensive health services, including preventive, rehabilitative, and environmental health services in addition to hospital and ambulatory medical care.<sup>41</sup>

Finding that the government's "unique legal relationship with, and resulting responsibility to," Native Americans required it to provide health services to maintain and improve the health of Indians, Congress passed the original IHCA of 1976<sup>42</sup> and its 1992 amendments.<sup>43</sup> In enacting this legislation, Congress recognized as major national goals the provision of "the quantity and quality of health services that will permit the health status of Indians to be raised to the highest possible level" and the encouragement of "maximum participation of Indians in the planning and management of those services."<sup>44</sup>

The IHCA of 1976 articulated the current mission of the IHS: to assure the highest possible health status for Native Americans. Comprehensive in

38. Transfer Act of Aug. 5, 1954, ch. 658, 68 Stat. 674 (codified as amended at 42 U.S.C. §§ 2001-2005f (1994)).

39. The name was changed to "Indian Health Service" in 1968.

40. *White v. Califano*, 437 F. Supp. 543, 552 (D.S.D. 1977), *aff'd*, 581 F.2d 697 (8th Cir. 1978).

41. TASK FORCE SIX REPORT, *supra* note 2, at 85.

42. Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (codified in scattered sections of 25 U.S.C.).

43. Indian Health Amendments of 1992, Pub. L. No. 102-573, 106 Stat. 4526 (signed into law Oct. 29, 1992).

44. Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (codified in scattered sections of 25 U.S.C.).

scope, the IHCA provided a new framework for the provision of health services to Native peoples by consolidating IHS programs, by authorizing funds to improve services and to extend services to urban Indians, and by establishing education programs for health professionals to work in Indian communities.<sup>45</sup> The IHCA and its 1992 amendments provided for a number of new programs which serve as models for public health care and national health planning. The Act specified the following objectives for the IHS: (1) to assure Indians access to high-quality comprehensive health services in accordance with need; (2) to assist tribes in developing the capacity to staff and manage their own health programs and to provide opportunities for tribes to assume operational authority for IHS programs in their communities; and (3) to advocate for Indians with respect to health matters and to assist them in accessing programs to which they are entitled.<sup>46</sup>

In order to fulfill its role and responsibilities, the IHS provides a comprehensive range of services for individual Indians that is unequalled by any other system of care. Combining traditional public health services with inpatient and ambulatory clinical services, the IHS emphasizes community and preventive medicine; in doing so, the IHS serves as a model for other providers. IHS prevention, treatment, and rehabilitation services include environmental services such as sanitation and water safety, immunizations, health education, and other public health nursing services, services such as inpatient and ambulatory medical services, specialty services (optometry, dental, mental health, drug abuse, and alcohol), and referral services. Other components of the IHS include Indian health manpower development programs and health facilities construction. The IHS delivers its many services directly through IHS facilities and staff, through tribes, and through contractual arrangements with private providers; these services are provided through the IHS direct care program, contracts with tribes, and the IHS Contract Health Services program, respectively. Service is based on need and the availability of funds.

The breadth of IHS responsibility is justified by the size of the Indian population living in isolated rural areas on or near reservations. These areas often lack the infrastructure of roads, utilities, and public services that support service delivery to other (non-Indian) rural and urban populations. The IHS facilities construction program provides hospitals, clinics, and living quarters for facility staff for reservation-based IHS services.<sup>47</sup>

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45. COHEN 1982 ED., *supra* note 31, at 700.

46. Everett R. Rhoades et al., *The Organization of Health Services for Indian People*, 102 PUB. HEALTH REP. 352, 353-54 (1987) [hereinafter Rhoades et al., *Organization of Health Services*].

47. OFFICE OF TECH. ASSESSMENT, U.S. CONGRESS, INDIAN HEALTH CARE 155 (1986) (No. OTA-H-290, U.S. Government Printing Office) [hereinafter OTA, INDIAN HEALTH CARE].

IHS programs for Indians who live in urban areas offer a range of ambulatory medical, dental, mental health, social support, and referral services; IHS urban projects do not provide hospital care directly but may refer Indians to an IHS hospital if one is located in the area. Urban Indian health projects, authorized and funded under the IHCA, operate separately from reservation-based IHS programs. Urban projects may receive funding from non-IHS sources as well as from the IHS; they are likely to treat non-Indians as well as Indians; and they may request payment from both Indians and non-Indians based on a sliding fee scale in accordance with income.<sup>48</sup>

The role of tribes in the provision of health services has increased significantly since passage of the Indian Self-Determination and Education Assistance Act of 1975.<sup>49</sup> Building on IHS policy, the Self-Determination Act and amendments give tribes the option of managing and staffing IHS programs in their communities under self-determination contracts and, more recently, self-governance compacts; the Self-Determination Act also provides funding for improvement of tribal capability to contract under the Act. Self-determination contracts permit tribes to administer a full spectrum of IHS services, including both direct care and contract care programs, facilities construction, community health representatives programs, mental health and drug abuse services, and health education initiatives. Most of these services are reservation based.<sup>50</sup> Self-governance compacts with tribes provide enhanced decision-making powers for tribes and encourage development of an expanded resource base.

### *C. Federal Responsibility, State Authority, and Tribal Sovereignty*

The extent of IHS responsibility for care vis-à-vis state responsibility and tribal sovereignty was addressed in *White v. Califano*,<sup>51</sup> a case involving the involuntary hospitalization of Florence Red Dog, an indigent member of the Oglala Sioux Tribe residing on the Pine Ridge Indian Reservation in South Dakota. Legal action was brought by Georgia White, sister of and guardian ad litem for Red Dog, against South Dakota state and county officials as well as federal officials, all of whom had denied responsibility for the cost of Red Dog's care. The U.S. district court found the U.S. government, via the IHS, responsible for the care, a decision that was upheld on appeal.

*White v. Califano* is particularly pertinent in its attention to issues of state authority and tribal sovereignty. These issues provided much of the basis for the district court's ruling in favor of the State of South Dakota and

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48. *Id.* at 155-56.

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

50. OTA, INDIAN HEALTH CARE, *supra* note 47, at 156.

51. 437 F. Supp. 543 (D.S.D. 1977), *aff'd*, 581 F.2d 697 (8th Cir. 1978).

affirmation of the ruling upon appeal to the U.S. Court of Appeals for the Eighth Circuit. South Dakota argued that it lacked the power to initiate and carry out involuntary commitment procedures against an allegedly mentally ill Indian residing in Indian country. The court of appeals agreed with the State's citation of *Williams v. Lee*<sup>52</sup> and its progeny in arguing that both the process and the act of involuntary commitment under the circumstances present in this case were so intrusive as to be inconsistent with the concept of tribal sovereignty, however "diluted" that concept might be.<sup>53</sup> Given that the State lacked the power to involuntarily commit Red Dog, the State had no duty to provide care.

Recognizing the difficulty in defining the trust relationship between Indians and the U.S. government as it evolved through history and doubting whether such an examination would provide more than a framework for analysis of the issues involved in *White v. Califano*, the district court relied instead on the IHCIA — signed into law while *White v. Califano* was being heard by the district court — as the most relevant statement of congressional intent regarding the federal responsibility for Indian health care and as the most recent interpretation of obligations deriving from the trust relationship. In doing so, the district court identified provisions of the IHCIA that extended authority of the IHS to provide mental health care through a variety of mechanisms including community-based, residential, and inpatient care services and that authorized training of mental health practitioners.

In *White*, the court of appeals affirmed the district court's finding of a federal responsibility for Red Dog's care given the absence of alternative sources of care, agreeing with the district court that where the state cannot act, the federal government must. Congress has "unambiguously declared" the existence of a federal responsibility to provide health care to Indians. This federal responsibility stems from the "unique relationship" between Indians and the U.S. government, a relationship that is reflected in both legislation and litigation. There is a certain degree of irony in this affirmation of tribal sovereignty in that while relieving the state of a responsibility customarily provided by states to all of their citizens, resources for the IHS to assume this care were not forthcoming. This question of responsibility remains unsatisfactorily resolved in parts of the country not included in the Eighth Circuit Court's jurisdiction. *White v. Califano* illustrates the ambiguities among federal, state, IHS, and tribal jurisdictions and among the three branches of the federal government.

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52. 358 U.S. 217 (1959).

53. *White*, 437 F. Supp. at 549.

#### *D. Residual Responsibility*

The importance of the public sector in the provision of health care is evidenced by the variety and volume of services supported by federal and state governments. Programs such as Medicare and Medicaid attest to public responsibility for the old and the poor; the PHS and its Centers for Disease Control attest to public responsibility for communities; and the IHS attests to public responsibility for Indians. Just as impoverished elders typically qualify for both Medicare and Medicaid, Indians qualify for certain services by virtue of their status both as citizens and as members of tribes. Unfortunately for Indians, although dual entitlement to certain services is established in law, actual receipt of services does not always follow; when it does, it is often only after extensive effort on the part of individuals and agencies.

The IHS is legally responsible for providing health care to Indians. Congressional appropriations for the IHS, however, are based on the assumption that Indians are entitled to care, provided in conjunction with other public programs for which they qualify as U.S. citizens and state residents. In practice, entitlement to these other public programs is frequently questioned and services are denied or delayed while clarification, negotiation, and/or litigation are pursued. Thus arises the issue of residual responsibility and the problems associated with it.

Legislation, regulations, judicial decisions, and legal interpretations have reaffirmed over the years that IHS services are *residual* to the services of other providers. This means that when Indians qualify for health care from other sources (such as Medicare, Medicaid, and private insurance), these alternative sources are to be utilized first, with the IHS becoming responsible for payment only after alternate sources have been exhausted. For services provided directly by the IHS, this residual payer role is discretionary.<sup>54</sup> As a matter of practice, the IHS typically provides services to patients in IHS facilities regardless of other potential sources of care and seeks reimbursement from other sources when appropriate.<sup>55</sup> When the IHS must contract for services from non-IHS providers, the residual payer role is mandatory;<sup>56</sup> individuals must apply for alternate resources before receiving care in the IHS contract health care program and IHS disbursements are authorized only for charges not covered by other providers.<sup>57</sup> In short, the IHS is to be the payer of last resort.

The issue of residual responsibility is particularly significant because many Indians who qualify for Medicare and Medicaid services, as provided

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54. 42 C.F.R. 36.12[c] (1996).

55. OTA, *INDIAN HEALTH CARE*, *supra* note 47, at 10.

56. 42 C.F.R. 36.23(f) (1996).

57. OTA, *INDIAN HEALTH CARE*, *supra* note 47, at 10.



under Titles XVIII and XIX of the Social Security Act,<sup>58</sup> choose to use IHS services instead. A 1968 HEW interpretation clarified that for those Indians who meet eligibility requirements, rights to medical services under state Social Security medical plans exist regardless of eligibility for IHS services. The HEW interpretation ruled further that the appropriate state agency retains primary responsibility for service delivery even when Indians participate in residual or substitute federal medical services.<sup>59</sup> The IHCIA authorized receipt of Medicare and Medicaid funds by the IHS for the treatment of eligible Indians; in accordance with this legislation, the IHS may also contract with states to provide services and may reimburse states for services provided to Indians.<sup>60</sup>

Unfortunately, the IHCIA of 1976 did not resolve the problem inherent in the dual entitlement to services. One persistent concern involves determining responsibility when state or local governments also claim a residual payer role. A proposed 1984 amendment to the IHCIA, known as the Montana amendment because it applied specifically to several Montana counties seeking relief from providing and paying for medical care for indigent Indians, would have made the IHS responsible for care when state or local services for indigents were funded by real property taxes from which Indians were exempt. President Ronald Reagan vetoed proposed 1984 amendments to the IHCIA in part because of his objection to the Montana amendment.<sup>61</sup>

Two principal arguments — the equal protection clause of the Fourteenth Amendment and the supremacy clause of the U.S. Constitution — would seem to support the position of the IHS, rather than state and local providers, as residual payer of last resort. Under the equal protection clause of the Fourteenth Amendment, Indians, as residents of the states in which they live, are constitutionally entitled to the same state and local benefits as other state residents. Further, states and counties cannot assume that Indians have an automatic right to all IHS health services; in fact, federal regulations<sup>62</sup> governing the IHS contract care program hold that such an entitlement does not exist with respect to contract care services (services of non-IHS providers made available to Indians under contract with the IHS). This IHS alternate resource rule authorizes payment by the IHS for non-IHS services only after available alternate resources are exhausted. States and counties, therefore, presumably cannot deny services to Indians on the grounds of double coverage; the supremacy clause of the U.S. Constitution,

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

59. COHEN 1982 ED., *supra* note 31, at 700 n.46.

60. *Id.* at 701; 42 U.S.C. § 1396j (1994).

61. OTA, INDIAN HEALTH CARE, *supra* note 47, at 11.

62. 42 C.F.R. 36.23(f) (1996)

it might seem, should resolve this issue in favor of the IHS.<sup>63</sup> Unfortunately, the courts have addressed the issue of residual responsibility, have considered arguments based on both the equal protection and supremacy clauses, and have thus far failed to provide unequivocal support for the IHS with respect to its role as payer of last resort.

In 1987, in *McNabb v. Bowen*,<sup>64</sup> the U.S. Court of Appeals for the Ninth Circuit affirmed the ruling of the U.S. District Court for the District of Montana,<sup>65</sup> which held that the IHS, rather than Roosevelt County, Montana, was responsible for the medical bills of an indigent Indian child. Both the IHS and Roosevelt County denied primary responsibility for the child, each citing its own alternate resource rule. The district court held that the IHS interpretation of its alternate resource rule to include state and local programs was inconsistent with congressional mandate, holding that the federal government was responsible "in the first instance" for the child's health care.<sup>66</sup> The Ninth Circuit reviewed the question *de novo* and ultimately held that the IHS interpretation of alternate resources as including state and local government programs was consistent with congressional intent. Nonetheless, the Ninth Circuit ultimately upheld the district court's decision in favor of Roosevelt County on other grounds.

Acknowledging that Congress failed to specify the appropriate role of the federal government (the IHS in this instance) *vis-à-vis* state and local agencies in terms of providing health care for Indians, the court relied heavily on congressional intent as expressed primarily by the trust relationship between the federal government and Indians, the Snyder Act, and the IHCIA. The court noted that the special trust relationship requires that statutes passed for the benefit of Indians are to be liberally construed with doubts resolved in favor of Indians.

The Ninth Circuit found that while there are numerous references to the federal responsibility for Indian health care as primary, Congress did not intend that the federal government be the exclusive provider of Indian health care. The court concluded that the inclusion, by the IHS, of state and local programs among its alternate resources conformed with congressional intent. This conclusion, noted the court, was consistent with both the trust doctrine and the equal protection clause of the Fourteenth Amendment which entitles Indians to the state benefits for which they qualify. The court declined, however, to decide whether Roosevelt County's alternate resource rule was valid under Montana law.

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63. OTA, INDIAN HEALTH CARE, *supra* note 47, at 11, 52-53.

64. 829 F.2d 787 (9th Cir. 1987).

65. *McNabb v. Heckler*, 628 F. Supp. 544 (D. Mont. 1986), *aff'd*, *McNabb v. Bowen*, 829 F.2d 787 (9th Cir. 1987).

66. *McNabb*, 829 F.2d at 791.

A pivotal issue for the Ninth Circuit — the issue that led the court to affirm the decision in favor of Roosevelt County — was the fact that while the IHS viewed Roosevelt County's funds as legally available to the Indian child, the County's refusal to pay meant that the funds were not actually available. Again seeking justification in congressional intent, the court acknowledged that Congress sought to provide the assistance necessary to enable Indians to avail themselves of nonfederal sources of health assistance, noting in particular the congressionally designated and self-proclaimed role of the IHS as the principal health advocate for Indian people. It was in this role as principal health advocate that the IHS had failed the McNabbs. While the IHS aided the non-Indian indigent mother in applying for County support for her own care, it did not help her secure care for her Indian son. The court ruled that the IHS should have assisted McNabb, either through advocacy or actual care for her son, noting that the burden of demonstrating McNabb's entitlement to County funds fell upon the federal government (that is, the IHS) rather than upon the indigent mother. If the County had paid for the child's health care, the IHS would have met its responsibility to assure access to care; continued denial of coverage by the County, however, meant that the IHS had not met this responsibility. Therefore, the IHS must pay for the child's care; the court ruled that any other result would be inconsistent with the trust doctrine.

The Ninth Circuit also addressed the IHS argument that Roosevelt County's alternate resource regulation violated the supremacy clause of the U.S. Constitution. Ruling against the IHS on its supremacy clause argument, the court held that the supremacy clause is violated only if Congress has preempted state power positively and by direct enactment. Finally, the court refused to address questions of state law, noting that the relief sought in this action had been provided.

Clearly, IHS resources used to advocate for the McNabb infant and to litigate critical issues such as conflicting alternate resource rules are resources that are thereby unavailable for the provision of health care for Indians in general. In light of IHS resource limitations and the propensity on the part of Congress to authorize programs without appropriating sufficient dollars to implement them, one could argue that a sympathetic interpretation of statutes designed to benefit Indians would have found in favor of the IHS, affirming the position of the IHS as payer of last resort and directing Roosevelt County to provide care. The apparent incongruity in the ruling — the finding that the IHS must provide care for the McNabb child when Roosevelt County failed to do so, juxtaposed with the court's acknowledgement that statutes designed to benefit Indians are to be liberally construed in favor of Indians — could have been avoided if the court had addressed directly the issue of incompatible alternate resource rules. However noble the desire to serve an indigent Indian child, however

negligent the IHS in failing to advocate effectively for the child, the ruling avoids the critical questions of primary and residual responsibility.

The *McNabb* ruling serves as a reminder of the important distinction between the federal government, as represented by the IHS in this case, and Indians themselves. In this instance, the federal government, as represented by the IHS, had a responsibility to assure access to care for Indians. This position would be admirable were resources more readily available.

The *McNabb* case illustrates a number of problems that have plagued the IHS in its attempt to provide health care for American Indians, not the least of which include the vague language and broad mandates that characterize federal legislation regarding Indian health care. The problem of unfunded mandates is nowhere better exemplified. From the Snyder Act, which provided the basic authorization for Indian health care but which did not define eligibility or specify goals, to the 1992 amendments to the IHCA, which set impressive goals and established measurable health objectives, Congress has acknowledged responsibility for Indian health care but has consistently failed to appropriate sufficient resources to support its otherwise impressive legislative mandates. Congressional appropriations for the IHS are based on the assumption that Indians are entitled to care provided in conjunction with other public programs for which they qualify as U.S. and state citizens. Unfortunately, Congress has failed to address the concept of residual responsibility directly, particularly with respect to Medicare and Medicaid. It should not be necessary for courts to surmise legislative intent with respect to an issue that has posed problems of such magnitude for so long. Ultimately, resources used in litigation are resources that could otherwise be directed toward care — the opportunity cost of litigation, unfortunately, is health care per se.

The residual doctrine suggests that IHS services should augment other health care services. It should thereby result in increased services for Indians. Unfortunately, the simple concept of the IHS as payer of last resort has grown ever more complicated as health care costs have risen and budget constraints have become increasingly restrictive throughout society. The higher the costs and more restrictive the budgets, the greater is the incentive for non-IHS providers to shift the burden of responsibility for payment elsewhere — frequently to the IHS.

### *III. IHS Structure, Capacity, and Service Delivery*

#### *A. Structure of the IHS*

The structure of the IHS is intended to ensure responsibility and accountability with respect to resource utilization while simultaneously providing well defined avenues for community and tribal participation in decision making and management. An emphasis on continuity and consistency guides the IHS in its provision of comprehensive community-

based services to a population of approximately 1.43 million Indians, the approximate IHS service population in Fiscal Year 1997.<sup>67</sup> One measure of the success of the IHS is the frequency with which it is studied by countries seeking to develop efficient systems for the provision of comprehensive care to large populations.<sup>68</sup>

As a result of recent reorganization of the DHHS, the IHS is now an operating division reporting to the DHHS Secretary.<sup>69</sup> In a structure similar to that of county and state public health departments, the IHS is comprised of local administrative units, called service units, which are grouped into larger jurisdictions administered by Area Offices. Eleven Area Offices are responsible for operating IHS programs within designated boundaries, with local management provided through 144 (sixty-eight IHS and seventy-six tribal) service units as of October 1, 1995.<sup>70</sup> At the national level, oversight is provided by the IHS headquarters in Rockville, Maryland. The Office of Health Program Research and Development, located in Tucson, Arizona, is an IHS headquarters office with responsibility for studies, investigations, and the administration of health services delivery; the Tucson office is considered an Area Office for statistical purposes, thereby making twelve Area Offices.

The organization of the IHS is illustrated in figure 1. The organizational configuration, with its departmentalization by Area and its heavy reliance on service units, suggests the degree of decentralization within the system and the importance of local input. The IHS is credited with uncommon success in coordinating a delivery system that is driven by local needs and decision making on the one hand and by limited dollars and public accountability on the other.<sup>71</sup> In addition to health programs administered by IHS Area Offices, some tribes operate their own health programs and there are a smaller number of urban projects.<sup>72</sup> Under the Clinton administration's efforts to "reinvent" government, continued financial constraints, and movement to program control by tribes, the IHS is presently in the process of reorganizing its headquarters. While it is not yet possible to describe just exactly what changes will occur, there is already a major exodus of positions from headquarters. Preliminary suggestions call for consolidating certain Area Offices into resource support centers, presumably

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67. IHS, TRENDS, *supra* note 18, at 4.

68. Rhoades et al., *Health on the Reservation*, *supra* note 33, at 105.

69. Statement of Organization, *supra* note 10, at 56,605.

70. IHS, TRENDS, *supra* note 18, at 4.

71. Rhoades et al., *Health on the Reservation*, *supra* note 33, at 105.

72. IHS, TRENDS, *supra* note 18, at 4.

with the intention of decreasing oversight while providing for technical assistance. It is not yet clear how these changes can avoid reducing certain services.<sup>73</sup>

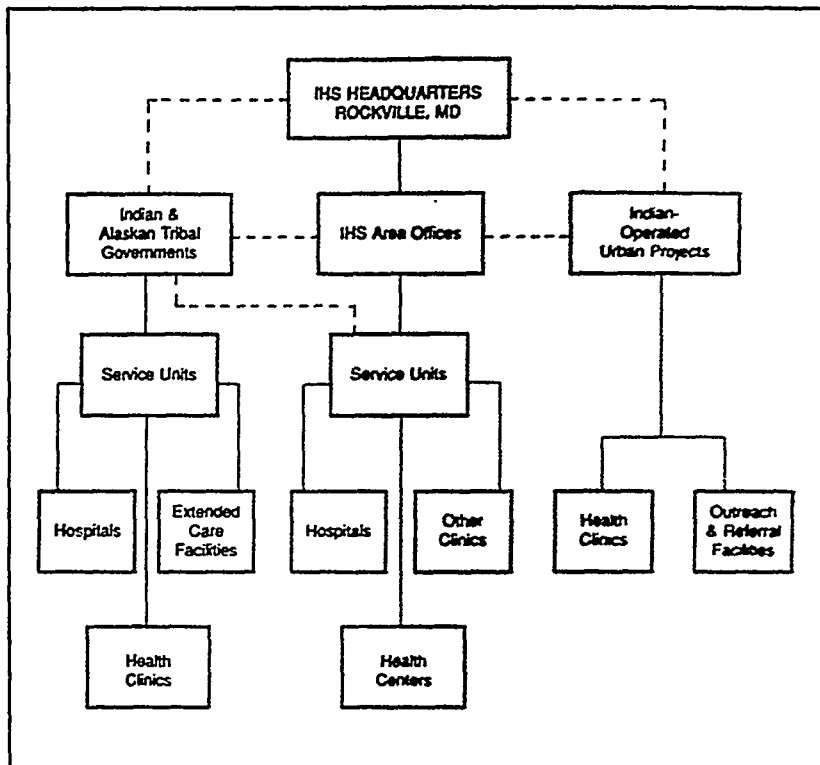


Figure 1. *Indian Health Service Structure*

Presently, the twelve Area Offices are responsible for overseeing the operation of IHS programs within designated geographic areas. While Area Offices generally (though not universally) have been established to serve contiguous geographic areas, their designation has also taken into account cultural and demographic factors. Individual Areas differ with respect to geographic and population size. Figure 2 is a map of Areas and a list of states served by each.

73. NATIONAL INDIAN HEALTH BD., DESIGN FOR A NEW IHS: RECOMMENDATIONS OF THE INDIAN HEALTH DESIGN TEAM: FINAL REPORT 51-54 (1995) (prepared for "Indian People and the Indian Health Service" by the Indian Health Design Team, Rockville, Md.).

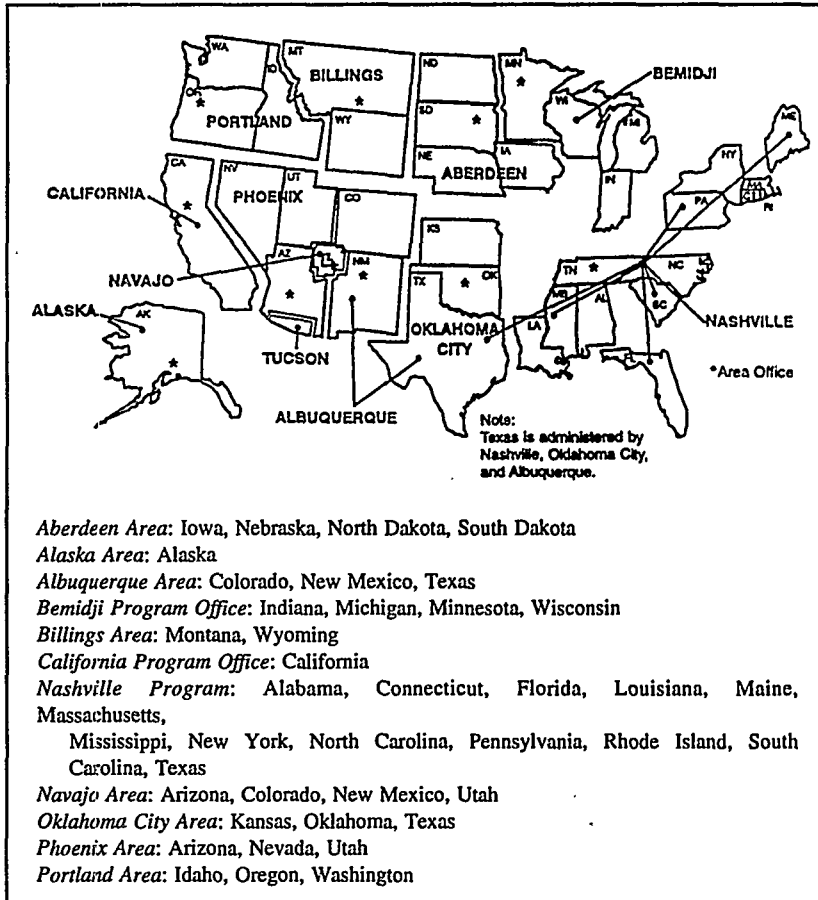


Figure 2. Indian Health Services Area Offices

Service units provide care within defined geographic areas typically centered around a reservation or, in Alaska, a population concentration. Some service units consist of multiple small reservations, while some serve only a portion of a large reservation.<sup>74</sup> The base of operations for a service unit is typically a small hospital or health center, with the level and type of services determined by the individual Area Office and the tribes served. Service provision is based on the needs of the population, the level of funding, and the availability of other sources of care.<sup>75</sup> Table 1 indicates the size of IHS service populations and number of service units by IHS Area.

74. IHS, TRENDS, *supra* note 18, at 2.

75. Rhoades et al., *Organization of Health Services*, *supra* note 46, at 353.

TABLE 1: SERVICE POPULATION AND NUMBER OF SERVICE UNITS BY IHS AREA<sup>76</sup>

Service Area	Estimated 1997 Service Population	October 1, 1995 Service Units	
		IHS	Tribal
Aberdeen	94,204	13	4
Alaska	103,209	2	7
Albuquerque	78,686	6	1
Bemidji	79,427	3	10
Billings	55,178	6	2
California	123,203	—	23
Nashville	72,836	1	19
Navajo	213,831	8	—
Oklahoma City	298,499	9	3
Phoenix	139,993	8	2
Portland	147,887	10	5
Tucson	27,571	2	—
Sum of Areas	1,434,529	68	76

The IHS direct care delivery system consists of hospitals, health centers, health stations, health locations, and school health centers. IHS and tribally operated hospitals differ markedly in terms of service capabilities and size, but most have active outpatient departments that provide outpatient dental, mental health, and other services. Health centers are facilities physically separated from hospitals; they offer a complete range of ambulatory services (including primary care physician, nursing, pharmacy, laboratory, and x-ray services) for a minimum of 40 hours per week. By comparison, health stations, often mobile units, offer fewer outpatient services for less than forty hours per week; primary care is often provided by mid-level practitioners, with physician care available on a regularly scheduled basis.<sup>77</sup>

### B. Capacity of the IHS

A total of 144 (sixty-eight IHS and seventy-six tribally operated) service units provide care within the twelve IHS Areas (as of October 1, 1995). The sixty-eight IHS service units administer thirty-eight hospitals and 112 ambulatory care facilities, consisting of sixty-one health centers, four school health centers, and forty-seven health stations; the seventy-six tribally operated

76. The source of estimated 1997 service population data is IHS, TRENDS, *supra* note 18, at 30 tbl. 2.1. The source of October 1, 1995, service unit data is IHS, REGIONAL DIFFERENCES, *supra* note 23, at 13-19 charts 1.2 to 1.14.

77. OTA, INDIAN HEALTH CARE, *supra* note 47, at 168.



service units administer eleven hospitals and 372 ambulatory care facilities, consisting of 129 health centers, three school health centers, seventy-three health stations, and 167 Alaska village clinics managed by community health aides. A total of thirty-four urban projects provide a range of services from information and referral and community health services to comprehensive primary health care services.<sup>78</sup>

As of January 1, 1996, all IHS hospitals, tribal hospitals, and IHS-eligible health centers were accredited by the Joint Commission on Accreditation of Healthcare Organizations. Six of nine Regional Youth Treatment Centers were accredited, with the remaining three preparing for accreditation. All hospital laboratories and 98% of health center laboratories operated by the IHS were accredited; the proficiency testing rating for all IHS laboratories exceeded the required 80% proficiency on all regulated analytes. The overall proficiency rating for IHS laboratories is 98%.<sup>79</sup>

IHS hospitals are typically smaller than U.S. short-stay hospitals, with 76% of IHS and tribal hospitals (Fiscal Year 1995) having less than fifty beds compared to 22% of U.S. short-stay hospitals (Census Year 1994). Only 4.1% of IHS hospitals have 100 to 199 beds and none have 200 beds or more (Fiscal Year 1995) as compared to 25.5% of U.S. short-stay hospitals with 100 to 199 beds and 30.7% with 200 beds or more (Census Year 1994).<sup>80</sup> IHS services have shifted over time from inpatient toward more ambulatory care; the average daily patient load for total IHS and tribal direct and contract general hospitals declined from 1594 in 1980 to 1087 in 1994, while ambulatory medical visits increased 64%; the tribal portion of both inpatient and ambulatory care has increased during this time period, from 1% to 15% in the case of inpatient care and from approximately 10% to 32% of ambulatory care.<sup>81</sup> IHS hospitals differ from U.S. community hospitals in terms of the scope and type of services offered, with IHS hospitals typically offering a more limited range of inpatient services and fewer high-technology services.

### C. Contract Health Services

Contract care involves the purchase of services unavailable through IHS or tribal providers from non-IHS, nontribal providers. The use of contract services in the provision of Indian health care has complicated service production and delivery, and may well have hindered the development of productive capacity within the IHS. Representing approximately 18% of total annual IHS allocations, \$368,325,000 of a \$2.05 billion budget in Fiscal Year 1997,<sup>82</sup>

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78. IHS, TRENDS, *supra* note 18, at 19-21.

79. *Id.* at 23-25.

80. *Id.* at 104.

81. *Id.* at 91, 105.

82. Indian Health Serv., U.S. Dep't of Health and Human Servs., Justification for Estimates for Appropriations Committees: Fiscal Year 1998, at IHS-1 (1997).

contract care is considered an essential component of the IHS delivery system. Its use is necessitated by, and ultimately may contribute to, limitations in staff and equipment that significantly curtail the range of services (specialty services in particular) available at IHS facilities.<sup>83</sup>

Increased reliance on contract services is due, in part, to the difficulty of delivering complicated services to many widely dispersed, small populations.<sup>84</sup> Unfortunately, continually using IHS resources to contract for services outside the IHS, means that fewer resources are available to develop the productive capacity of the IHS itself. Over time, the extent of this resource drain has been significant indeed.

Budget limitations (including fixed annual budgets) have made it increasingly difficult for the IHS to meet the growing demand for contract care. Contract services are currently rationed by application of more restrictive eligibility requirements than those associated with services provided directly by the IHS, authorization of services in accordance with medical priority determinations, and required first use of alternate resources.<sup>85</sup> Medical priority rationing results in contract care being reserved for relatively high-cost care rather than supplementing the full range of direct IHS services as originally intended.

Medically-necessary direct care services are generally restricted to members of federally-recognized tribes or their natural minor children residing in communities served by the local facilities and programs.<sup>86</sup> To qualify for referral to contract services, an individual must also reside within a contract health service delivery area (CHSDA) as designated by the IHS. Since a CHSDA is comprised of counties on or near-reservations, Indians who move to distant locations lose eligibility for contract care. Even upon return to a CHSDA, an individual must establish residence and remain there for a period of 180 days in order to become eligible for contract care.<sup>87</sup>

Unfortunately, because the needed contract services are typically specialized and involve newer technologies, they tend to be relatively expensive; their purchase imposes a considerable drain on the IHS budget. The growing size and importance of the IHS contract services program has forced the IHS to become a health care financing organization much like the Health Care Financing Administration and other payers.<sup>88</sup> Management problems, potentially plentiful in any such program, are greater for the IHS to the extent that it is not competitive in bidding, has limited leverage in bargaining,

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83. OTA, *INDIAN HEALTH CARE*, *supra* note 47, at 175.

84. *Id.* at 30.

85. *Id.* at 185.

86. 42 C.F.R. 36.12 (1996).

87. Everett R. Rhoades & Mary Helen Deer Smith, *Health Care of Oklahoma Indians*, 89 J. OKLA. ST. MED. ASS'N 169 (1996).

88. *Id.* at 168-69.

experiences problems in collection, and is inadequately reimbursed — all problems that have historically plagued the IHS contract care program.<sup>89</sup>

#### *D. Self-Determination and Self-Governance*

Indian-White relations over time have reflected the practical consequences of an ongoing struggle among advocates of termination, integration, and assimilation; proponents of autonomy and tribal self-governance; and those who continue to favor direct federal services. Whether health policy and the provision of services have evolved in spite of or in response to this struggle, the self-determination and self-governance movements have clearly influenced Indian health service delivery.<sup>90</sup> The extent of this influence is significant and potentially profound, promising tribally sensitive programs and the development of tribal capacity while potentially weakening Indian health programs.

The Indian Reorganization Act (IRA)<sup>91</sup>, passed in 1934 as part of President Roosevelt's New Deal legislation, established economic development programs and encouraged the formation of federally recognized tribal governments on a voluntary basis, thereby rejuvenating Indian communities and providing a foundation for tribal self-governance. Assimilationist sentiments, taking hold by the end of the decade, resulted in a move to terminate not only Native programs but tribes themselves.<sup>92</sup>

While the federal policy of blatant termination was abandoned in the late 1950s, comprehensive reform legislation affecting major service programs was not developed until the 1970s.<sup>93</sup> Two major pieces of legislation enacted in the 1970s — the Indian Self-Determination and Education Assistance Act of 1975 and the IHCA of 1976 — dramatically influenced Indian health care. Recognizing that federal domination of Indian service programs had hindered rather than assisted the progress of Indian people, the Indian Self-Determination and Education Assistance Act provided a mechanism for the transfer of programs traditionally administered by the IHS to tribal governments and authorized technical assistance to tribes to enhance their ability to administer such programs. The IHCA encouraged participation of Indians in planning and managing health services and authorized grants for recruitment of Indian health professionals, scholarships, and continuing education allowances.<sup>94</sup>

The Indian Self-Determination and Education Assistance Act authorized the IHS to contract with tribes to provide health services. These contracts, generally referred to as "638 contracts," permit tribes to administer a full spectrum of services, including both direct and contract health care services,

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89. OTA, INDIAN HEALTH CARE, *supra* note 47, at 189.

90. Pfefferbaum et al., *supra* note 3, at 381.

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

92. Pfefferbaum et al., *supra* note 3, at 379.

93. COHEN 1982 ED., *supra* note 31, at 180.

94. Pfefferbaum et al., *supra* note 3, at 384.

facilities construction, community health representatives programs, mental health and drug abuse services, and health education initiatives. The 638 process has resulted in new policies and modified contract regulations within the IHS, with considerable variation across IHS Areas in how contracts are implemented and monitored. While officially neutral with respect to tribal self-governance, the IHS often considers tribal programs to be extensions of the IHS itself. Hence, in addition to providing technical assistance to tribes and helping prospective tribal contractors develop applications, the IHS has continued to assume responsibility as well as oversight and control of these "638 contracts"<sup>95</sup> — much to the objection of some tribal leaders as well as some members of Congress.

Amendments to the IHClA enacted in 1992 reauthorized the Indian Self-Determination and Education Assistance Act and provided for the negotiation and implementation of a Compact of Self-Governance and Annual Funding Agreement with tribes participating in tribal self-governance demonstration projects; the amendments also authorized appropriations necessary to carry out the projects. The Tribal Self-Governance Demonstration Project Act,<sup>96</sup> enacted in 1991, increased the number of tribes involved in the demonstration projects and authorized increased appropriations. Whereas 638 contracts require tribes to provide the same level and types of services provided by the IHS programs they replace, compacts give tribes greater latitude in decision making and permit them to use resources for a broader variety of purposes. Compacting, which has developed in response to criticisms from some tribes and federal legislators of excessive oversight and regulatory interference on the part of the IHS, is seen as a mechanism for promoting and supporting tribal initiative.<sup>97</sup> Compacting is expected to reduce the bureaucracy of the IHS and shift authority away from the IHS to tribes.<sup>98</sup> Other potential consequences are less obvious but will likely include questions about accountability in the use of federal funds which are sure to arise in conjunction with the reduction in IHS oversight and regulatory control that accompanies compacting.<sup>99</sup>

A potential problem associated with tribal self-governance in the provision of health care — whether through contracts or compacts — arises out of unique characteristics of the health care market. This market relies extensively on specialized resources that quickly become outdated with continuous technological change. This is a market that must exhaust any potential economies of scale if quality care is to be provided efficiently. Problems associated with the provision of care in isolated rural areas and on reservations

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95. OTA, *INDIAN HEALTH CARE*, *supra* note 47, at 215-29.

96. Tribal Self-Governance Demonstration Project Act, Pub. L. No. 102-184, 105 Stat. 1278 (1991).

97. Kunitz, *supra* note 37, at 1469-70.

98. Rhoades & Smith, *supra* note 87, at 169.

99. Kunitz, *supra* note 37, at 1470.

have been addressed, with some success, by the IHS. IHS success in the provision of a comprehensive range of services within a system that permits local and regional involvement has depended to no small extent on the ability of the IHS to integrate services both regionally and nationally. It would be a mistake to think that transferring responsibility for service provision to tribes will leave IHS successes undisturbed — particularly when they depend on systemic characteristics — while freeing up resources for attention to its failures. This is especially true to the extent that IHS failures have been the result of insufficient resources rather than structural factors.

The existence of economies of scale in the provision of health care and the scarcity of health care resources in isolated geographic areas require cooperation among service providers rather than increased competitive pressures that may result from individual tribal provision of services. Economies of scale exist when a larger operation results in a lower per unit costs of production. Economies of scale may evolve from any number of factors, such as shared use of resources (equipment, for example), auxiliary benefits attributable to size (improved information gathering and analysis through computerized systems for medications, diagnostic data and treatment regimens, for example), and the ability to purchase in volume at lower per unit costs. Efficiency considerations dictate that production take advantage of economies of scale. The current self-governance trend is moving in the opposite direction.

Efficiency considerations, of course, also require recognition of potential diseconomies of scale. Diseconomies of scale exist when a larger operation results in higher per unit costs of production. Diseconomies are likely to arise as a result of problems associated with managing a large scale operation. Tribal self-governance may be an appropriate response to such problems by providing a mechanism for injecting even greater decentralization into the management process than that which characterizes the IHS. If adequately funded, tribal programs may also permit more appropriate response to unique tribal concerns and encourage tribal initiative. Limited ventures in tribal self-governance, with continued reliance on the IHS for guidance and collective purchasing, may provide a balance between diseconomies and economies of scale.

Congress has provided that the trust responsibility remain in self-governance and has been explicit in its direction that self-governance not be implemented at the expense of tribes receiving IHS services directly. There has, nonetheless, been no attention given to the fact that, as the IHS downsizes, services to tribes receiving direct services can only diminish. This in turn exerts tremendous pressure on those tribes who wished to receive their services directly from the IHS. They naturally feel compelled to join in self-governance for self protection, whether they believe it is in their best health care interests or not.

Unfortunately, tribal self-governance in the provision of health care does nothing, in and of itself, to increase and enhance the very limited pool of

health care resources available in many isolated rural and reservation areas where Indians live. Tribal provision of health care not only threatens to disrupt the highly integrated system of services provided by the IHS, but may also result in increased costs of production as tribes compete within and among themselves for these limited resources. Furthermore, any disproportionate increases in IHS resource allocations to contracting and compacting will reduce the proportion of resources — and therefore services — available for those tribes which do not participate in contracts and compacts. This could force tribes to participate in what were intended to be voluntary programs.<sup>100</sup>

Full scale ventures in health care self-governance might very well proceed deliberately in order that individual tribes amass clinical expertise, an infrastructure for service delivery, and the capacity to manage a health care system. In doing so, however, tribes must be mindful of the importance of economies of scale in the provision of health care and should consider developing a mechanism, through the IHS or other entity representing the collective interests of tribes, by which they might benefit from the advantages that a large operation can provide. Politically, tribes risk losing those benefits any time their individual actions undermine the collective interests of tribes.

Some economists would argue that tribal delivery of health care exerts pressure on the IHS to improve its performance. Any benefits that might accrue from competitive pressure brought to bear on the IHS as a result of tribal self-governance are likely to be short-lived, should the IHS be sufficiently weakened by the diminution of resources associated with it. Furthermore, without some collective entity, tribes could lose their potentially significant and increasingly important political and market power.

Tribal response to self-determination and self-governance in health care has been mixed. Some tribes have been enthusiastic in assuming management responsibility for major components of their health care and some have begun establishing the foundation for self-governance in health care. Other tribes, however, have been reluctant to participate, choosing instead to continue receiving health care from the IHS. Reasons for continued full participation in the IHS system vary among tribes: some tribes appear to be relatively satisfied with the IHS, other tribes recognize that they lack sufficient experience in delivering health care services, still others may consider funding for tribal programs to be insufficient; and some may 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.<sup>101</sup>

Whether or not tribes elect to participate in contracting and compacting, the problem associated with insufficient resources remains central to ongoing attempts to provide health services to Indians in response to the government's trust responsibility to Indians and to specified congressional goals for "the

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100. *Id.*

101. Pfefferbaum et al., *supra* note 3, at 388.

quantity and quality of health services that will permit the health status of Indians to be raised to the highest level possible.<sup>102</sup> Over the long run, continued failure to fund services for Indian health care, whether service is provided through the IHS or in the context of self-governance arrangements, contravenes national law and policy and threatens the health of Native peoples.

#### *IV. The IHS Resource Allocation Process*

##### *A. Uneven Distribution of IHS Resources Across Areas*

The IHS is frequently criticized, internally and externally, for its resource allocation methods and the resulting distribution of health facilities, personnel, and services. To a large extent, these criticisms reflect the inadequate levels of congressional appropriations for IHS services and facilities. It also reflects, however, a belief among many that the IHS is not distributing resources equitably or cost-effectively.<sup>103</sup> The lack of consensus among critics as to what would constitute an equitable resource distribution attests to the difficulty inherent in attempting to resolve issues of equity so as to satisfy the many varied and competing interests.

The present distribution of IHS facilities, personnel, and services has evolved over many years, primarily in response to congressional appropriations, directives, and administrative and legal decisions that often override deliberate health systems planning. The resulting distribution of services is clearly uneven, despite IHS cognizance of the needs of the population, the level of funding, and the availability of other sources of care within and across Areas. IHS regulations do not require the same range or level of services across Areas, but the courts have held that resource allocation must aim for equitable distribution.<sup>104</sup>

To support existing facilities and programs, the IHS has traditionally allocated annual appropriations on a program continuity (or historical) basis. To some extent, differences in health status and service provision across IHS Areas are attributable to IHS reliance on program continuity budgeting. Essentially, this process maintains base budgets from one year to the next, with additions to the base in accordance with percentage increases in IHS funding from year to year. Program continuity budgeting helps the IHS avoid service disruption and provides some assurance that programs will remain in operation from year to year, thereby lending stability to the system. Exceptions to program continuity budgeting occur when Congress provides special funds for new programs or areas or when increased staffing and support accompany new

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102. Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. at 1400 (codified at 25 U.S.C. § 1602(b) (1994)).

103. OTA, INDIAN HEALTH CARE, *supra* note 47, at 229.

104. *Id.* at 22.

IHS facilities.<sup>105</sup> The latter has been a major contributor to maldistribution of resources.

A Resource Requirement Methodology (RRM) process is undertaken annually to estimate the resource needs of Areas and their service units; these estimates are based on workload history and population projections. While the RRM process is used to develop IHS budgets, it is not the basis for actual budget allocations except for relatively limited equity funds.

### *B. Differences in Demographics and Services Across Areas*

The tremendous differences in numbers of individuals in various IHS Areas and considerable differences in the relative burden of illness experienced by various tribes in IHS resource distribution, inevitably result in wide variation in services across IHS Areas. For example, there are only two service units in Tucson as compared to twenty-three in California, and, while there are eight hospitals in both Aberdeen and Phoenix, there are none in either California or Portland.<sup>106</sup> Although not all allocation differences can be explained by these demographic variations, they do play an important role. They are specifically reflected in the IHS user population, defined as Indians who have used IHS services at least once during the previous three-year period. The total IHS user population exceeds 1.2 million in Fiscal Year 1994. It varies from 20,622 in the Tucson Area to 265,075 in the Oklahoma Area, with approximately 41% of the entire user population concentrated in the Oklahoma and Navajo Areas. Thus, Area differences often reflect differences in geographic and population size and differences in the availability of services.<sup>107</sup>

Differences in mean age of different Indian populations, with attendant differences in the proportion of certain diseases experienced by various Indian populations, also create the need for differential allocation of resources. The proportion of the Indian population older than fifty-four years of age varies from 8.3% for Phoenix to a high of 12.5% for Oklahoma.<sup>108</sup> The effect that this has on the proportion of chronic diseases requiring prolonged follow up and generally much higher pharmacy costs is apparent. Likewise, variations in median household income also influence illness patterns and, therefore, the relative need for health care and resources necessary to provide that care. Finally, differences in socioeconomic status as reflected, for example, by education attainment, affect the burden of illness experienced by all communities, including Indian. When possible, the IHS incorporates estimates of the burden of illness into its resource allocation methodologies, utilizing the concept of years of premature life lost (YPLL), and allocating additional funds to those with the highest YPLL. Ultimately, resource allocation should take

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105. *Id.* at 229.

106. IHS, REGIONAL DIFFERENCES, *supra* note 23, at 13-19.

107. *Id.* at 21.

108. *Id.* at 22.



into account these many and varied factors. Presently, however, there is no practicable way to do so.

IHS budget allocations vary considerably across the twelve IHS Areas. Allocation per IHS user varied from a high of \$1908 in Alaska to a low of \$575 in Oklahoma. Per capita allocation based on IHS Area service population ranged from a high of \$1906 in Alaska to a low of \$525 in Portland. There are multiple reasons for these differences, including program continuity budgeting, regional differences in cost and availability of care, differences in service delivery mechanisms (for example, the mix of direct versus contract care), and variations in the influence of tribes on state congressional representatives.<sup>109</sup>

In some Areas — namely, Aberdeen, Albuquerque, Billings, and Navajo — the IHS user population exceeds the IHS service population (1993). The user and service populations are virtually equal for Alaska (1993). In Portland and California, the user population is just over half of the service population (1993). The Areas with high user-to-service population ratios are Areas with large reservations, historically the focus of IHS programs. Many of the excess users in these Areas are likely to have migrated from these Areas to places where program services are not readily available and have no health insurance. Therefore, they return home in time of need.<sup>110</sup>

### C. Development of Resource Allocation Criteria

With the development of Resource Allocation Criteria (RAC) in the early 1970s, the IHS initiated action to establish as rational a process as possible for resource management. Developed for the purpose of planning, rather than actual resource distribution, RAC standards specified the quantity of resources (primarily manpower) required to provide a specific volume and mix of services. The development of criteria and standards relied heavily on literature, academia, existing manpower criteria from professional associations, and industrial engineering techniques including time-and-motion studies, rather than on field work specific to the IHS. (Only in the case of ambulatory care services were standards based on IHS-specific field work.) The use of RAC resulted in staffing tables that identified the number of staff for each workload level based on estimates of the times and frequencies of performing defined tasks, by type of service and provider.<sup>111</sup> Detailed RAC criteria sets were designed to reflect the staffing levels needed to provide health services under ideal conditions. While this was logical for purposes of planning, available IHS resources fall far short of the ideal RAC levels. The result has been a cumbersome deficiency-level approach to assessing relative resource needs among service units.<sup>112</sup>

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109. Kunitz, *supra* note 37, at 1467-68.

110. *Id.* at 1468.

111. OTA, INDIAN HEALTH CARE, *supra* note 47, at 232.

112. *Id.*

RAC development was undertaken to provide a consistent, comprehensive, and systematic process for determining health care needs and the resource requirements to satisfy those needs. Modified versions of RAC — now known as RRM — continue to be used in developing annual IHS budgets and in determining staffing requirements for new facilities. Except for a small annual equity fund available for several years in the 1980s, the RRM process is not used to determine actual Area budget allocations.<sup>113</sup> Furthermore, reduction in headquarter's staffing has resulted in no recent updates of the data employed in RRM.

#### *D. A Rational Basis for Equitable Resource Distribution*

IHS resource allocation methods were challenged in the 1970s in *Rincon Band of Mission Indians v. Califano*.<sup>114</sup> The IHS claimed that congressional appropriations were insufficient to enable it to serve all eligible beneficiaries. Citing *Morton v. Ruiz*,<sup>115</sup> the *Rincon* court held that, even in the absence of sufficient resources to reach all eligible beneficiaries, the IHS was obligated under the Snyder Act to establish and consistently apply criteria to ensure an equitable distribution of its resources. The Northern District Court of California found that the IHS allocation system violated the California Indians' constitutional right to equal protection.<sup>116</sup> The IHS breached its statutory responsibilities as provided in the Snyder Act. The Ninth Circuit did not reach either trust or constitutional questions raised in the original decision.

Issues addressed in *Rincon* illustrate the particularly complex and problematic nature of resource allocation within the IHS. The Rincon Band of Mission Indians brought a class action suit against the IHS for discriminatory and illegal distribution of federal funds in the provision of health care services, contending that the IHS denied Indians living in California their fair share of federal funds allocated pursuant to the Snyder Act. As part of a formal California policy to end the trust status of Indians, IHS services had ceased to be provided for California Indians in the early 1950s at the request of the State of California. California received no federal health service funds until 1967 when the State and the PHS funded an outreach program for rural Indians; at the request of the State, Congress reinstated California Indians into the IHS with an appropriation for the California Rural Indian Health Board (CRIHB), a private organization that administered the rural outreach program.

Data provided as part of discovery in *Rincon* showed a "conspicuous pattern of disproportionate funding in California."<sup>117</sup> In Fiscal Year 1977, approx-

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113. *Id.* at 229-38.

114. 618 F.2d 569 (9th Cir. 1980).

115. 415 U.S. 199, 230-31 (1974).

116. *Rincon Band of Mission Indians v. Califano*, 464 F. Supp. 934, 934 (N.D. Cal. 1979), *aff'd*, 618 F.2d 569 (9th Cir. 1980).

117. *Id.* at 936.

imately 10% of the IHS national service population resided on or near reservations in California. In the previous five years, the IHS had allocated a yearly average of only 1.18% of its total funds to California. Less than 0.60% of IHS health care personnel in the U.S. were assigned to California. Of a total of fifty-one hospitals, ninety-nine health centers, and several hundred health stations in the U.S., California was served by only one hospital and two health centers. Only 0.35% of IHS health facilities funds were to be allocated to California over the next seven years.

The IHS system for the allocation of Snyder Act funds gives highest priority to program continuity, followed in order by mandatory costs, congressional mandates, and program expansion. Program continuity funds represented approximately 85% of the health services portion of the IHS budget from 1970 to 1978. Under the IHS priority system, services for California Indians were funded initially through congressional mandates for the CRIHB; programs received continuity funds in subsequent years. The court of appeals agreed with the district court in its conclusion that program continuity allocations which provide funds to programs merely because they received funds in the prior year — regardless of whether the programs were "ineffective, unnecessary or obsolete" — were not a rational mechanism for achieving an equitable distribution of funds.<sup>118</sup>

The IHS asserted that their allocation system was rationally based and mandated by Congress. They argued that Congress had implicitly ratified the allocation system by its limited response to requests for substantial increases in funding for the CRIHB. The Court held this argument to be without merit, noting that congressional appropriation of funds did not constitute ratification of the IHS's allocation to California Indians nor the IHS distributive criteria.

Finding that the RAC system was utilized to allocate less than 3% of the IHS's 1978 annual appropriation for Indian health services, the district court held that the RAC system was "no more than a bureaucratic charade with respect to all IHS funds in general, and California Indians in particular."<sup>119</sup> The Court also cited a "conspicuous absence" of data necessary to make the RAC system an effective mechanism for the rational allocation of resources;<sup>120</sup> namely, the workload and utilization data that are required to complete the RAC tables used to determine needs.

The IHS, in response to the *Rincon* court order, proposed using an equity fund, with allocation based on the unmet needs of tribes. In years when Congress has failed to designate a portion of the IHS appropriation for the equity fund, the IHS has done so. While equity funds account for a relatively

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118. *Rincon*, 618 F.2d. at 573.

119. *Rincon*, 464 F. Supp. at 937.

120. *Id.* at 938.

small portion of the IHS budget, once granted they become part of the base budget for determining future funding (that is, program continuity funds).<sup>121</sup>

Increased reliance on the RRM process in the allocation of IHS funds might satisfy some who contend that program continuity budgeting is unfair, but it would not resolve the resource distribution issue for most. Major impediments to the development of a redistribution formula aimed at increasing equity that might be applied to the total IHS clinical services budget include: disagreement as to what constitutes the eligible population, changing health conditions, differences in the type and extent of services (including services other than those provided by the IHS), and questions regarding the validity of data.<sup>122</sup> In addition, the economies of scale available to larger Indian populations, compared to very small populations, create differences that are hard to correct through existing techniques, as is the widely differing availability of alternate resources for various tribes that should properly be taken into account in the allocation of IHS funds.

By virtually any measure — absolute or relative — the need for Indian health care services is obvious. This need, coupled with ever severe budget constraints, makes the resource allocation process particularly important since, ultimately, the resource allocation process influences the production and distribution of services to Indians. The resource allocation process is central to fulfilling the congressional mandate of raising the health status of Indians to the highest possible level. The resource allocation process is entwined with issues of access, eligibility, and rationing. In the mid-1980s, the Director of the IHS, recognizing the futility of redistributing the base of IHS funding or achieving true equity in resources, adopted the policy that IHS allocations should be administered in a way to eliminate as much as possible *unfair inequity* in the system. It is to be noted that Congress, for whatever reason, soon abandoned the appropriation of funds for equity distribution and the tribes have remained silent on this issue in recent years. Nonetheless, a rationally based resources allocation system remains a premier objective because of the impact of resource allocation on the production and delivery of health services.

### V. Access, Eligibility, and Rationing

#### A. Access to Care

Access to health care is difficult to define and measure. It implies, at the very least, four aspects of health care coverage: (1) availability of care as indicated by the provision of staff and facilities and measured, for example, by the ratio of providers to population; (2) accessibility or usability as indicated by the provision of insurance, eligibility for and/or entitlement to care, and ease of service utilization; (3) affordability as indicated by the ability to purchase

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121. OTA, INDIAN HEALTH CARE, *supra* note 47, at 233-35.

122. *Id.* at 28.

insurance or care; and (4) acceptability as indicated by a perception of value associated with obtaining care and of the care obtained.<sup>123</sup> All four aspects of coverage — availability, usability, affordability, and acceptability — have been and continue to be issues of concern in the provision of health services to Indians. Availability and usability of health care for Indians are influenced significantly by the organization of the IHS and its service delivery system. Affordability of care within the IHS system has generally been ensured for those services which are provided to eligible Indians. Acceptability of modern health care has grown with the help of visionary Indian leaders and with the acknowledgement of Indian healing methods as potentially complementary to modern medicine.<sup>124</sup>

While availability and usability of care for Indians are influenced significantly by the organizational structure of the IHS and its service delivery system, the structure of the IHS and its service delivery system developed as they did in part because of concerns about availability and usability of services. IHS organization and service delivery have, of course, also been determined to a great extent by federal regulations, funding limitations, and economic considerations in health care delivery. The organization of the IHS into Areas comprised of service units is designed to promote local tribal involvement, input, and management, thereby increasing availability, usability, and to a lesser extent, acceptability.

Access to care requires identifiable and convenient points of entry into the health care system. One of the remarkable features of the IHS is its recognition as a source of care; unfortunately, IHS service sites are limited geographically and technologically. Data from the National Medical Expenditure Survey suggest that Indians, as compared to other minority populations as well as to the general U.S. population, are more apt to identify a usual source of health care; but Indians, as compared to the general U.S. population, tend to travel further and wait longer for care and are less likely to have an appointment. Travel time, waiting time, and appointment patterns for Indians living on or near a reservation or in Alaska, and eligible for IHS supported services, whose usual source of care is at a non-IHS supported site are more comparable to the general U.S. population than to those Indians whose usual source of care is the IHS; but, since estimates did not compare IHS-operated facilities with other providers in the same geographic location, differences may be due in part to a general shortage of services in areas of greatest IHS or tribal facility use.<sup>125</sup>

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123. DONALD L. PATRICK & JENNIFER ERICKSON, HEALTH STATUS AND HEALTH POLICY: QUALITY OF LIFE IN HEALTH CARE EVALUATION AND RESOURCE ALLOCATION 48 (1993).

124. Rhoades et al., *Health on the Reservation*, *supra* note 33, at 113-14.

125. K.M. BEAUREGARD ET AL., ACCESS TO HEALTH CARE: FINDINGS FROM THE SURVEY OF AMERICAN INDIANS AND ALASKA NATIVES 3 (1991) (Agency for Health Care Policy & Research, U.S. Dept of Health & Human Servs., National Medical Expenditure Survey Research Findings No. 9) (AHCPH Pub. No. 91-0028).

National Medical Expenditure Survey data suggest that those Indians living on or near a reservation or in Alaska, who are eligible for IHS supported services, and who use IHS-supported services, receive medical care for specific acute health problems at a rate similar to that of the U.S. population.<sup>126</sup>

In the absence of large-scale epidemiological studies of Indian health, indicators of access to care typically rely on service availability and utilization data. Though there are IHS hospitals in Phoenix, Albuquerque, and Anchorage, the IHS primarily serves Indians on or near reservations or in rural areas. This was certainly appropriate when most Indians lived on or near reservations. Today, however, over half of the American Indian population live in urban areas, less than a quarter live on reservations, and the remainder live in rural areas (often defined as Indian Country, and containing generally eligible Indians). At the same time, despite the movement to urban locations, the demand for care in local IHS and tribal programs continues to increase. It is not uncommon for Indians living in urban areas to return to their home areas to receive health care services at IHS facilities rather than receive care at non-Indian facilities.<sup>127</sup>

A 1976 report to the American Indian Policy Review Commission, *Task Force Eight*, addressed the problems of nonreservation Indians. Two decades later, limited progress has been made in solving problems, such as the need for additional facilities, personnel, medicine, and information, associated with the delivery of health care off reservations. The IHClA recognized the health needs of urban American Natives by authorizing funds for urban Indian health projects. Funding has resulted in the establishment of health clinics as well as outreach and referral programs. Some of these health clinics that have developed close political and financial relationships with municipal governments, are supported by diversified funding sources, and have become comprehensive ambulatory health centers.<sup>128</sup> Nonetheless, because Indian health care facilities continue to be located primarily on reservations, Indians residing in cities or nonreservation areas have limited access to care. Some Indians are hesitant to utilize non-Indian health facilities in their communities;

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126. *Id.* at 9. For sore throat with fever, 60.8% of IHS-users (defined as Indians living on or near a reservation or in Alaska, and eligible for IHS supported services, who use IHS-supported services) did not receive care, as compared to 56.1% of the general U.S. population; for abdominal pain of two or more days duration, 75.4% of IHS-users did not receive care, as compared to 73.2% of the general U.S. population; for skin rash/infection, 51.0% of IHS-users did not receive care, as compared to 70.0% of the general U.S. population; for ear infection among those under age 18, 29.5% of IHS-users did not receive care, as compared to 32.0% of the general U.S. population; for diarrhea of at least two days duration among those under age 18, 74.9% of IHS-users did not receive care, as compared to 84.1% of the general U.S. population. *Id.*

127. T.L. Taylor, *Health Problems and Use of Services at Two Urban American Indian Clinics*, 103 PUB. HEALTH REP. 88, 89 (1988).

128. *Id.*

and non-Indian providers are often averse to treating Indians because of uncertainty about reimbursement or provider reluctance (sometimes outright refusal) to assume responsibility for treatment even though they may in fact be responsible for the provision of care. Non-Indian providers often refer Indians to Indian facilities, usually at some distance; unfortunately, this means that Indians often do not receive care until their health needs become critical.

The longstanding doctrine of assigning highest priority to Indians living on or near reservations is based on two major principles. First, with inadequate resources, it is generally accepted that highest consideration should be given to those living in locations where there are simply no other health services, Indian or non-Indian, available. A number of reservations remain in this situation. Although it is recognized that proximity to other health services such as exist in urban locations does not ensure access, Indians residing in urban areas theoretically have access to health care not generally available on most reservations. This is the primary reason that the original intent of IHCA was for outreach and referral services to assist urban Indians in gaining access to health care.

The second principle is somewhat more subtle but important nevertheless. It has to do with the fact that health services accrue to Indian individuals only through their membership in federally recognized tribes. Tribal sovereignty and the resulting government-to-government relationship between the federal government and the respective tribes, places the focus on the tribes, which with very few exceptions, continue to remain reservation based. IHS services indeed are provided to tribes located in or near metropolitan centers on the same basis as for rurally based tribes. Examples include the Pascua Yaqui of Tucson, the Agua Caliente of Palm Springs, and the Tohono O'odham Nation of the Gila Bend Reservation, Arizona. In addition, the Congress continues to belabor the point that the IHS is to conduct its business in a spirit of upholding the sovereignty of the tribes.

### *B. Eligibility*

Increasing demand, escalating costs of production, and wide variations in eligibility for tribal membership make eligibility an issue of growing importance in the provision of Indian health services. Eligibility concerns arise primarily with respect to identifying who is Indian and determining which Indians should receive services, a question dealt with in other contexts including education. There is a commonly overlooked issue of the exclusionary aspect of rules of eligibility: Such rules are designed to identify those for whom services are *not* intended. The Solicitor of the Interior stated, "The function of the definition of 'Indian' is to establish a test whereby it may be determined whether a given individual is to be excluded from the scope of

legislation dealing with Indians.<sup>129</sup> For Indians, it seems, the very definition of a people is tied to matters of service eligibility.

The question of eligibility is inextricably intertwined with questions of tribal membership. The courts have repeatedly recognized the rights of tribes to determine their membership. Today, membership is typically defined by a tribal constitution or law and is implemented by a tribal roll.<sup>130</sup> While specific membership requirements vary widely, the overwhelming majority of tribes have required some level of blood quantum to establish membership.

Most tribes have appeared reluctant to draw the inference that tribal membership is not the same as eligibility for a limited number of services, arguing that tribal membership — not the IHS — should determine eligibility for health services. The IHS would have no interest in eligibility criteria if there were sufficient funds to meet the great demand for services. It has had a tradition of inclusion rather than exclusion that has grown out of its emphasis on community care and a history in which the Indian community was fairly well defined. The problem, of course, is that decisions regarding eligibility become critical when limited resources have to be allocated across competing demands. The issue is complicated by the lack of a common definition of membership across tribes. Unfortunately, any advantages associated with relatively permissive eligibility requirements must be balanced against budget considerations, a continuing dilemma that will only grow more acute.

The Snyder Act, with its lack of specificity regarding legal rights and responsibilities, contains no express language identifying beneficiaries other than "Indians throughout the United States."<sup>131</sup> Courts have ruled repeatedly that the Snyder Act is to be construed liberally in favor of Indians. Exactly what this may mean with respect to eligibility requirements is unclear except that there appears to be considerable latitude for agency discretion in determining who qualifies for services designed to benefit Indians. While ruling against the BIA in its restriction of eligibility for services in the landmark case *Morton v. Ruiz*,<sup>132</sup> the U.S. Supreme Court did acknowledge the importance of agency decision making in allocating limited funds.

*Morton v. Ruiz* involved a Papago Indian and his wife who left their reservation in 1940 to seek employment nearby with the Phelps-Dodge copper mines in Ajo, Arizona. They settled in "Indian Village," a community in Ajo populated almost exclusively by Papago Indians. The Ruiz family maintained a close tie to the Papago reservation, spoke and understood the Papago language but only limited English, maintained a home on the reservation and

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129. FELIX S. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 2 (Univ. of N.M. photo. reprint 1971) (1942).

130. COHEN 1982 ED., *supra* note 31, at 20-23.

131. Ch. 115, 42 Stat. 208 (codified as amended at 25 U.S.C. § 13 (1994)).

132. 415 U.S. 199 (1974).



planned to return there upon retirement, and were not assimilated into the dominant culture.

Ruiz applied to the BIA for general assistance benefits under the Snyder Act during a prolonged strike at the mines. The BIA denied benefits, citing a provision in the BIA Manual<sup>133</sup> that limited eligibility to Indians living "on reservations" and in BIA jurisdictions in Alaska and Oklahoma. After failing to secure benefits through administrative appeals, Ruiz instituted a class action against Morton, Secretary of the Interior, claiming entitlement to general assistance as a matter of statutory interpretation and challenging the BIA eligibility provision as a violation of Fifth Amendment Due Process and the Privileges and Immunities Clause of Article 4, Section 2 of the Constitution. The district court's summary judgment for the Secretary was reversed on appeal on the basis that the BIA's residency limitation was inconsistent with the broad language of the Snyder Act. Congress intended general assistance benefits to be available to all Indians, and congressional appropriations for the BIA general assistance program did not ratify the BIA residency limitation as argued by the BIA. The appellate court concluded that, short of clear congressional action, geographical limitations were precluded by the Snyder Act's provision for assistance to Indians "throughout" the U.S. Without addressing the question of whether Congress intended assistance to be available to all Indians, regardless of residence and assimilation, the U.S. Supreme Court affirmed the Appellate Court's decision on the narrower basis that the Congress intended benefits for full-blooded, unassimilated Indians living in an Indian community near their native reservation who maintain close economic and social ties with that reservation.

The Supreme Court did acknowledge in *Morton v. Ruiz* that it may be necessary to establish eligibility requirements when allocating limited funds. In such cases, an agency must ensure that the standard is rational, generally known, and consistently applied. The BIA did not meet these criteria, failing to comply with its own internal procedures and the Administrative Procedure Act with respect to the publication of substantive policies.

The current IHS eligibility criteria remain very loose, requiring only that a person be of Indian descent and have close socioeconomic ties to the Indian community served by the local facilities and program.<sup>134</sup> In the mid-1980s, criteria were made more restrictive by ending the previous eligibility of non-Indian wives of Indians (non-Indian male spouses had long since been excluded). An exception was made in the case of a non-Indian woman pregnant with an eligible Indian child in order to ensure care for that unborn eligible Indian. The non-Indian mother remains eligible for care throughout the puerperium and therefore care is afforded for six weeks after delivery.

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133. 66 INDIAN AFFAIRS MANUAL 3.1.4 (1965).

134. 42 C.F.R. 36.1 (1996).

An obvious difficulty in interpreting eligibility rules is the vague language "close socioeconomic ties," which has never been precisely defined. For most purposes, the IHS regards individuals within the scope of its services if they are regarded as Indian by the community in which they live, as indicated by factors such as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, or active participation in tribal affairs.<sup>135</sup> These rules apply to those eligible for medically-necessary direct care services. Because of the increased reliance on high-cost contract care, additional criteria have been adopted for receipt of contract services. In addition to meeting the criteria for direct care services, individuals must also reside within a specific contract health service delivery area (CHSDA), generally comprised of counties on or near reservations. Indians who have moved from a CHSDA do not qualify for contract care in the new locations and when these individuals return to a CHSDA, it is necessary to reestablish residence and remain there for 180 days before again becoming eligible for contract services.<sup>136</sup>

A recent analysis of the ramifications of restricting Indian eligibility for health care by requiring minimal (one-quarter) blood quantum levels found the following: a consistent declining trend in the distribution of blood quantum by age group; a consistently lower level of service utilization among Indians with less than one quarter Indian ancestry; and lower proportionate cost of care for those with less than one quarter Indian blood quantum. Serious negative consequences may result from eligibility requirements based on blood quantum levels: for the individual with a low blood quantum, care will be denied; for families, there will be fragmentation in the delivery of health services; for the service unit, the relatively low user and less costly segment of the service population will be removed resulting in higher per capita costs for the remaining users; and for the Indian culture, there may be a forced exodus from reservations and decreased participation in Indian affairs.<sup>137</sup> While these effects may be exacerbated by stricter eligibility criteria, they are already operative as part of continuing demographic changes.

Eligibility restrictions based on blood quantum also may be problematic for Indians with multiple tribal heritage. One's entire heritage may be Indian, without having sufficient blood quantum to qualify for membership in any specific tribe. Thus, a full-blood with tribal heritage from a number of bands might be excluded while a quarter or eighth blood from a single tribe would be eligible. While it would be relatively simple to provide IHS services based upon the total degree of Indian blood possessed by individuals, eligibility for service under self-governance may be questioned. This entire issue of blood quantum will only grow more serious and complex; it must eventually be

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135. Rhoades & Smith, *supra* note 87, at 168.

136. *Id.* at 169.

137. Rashid Bashshur et al., *On Changing Eligibility for Health Care*, 77 AM. J. PUB. HEALTH 690, 692 (1987).

addressed by tribes, the Congress, and/or the courts. An unexpected development of the self-governance process is already having an effect on eligibility. For example, some tribes are beginning to resist the provision of services to "non-indigenous" local Indians (that is, Indians belonging to tribes not traditionally resident in that particular location).

Another perennial consideration in eligibility and rationing of care involves the relative ability of some Indians to pay for part of the care received through the IHS. It is argued that for a given fixed budget, means testing would permit more permissive standards with respect to other eligibility criteria. Means testing could be coupled with fee-for-service payments for those able to pay, thereby increasing IHS or tribal revenues and decreasing dependency on federal appropriations. But means testing and fee-for-service delivery raise at least as many questions as they answer, particularly in terms of congruence with a federal responsibility for, and legal obligation to provide, Indian health care. It is unlikely that means testing would be implemented without some abrogation of treaties or the possibility of termination of the existing federal-Indian relationship. In fact, earlier IHS eligibility criteria provided for charging certain Indians for care. This had been successfully ignored by the IHS and until this year, congressional language in the administrative provisions of IHS appropriations each year specifically prohibited charging Indians for care. Its deletion by Congress in the Fiscal Year 1997 budget may be a harbinger for the future.

### *C. Rationing*

Rationing of health care services is ubiquitous. It arises in response to the basic economic problem of scarcity, the problem of limited resources coupled with virtually unlimited needs and wants. Rationing is the process for determining who receives particular goods and services and who does not. Mechanisms for rationing occur by design or develop out of indecision. Markets rely on price as the method for rationing. Other familiar rationing devices include coupons, queuing, and age restrictions. With respect to health care, medical need may form the basis of rationing, as is the case with medical priority rationing for the IHS contract services program. Eligibility requirements also serve to ration, as typified by IHS eligibility requirements of residence in a CHSDA for receipt of IHS contract services.

One of the presumed advantages of the market system is the role of an "invisible hand" that guides the system toward answers to the three economic questions: what (and how much) to produce, how to produce it (the issue of resource utilization), and for whom to produce it (the distribution question).

Price is less effective as a rationing device in the presence of market imperfections such as limited information, barriers to entry, and external benefits and costs. Unfortunately, imperfections abound in health care markets. Furthermore, attitudes about health care as a right and a necessity may make reliance on price as a rationing device unacceptable to many, if not to most.

In the absence of price as a rationing mechanism, other bases for rationing become necessary either as a result of conscious decision or as a result of some discriminating process already operative within the system. Because of the centrality of health care to quality of life, it would seem that rationing should be a careful and deliberative process. Unfortunately, there is a general tendency to ignore the reality of the need to ration services — perhaps in the hope that the problem will resolve itself. The IHS is rare in its acknowledgement of rationing and should be applauded for its attempt to deal with it systematically and in accordance with health parameters.

Rationing affects, and is affected, by the services provided. Hence, decisions about what services will be available go hand in hand with decisions about the distribution of those services. A relatively limited package of benefits serves more individuals than do more comprehensive packages at comparable costs. There are no universally accepted criteria for determining what constitutes a comprehensive package of basic health services. After much debate, the IHS has adopted a concept of a benefits package defined as those services which in the judgment of the attending physician are necessary to preserve life, limb, and sensory organs or to prevent clear deterioration of health status.<sup>138</sup> This has the advantage of leaving the decision with the attending physician rather than with a lower level health professional, a clerk, or a bureaucratic list or manual, and accords with the comprehensive thrust of the IHS.

### *Conclusion*

A number of basic and complex forces have converged in the establishment of the IHS as a unique health care delivery system. These factors include: (1) the special legal and sovereign relationship between the federal government and tribes, marked by the continuing conflict between self-determination and self-governance and maintenance of the trust responsibilities of the federal government; (2) the genetic, social, cultural, and demographic attributes of the American Indian population; (3) the operation of a comprehensive, community-based health care program; (4) the Congress as the central policy determining agency; (5) historic factors that have often required diametrically opposite and often conflicting policies on the part of the federal government; (6) the genuine effort of the IHS to engage fundamental questions such as the universal cap on resources, determination of eligibility for services, the very definition of "Indian," the most equitable allocation of scarce resources, and determination of the most appropriate array of services; and (7) the overriding goal to which the system aspires, raising the health status of a given population to the highest possible level.

Against these social, legal, historic, political, and administrative determinants, there are modern pressures facing the entire nation. These

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138. Rhoades & Smith, *supra* note 87, at 168.

include a desire for universal access to health care; an ultimate cap on available resources in the face of continually growing demand; the need to place the rationing of care on as reasonable and humane a basis as possible — preferably driven by health, rather than cost, considerations; the reciprocal relationship between the number of persons who can be served versus the number of services that can be provided. In the IHS, the complexity of these basic elements is compounded by the far more fundamental, difficult, and competing questions of tribal sovereignty on the one hand and the federal trust responsibility on the other. Just as the operation of this community-based health care delivery system serves as a very useful model for study, so too do the special governmental and political considerations. At the heart of much of the health care debate in America are questions of the authorities and responsibilities of the federal government relative to other levels of government, especially the states. The IHS provides a model in which these questions may be examined.

In spite of its now rather large bureaucracy, with its attendant adverse effects, the IHS has often led the nation in the application of new and innovative health concepts and interventions. The development of rural emergency medical services; the effective implementation of community involvement in the planning and execution of health care practices; the development of community health lay workers; advances in application of principles of resource allocation; efforts to address the conflict between the number of services available and the number of persons to be served; attempts to base necessary health care rationing on indices of health status; and a number of other innovations are examples of pioneering efforts by the IHS.

The value placed on the synthesis of these and other disparate elements into a coherent whole by the Congress and the tribes is now being tested through downsizing of the government and division of the program among individual tribes. These movements do, however, provide an opportunity to correct many of the deficiencies for which the IHS is often criticized, including the problems inherent in federal bureaucracy, the intrinsic paternalism in serving as a trustee, the too-often absence of a concern for service to customers, the perception of a bloated and unresponsive central bureaucracy, and failure to respond to the expressed wishes of individual tribes. The IHS has attempted to respond to these criticisms, but many of the criticisms directed at the IHS arise from fundamental elements beyond the ability of the IHS to correct. Nonetheless, for many issues, the IHS in cooperation with the tribes themselves, has often led the nation.

It is unclear whether the changes underway for both the tribes and the federal government will correct current deficiencies in the system. There seems to be little effort to examine potential adverse effects on either health care delivery or the underlying federal-Indian relationship. Whether the results prove to be a benefit or a loss should become clear relatively quickly. In the meantime, the IHS remains a largely unknown and misunderstood health care

system. It provides the nation with a unique and important opportunity to examine fundamental questions as they are worked out within a system charged with providing for the health care needs of Native Americans.

More than five hundred years ago, concepts of world medicine were revolutionized by the introduction of techniques and drugs from Native Americans. The entire health care delivery system may soon find itself drawing upon the lessons — good and bad — of the Native Health Care Delivery System. As it struggles to adapt to changing medical needs, the United States has a unique laboratory of more than two hundred years of public health care policy, programs, procedures, and practices to use in examining many fundamental questions.

## GLOSSARY

*Access to Care:* Implies at least four aspects of health care coverage including availability, usability, affordability, and acceptability of care. (Source: Patrick and Erickson, 1993, p. 48)

*Area:* A geographic region consisting of IHS service units defined by the IHS for administrative purposes. Generally, though not universally, comprised of contiguous geographic areas, Areas differ with respect to geographic and population size; cultural and demographic factors are considerations in their designation. The eleven Areas are: Aberdeen, Alaska, Albuquerque, Bemidji, Billing, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland; an IHS headquarters office in Tucson is often counted as a twelfth Area for statistical purposes. (Source: IHS, Trends-1996, p. 14)

*Average Daily Patient Load:* The average number of occupied beds in a hospital on a daily basis, calculated by dividing total annual inpatient days by 365. (Source: IHS, Trends-1996, p. 14)

*Community Health Representative (CHR):* Indians selected, employed, and supervised by their Tribes and trained as paraprofessionals by the IHS to provide specific health care services (including health promotion and disease prevention) at the community level. (Source: IHS, Trends-1996, p. 14; U.S. Congress, Office of Technology Assessment, 1986, p. 361)

*Compact:* A mechanism for executing an agreement between the BIA or IHS and Tribes under self-governance. It is intended to replace the more burdensome and disliked mechanism of contracting.

*Contract Care:* Health services not available directly from the IHS or tribes that are purchased under contract from non-IHS community hospitals and practitioners. (Source: IHS, Trends-1996, p. 14; U.S. Congress, Office of Technology Assessment, 1986, p. 361)

*Contract Health Service Delivery Area (CHSDA):* Comprised of counties on or near reservations; residence in a CHSDA is required for referral for contract health care services. (Source: U.S. Congress, Office of Technology Assessment, 1986, p. 176)

*Direct Care:* Health care provided to eligible Indians through IHS facilities and staff. (Source: U.S. Congress, Office of Technology Assessment, 1986, p. 361)

*Economic Questions:* Three fundamental questions that every economic system must address (either deliberately or inadvertently), consisting of what (and how much) to produce; how to produce it; and for whom to produce it. The three questions are often referred to simply as what, how, and for whom to produce.

*Economies of Scale:* Decreases in long run per unit costs of production associated with increases in plant and capacity.

*Equity Fund:* A small annual fund established in the 1980s through special Congressional appropriation (or through IHS set asides of a portion of its

appropriations) to address unmet needs of tribes and distributed to IHS service units identified as being deficient in resources relative to other IHS service units. (Source: U.S. Congress, Office of Technology Assessment, 1986, p. 361)

*Diseconomies of Scale:* Increases in long run per unit costs of production associated with increases in plant and capacity.

*Health Center:* An ambulatory care facility (separate from a hospital) that offers a comprehensive range of outpatient services including primary care physician, nursing, pharmacy, laboratory, and x-ray services, for at least 40 hours a week. (Source, IHS, Trends-1996, p. 14)

*Health Station:* A facility or mobile unit (separate from a hospital or health center) that offers primary care physician services on a regularly scheduled basis for less than 40 hours a week. (Source: IHS, Trends-1996, p. 14)

*Invisible Hand:* Concept, coined by Adam Smith in the *Wealth of Nations* (1776) and associated with capitalism, used to illustrate how individuals, each operating in their own self interest and without interference, are led - as if by an invisible hand - to the best good for society as a whole.

*Market Imperfection:* Characteristic of a market that prevents it from allocating resources efficiently. Imperfections may include, for example, barriers to entry, externalities, and incomplete information.

*Program Continuity (or Historical) Budgeting:* A budget process, used by the IHS to allocate its annual appropriations, that maintains base budgets from year to year with increases in funding allocated to Areas in accordance with each Area's proportion of the total budget. (Source: U.S. Congress, Office of Technology Assessment, 1986, pp. 361-2)

*Rationing:* Any method for distributing limited commodities (goods, services, and resources). Mechanisms may be deliberately selected or develop out of indecision; examples include price, coupons, queuing, and age.

*Reservation State:* A state in which there is at least one federally recognized Indian tribe and in which the IHS has responsibilities for providing health care to eligible Indians. The 35 reservation states are: Alabama, Alaska, Arizona, California, Colorado, Connecticut, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. (Source: IHS, Trends-1996, p. 15; U.S. Congress, Office of Technology Assessment, 1986, p. 362)

*Residual Responsibility:* IHS responsibility to provide health services for eligible Indians after other sources of care have been utilized.

*Scarcity:* The basic economic problem; a situation of virtually unlimited needs and wants coupled with limited resources.

*Service Population:* Intended to reflect American Indians and Alaska Natives who are eligible for IHS services, a projection made from the decennial census of that population residing in certain counties in the 35



reservation states thought to most closely represent those who are eligible to receive services from the IHS. (Source: IHS, Trends-1996, p. 8)

*Service Unit:* The local administrative unit of the IHS consisting of a defined geographic area typically centered around a federal reservation or population concentration. (Source: IHS, Trends-1996, p. 2, 16)

*User Population:* Indians eligible for IHS services who have used IHS services at least once during the previous three-year period. (Source: IHS, Trends-1996, p. 16)

*Years of Premature Life Lost (YPLL):* A measure of the burden of premature deaths, calculated by summing over all deaths the difference between age at death and age 65. (Source: IHS, Trends-1996, p. 16)

*638 Contracts:* Contracts between tribes and the IHS (or BIA), authorized by the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638), by which tribes assume planning, operation, and administration of programs. (Source: U.S. Congress, Office of Technology Assessment, 1986, p. 363)