The Modern American

Volume 1
Issue 2 *Fall 2005*

Article 5

2005

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Deborah Broken Rope

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Keywords
Tribal Nations, Trust obligation, Alaskan Natives, Federal American Indian policy

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*By Deborah Broken Rope, Esq.**

In the United States today, the Tribal Nations' history is hardly known by the general public. Sadly, history textbooks largely overlook the contributions that Tribal Nations have made in the formation of this country, as well as their role and status growing out of their unique legal stature today. Their unique status, that of a "dependent nation,"[1] has distinguished the legal governmental foundations between the United States and the tribes, which results in dual citizenship status for tribe members (as a United States citizen and as a tribal citizen). This political citizenship status also distinguishes Indian relations and services as politically derived, rather than racially based.[2]

Today, there are 335 Tribal Nations recognized by the federal government as having unique sovereign status[3] and to whom the United States has a trust obligation. This trust obligation has two prongs: (1) there is a United States fiduciary duty to protect tribes and their resources, and (2) that determining what is in a tribe's best interest has been held to be vested principally with the Congress in exercise of its plenary power over tribal affairs.[4] The combination of the unique political citizenship, trust obligation, and stature of dependent nations has created a complicated legal quagmire. This article addresses how this legal framework has left many Tribal Nations without appropriate medical care. This article also addresses common misconceptions about American Indian and Alaskan Native peoples that often lead to the mishandling of the health needs on the federal and state levels.

Background: How American Indian Health Became a Federal Concern

In its pre-Constitution era, the United States' relations with the Tribal Nations consisted of European colonial agreements or treaties with various eastern and other coastal Tribal Nations. European and tribal parties both benefited by utilizing international law principles that provided rights recognized by other European powers, such as safe trading routes, specific point of entries, and land for the base of such operations. These colonial agreements with Tribal Nations, with the recognition and permission to enter into such arrangements, were advanced during the United States' formation[5] and in subsequently adopted treaties with specific tribes.[6]

The content of these treaties evolved over time, both in scope and nature. The earliest treaties were often made to promote peace, cement military alliances against other colonial powers, and protect trading rights and routes. In order to accomplish this, these agreements would define specific tribal lands and require traders and others to secure federal approval, including payment of fees, before hunting and trading could occur within such delineated territories. Later, treaties were established to ensure that traditional tribal lands used for hunting or other activities, such as animal and habitat harvesting, or farming, would be protected while permanently securing some portion of the land for federal ownership and later sale. These tribal land cessions became the core feature of all treaties in the late eighteenth century.

In return for these peaceful land cessions and the conveyance of hunting or other rights, Tribal Nations were to receive federal assistance in lieu of lost resources. Federal promises of aid were expected to compensate tribes for their diminished area of authority and territory that had made them self-sufficient in the provision of food, housing material, medicinal plants, etc.

In the last part of the Indian treaty era, when Indian lands previously recognized as inviolate were invaded for gold or homesteading purposes, agreements were entered into to mark the end of military conflict between the Tribal Nations and the United States. Once again, these treaties became the vehicle for identifying the respective rights and territories belonging to the affected Tribal Nations and the United States, and these were made in exchange for promises of future federal aid.

Treaty making with the Tribal Nations was abolished in 1871[7] under pressure by the House of Representatives because Members wanted a voice in determining future tribal agreements. Future Tribal-United States agreements were accomplished through legislative means, with or without tribal consent. This legislative method has remained the primary federal mechanism for resolving tribal concerns to this date, whether for tribal-specific matters or national policy questions, such as health care services.

American Indian Health Care

Several statutes have been enacted for addressing Indian health and related needs. These congressional actions were undertaken in fulfillment of the United States' responsibilities to the tribes. These responsibilities derive from the Federal Indian law principles drawn collectively from the Constitution, treaties, statutes, executive orders, and case law that have been enacted over the past three centuries.

There are two important facts to recall in identifying federal American Indian policy and rights. The first is the dual citizenship status that many American Indians have. This means that such Indian person carries the rights of any United States citizen to federal aid and protection, as well as those to benefits owed to their tribe under such separate legal agreements and standards.

The second is that federal Indian benefits have changed as contemporary circumstances have grown. Today, federal assistance is structured to try to fulfill the original intent of the treaties in context of current standards of care, expertise, and technology. Federal goals are designed to ameliorate health and economic disadvantages and disparities as compared to the rest of the country.

Previously, treaties differed as to what was proper medical care. Where one tribe's treaty would specifically require that a doctor be available to help treat injuries, another treaty or statute may indicate that the federal government is obligated to provide for the well-being of and public health prevention services to another community. These two provisions, taken together, have evolved to mean that the United States has a federal health responsibility beyond the mere provision of one doctor or what the 1800s' perception of adequate health care was deemed to be.

Federal and State Health Care Issues

Given the limited knowledge of American Indian and Alaskan Native political, legal, and cultural attributes, the general public cannot fully comprehend "Indian"-related news stories. Such stories include articles highlighting tribal gaming, the socio-economic substandard conditions prevailing among many tribes, and tribal land and its federal "trust" protection status. Additionally, misperceptions are caused by the way tribal people participate in federal or state assistance programs, especially health care services, through specifically established federal Indian programs. The lack of informed policy leaders and federal health advocates results in inadequate direction and resources to address tribal health needs, as well as their exclusion or lack of access to public health care and related services.

Today, there exists a separate federal health care delivery system serving federally recognized Tribal Nations - the Indian Health Service (IHS). IHS was originally established as a function of the Indian Affairs agency. The Indian Affairs agency was first created in the War Department. Later, Congress reorganized the Indian Affairs agency and established it within the Interior Department. The federal health responsibilities were later transferred out of the Interior Department's Bureau of Indian Affairs (BIA) to the then Department of Health, Education and Welfare (HEW) in 1955.[8] This action was initiated, in large part, as a federal assimilation policy to encourage tribal people to view their health care rights no differently than those owed to non-Indian persons. This Indian health function transfer was also seen as a step towards eliminating separate Indian rights.

The IHS health care delivery system has established 50 hospitals, approximately 250 outpatient clinics, and 200 health stations in tribal communities from Alaska to the east coast.[9] In addition to these federal facilities, tribes are also operating many of their own health facilities, whether hospitals or clinics. The growth in tribally controlled health services is supported by both specific Indian health legislation[10] and the Indian Self Determination Act, whose goals were to strengthen tribal governing capabilities.

Due to the nature of this federal health care system, the IHS program is viewed as the principal and sometimes sole health care avenue to be utilized by tribes. This misperception is enhanced during difficult fiscal years, when states are trying to limit costs for those health entitlements and other programs that require them to serve persons who fit a certain low-income profile, or who fall into some category of defined care (e.g., 65 years of age, end stage renal disease, etc.).

Many states carry a co-pay or matching fund requirement on receipt of federal health care funds for state residents who qualify for such care. States are reluctant to ensure that tribal members fully access this care because it is perceived as an added drain on their state funds. Many mistakenly believe that tribal members do not contribute to the state tax scheme. Generally, tribes are exempt from paying a state tax as it is unconstitutional for one sovereign to tax another. Consequently, many tribal members living within their tribal lands or "reservation" are exempt from state employee taxes when they work for their tribe or federal agency office located on tribal lands. However, many tribal members are employed outside their reservation and do pay employee taxes as would any other state resident.

The perception that tribal persons do not pay state taxes and should be discouraged from using state funded services is only slowly being addressed through federal channels, whose funds often make up the nucleus of state health care assistance.

Federal and State Health Care Access

Although there are several federal health policies, they are not always accessible for tribal members. The federal health policy makers in the Executive Branch have often found it easier not to address the dual citizenship rights of tribal people in their budget formulation and policy initiatives. However, such conduct is irresponsible, as there are many individuals who have dual health or other entitlement and assistance status. These individuals are eligible to utilize multiple federal benefits that complement or overlap one another. The option of having multiple benefits received, such as Veterans Affairs, Medicaid, Children's Medicaid, or Substance Abuse Prevention, can be no more difficult to administratively manage than the incorporation of Indian health care rights. While the Congress and the Administration may work to address overlapping or duplicative benefits, complementary services will remain.

The federal government has also found it easier to support strictly state block grants rather than state-tribal block grants. The Administration cites that working with 335 tribes in addition to working with 50 states would be too burdensome for the affected federal agencies. States are, however, permitted to count tribal members for inclusion in their federal application for funds, yet often do not provide the proportionate share of funds to tribal communities for assisting their members. This action means that tribal people have to either seek state or county facilities to receive such federal or federal-state aid, or lobby the State for a tribal "piece of the pie." When a State legislature has few to no Indian representatives, a plea for tribal

provisions is unheard. Tribal members are not often perceived as integral members of such constituencies, due to low political voter turnout, as well as the lack of economic and political clout of many tribes. Conversely, tribal members find it difficult to receive assistance in non-tribal settings due to discriminatory treatment in the lack of patient-consumer education and outreach, as well as the simple requirement of being welcomed to receive such assistance.

Members of Congress view news stories on Indian gaming and wonder why tribes are unable to assume greater financial responsibility. Lack of information concerning tribal economic disadvantages has resulted in an inadequate foundation to sufficiently grasp the gaping holes in such news coverage. Unfortunately, tribal economic circumstances in their entirety are not mainstream news. This includes low tribal employment rates, which in turn means low tax revenues. Tribes are unable to promote economic industry beyond gaming without their own investment or contributions, which is difficult to accomplish without an existing revenue base. For example, the tribal gaming market, contrary to high profile stories, is not very lucrative for many tribes because of their geographic isolation. Members are reluctant and handicapped in efforts to provide effective policies when comprehensive information and education is sparse and not readily available.

The congressional committees having an interest in Indian health matters have increased over the years. In the House, four committees can influence the debate on Indian health legislation. These committees are the House Resources Committee from its Indian jurisdiction, the House Energy and Commerce from its public health jurisdiction, the House Governmental Affairs for agency organization and functions issues, and the House Ways and Means Committee over Medicaid and Medicare revenue collection and expenditure matters. Unlike the House, the Senate has a separate committee to handle Indian legislation, the Senate Committee on Indian Affairs. Here too, however, the chamber is moving towards multiple-committee review on pending legislative proposals by using the Senate Finance, Health, Education, Labor, and Pension committees. The result of this dispersed governance is that Indian health legislation designed to strengthen health care services and tribal control has become mired in bureaucracy.

INDIAN HEALTH OUTLOOK

Tribal health status has been documented to reflect morbidity and mortality levels that far exceed the national average.[11] Yet this data has not produced the necessary support for correcting such obvious health disparities through federal legislative and funding action.

Navigating this maze in Congress, while placating special interest groups and states, and negotiating with the Administration for significant investment, has proven to be a cumbersome and difficult task. Tribal advocates have been attempting to pass the reauthorization of the Indian Health Care Improvement Act for the past five years to no avail. Lack of legislative action is due to the cost and size of the bill, the need to allay committee questions over certain new program provisions, and the need to respond to the Administration and Members' questions over the long-term benefits of this unique federal health care system.

CONCLUSION

As the United States advances into the twenty-first century of emergency preparedness, continued Middle East military conflicts, rising federal deficit, and trade imbalances, the federal government's inclination will be to push tribal health needs to the side or to expect that tribal needs are met within the confines of state-structured systems. Such inaction will undermine effective Indian health care services on two levels. The first level is in the outreach to Indian patients and also in strengthening tribal governments who have the greatest interest in protecting their future. Second, the deferral or hands-off approach is inconsistent with the United States treaties and other legal agreements with the tribes.

Tribal Nations are resourceful and American Indian/Alaskan Native people have adapted without assimilating and losing their political and cultural identity over the past three centuries. The new century will test both tribal resolve and the United States' integrity to fulfill its obligations. Such federal fiduciary fulfillment would be easier to obtain were the citizens of this country properly informed on who the First Nations are and what their roles and rights are in this great country.

ENDNOTES

* Deborah Ann Broken Rope is a public policy advisor in the Indian law practice group at Holland & Knight LLP. Ms. Broken Rope was a Legislative Analyst with the Indian Health Service, Department of the Health and Human Service for several years. Ms. Broken Rope earned her law degree in 2000 from American University Washington College of Law.

[1] *See generally Cherokee Nation v. Georgia*, 30 U.S. 1 (1831) (distinguishing Indian tribes from foreign nations given their occupancy in U.S. territories to which the U.S. "assert title, independent of their will").

[2] *See Morton v. Mancari*, 417 U.S. 535, 553-554 (1974) (holding that Indians are not members of a "discrete racial group," but are members of a sovereign entity whose "lives and activities" are governed by the Bureau of Indian Affairs).

[3] List of Federally Recognized Tribes, 67 FED. REG. 134 (July 12, 2002).

[4] *See Lone Wolf v. Hitchcock*, 187 U.S. 553, 562 (holding that Congress' power over the Kiowa, Comanche, and Apache Indians is not precluded by provisions of any treaties).

[5] U.S. CONST. Art. I, § 8, cl. 3.

[6] Francis Paul Pucha, *The History of a Political Anomaly* (University of California Press 1997) (stating that the Treaty Era between 1778-1868 resulted in 370 ratified treaties).

[7] Indian Appropriation Act, 16 U.S.C. § 566 (1871).

[8] 1955 Transfer Act.

[9] *FY 2006 Budget Justifications*, U.S. Department of Health and Human Services Indian Health Service, *available at* http://www.ihs.gov/AdminMngrResources/Budget/FY_2006_Budget_Justification.asp.

[10] E.g., Indian Sanitation Facilities Act, PL 86-121; Indian Health Care Improvement Act, 25 U.S.C. 1601; Indian Alcohol And Substance Abuse Prevention And Treatment, 25 U.S.C. 26; Special Diabetes Program for Indians, 42 U.S.C. 254c-3(c)(2). ,

[11] *Trends in Indian Health, 2000-2001*, Division of Program Statistics, Indian Health Service (IHS), U.S. Department of Health and Human Services (DHHS), *available at* http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/IHS_HQ_Publications.asp.