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## **LEGAL AND HISTORICAL ROOTS OF HEALTH CARE FOR AMERICAN INDIANS AND ALASKA NATIVES IN THE UNITED STATES**

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*for*

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## Introduction

The Kaiser Family Foundation has developed a series of issue briefs addressing American Indian and Alaska Native (AI/AN) health care. This issue brief was prepared to examine the legal and historical background underlying today's AI/AN health care system.

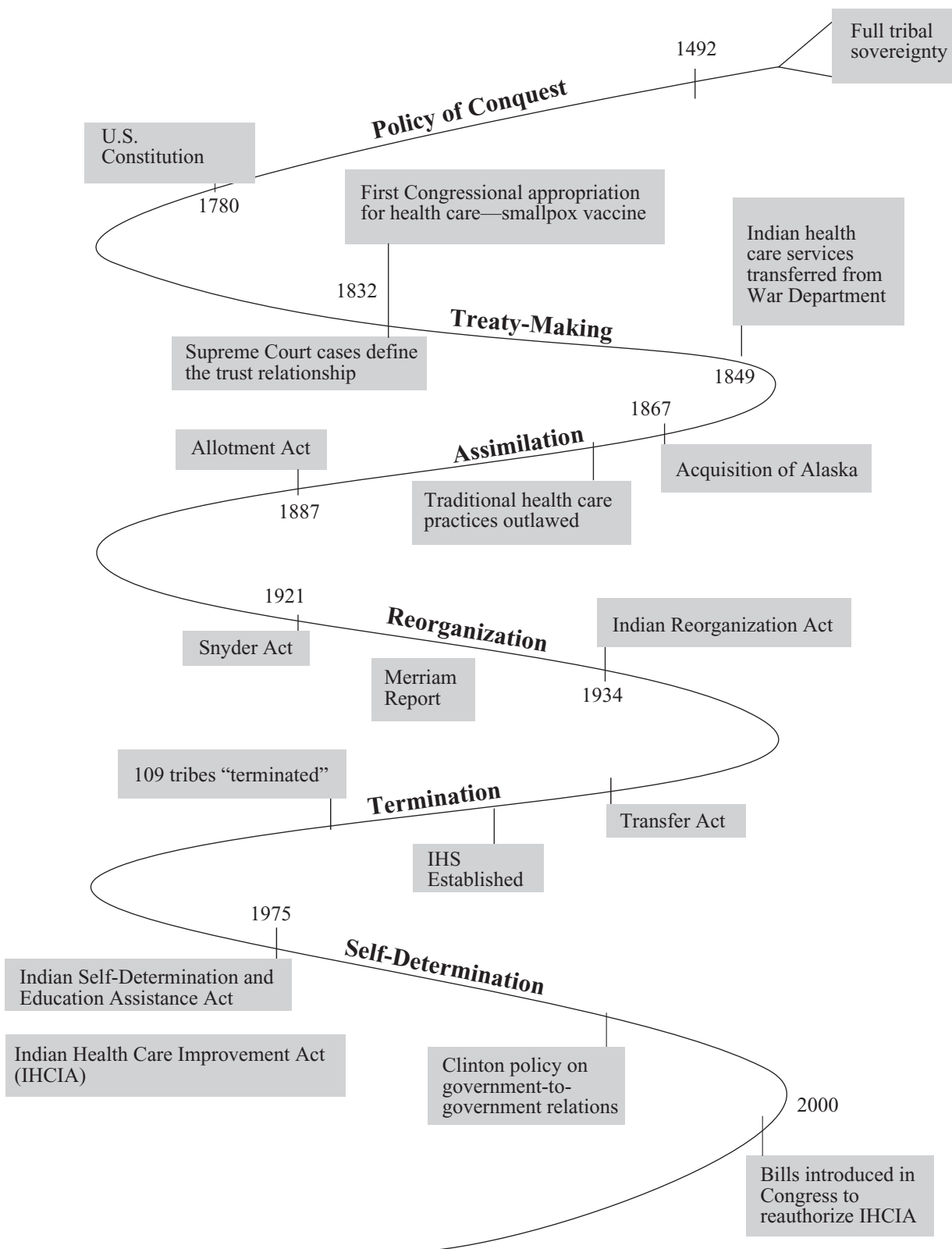
Health care for members of American Indian tribes and Alaska Natives often comes from a system that is separate from that of mainstream America. The Indian Health Service (IHS), part of the US Department of Health and Human Services, is currently the federal agency with primary responsibility for fulfilling the United States' trust obligation to provide health care for AI/AN people. The IHS and tribes have developed a system of hospitals, clinics, field stations, and other programs in the attempt to fulfill the federal trust responsibility and meet the health care needs of AI/AN people. The roots of all of this activity lie in the federal trust responsibility.

A separate health care delivery system for AI/AN people is an outgrowth of a unique, complex, and sometimes inherently contradictory history of interactions between the various tribes and the United States government. Most reservation-based AI/AN people receive their health care from this separate system. However, not all health care for all AI/AN comes from IHS, because many AI/AN people are not eligible for such services and many who would otherwise be eligible do not live where such services are available.

The legal and historical background in which the Indian health care system exists is the result of an ever-changing political landscape. There have been different time periods during which distinct policies dominated, but legal doctrine "threads" remain from each period long after the period itself has passed. From the beginning, tribal sovereignty, government-to-government relations between tribes and the United States, and tribal autonomy have existed as common themes underlying federal-Indian relations. In addition, a unique federal trust responsibility has grown as a result of the relations between the federal government and tribes.

Along with these common themes, there have been pendulum-like shifts between U.S. policy preferences for assimilation or for self-determination of Indian people. Some new laws have developed as the political landscape has changed over the decades, while other laws, which were remnants from earlier times, remain intact or are reinterpreted in light of prevailing political perspectives (see Figure 1). Much of what is considered groundbreaking can actually be traced back to older policies of strikingly similar character. The result is a very complicated field of law addressing Native Americans, Alaska Natives, and their tribes. Traditional Indian health care practices and the western-model Indian health care system exist within this complex legal and historical framework, as does the rest of Indian life.

# Timeline of Major Legislative and Historical Events in Health Care for American Indians and Alaska Natives



## Early Roots: Sovereignty and the Federal Trust Responsibility

To fully understand where AI/AN people and tribes find themselves today, it is first necessary to understand where they started. Even prior to contact from the colonizing European nation-states, nations of people in this hemisphere were sovereign. They governed themselves. They also had highly developed systems for health care and maintenance. In fact, many components of traditional Indian health care are being studied for applications in modern medicine today. Traditional uses of plants and animals for healing, as well as diets, are increasingly being studied in search of answers to modern medical problems for native peoples and others around the world.

Tribes today retain sovereign powers that they have held all along as separate governments that predate the United States or its predecessors. The amount of sovereignty retained by AI/AN tribes depends on numerous factors including the varying degrees of assimilation that each particular nation has undergone and the outcome of past and present disputes about tribal governance. The amount of sovereignty that a tribe exercises can have an impact on the health care available to its members, because sovereignty affects the choices available to the tribe in providing health care services.

The historical sovereignty of tribes, and health care for their people, was indelibly impacted as soon as widespread immigration from Europe began in the 16th century. Among the colonizing nations of Europe, the first discoverer had the right to control the land it “discovered.” Under this *doctrine of discovery*, the step of actually obtaining the right to the land from the local native people became a mere formality. The local Indians’ right was relegated to one of mere occupancy—the right to be on the land and not be found guilty of trespassing. However, even the right of Indians to occupy the land still had to be eliminated before a colonizing nation could make full use of the land. This was accomplished through treaties with the resident tribes—either treaties of peace or treaties of war.<sup>1</sup> Beginning in 1836, as a precursor to the Indian Health Service, some treaties between tribes and the United States, such as the Treaty of Fort Laramie,<sup>2</sup> provided for medical supplies and physician’s services as partial consideration for tribal land cessions to the United States.<sup>3</sup>

Many tribes were understandably unwilling to leave their lands. The colonizers used the doctrine of conquest to remove Indians who were not willing to give up their lands. Under the doctrine of conquest, when a nation defeats another nation in war, they obtain title to the defeated nation’s land and control of its people. This was a time period before international laws and forums like the United Nations. Because the doctrine of discovery gave the colonizing nations exclusive control over the lands they claimed under the doctrine, those nations could do whatever they wanted with respect to the inhabitants of the claimed lands. Therefore, the doctrine of conquest was a readily available means of removing tribes from lands desired for colonial expansion.

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<sup>1</sup> The US government entered into 370 treaties with various Indian tribes between 1789 and 1871. The Indian Appropriations Act of 1871 ended the treaty-making process with tribes.

<sup>2</sup> 15 Stat. 635-47 (1868).

<sup>3</sup> While the United States attempted to settle outstanding claims for Indian land via the Indian Claims Commission and the Court of Claims, treaty provisions for Indian health care have not been explicitly addressed in court. The current federal interpretation is that funding for AI/AN health care is discretionary and done in observance of a moral obligation on the part of the federal government. However, tribal members frequently maintain that health care is a treaty obligation as well.

## Constitutional Provisions Guiding Indian Health Policy

The United States was born into the established legal tradition that included the doctrines of discovery and conquest. The deepest roots of federal Indian law are in these doctrines. Upon gaining its independence, the United States assumed the role previously held by England with respect to American Indians. The federal government declared that it would be the gatekeeper for relationships with local indigenous peoples in the Commerce and Treaty Clauses of the Constitution. The *Commerce Clause* (Article I, § 8, clause 3) authorizes Congress to regulate commerce “with foreign Nations, and among the several States, and with Indian Tribes.” The Treaty Clause (Article II, § 2, clause 2) grants to the federal government the exclusive authority to make treaties on behalf of the United States.

While these clauses in the Constitution are the cornerstones of federal Indian policy, their precise meanings are continually in dispute in the courts. Nonetheless, interpretation of them has led to some broad-ranging legal rules concerning tribes. These rules form the basis for federal Indian law, a field of law that governs Indian peoples’ lives. The tribes, the federal government, and states are each sovereign and may make their own laws. However, certain principles of federal Indian law constrain the ability of each sovereign to make laws that affect AI/AN people.

Early U.S. Supreme Court cases held that since the United States chose to relegate tribes to a dependent status in terms of tribal dealings with other nations, the federal government also assumed a trust responsibility towards the tribes and their members. In *Worcester v. Georgia*,<sup>4</sup> the Court explained some of the implications of this trust relationship, and the federal obligation to look after the tribes’ well-being:

From the commencement of our government Congress has passed acts to regulate trade and intercourse with the Indians; which treat them as nations, respect their rights, and manifest a firm purpose to afford that protection which treaties stipulate. All these acts ... manifestly consider the several Indian nations as distinct political communities, having territorial boundaries, within which their authority is exclusive, and having a right to all the lands within those boundaries, which is not only acknowledged, but guaranteed by the United States. ... The treaties and laws of the United States contemplate the Indian territory as completely separated from that of the States; and provide that all intercourse [trade] with them shall be carried on exclusively by the government of the Union.<sup>5</sup>

The case established that the federal government, and not the states, has authority over and responsibility for matters relating to members of Indian tribes. However, the federal responsibility only applies to those tribes that are in some way recognized by the federal government.<sup>6</sup>

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<sup>4</sup> 31 U.S. (6 Pet.) 515 (1832). This was a decision addressing a dispute between the Cherokee Nation and Georgia.

<sup>5</sup> Id. at 556-7.

<sup>6</sup> Federal recognition may be by treaty or other methods. According to the National Congress of American Indians (NCAI), “there are roughly 563 federally recognized tribes in the United States, with a total membership of about 1.7 million. In addition, there are several hundred groups seeking recognition (NCAI, [www.ncai.org/main/pages/issues/other\\_issues/federal\\_recognition.asp](http://www.ncai.org/main/pages/issues/other_issues/federal_recognition.asp)). There are an estimated 115,000 Indians who are members of non-recognized tribes, including tribes that are state- but not federally recognized. (Champagne, p. 614).

Thus, four of the most basic principles of federal Indian law were established early in U.S. history: (1) tribes retain all of their inherent sovereignty that the federal government has not encroached upon; (2) the federal government, and not states, is in charge of Indian affairs; (3) the federal government only deals with tribal organizations or governments that it has recognized; and (4) the United States has assumed a trust responsibility towards Indian nations, resulting from treaty language and from the role it has assumed with respect to limiting tribal sovereignty. The influence of these principles on federal policy on health care for AI/AN people has varied greatly throughout several periods of federal Indian policy.

### **A Special Case: Treatymaking and Alaska Natives' Land**

In 1867, near the end of the treaty-making era, the United States acquired Russia's right to Alaska. The Treaty of Cession provided that Alaska Natives would be treated the same as aboriginal peoples in the rest of the United States.<sup>7</sup> Treaties were never negotiated with Alaska Natives, and few reservations were created in Alaska. The federal government eventually pursued its relationship with Alaska Natives on a village-by-village basis through the Bureau of Indian Affairs (BIA) and the Alaska Native Claims Settlement Act, which was passed in 1971 to clear the title to Alaskan land for oil development.

### **Early Wars Shape Federal Role in Indian Health Care**

Almost as soon as the United States was founded, pressure to expand westward mounted and the country's boundaries almost continually shifted in that direction. The 1800s marked a time of great conflict between the United States and Western tribes. During this era, the US Army took steps to curb infectious diseases among tribes living in the vicinity of military posts, in order to protect its soldiers and neighboring non-Indians. This was the first provision of health services to American Indians by the federal government. Non-Indian settlers brought smallpox, measles, diphtheria, malaria, and other infectious diseases. Because many American Indians had never been exposed to these diseases, they were particularly susceptible. Epidemics spreading through neighboring tribes increased the risk of infectious disease for non-Indian settlers and military personnel (Cohen 1982).

The first Congressional appropriation specifically for Indian health care was in 1832.<sup>8</sup> This appropriation authorized the purchase and administration of smallpox vaccine. Some additional federal expenditures for Indian health care were made from tribal treaty funds, and some health services were provided with general educational appropriations distributed to religious and philanthropic organizations active in the "civilization" of Indians (Cohen 1982).

<sup>7</sup> Treaty of March 30, 1867, 15 Stat. 539.

<sup>8</sup> Act of May 5, 1832, ch. 75, 4 Stat. 514.

The War Department was initially in charge of Indian affairs. This only made sense because the power to control Indian affairs arose from the doctrines of discovery and conquest (Cohen 1982). Indian health care passed from the military and missionaries to civilian control in 1849, when the Bureau of Indian Affairs (BIA) was transferred from the War Department to the newly formed Department of the Interior.<sup>9</sup>

Over 24 years after its transfer, the BIA made its first attempt to expand services by establishing a medical and educational division. Funding for the new division was inadequate, however, and the medical section of the BIA was terminated in 1877. By 1880, 77 physicians were serving the entire American Indian population in the United States and its territories (Cohen 1982).

Funding for medical services to Indians continued to be meager during the last half of the 19th century. The focus of U.S. efforts during the ensuing years was the eradication and removal of Indians from land. Early in the century, removal was accomplished primarily through treaties and attempts to integrate tribal members into “American” society. With the rise of a period of “Indian wars” in the last part of the 19th century, federal policy shifted from integration towards vanquishing Indians in massacres. There was little incentive for the federal government to provide health care for Indians at a time when it was focusing on killing them in battle.

## **The Rise of Assimilation Policy**

Westward expansion by the United States resulted in tribes residing in a smaller portion of their original homelands. The move to reservations had harmful health effects, in part because it often created a shift away from traditional diets. It became increasingly difficult or impossible to hunt and gather traditional foods and medicines. Many of the health problems faced by AI/AN people today, such as diabetes, cancer, and heart disease, are related to shifts from traditional dietary patterns.

Because tribes were forced to live on land unable to support them, the United States was obligated as “guardian” to help tribal members subsist. However, the trust responsibility carried with it a high price—the growing expense of providing food for an increasing number of people placed on reservations. The policy of assimilation gained favor as the best approach for dealing with the federal government’s “Indian problem.” The goal of assimilation was to bring Indians into mainstream society, and have them abandon their former ways of life.<sup>10</sup>

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<sup>9</sup> Act of March 3, 1849, ch. 108, § 5, 9 Stat. 395.

<sup>10</sup> The U.S. policy of assimilation of AI/AN people (i.e., the destruction of AI/AN culture) is a common, albeit frequently unspoken, theme throughout American history. When the policy of removal and eradication lost favor because it was expensive and embarrassing, the next approach was to assimilate Indians into the mainstream culture. As Richard Henry Pratt, founder of the Carlisle Indian Industrial School (an Indian boarding school) put it, the goal of assimilation was to “kill the Indian and save the man” (Woodhead 1995). Variations on this same theme were repeated later in the forms of relocation and termination policies.



A fundamental objective of assimilation was wresting the notion of group ownership from Indians and replacing it with the “civil” notion of private property. One of the primary tools of assimilation policy was allotment of reservation land. Under the General Allotment Act of 1887,<sup>11</sup> the group title of a tribe to the land on its reservation was abolished and replaced with individual plots. Reservation lands that were not allotted were usually made available to non-Indians.

Another primary tool of assimilation policy was education administered by the BIA through a boarding school system. In the BIA boarding school system, anything Indian—dress, hairstyle, language, religious practices, traditional medicine, philosophies—was prohibited. The boarding schools also contributed significantly to the spread of diseases, such as tuberculosis, among Indians. The ripple effects of the boarding school system, like all assimilation policies, can still be seen today. Some of the tragic effects are a legacy of physical, emotional, and sexual abuse of children in the BIA boarding schools (Woodhead 1995), as well as a lack of parenting and historical grief from this trauma. These are commonly regarded as contributing factors for the relatively high rates of alcoholism, depression, suicide, and domestic abuse in the Indian community.

Many traditional health care activities were banned during the assimilation era. For example, some traditional ceremonies were prohibited and practitioners were aggressively sanctioned. The Courts of Indian Offenses, federal courts set up on reservations, were empowered to detain “medicine men” indefinitely if they practiced their traditional ceremonies.<sup>12</sup> The United States continued to prohibit the practice of traditional ceremonies and medicine until the last half of the 20th century.

Developments in federal health care for AI/ANs during the heart of the assimilation era provided the earliest roots for modern AI/AN health care. The BIA attempted to reorganize its health services in 1908, when it created a chief medical supervisor position.<sup>13</sup> Congress began appropriating funds for BIA health care services in 1910.<sup>14</sup> Yet, despite these early efforts, the health of people on the reservations continued to be dismal.

In 1912, President Taft sent a special message to Congress summarizing the results of several surveys documenting deplorable health and sanitary conditions on reservations (Cohen 1982). Eventually, actions were taken to improve AI/AN health services. Congress passed the Snyder Act in 1921,<sup>15</sup> providing explicit legislative authorization for federal health programs for Indians by mandating the expenditure of funds for “the relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes.” This provided the first formal authority for federal provision of health care services to members of all federally recognized tribes. Prior to

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<sup>11</sup> 24 Stat. 388-91 (also known as the “Dawes Act”).

<sup>12</sup> U.S. Department of the Interior, *Rules Governing the Court of Indian Offenses*, 4th ed. (March 30, 1883) quoted in Dixon and Roubideaux at p. 15.

<sup>13</sup> American Medical Assoc., Council on Medical Service, *Health Care of the American Indian* (1973), reprinted in Indian Health Care Improvement Act: Hearings before the Subcommittee on Health and Environment of the House Committee on Interstate and Foreign Commerce, 94th Cong., 2nd Sess. 219, 226 (1976); Cohen at 696-7.

<sup>14</sup> Appropriations Act of April 4, 1910, ch. 140, § 1, 36 Stat. 269, 271.

<sup>15</sup> 25 U.S.C. § 13 (1921).

this Act, provision of health care services to Indians was done piecemeal for a variety of reasons such as in the interest of protecting non-Indian settlers, as part of religious “educational” programs designed to “civilize” Indians, or in observance of treaty obligations when a particular treaty included terms for health care provision. BIA health care services received another boost in 1926 when physicians from the Commissioned Corps of the U.S. Public Health Service were first assigned to Indian health programs.

At the request of the Secretary of the Interior, the nongovernmental Institute for Government Research conducted a two-year survey of the condition of Indian affairs, resulting in publication in 1928 of what is frequently called the “Merriam Report.” The report compared Indian health services with health services for the general population, with the goal of identifying what factors would help Indians meet a minimum standard of health. The report described the devastation caused by allotment, the failures of Indian education, and the dreadful health status of American Indians. Its recommendations were not radical: more money should be appropriated and Indian health services should be reorganized to run more efficiently.<sup>16</sup> While the report still reflected assimilationist philosophies in many regards, it also defined the goal of Indian policy to be “the development of all that is good in Indian culture “rather than to crush out all that is Indian.”<sup>17</sup> The authorization for health care provided in the Snyder Act and the subtle shift in policy reflected by the Merriam Report’s recommendations set the stage for a new era: Indian Reorganization.

## **Reorganization, Termination, and the Creation of IHS**

In 1933, the longtime Indian reform activist John Collier became the Commissioner of Indian Affairs. Collier was determined to undo the damage done by allotment and assimilation policies. His 1933 report to Congress addressed the need for consolidation of tribal land bases, the importance of day schools rather than boarding schools, decentralization of the Indian service, and more Indian employment by the BIA.<sup>18</sup> The next year he issued a report that called for a revival of tribalism and the preservation of Indian heritage.<sup>19</sup>

Although Collier’s initiatives met opposition that resulted in compromises in Congress (Cohen 1982), Congress passed several acts that drastically changed the course of Indian policy. The *Johnson-O’Malley Act of 1934*<sup>20</sup> authorized the Secretary of the Interior to contract with states and territories for provision of services for Indians, as long as the services met standards established by the Secretary. This allowed the BIA, and later the IHS, to contract for provision of Indian health services.

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<sup>16</sup> The survey report, was formally entitled, *The Problem of Indian Administration*. Its editor and director was Lewis Merriam. Many people working in AI/AN health policy maintain that these recommendations are still applicable today.

<sup>17</sup> Cohen (1982, p. 144–5) quoting Institute for Government Research (1928).

<sup>18</sup> 1933 SEC INT. ANN REP. at 68–69.

<sup>19</sup> 1934 SEC INT. ANN REP. at 90.

<sup>20</sup> 25 U.S.C. §§ 453–454 (1934).

The *Indian Reorganization Act of 1934* (“IRA”)<sup>21</sup> created sweeping changes designed to encourage economic development and self-determination by tribes. The IRA included provisions intended to stop the alienation of tribal lands and provide for recovery of some lands lost due to previous federal policies. Tribes were encouraged to organize in a manner much like modern business corporations.<sup>22</sup> Educational and technical training opportunities were created. Limited tribal autonomy was allowed, with retained federal supervision over tribal affairs.

Although reorganization was arguably helping tribes exercise more self-determination, the political pendulum quickly reversed its course. In the 1950s, assimilation policy re-emerged. This time the policy was rapid assimilation through terminating tribes’ legal existence by removing their federal recognition as tribes, eliminating their reservations, and relocating Indians away from their homelands. Termination was promoted as a way to “free” Indians from the supervision and control of the BIA. Ultimately, Congress passed Acts terminating the special federal-tribal trust relationship with 109 tribes and bands. The basic elements of the termination plans included: sale of tribal lands, imposition of state legislative and judicial authority on the terminated reservations, elimination of exemptions from state taxation, and an end to tribal sovereignty. Reservation Indians were relocated to major urban areas for vocational training and better employment opportunities. The result was a marked increase in the urban Indian population in cities across the country. The effects of termination on tribal economies, society, and health were devastating.<sup>23</sup>

Despite early attempts at improvements, Indian health care during the reorganization and early termination eras remained inadequate under the BIA. Many critics, including several Indian organizations, urged that the BIA be relieved of responsibility for Indian health care.<sup>24</sup> In 1954, the Transfer Act<sup>25</sup> moved responsibility for Indian health to the Public Health Service, which at the time was a division of the Department of Health, Education, and Welfare.

The IHS was established as an agency under the Public Health Service in 1955. As the IHS began to build and staff hospitals and health centers in or near AI/AN communities, Indian health care began to improve. While the IHS has never been fully funded, its creation is one of the few termination era actions of the federal government that was helpful to Indian people.

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<sup>21</sup> Ch. 576, 48 Stat. 984 (codified as amended at 25 U.S.C. §§ 461, 462, 463, 464, 465, 466-70, 471-473, 474, 475, 476-478, 479) (1934). This Act is sometimes referred to as the “Wheeler-Howard Act,” after its sponsors in Congress.

<sup>22</sup> An almost boilerplate constitution was adopted by many tribes during reorganization. Tribal governments organized under these constitutions are frequently referred to as “IRA governments.” The IRA form of government is commonly criticized by Indian people because it supplanted more traditional tribal forms of government. As an example, many tribes traditionally use a consensus-based approach to decision making. IRA governments reach decisions by majority vote, which can lead to a disgruntled minority and cause divisions within a tribe (Young Bear and Thiesz 1994).

<sup>23</sup> See, e.g., Chairman Allen Foreman et al., “Termination: An Account of the Termination of the Klamath Reservation from the Tribe’s Point of View,” *Herald and News*, Klamath Falls, Ore. Oct. 13, 1999, describing the many devastating health effects of termination on the Klamath Tribe.

<sup>24</sup> See Transfer of Indian Hospitals and Health Facilities to Public Health Service: Hearings on H.R. 303 Before the Subcommittee on Indian Affairs of the Senate Committee on Interior and Insular Affairs, 83rd Cong., 2nd Sess. (1954).

<sup>25</sup> Indian Health Facilities Act of 1954, 68 Stat. 674, codified as amended at 42 U.S.C. §§ 2001-2005f.

## Statutory Authority for Contemporary Indian Health Programs

Along with the civil rights movements and American Indian Movement of the 1960s and 1970s came a shift from the policy of termination towards self-determination for American Indian tribes. In the early to mid-1970s, Congress passed several laws designed to strengthen and restore tribal sovereignty. These laws restored the sovereignty of some individual tribes that had been terminated in the previous decades. The stage was set for two key acts promoting tribal sovereignty and better health care: the Indian Self-Determination and Education Assistance Act of 1975<sup>26</sup> and the Indian Health Care Improvement Act of 1976.<sup>27</sup>

The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) was passed thanks to the congruence of: (1) the desires of many tribes to provide federal Indian programs to their own people, (2) the historical preference of Congress that tribes become self-sufficient, and (3) the goal of the Nixon administration to turn back the termination policy in favor of tribal self-determination. The “Self-Determination Act” directs the Secretary of the Department of Interior (DOI) and the Secretary of the Department of Health and Human Services (DHHS), upon the request of any Indian tribe, to enter into self-determination contracts or compacts with tribal organizations (Bauman et al. 1999). These “638 contracts” may be for planning, conducting, and/or administering programs that are provided by the federal government for the benefit of Indians. Self-governance “compacts” or annual funding agreements enable tribes to receive more of their “share” of the overall IHS budget to manage their health programs by claiming the funds to assume administrative functions (Roubideaux 2002).

Originally, the “Self-Determination Act” only applied to the activities and programs of the two agencies with the greatest involvement in Indian affairs: the BIA and the IHS. But one of the earliest amendments to the Act expanded self-determination to cover all bureaus within the DOI.<sup>28</sup> Recent developments in P.L. 93-638 policy continue to center around self-governance. Due largely to support and advocacy by tribes who had successfully taken over management of their own affairs, Congress made self-governance a permanent program in 2000, through P. L. 106-260.

In spite of the success stories of some tribes, a controversy about self-governance continues. The Act includes provisions stating that there is no intent on the part of Congress to diminish the federal trust responsibility to Indians or Indian tribes.<sup>29</sup> However, some tribal leaders are concerned that too much contracting or compacting can expose a tribe to the risk of a hidden type of termination,<sup>30</sup> sometimes called “termination by appropriation.”<sup>31</sup> Other tribes do not see any benefit in contracting to administer programs that are chronically underfunded—seeing little benefit in taking over the helm of what they see as a “sinking ship.”

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<sup>26</sup> P.L. 93-638, codified as amended at 25 U.S.C. §§ 450a-450n (1975).

<sup>27</sup> P.L. 94-437, codified at 25 U.S.C. §§ 1601 et seq., and 42 U.S.C. §§ 1395qq and 1396j (1976).

<sup>28</sup> P.L. 100-472, 102 Stat. 2285.

<sup>29</sup> 25 U.S.C. 458ff(b).

<sup>30</sup> Indian Self-Determination and Education Assistance Act Implementation, Hearings before the United States Senate Select Committee on Indian Affairs, 95th Congress, 1st Session, on Implementation of Public Law 93-638 (1977).

The *Indian Health Care Improvement Act of 1976* (“IHCIA” or P.L. 93-437) addressed the continuing lag of Indian health behind that of the general population, setting forth a national 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>32</sup> The Act contained a vast array of provisions designed to increase the quantity and quality of Indian health services and to improve the participation of Indians in planning and providing those services. IHCIA provided for the consolidation and authorization of funding for existing IHS programs, funding authorization for facilities construction, and authorization for health and medical services for urban Indians. Most of the facilities and programs are located on Indian reservations, although limited health care services are available for AI/AN people living off-reservation in some urban areas. IHCIA also established the IHS Scholarship Programs to educate AI/AN health professionals to work in Indian communities. It authorized construction of safe water and sanitary waste disposal facilities in Indian homes and communities. IHCIA allows preference to Indian contractors in construction projects. For the first time, IHCIA authorized Medicare and Medicaid reimbursement for services performed in Indian health facilities. The last reauthorization of this Act was in 1992 (Kauffman 1999), and a bill for reauthorization of IHCIA was introduced in 2001 and again in 2003. Although the IHCIA reauthorization expired in 2000, Congress has continued to appropriate funds for IHS each year.

### **Alaska Native Claims Settlement**

Another Act of major importance passed during the early 1970s was the Alaska Native Claims Settlement Act of 1971 (“ANSCA”), which finally addressed the land claims of Alaska Natives. Native corporations were created to hold the settlement funds and lands. Alaska has a complex mix of village governments, tribal governments, village corporations, regional Native profit-making corporations, and regional Native non-profit corporations. In general, it is the regional Native non-profit corporations that provide health care to Alaska Native people.

### **Current Issues**

Changes in AI/AN health care due to policy choices and preferences continue into the present times. One of the more important developments in recent years was President Clinton’s 1994 issuance of executive documents on government-to-government relations, which were designed to be major policy instruments to facilitate tribal involvement in the administration of Indian programs. In 1998, the Clinton administration issued an Executive Order entitled “Consultation and Coordination with Indian Tribal Governments” that further defined the policy requiring executive departments and agencies to consult with tribal governments. All of these directives recognized that Indian tribes retain the inherent ability and responsibility to look after the

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<sup>31</sup> Put roughly, the concern is that when tribes take over responsibility to administer programs and the sole remaining activity of the federal government is funding for the programs, it would be very easy for the federal government to deny any further responsibility for the tribes, and to cut funding.

<sup>32</sup> 25 U.S.C. § 1602.

interests of their people. President Bush has continued the policy of tribal consultation. DHHS implemented its tribal consultation policy in 1997; however, IHS has been the only agency to implement a successful formal consultation process with tribes (Roubideaux 2002).

As we begin the 21st century, federal health care policy toward American Indians and Alaska Natives is governed by statutes and legal doctrines that may be traced back to the 16th century doctrines of discovery and conquest. Today, acting under the broad authorization of the 1921 Snyder Act, the Congress every year appropriates funds to the Indian Health Service to fulfill the federal government's trust responsibility to provide health care services to AI/AN people. Few would argue that the amount of funds appropriated—\$2.8 billion in FY 2003—adequately fulfills that responsibility, particularly in light of the demonstrable disparities in health status between AI/AN people and other population groups. The current Congressional debate over the reauthorization of the Indian Health Care Improvement Act of 1976, which expired in 2000, presents an ideal opportunity for a reexamination of current federal policy. This reexamination, however, must be done with an understanding of, and careful attention to, current policy's legal and historical roots.

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## Appendix A

### Key Legislative and Historical Events in Health Care for American Indians and Alaska Natives

#### Pre-European Contact: prior to 1492

Full tribal sovereignty; Traditional health care practices only

#### Policy of Conquest: 1492–1700s

- 1776 U.S. declares independence, succeeds to Britain's Indian policy
- 1780 Constitution gives federal government lead authority in dealing with Indian tribes

#### Treaty-Making and Indian Wars: 1800–1877

- 1800s Federal health funding to curb infectious diseases among tribes living near military posts
- 1830s Supreme Court rules on cases that establish federal trust relationship
- 1830s Some treaties include provisions for health care
- 1832 First Congressional appropriation for Indian health, authorizing purchase of smallpox vaccine
- 1849 Indian Affairs transferred from War Department to Department of the Interior
- 1867 U.S. purchases Russia's colonial right to Alaska
- 1873 BIA medical and educational division established
- 1877 Medical section of BIA terminated

#### Assimilation and Allotment: late 1870s–early 1900s

- 1880s Growth of BIA Boarding Schools that removed children from families to teach mainstream values
- 1883 Court of Indian Offenses issues rules outlawing traditional health care practices
- 1887 General Allotment Act abolishes group title to tribal lands

#### Reform and Reorganization: 1900s–1950s

- 1910 Congress begins appropriating funds for BIA health care services
- 1912 President Taft's report to Congress documents "deplorable health conditions"
- 1921 Snyder Act authorizes funding for Indian health
- 1928 Merriam Report describes devastation caused by allotment policy
- 1933 Collier's Report to Congress calls for revival of tribalism
- 1934 Indian Reorganization Act encourages tribal economic development and self-determination

#### Termination and Relocation: 1950–1960s

- 1953 P.L. 280 erodes tribal sovereignty in 6 states (AK, CA, MN, NE, OR, WI)
- 1954 Transfer Act moves responsibility for Indian health to U.S. Public Health Service
- 1955 Indian Health Service (IHS) established

#### Self-Determination: 1970–2000

- 1970 Nixon's address to Congress calls for "self-determination without termination"
- 1971 Alaska Native Claims Settlement Act passed to foster oil development
- 1975 Indian Self-Determination and Education Assistance Act
- 1976 Indian Health Care Improvement Act (IHCIA)
- 1990s Clinton's policy on government-to-government relations
- 2000s Bills introduced in Congress to reauthorize IHCIA





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