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Achieving Nationhood Through Health Care Delivery: A History of the Relationship between the Indian Health Service and Indian Tribes

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Abstract

By the measure of its mission, the Indian Health Service is one of the most successful and productive government agencies. At the same time, it is an agency often criticized for not achieving enough. Part of this criticism undoubtedly results from the negative effects caused by a chronic lack of funding. Another part of the criticism, however, comes from a deep-seated belief that they agency's priorities are too deeply intertwined with the federal government's national policy agenda and are not sufficiently responsive to the needs of those who receive its services. This paper examines both of these criticisms in light of the transformation of the Indian Health Service from a dominating, centralized federal agency to an agency redefining both its cause and its structure in a time of expanding Indian sovereignty. The paper concludes with an analysis of how the Indian Health Service can support the expansion of sovereignty by pursuing

policies that do not just mimic national trends, but that instead develop from cooperation and negotiation with tribal "almost-equals."

Introduction

Indian health status is alarmingly poor. American Indians[1] have a five-year lower life expectancy than the general US population, are 770 percent more likely to die from alcoholism, 420 percent more likely to die from diabetes and 280 percent more likely to die an accidental death. American Indian youth are twice as likely to commit suicide[2].

Nonetheless, these statistics represent significant improvements in Indian health indicators over the last thirty years. These improvements include a decrease in mortality rates of tuberculosis (78%), gastrointestinal diseases (77%), accidents (56%), pneumonia and influenza (48%), and homicide and alcoholism (33%).[3] In addition, a recitation of these statistics masks an impressive transformation in the delivery of health services to the Indian population, a transformation marked by the transfer of responsibility for Indian health services from the federal government to the tribes.

This paper places the transformation of the delivery of Indian[4] $health services$ in the context of the development

[1] I use the terms American Indian and Indian interchangeably; for the purposes of my paper, this description does not include Alaskan or Hawaiian Natives. While some scholars might choose to use the term Native American instead of Indian, many Indian scholars do not. They argue that everyone born in the United States is a Native American, and that the term exemplifies colonial efforts to subordinate sovereignty to ethnicity. See Robert B. Porter, Strengthening Tribal Sovereignty through Peacemaking: How the Anglo-American Legal Tradition Destroys Indigenous Societies, *28 Colum. Hum. Rights. L. Rev. 235*, 237 (1997).

[2] US Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health System* 8 (2004).

[3] George R. Brenneman, et al., *Health Status and Clinical Indicators in American Indian Health*, in American Indian Health: Innovations in Health Care, Promotions and Policy (Johns Hopkins University Press 2000), 104.

[4] Government agencies do not use a unitary definition for "who is an Indian." For the purpose of eligibility for federal health care funds, the federal government defines "an Indian" as a member of recognized tribe, regardless of blood quantum. For US census purposes, an Indian is anyone who declares herself to be one. See Jack Utter, *American Indians: Answers to Today's Questions* (University of Oklahoma Press 2001), 25-27. Tribes retain the right to determine their own membership using a

of the federal-Indian and state-Indian relationships from the New Deal era to the present day. Because the development of the federal Indian relationship mimics many of the broader changes in the administrative state, the paper will look at how the shift from a top-down administrative order to a governance model has affected Indian sovereignty. In doing so, the paper will seek to answer the question of whether a shift in governance promises to benefit the Indian population by moving it closer to equal health status or whether steps toward equal status will again prove illusory.

In answering this question, the paper will review the divergent approaches of the legislature, executive, and judiciary to the development of tribal sovereignty. The paper will also examine the role tribes have played in using the administrative trend toward governance to assert their sovereignty in the delivery of health services. It will conclude with the observation that federal Indian health policy can incorporate broader national policies without jeopardizing Indian health goals as long as there is sufficient cooperation and equalization of bargaining power to protect tribal interests.

Sociopolitical, Moral and Legal Foundations for the Provision of Health Services to American Indians

The government provides health services to American Indians for sociopolitical, moral, and legal reasons. The degree to which each of these reasons has influenced federal Indian policy depends on the era and the nature of the political administration in power. Each of these reasons, however, continues to provide impetus

variety of criteria. While some tribes require members to prove that they have a certain blood quantum, others have moved away from the use of blood quantum and have adopted descent criteria. The question of "who is an Indian" continues to be very controversial, particularly in light of the government's publication in 2000 of proposed regulations on the standards required for Indians to "receive a certificate of degree of Indian blood." See David Wilkins, *American Indian Politics and the American Political System*, (Rowman & Littlefield 2002), 25-27.

to the government's provision of health care to Indians to the present day.

Sociopolitical Objectives

The first formal appropriation for Indian health needs was for $40,000 in 1911[5], but the government has provided Indians with some form of health services since the mid-1800s.

The provision of health care in the 1800s was one of the many ways in which the government sought to assimilate and "civilize" the Indian population.[6] While assimilation and civilization were not the only reasons behind the provision of care to the tribes, the government believed that the providers could successfully use the benefits offered by Western medicine to persuade the tribes to accept Western ways, including Christianity.[7] By the mid-1890s, missionaries had also begun using medical assistance as a way to spread Christianity.[8] Both the early missionaries and the government were particularly keen to replace the Indians' inherently religious healing ceremonies with Western medical care and religion. A missionary from the Christian Reformed Church described these dual religious and medical goals when he stated that the medical missionary "must first be a missionary and then a doctor."[9]

[5]Emery A. Johnson & Everett R. Rhoades, *History and Organization of the Indian Health Services and System in American Indian Health*, in American Indian Health: Innovations in Health Care, Promotions and Policy (Johns Hopkins University Press 2000), 74.

[6]Robert A. Trennert, White *Man's Medicine: Government Doctors and the Navajo, 1863-1955* (University of New Mexico Press 1998), 52. See also Loretta Fowler, *Tribal Sovereignty and the Historical Imagination* (University of Nebraska Press 2002), 44. The federal government considered the establishment of boarding schools, among other federal Indian policies and programs, to be part of the "Great White Road." The purpose of the "Great White Road" was to ensure that Indians would eventually assimilate and become self-supporting.

[7]Id.

[8]Trennert, *supra* note 6, at 79

[9]Wade Davies, *Healing Ways: Navajo Health Care in the Twentieth Century* (University of New Mexico Press 2001), 19.

Perhaps because of the government's emphasis on achieving sociopolitical and religious objectives[10], rather than on the quality of care, health services for the Indian population throughout the 1800s were consistently under-funded and for the most part exceedingly poor.[11] The Indian Office doctors were often employed as the result of political favors and tended to be either terribly incompetent or ineffective.[12] Exemplifying the sociopolitical goals of the government at that time are Bureau of Indian Affairs regulations from 1884 which state, "The chief duty of an agent is to induce his Indians to labor in civilized pursuits."[13]

While sociopolitical goals continue to play a role in the way in which the government funds Indian health care, the goals have changed. Geared toward assimilation and "civilization" from the 1800s to the mid-1900s, the government's policies began to change in the 1960s. This change occurred for two reasons. First, it was clear that 150 years of assimilation efforts had failed. Second, the government could no longer ignore the tribes' increasingly politically sophisticated demands to be respected as the nation's original inhabitants and treated as self-governing entities.

Nevertheless, the government continued to make sure that its Indian policy was consistent with its own sociopolitical goals. Because one of the government's main goals at this time was to help minorities enjoy the same benefits that mainstream America enjoyed, it agreed to include the Indian population in its antipoverty and health access programs. In addition, because it sought to expand the economic and political participation of minorities, the government encouraged tribes to play a role in the administration of these programs.[14]

The government's sociopolitical goals, and consequently the shape of its policies concerning Indians, shifted once again in the 1980s. During the 1980s, the Reagan Administration cut the budgets of most of the

[10]David W. Daily, *Battle for the BIA* (University of Arizona Press 2004), 80.
[11]Trennert, *supra* note 6, at 61
[12]Id. at 72
[13]Marks, *In a Barren Land* (William Morrow and Company 1998), 201.
[14]Mark Edwin Miller, Forgotten Tribes (University of Nebraska Press 2004) 32.

government's social welfare programs, including federal assistance for Indian health. Many western tribes felt that Reagan viewed them as "stumbling blocks in the development of the West," and perceived the administration as generally hostile to Indian interests.[15] While this may have been true for interests that the tribes and the government did not share, such as increased funding for Indian needs, the government's self-help philosophy was actually quite compatible with the tribes' desire and demands to increase their self-governance.[16] This meant, at least in the area of support for self-governance, that the government could again pursue its own sociopolitical goals under the guise of supporting Indian interests.

Since the mid-1990s, the government has pursued sociopolitical goals of decentralization and privatization of services and government programs. It has been successful in combining its sociopolitical goals of decentralization and privatization with its policy of expanding sovereignty for Indians, particularly in the health care arena where it has sought to decrease the government's role in the direct provision of services.

While the government's sociopolitical objectives may changed throughout the years, it has remained the case, since the days of assimilation and Christianization, that the government's sociopolitical goals are borne out in its approach to Indian affairs in general, and to Indian health policies in particular.

Moral Obligations

The government's moral responsibility to compensate the native population for the devastation the tribes experienced during westward expansion is an important reason why, more than three hundred years after the settlers colonized North America, the US continues to provide health care to the American Indian popula-

[15]Marks, *supra* note 13, at 352.
[16]Id.

tion.[17] The government rarely expresses this moral responsibility explicitly[18]; a tacit understanding exists, however, that the government will continue to provide services to American Indians until their economic and health status approximates that of the general US population.

No matter how tacit the understanding of the existence of moral responsibility, it is hard to dispute that the American Indian population has a moral claim for some sort of long-term compensation, if not for the delivery of services in perpetuity. The claim is moral rather than legal in nature because it is not captured in the specific rights the government negotiated with tribes that found expression in treaties. It also has little to do with the concept of reparations, or monetary compensation for the specific injuries to Indian tribes or families caused by acts of the government that are now considered illegal on a national and international level.[19] It is simply an understanding that the government does not want to be responsible for wiping out or keeping impoverished an entire group of people.

The arrival of the settlers was truly devastating to the Indian way of life. In 1871, buffalo herds, a significant

[17]The government also compensates tribes by providing them with funds and technical assistance in the areas of education, housing, management of resources, and development of tribal governments and courts. See Utter, *supra* note 4, at 63.

[18]The government's general referencing of its moral obligations to American Indians is illustrated by President Clinton's 1997 proclamation of American Indian Heritage Month in which he stated: "...In recognition of America's moral and legal obligations to American Indians and Alaska Natives , and in light of the special trust relationship between tribal governments and the Government of the United States, we celebrate National American Indian Heritage Month." Id. at 52.

[19]In thinking about the government's moral obligation to American Indians, it is important to distinguish it from a similar obligation one could argue the government owes to African-Americans. Just like the inequalities created by the government's assault on Indian existence, the government's complicity in the practices of slavery, Jim Crow, and housing discrimination resulted in deep seated economic, educational and health inequalities between the African American and white populations that persist today. Nevertheless, American Indians continue to receive government benefits, at least in part as a means to compensate for the government's racist policies, while African-Americans receive no special treatment from the government (with the arguable exception of affirmative action). While one could argue that both groups are equally entitled to compensation for the moral failures of the government – and to economic reparations for specific injuries – there appear to be three reasons why the government has consistently treated American Indians differently. The first is that tribes are sovereign nations who were "first in time, first in right" and who at one point negotiated and signed treaties with the government. No other group can claim that status. Id. at 14. The second reason is that the tribes still hold lands as an identifiable, non-assimilated group; this facilitates the identification of the population that deserves services as well as provides as a physical reminder of the wholesale change in lifestyle that followed in the wake of the government's Indian policies. The third reason is historical and institutional; infrastructure for the provision of services to American Indians has existed since the 1800s and the government would be hard-pressed to explain why it should dismantle this infrastructure when health and socioeconomic inequalities persist. The government likely also has a more self-interested reason for maintaining this infrastructure in terms of wanting to ensure its own institutional survival.

source of food for the Plains Indians as well as integral part of their spiritual life, numbered 15 million. By 1903, only 34 buffalo remained in the entire country.[20] The loss of land, although not as rapid, was similarly devastating. Between 1817 and 1843, the government forced any remaining Indian tribes with landholdings east of the Mississippi to move west to open lands for white settlement.[21] The forced migration was largely the result of President Jackson's Indian Removal Bill which the Congress passed in 1830 and which gave the president authority to "transfer any eastern tribe to trans Mississippi area."[22] For the most part, the government paid for the lands relinquished by the Indians. Nevertheless, the consideration the government offered was so minimal that it could not sustain tribal populations who had no way to survive once the money ran out. An example of this meager consideration is government's payment of $30,000 in goods and horses and a five-year annual cash annuity of $10,000 to the Caddos tribe in exchange for a million acres of land in Louisiana.[23]

Even when the government offered alternative lands in compensation for what it took from the tribes, its unwillingness or inability to enforce native land claims led to white settlers simply moving onto Indian lands of their own accord. Oftentimes this was not the fault of the federal government but was a result of the state's eagerness to seize Indian lands. States routinely encouraged settlers to take over and to start farming or ranching or on Indian lands. In 1895, for example, settlers successfully prevented an agent from removing white intruders from Indian lands in spite of the fact that the agent had 50 men with him.[24]

For most tribes, this continual encroachment by states and settlers meant that movement to reserved lands

[20]Shannon O'Brien, *American Indian Tribal Governments* (University of Oklahoma 1989), p. 69.
[21]Marks, *supra* note 13, at 62.
[22]The forced migration of the Cherokees, known as the Trail of Tears, resulted in the deaths of 8,100 Cherokees. Wilkins, *supra* note 4, at 130.
[23]Marks, *supra* note 13, at 68.
[24]Marks, *supra* note 13, at 216.

further out West was their only chance to retain their way of life and to establish another homeland. It would turn out in many cases, however, that reservation life only led to a slower and more painful death than the one experienced by those tribes who refused to leave their lands. The soil of the reservation lands given to the Indians was often too poor to cultivate. Tribes who received rations to supplement whatever little sustenance they could eke out of the land did not do much better; the rations were often too limited to stop the ravages of starvation.[25] In addition, the government forced the Indians to work for the rations despite the fact that they were supposed to be part of the government's payment for lands relinquished by the tribes.[26] In addition to the near extinction of the buffalo and exposure to the white man's diseases, the malnutrition that resulted from the loss of land caused an incredible diminishment of the Indian population. By 1880, Indians had suffered a loss of 95 percent of their population and numbered just 125,000.[27]

The decline in the Indian population, combined with the increased dependence on the government and the destruction of their way of life, led many tribal leaders and members to become despondent about the future and to dream of the past. This sentiment resonates in a statement made by Ten Bears of the Comanches: "I was born upon the prairie, where the wind blew free, and there was nothing to break the light of the sun. I was born where there were no enclosures, and where everything drew a free breath. I want to die there, and not within walls... Why do you ask us to leave the rivers, and the sun, and the wind and live in houses?"[28] Many Indians, however, realizing that they would never be able to return to the traditional ways of life, adapted their way of life to the reservations.[29] The problem was that the government did not want the Indians to find a way to sustain or adapt their culture by minimizing the influence of the white man. Instead, it wanted the tribes to acknowledge that native culture was inferior and to embrace western

[25]Id. at 205.
[26]Id.
[27]O'Brien, *supra* note 20, at 76.
[28]Marks, *supra* note 13, at 187.
[29]Fowler, *supra* note 6, at 42.

ways. While the Indians recognized these pressures, they continued to resist the white man's influence. They thought, perhaps, that after forcing them to surrender their original homelands and giving them less valuable land in exchange, the government would eventually leave them alone.

Nevertheless, despite government assurances that the tribes would not lose any more land if they accepted reservation life, the government continued to strip the Indians of much of their reservation land throughout the 1930s.[30] The government's allotment policy, promulgated in 1887 by Senator Dawes as a way to acculturate the Indian population by encouraging individual property ownership, was the primary source of the continued loss of lands.[31] The Dawes Act divided the reservation lands into individualized farm or grazing plots. The government held these divided plots of land in trust for 25 years, after which time the Indians received title and could decide whether to sell, to lease or to continue to farm the land themselves. The government could also sell the lands that it had not distributed in the allotment despite the fact that the lands were part of the reservation that they government had promised to the tribe. Because this "leftover" land tended to be the most fertile pieces of the reservation, the government had many buyers.[32] By the end of the allotment period, it had sold 60 million acres of these "leftover" lands.[33]

It was not only because of the government's sale of "surplus" lands that Indians lost land during this time. After the 25-year trust period ended, and Indians received title to their lands, many had no way to generate income aside from selling the lands.[34] They had no capital to buy necessary tools, nor the skills needed to become adept farmers, particularly on the poor soil of the reservation lands. Nor did they have the ability to

[30]David Wilkins, *From Time Immemorial: The Origin and Import of the Reserved Rights Doctrine*, in Native Voices: American Indian Identity and Resistance, (University Press of Kansas 2003), 81.
[31]Id.
[32]Id.
[33]O'Brien, *supra* note 20, at 78.
[34]Id.

enter the work force. The situation of the Indians who received title to their lands, then, was somewhat akin to the situation of freed slaves. Even though they were free, many former slaves ended up working on the same plantation, not only because they lacked necessary capital and skills to either start their own business or buy land, but because racism often kept them out of wage work.

Unable to make a living farming or working, and desperate for money, many Indians sold or leased their lands to whites for much less than the lands were worth. Others relinquished their lands to the government when they could not afford to pay taxes on it. The statistics reveal the rapid nature of the loss of land that resulted. In 1887 when the allotment policy began, Indians held an estimated 138,000,000 acres. By 1934, when government officially ended its allotment policy, Indian landholdings amounted to 48,000,000 acres.[35]

Westward expansion, the creation of reservations, and the consequent destruction of the tribal way of life wrought such long-lasting damage on the health and welfare of the native population that the population never recovered. Until recently, Indian health indicators were well below the national average, despite the provision of "free" health care.[36] And despite some improvements in economic well-being, Indians continue to be one of the poorest groups in American society.[37] In compensation for the persistent negative effects of the government's past policies, the government recognizes that it continues to have a moral obligation to provide services, especially in the area of health care.

Some might argue that moral obligations are a weak argument for continued government funding of Indian

[35]Utter, *supra* note 4, at 217.

[36]Even though Indians who use government health services do not have to pay out of pocket, the services are not really what we would deem "free." Indians believe that they pre-paid for these services when they ceded their land to government. See Johnson & Rhoades, *supra* note 5, at 75.

[37]C. Matthew Snipp, *Selected Demographic Characteristics of Indians*, in American Indian Health: Innovations in Health Care, Promotion and Policy (Johns Hopkins University Press 2000), 52-53.

services, especially because the government does not fund services for any other group in the same way. Others might make the argument that the government has an equivalent moral obligation to fund health services for the 30 percent of the American public that does not have health insurance. For tribes, however, the discussion of such obligations is an indispensable complement to reliance on a legal structure that not only lacks consistency but is inherently stacked against Indian interests.[38]

Legal Responsibilities

The government's legal responsibility for the provision of services to the Indian population is rooted in various sources including treaties, statutes, executive orders, and court decisions. Treaties form the backbone of all federal Indian relations by providing a foundation upon which to build additional legal principles and responsibilities. Treaties also serve as a written, and therefore indelible, reminder of the promises made by the government to the Indian population.[39] In other words, the treaties have forced the government, if not always to keep its word, to recognize that the principles of contract and property ensconced in the treaties are the same principles that define and legitimize our legal system.[40] Yet while the treaties are the source of important rights, including a specific right to health services in some instances,[41] it is not the rights, but the status that the treaties confer which has become the central issue in federal Indian relations.

Article II, Section II of the US Constitution gives the executive, with two-thirds consent of the Senate, the

[38] Glenn Morris, *Vine Deloria, Jr. and the Development of a Decolonizing Critique of Indigenous Peoples and International Relations*, in Native Resistance, *supra* note 39, at 117.

[39] Between 1789 and 1871, the government and the tribes negotiated 800 treaties. The first treaties were negotiated in times of peace when the tribes and the government had relatively equal bargaining power. The treaties negotiated after the initiation of westward expansion, however, were characterized by unequal bargaining power between the two parties. As military victor, the government was able to bargain for favorable terms that left the Indians with very little land. The government also negotiated many of the treaties in bad faith, oftentimes plying Indian leaders with alcohol before they signed the treaty. Government representatives similarly encouraged Indian leaders, who the government knew did not represent the entire tribe, to consent to give away tribal territory.

[40] Joseph Singer & Joseph Kalt, *Myths and Realities of Tribal Sovereignty: The Law and Economics of Indian Self-Rule*, Joint Occasional Papers on Native Affairs, 8 (2004).

[41] Johnson & Rhoades, *supra* note 5, at 75.

power to make treaties. Because treaties by their very nature are agreements with other governments,[42] the US government was acknowledging the tribes' status as separate political nations when it entered into treaties with them.[43] However, because of the rapid change in the relationship between the US government and the tribes from one of two strong sovereigns to one of victor and vanquished, the status of tribes as independent nations was challenged even while many of these treaties were being negotiated. It is interesting to note that even though the US government was the military victor, it did not seek to use treaties to end the tribes' political independence. Nor did it use military force to put an end to the possibility of ever having to coexist with another sovereign. Instead, the government chose to continue to respect tribal sovereignty all the while pursuing goals that would cause its erosion.

The erosion of sovereignty began with the Supreme Court case of *Johnson v. McIntosh*.[44] The decision, written by John Marshall, attempted to address the inconsistency inherent in the act of signing treaties with sovereigns who were continually being forced to give up the very thing that conferred sovereignty upon them – their land. Acknowledging the reality of a westward expanding U.S. population, and the consequent difficulty of allowing the Indians to remain on their lands, Marshall stated that the United States, as the inheritors of the land from the British discoverers, had the right to control and regulate its use. Pragmatic, although not necessarily just in his approach, Marshall underscored what he viewed as the inevitable results of conquest, "However extravagant the pretension of converting the discovery of an inhabited country into conquest may appear; if the principle has been asserted in the first instance, and afterwards sustained; if a country has been acquired and held under it; if the property of the great mass of the community originates in it, it becomes the law of the land, and cannot be questioned."[45]

[42]Singer & Kalt, *supra* note 40, at 9.
[43]Jeffrey Ashley & Secody Hubbard, *Negotiated Sovereignty* (Praeger Publications 2004), 17.
[44]21 US 543 (1823)
[45]Id. at 591.

Marshall nonetheless remained bothered by the contradiction between the established legal principle of "first in time, first in right," and the solution he was advocating. Attempting to forge some sort of compromise, he recognized that while the tribes did not own the land and therefore did not have any property rights, they did have rights as occupants of the land.[46] In the words of Marshall, "So, too, with respect to the concomitant principle, that the Indian inhabitants are to be considered merely as occupants, to be protected, indeed, while in peace, in the possession of their lands, but to be deemed incapable of transferring the absolute title to others."[47] Because the Indians did not hold title to their lands, they could not transfer their lands to anyone else but the United States government.[48] With this decision, Marshall made it clear that there would be no valid challenge to the right of the United States to claim any and all the lands it wanted, with the caveat that the Indian right to occupation was to be respected.

The battle over state, federal, and Indian sovereignty came to a head in *Cherokee v. Georgia,*[49] a case in which the Cherokee tribe challenged Georgia's ability to force them to cede land. The question Marshall had to answer was whether the Supreme Court had jurisdiction to hear the case. The Cherokees argued that because this was a matter between foreign states, the Cherokee nation and the state of Georgia, the Court had jurisdiction under Article III, Section II of the Constitution. In arguing for their status as a state, the Cherokee were not asserting that their status was equivalent to that of a state of the union; instead, they argued that they were another kind of state which was foreign not only to the state of Georgia, but to all other states, and to the United States government as well.[50]

Acknowledging that the Cherokee nation fit the definition of a state, Marshall nonetheless rejected the idea

[46] Hubbard & Ashley, *supra* note 42, at 18.
[47] *Johnson*, 21 US 543, 603 (1823)
[48] Dale M. Mason, *Indian Gaming: Tribal Sovereignty and American Politics* (University of Oklahoma Press 2000), 16.
[49] Id.
[50] Mason, *supra* note 48, at 17.

that the Cherokee were a foreign state as defined in the Constitution. First, he was unable to reconcile the Founders' description of Indian nations as "tribes" in the Indian Commerce Clause with the Cherokee's contention that it should be categorized as a foreign state; in other words, if the Founders meant the tribes to be considered foreign states or nations, it would have not have distinguished them as tribes. Second, and likely the sticking point for Marshall, was the issue of land. If under *Johnson* the United States held ultimate title to the Cherokees' land, and the Cherokees had signed treaties acknowledging that they were under the protection of the United States, how could they now assert that they were foreign? Marshall's answer to this question was that the Indians retained a status somewhere in between the independent, autonomous stature of a foreign nation and the reserved right status of the states: "They may, more correctly be denominated domestic dependent nations. They occupy a territory to which we assert a title independent of their will, which must take effect in point of possession when their right of possession ceases. Meanwhile, they are in a state of pupilage. Their relation to the United States resembles that of a ward to his guardian."[51] Because the Cherokee were determined to be neither foreign nation or states, the Court declined jurisdiction over the case.

Because Marshall's decision dealt only with the question of jurisdiction, the question of what power the states retained in dealing with the Indian nations remained unanswered. The final case in the Marshall trilogy, *Worcester v. Georgia*, defined the relationship of the tribes to the states and reaffirmed the federal government's control over Indian affairs. The law in question was a Georgia law rendering it a misdemeanor for non-Indians to live on Cherokee land without a license from the state. There is absolutely no equivocation in Marshall's decision; the state of Georgia has no right to assert jurisdiction over either Cherokee lands or people: "The Cherokee Nation, then, is a distinct community, occupying its own territory, with boundaries

[51] 30 US 1 (1832)

accurately described, in which the laws of Georgia can have no force, and which the citizens of Georgia have no right to enter but with the assent of the Cherokees themselves or in conformity with treaties and with the acts of Congress. The whole intercourse between the United States and this nation is, by our Constitution and laws, vested in the government of the United States."[52]

Marshall's statement that the Constitution vested all of the powers to regulate Indian affairs in the federal government led to the establishment of the plenary power doctrine. The government's plenary power over Indian affairs has its origins in Article I, Section 8 of the Constitution, the Indian Commerce Clause, which bestows upon the federal government the power to regulate trade with the Indian tribes. In interpreting this clause to mean that the states could not exert regulatory power over the tribes, Marshall was asserting that only the federal government could deal with the tribes on a government-to-government basis.[53]

While one could interpret Marshall's decision as an effort to protect the Cherokee nation from the states' control and to preserve Cherokee sovereignty, one could also interpret the decision as an effort to prevent state usurpation of federal power. The reality seems to be somewhere in between. Theoretically, Marshall could have just used the state's exercise of control over Cherokee lands and people as a means to reassert federal power, without discussing the reciprocal nature of the government-Indian relationship. Instead, he emphasized the government's treaty obligations to the Indian nations, including the provision of protection "without destruction of the protected" and the recognition of the 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..." The description of the federal government as protector of the Indian nations is often referred to as the trust doctrine. These two elements – the trust doctrine and lim-

[52]31 US 515 (1832)
[53]Mason, *supra* note 48, at 19.

ited sovereignty – would later form the basis for the government's Indian policies with the trust doctrine providing the foundation for the creation of the Indian Health Service and limited sovereignty providing the foundation for self-determination and self-governance initiatives.

Inherent in both the *Cherokee* and *Worcester* decisions, however, is the sense that the Indian nations cannot be wholly sovereign if they depend on the government for protection from the states and for food, shelter, and other services. Similarly, there is a belief permeating both decisions that the Indians, despite being under federal protection and having occupancy rights to their lands, will eventually assimilate. Indeed, while Marshall laments the demise of a once-strong people, he clearly sees this demise as inevitable and even arguably preferable. Marshall's rhetoric about the subjugated character of the Indian tribes allowed later courts to extend Congress' role beyond that of protector to controller of the tribes in *U.S. v. Kagama*: "... but these Indians are within the geographic limits of the United States. The soil and people within these limits are under the political control of the government of the United States."[54]

Following on the heels of *US v. Kagama*, the Court's decision in *Lone Wolf v. Hitchcock* further expanded Congress' control over tribes.[55] In the case, the Kiowa tribe challenged the validity of the terms of a treaty on the ground that Congress had entered into the treaty in bad faith. The alleged bad faith was Congress's act of signing the treaty despite its knowledge that only a minority of the tribe had agreed to the treaty terms. Asserting that Congress' plenary power over the tribes had always been political, and could therefore not be controlled by the judiciary, the court refused to review Congress' actions.[56] In stating that "when... treaties were entered into between the United States and a tribe of Indians it was never doubted that the power to abrogate existed in Congress, and that... such power might be availed of from considerations

[54]US v. Kagama, 118 US 375, 379 (1886)
[55]Lone Wolf v. Hitchcock, 187 US 553 (1903).
[56]Id. at 565

of governmental policy, particularly if consistent with perfect good faith towards the Indians", the court dispensed with Marshall's protective language and replaced it with the language of total dominance.[57] As the American Indian scholar Vine Deloria, Jr. notes, the Supreme Court was rewriting history when it stated in its decision that "Congress had always had absolute power over Indians and their property"; such an assertion was "fraudulent on its face considering the long history of treaties with the tribes."[58]

Historian David Wilkins has further delineated the judicial irresponsibility that characterized the *Lone Wolf* and *Kagama* decisions, accusing the justices of employing "masks like 'wardship', 'dependency', 'savagery', 'primitivism', 'plenary power', 'political question,' in various ways to achieve whatever ends they deem viable."[59] Wilkins believes that there is no question that "it was the Court, not the [indigenous nation], the individual, the states or even Congress, which retained plenary discretion to decide the scope of Congress's powers and the degree, if any, to which treaty rights were to be protected."[60] In other words, the Court abrogated its judicial role by leaving the question of treaty rights to Congress.

The legal principles that emerged out of these early cases, including Congress's plenary power over tribes, its trust responsibility toward tribes, and the lack of state jurisdiction over tribal lands continue to evoke emotional response and vigorous debate to this day. The debate, however, has taken on even greater import since tribes have begun expanding their exercise of sovereignty. Perhaps the most vital question emerging out of the debate over how Marshall's seminal framework affects the expansion of sovereignty is how the government and the tribes can reconcile expansions of sovereignty with continued Indian dependence on the federal government, not only for the services it provides but also for the continued recognition of tribal

[57]Id. at 566
[58]Vine Deloria, Jr., *Behind the Trail of Broken Treaties* (Delacorte Press 1974), 135.
[59]Wilkins, *supra* note 4.
[60]Id.

legitimacy.

A governance framework under which the federal government devolves greater power to the tribes as part of a larger decentralization effort might provide one answer about how to reconcile these conflicting realities. However, it is unclear that governance will have much meaning for the tribes without greater legislative (and judicial) acknowledgment of sovereignty. Without such recognition, Congress will retain the ability to terminate its decentralization policy at any time, potentially leaving the tribes once again questioning their status and identity as sovereigns.

Nor does decentralization solve the conflict inherent in requiring the federal government to continue to comply with its trust responsibilities while stripping it of its plenary power over tribal affairs. While it is not impossible to imagine a one-sided trust doctrine under which the government continued to have a responsibility to fund and to protect tribes but no could no longer exercise any control over Indian affairs, it is unlikely that Congress will want to change the reciprocal nature of the trust doctrine. Nevertheless, as the tribes move further toward developing the ability to become their own guardians, rather than the wards of the federal government, such a one-sided trust doctrine remains a possibility. A strong argument for the development of a one-sided trust doctrine is that the transfer of actual control and power, rather than a mere shift of resources, is critical to the success of any governance regime, and particularly critical to the development of Indian self-governance. Indeed, decentralization to states and to private parties does not work if the federal government is pulling the strings in the background.

Whether or not the solution is changing Marshall's trust doctrine, there is room for governance to succeed between the dominance/protection principles espoused by Marshall, and sovereignty as exemplified by the

complete takeover of all services by the tribes without any Congressional control. Fashioning a compromise that suits the power, independence, and financial priorities of both the government and the tribes, however, will be a challenge. For the government to meet this challenge successfully, it will have to align its sociopolitical goals, moral obligations, and legal responsibilities more closely with those of the tribes.

The Creation of the Indian Health Service

On a micro-level, the story of the Indian Health Service is the story of a shift from dependence to self-management in Indian affairs. On the macro-level, it is the story of a shift in government regimes from New Deal to governance. As such, it provides the perfect lens through which to examine the potential of governance to offer not only a truer form of sovereignty to the tribes but also improved health care.

The Indian Health Service has its origins in the Bureau of Indian Affairs (BIA). The BIA was responsible for the provision of Indian health services until 1955 when the government transferred that responsibility to the Public Health Service (PHS).[61] Through the 1920s, the health care arm of the BIA functioned as a vehicle for the government's assimilationist goals.[62] It did so by serving as a support organization to the boarding schools the government had developed to encourage Indian children to adopt the ways of the whites.[63] The majority of these schools got their start in the late 1800s when the government faced the question of what to do with the members of the numerous tribes whose defeat had rendered them dependent on the government.

It made sense that the government responded to this question with a plan for assimilation. Indeed, by retaining a limited degree of sovereignty for the Indian tribes, the Marshall decisions had made it difficult for

[61] Johnson & Rhoades, *supra* note 5, at 74.
[62] Davies, *supra* note 9, at 21.
[63] Id.

the government to alter the independent status of the tribes through legislation, thus leaving the government to use assimilation as a way to induce the tribes to relinquish their independence. Many tribes, aware that the failure to educate their children would lead to further impoverishment and dependency, embraced the opportunities provided by the boarding schools.[64] They did so even despite their understanding of the government's assimilationist intent.[65]

Regardless of strong initial Indian support for these schools, the government realized that unless the children were healthy when they returned to their homes, Indian parents would likely withdraw their children from the schools and the government's assimilation project would fail. Concern for the health of the children was not misplaced. The boarding schools often served as incubators for numerous diseases which spread fairly rapidly due to the proximity of the children to one another.[66] Serious health disasters often ensued when children who had contracted infectious diseases on the reservation returned to their schools where the disease would spread throughout the student population.[67] While many boarding schools offered the children quality health care, there are also numerous examples of boarding schools that offered extremely poor medical treatment and did nothing to improve dangerous living conditions.

In perhaps the most egregious examples of medical neglect at the boarding schools, seven Indian children died and 35 became sick from a typhoid epidemic at the Sherman Institute boarding school in 1904.[68] This was in addition to four children who had died from typhoid earlier that year. While contracting typhoid was not an unusual occurrence in that era, it was unusual for such a large number of students to die. Out of a

[64] Fowler, *supra* note 6, at 24.

[65] In fact, the Cherokees protested the government's efforts to make them pay for the schools, citing the government's treaty obligations to provide services. They likely also did not want to pay for government aims that did not appear to be wholly benevolent. See Id.

[66] Davies, *supra* note 9.

[67] Id.

[68] Jean Keller, *Typhoid Fever Deaths at Sherman Institute, 1904* in Trafzer & Weiner, Medicine Ways, (Altamira Press 2001), 45.

population of 1,009,500 in California, 28 people died from typhoid in 1904.[69] Comparing this number to the seven deaths out of 600 students at the Sherman Institute, a much higher proportion of deaths per population occurred at the school than occurred in the general population of the region.[70] Even more unusual than the deaths, however, was the head of the school's failure to say anything more than "in the fall of the year, we were troubled with some sickness" in the annual report about the school he sent to the Commissioner of Indian Affairs.[71] Speculation persists about why he failed to report the deaths. At least one author suggests, however that his failure to report the deaths and illnesses is reflective of the government's belief that the ends often justified the means in its attempt to assimilate and civilize the Indian population.[72]

Additional evidence for this conclusion comes from the Office of Indian Affairs' practice of enrolling Indian students with active tuberculosis in the boarding schools despite knowledge of the potential for a public health crisis.[73] A statement made by Commission of Indian Affairs William Jones in 1904 captures the government's belief that the ends of assimilation justified most, if not all, means: "The physical welfare of the Indian is, and always must be the fundamental consideration in the scheme to educate or civilize him.

[69]Id.

[70]Id.

[71]Id. at 44

[72]Id. Another example of the government's disregard for the human rights of Indians in the name of medical, racial and assimilationist progress was the trachoma campaign it pursued between 1924 and 1927. Trachoma is an infectious eye disease that can lead to blindness or severely damaged vision. The disease was rampant on the reservations during the 1920s, with an estimated one in four Indians suffering its effects. However, instead of improving sanitation or prescribing medication – two treatments proved to have been successful in the earlier eradication of trachoma among the Appalachian population – the Office of Indian Affairs endorsed the use of two different surgical procedures. Rejecting the idea of using a trial period to assess the effectiveness and safety of the surgical procedures, the OIA had fifty doctors and physicians performing the surgeries on almost all reservations and schools within five months of deciding upon their use. The results were devastating. In numerous cases, Indians were operated on without ever having shown evidence of having the disease while others had undergone the surgery only to discover that they were still infected with trachoma. The surgery was nevertheless justified as the only way to treat Indians who were intransigent in the face of public health efforts: "It is exceedingly difficult," said one trachoma specialist, "to induce the Indians to adopt hygienic measures for their own protection. They are very much like children, and one is obliged to keep at them continually, teaching them the dangers of neglecting these matters." In accordance with these views, many of the physicians who carried out the surgeries would later blame their patients for the failure of the treatment, citing the patients' unwillingness to continue postoperative care. Overall, nearly 3,000 patients had damaged or lost eyesight after the campaign. p. 67 See Todd Benson, *Blinded with Science*, in Medicine Ways, *supra* note 68, 52-68.

[73]Keller, *supra* note 68, at 54.

It is impossible to develop his mental and moral capabilities without healthy material to work on."[74] The government's fear was that if it disregarded the health of the native population, American Indians would be unable to work and would become permanently dependent on the government.[75]

Regardless of the motivation for its provision of services to Indians, the government experienced some success in its efforts to improve Indian health during the early 1900s.[76] In 1908 and 1912, the Office of Indian Affairs carried out scientific studies to determine the source of Indian health problems. Finding that poor sanitary conditions and facilities served as incubators for infectious and other diseases, the Office fought for and won increased appropriations for Indian health care.[77] Nevertheless, the sheer gravity of the medical problems overwhelmed even these larger appropriations. Nearly three-fifths of Indian infants died before they were five and epidemics of tuberculosis and trachoma persisted.[78]

During World War I, however, the government scaled back on its provision of services to Indians. This resulted in a rather severe decline in the health and welfare of all Indian populations.[79] Many reservations had no doctors on site and most supplies became prohibitively expensive.[80] While the retraction of services was due in part to the government's decision to transfer funds from Indian services to the war effort, the retraction also occurred because of the plethora of doctors and nurses who left the Indian health service to serve in the military or to accept private employment.[81] The fact that many of their replacements were

[74]Id.
[75]Id.
[76]Scholars also cite the increased proximity of whites to Indians as a reason for the increased interest in Indian health. Many whites who had purchased the "surplus" Indian lands made available by the allotment process lived on the perimeter or sometimes within tribal lands. These whites were certainly vulnerable to contracting any diseases the Indian population might have been carrying. Id.
[77]Id. at 53.
[78]Trennert, *supra* note 6, at 114.
[79]O'Brien, *supra* note 20, at 80.
[80]Trennert, *supra* note 6, at 119.
[81]Keller, *supra* note 68, at 55.

unqualified also had a significant impact on the quality of care.[82] Even in peacetime, the frequency with which providers entered and exited the Indian Health Service, and the relatively poor quality of those who remained in the service, would continue to be a significant problem for the HIS. As it would in any business requiring skilled and trained employees, this kind of turnover greatly hampered the efforts of the IHS to improve health services.

In 1921, Congress passed the Snyder Act, the first legislative authorization of continued support for federal Indian programs, including programs for the "relief of distress and conservation of the health of Indians."[83] Appropriations increased for health care fairly soon after the passage of the act, allowing the BIA to build hospitals and tuberculosis sanatoriums on reservations.[84] In the case of the BIA's work on the Navajo reservation, hospital construction increased between 1920 and 1928, leading to a rise in the number of available hospital beds from 184 beds in 1920 to 268 beds in 1929.[85] The number of staff rose accordingly, including an increase in the number of field nurses who could visit the Navajo hogans with health information and could offer basic care.

As demonstrated by the results of a survey of residents who used the services of the field nurses between 1930 and 1950, the residents largely accepted and appreciated the care offered by the IHS nurses.[86] According to the survey, residents were more likely to accept the care if no equivalent for that care existed in Indian medicine. For example, residents widely accepted smallpox vaccinations and agreed to have surgery performed by government nurses and doctors because traditional healers could not respond to these medical

[82]Trennert, *supra* note 6, at 119.
[83]25 U.S.C. 13 (1921)
[84]The government increased the health budget of the Office of Indians Affairs by $500,000 in 1924. Davies, supra note 9, at 21.
[85]Id.
[86]Nancy Riefel, *American Indian Views of Public-Health Nursing, 1930-1950* in Medicine Ways, supra note 68, at 101.

problems.[87]

Nevertheless, there was far from a complete embrace of Western medical approaches among the Indian population as many Indians continued to reject Western medicine in favor of traditional healers, and to resist entering sanatoriums. This was particularly true when the Western approach required Indians to leave their families and spend lengthy amounts of time in sanatoriums or hospitals. Many Indians were also afraid of sanatoriums because of the seemingly large numbers of people who would enter them and die. While the high death rate from tuberculosis in the sanatoriums was more likely indicative of the tendency of the American Indians to wait until they were gravely ill to seek any treatment rather than a result of provider incompetence, it is understandable that many Indians would perceive the high death rate as being the result of poor care. Despite the reluctance of some Indians to enter sanatoriums or hospitals, the government experienced greater success in stemming the spread of infectious diseases throughout the early 1900s than it had ever before experienced.[88] Much of this success was undoubtedly due to the public health methods the field nurses used to educate the Indian population about the origins of the disease and means of prevention, rather than successful sanatorium treatment.

In addition to the Snyder Act, the Indian Citizenship Act of 1924 and the release of the Meriam Report in 1928 helped catalyze the renewal of government efforts to improve the delivery of health care to the Indian population in the postwar period. Prior the passage of the Indian Citizenship Act, the government considered those Indians who had not gained citizenship through marriage or through cession of their tribal membership to be members of their tribes only.[89] While some Indians viewed the extension of citizenship

[87]Id.
[88]Id. at 102.
[89]O'Brien, *supra* note 20, at 80.

as merely one more tactic in the government's efforts to assimilate the Indian population[90], other Indians, particularly those who had returned from fighting for the United States in World War I, both wanted and believed that they deserved the same rights as United States citizens.[91] Viewing themselves as both citizens of their tribe and of the United States, these veterans were likely some of the first Indians to develop this kind of dual loyalty.[92]

Although many in Congress were opposed to expanding citizenship to the Indian population, others felt it was an important way to recognize the service of Indians in World War I. Some Congressmen might have also believed that citizenship was an important step in encouraging assimilation. Either way, once all Indians became citizens of the United States, it became more difficult for the government to ignore the difficult conditions under which they lived.

Ignoring the conditions became almost impossible after the publication of the government-commissioned Meriam Report.[93] A study of the economic and social welfare of the Indian population, the Meriam Report had well meaning, albeit modest goals for the delivery of health, economic and educational services to the Indian population. Its objective "was not to say whether the Indian Service has done well with the funds at its disposal but rather to look to the future and insofar as possible to indicate what remains to be done to adjust the Indians to the prevailing civilization so that they may maintain themselves in the presence of

[90]The Iroquois, for example, sent a letter to the United States government declining citizenship. They have never wavered from that position. See Deloria, Jr., *supra* note 58, at 19.

[91]`http://www.nebraskastudies.org/0700/frameset_reset.html?http://www.nebraskastudies.org/0700/stories/0701_0146.html`. (Last visited April 18, 2005)

[92]Many American Indians would say that self-identifying as tribal members does not prevent them from simultaneously identifying as Indians and Americans. Consequently, they would disagree with the argument many made at the time of the Indian Citizenship Act that by identifying as Americans, American Indians were relinquishing their tribal identity. Social scientists and courts have termed the ability to feel as if one belonged to various groups at the same time as "community consciousness." See Utter, *supra* note 4, at 32.

[93]Institute for Government Research, The Problem of Indian Administration [Meriam Report] (Johns Hopkins Press 1928).

that civilization according at least to a minimum standard of health and decency."[94] The Report generated significant attention from the media and from the public, many of whom were not aware of the extent to which the American Indian population remained marginalized in US society.[95]

The Report found that despite modest improvements, the health of the Indian population was bad as compared to the white population; in particular, the report noted that Indians suffered from much higher rates of infant mortality and infectious disease. Indeed, the death rate from tuberculosis for Navajos in Arizona was 17 times higher than the death rate of whites for the same disease.[96] In addition, the report found that sanitation was either deficient or altogether absent; most Indian homes lacked toilets and many lacked any sort of privy. There were not enough hospitals, and most hospitals lacked equipment and quality providers. The report identified greater government appropriations as an important part of the solution to the crisis, a solution articulated in every report on Indian health since conducted.[97]

Determined to increase the government and public's understanding of the desperate situation in which the majority of Indians lived, the report rejected the assertion that "the Indians prefer to live as they do; that they are happier in their idleness and irresponsibility" and stated that there was "too much evidence of real suffering and discontent to subscribe to the belief that the Indians are reasonably satisfied with their condition."[98] The report was equally clear about where the blame for such suffering lay: "Several past policies adopted by the government in dealing with the Indians have been of a type which, if long continued,

[94]Id.
[95]Trennert, *supra* note 6, at 138.
[96]Meriam Report, *supra* note 93.
[97]For example, in the September 2004 report of the US Commission on Civil Rights, the Commission noted that the persistence of disparities was due in part to "our nation's lengthy history of failing to keep its promises to Native Americans, includ[ing] the failure of Congress to provide the resources necessary to create and maintain an effective health care system for Native Americans." See Broken Promises, *supra* note 2, Introduction.
[98]Meriam Report, *supra* note 93.

would tend to pauperize any race."[99]

Pauperization was an apt description for what happened to the Indian population between the time the government confined them to life on reservation lands and the date of the Meriam Report. By the onset of the Great Depression, most Indians who had held on to their allotted lands and had attempted to make a go of it by farming, ranching, or leasing were no longer able to earn a sufficient income to support their family.[100] While these Indians still had an option to sell their land, albeit at a devastatingly low price, most Indians no longer had any land left to sell. By one historian's estimate, "two-thirds of America's Indians were either completely landless or did not own enough land to make a subsistence living."[101] The combination of discrimination, lack of education, and poor health meant that the majority of wage jobs were also unavailable as sources of income. In fact, in 1928, at a time when the average income-earner in America earned approximately $900 a year, more than 50 percent of the Indian population earned less than $200 a year. Even those Indians who earned more than $200 a year still earned significantly below the average American earners, with only 2 percent of the entire Indian population making more than $500 a year.[102]

While the Meriam Report did increase public and government awareness of the hardships suffered by the Indian population, the awareness did not lead to action until the worst of the Great Depression was over. In the 1930s, however, recognition of the government's historical responsibility for Indian health and welfare would coalesce with increased government involvement in the nation's economic and social conditions to produce an "Indian New Deal."

[99]Id.
[100]Marks, *supra* note 13 at 271.
[101]Id.
[102]Id. at 269.

The Advent of the Indian New Deal

The New Deal revolutionized the structure, function, and societal role of the US government. Prior to the 1930s, presidents strongly believed in the power of the invisible hand and were consequently reluctant to enact social or economic regulations.[103] The courts were equally laissez-faire in their approach and had gone so far as to interpret the Constitution's due process clause as disallowing government regulation of wages and hours.[104]

President Roosevelt believed, however, that the struggle to bring the nation's economy out of depression called for a different approach in the form of a "New Deal" for Americans.[105] Roosevelt advocated numerous reforms as part of his New Deal plan, the most prominent of which was the establishment of a social safety net.[106] Some of the structural changes resulting from the New Deal included the centralization of policy generation, the implementation of policy by the federal government, and the subsequent expansion of the administrative state.[107] With the growth of the administrative state came a corresponding increase in the number of experts employed by the federal government to develop social and economic policy.[108] These experts were educated professionals whose qualifications and experience lent legitimacy to their role as decision makers for the national polity.[109] Taking their places in high-level administrative positions throughout the government, these experts crafted policies that would "help[ed] to restore our Nation to

[103]Orly Lobel, The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought, *89 Minn. L. Rev. 342*, 351 (2004).
[104]Lochner v. New York, 98 US 45 (1905)
[105]Roger M. Barrus, et al., *The Deconstitutionalization of America*, (Lexington 2004) 76.
[106]Id.
[107]Lobel, *supra* note 103, at 351.
[108]Id. at 344.
[109]Id.

prosperity and define[d] the relationship between our people and their Government for half a century"[110].

By offering a vision of society and economy that superseded state and local politics, the New Deal transformed people's expectations of the federal government.[111] People believed big government could correct the deficiencies of the market and help establish a more level playing field for the disempowered.[112] Central to the focus on improving opportunities for the disempowered was a sense that America should embrace its cultural pluralism.[113] And when the government thought about cultural pluralism, it thought first about America's original inhabitants, the Indians. It therefore made sense that as the historical "protector" of American Indians, the Bureau of Indian Affairs was the ideal agency through which to implement policies that sought to reinforce the importance and preservation of pluralism.[114]

The government therefore became much more involved in Indian affairs than it had ever been before. Scholars offer two different explanations for the government's motivation for the creation of an Indian New Deal. The less benevolent explanation is that because federal regulations already circumscribed the functioning of the tribes and that because tribes were already accustomed to "rule by a department," it would not be a stretch to impose further government policies. This view belies Marshall's description of the tribes in Cherokee v. Georgia as "distinct, independent political communities," and instead envisions them instead as needing government involvement and organization. In this view, then, government administrators sought to bring the New Deal to the tribes simply because they could and because they always had.[115]

[110]Id. at 354.
[111]Id. at 380.
[112]Id.
[113]Graham D. Taylor, New Deal and American Indian Tribalism (University of Nebraska Press 1980), 1
[114]Id.
[115]Id. at xiii.

The less cynical view of the origins of the Indian New Deal is that government administrators viewed the BIA as an ideal agency through which to implement New Deal legislation because they saw tremendous potential for positive government action and direction in the area of Indian affairs.[116] Like other social and economic problems the New Deal sought to address, the struggle for cultural survival and better health and welfare faced by the American Indian population appeared likely to respond to a national vision. This was particularly true when the government intended to support this vision with better planning and funding directed at the achievement of specific goals. That the proposed solutions were national in scope was essential; despite the Marshall trilogy denying states power over the tribes, Indians continued to suffer from state attempts to usurp their land and to deny them benefits that other state citizens received.[117]

Unlike the majority of Americans who embraced the recovery from the Depression and the concomitant implementation of the New Deal, the American Indians were wary of greater government control over their lives. This fear of government programs made sense considering the damage the government's previous policies had had on the culture and welfare of the Indian peoples.[118] Roosevelt's appointed expert on Indian affairs was John Collier, an anthropologist who earlier in his career had assisted the Pueblo Indians in their fight for their land. Collier was representative of the New Deal reformers; committed to bettering Indian economic and social conditions, he had a strong personal sense of the importance of cultural pluralism and an equally strong belief that the federal government was central to its promulgation.[119] What he and other Indian New Dealers may have lacked, however, was the understanding that top-down legislation enacted without input from the regulated parties, even if well-meaning, may have unintended and negative consequences.

[116]Id. at xii.
[117]Mason, *supra* note 48 at 32.
[118]Marks, *supra* note 13, at 273.
[119]Taylor, *supra* note 113, at xiii.

Collier's efforts to protect Indian culture and tradition from further erosion resulted in the passage of the Indian Reorganization Act of 1934 ("IRA"). The Act consisted of five central components: 1) the strengthening of the government-to-government relationship between tribes and the federal government; 2) the end of the allotment policy; 3) increased BIA hiring of Indians; 4) renewed focus on economic development of the reservations; and 5) helping tribes continue to engage in traditional activities and to speak indigenous languages.[120]

While these policies in no way compensated for the destruction of the Indian way of life, they did illustrate the government's understanding that it needed to offer the Indian population some way to regroup and recover from the trauma it had experienced. Recognizing that the Indian population would have to be integrally involved in directing the recovery if it were to be successful, the IRA encouraged tribal and resource self-management.[121] This was a significant departure from the policies of the past, which had advocated integration with the white population through adoption of white culture and Christian beliefs.[122]

The hallmark of the IRA's efforts to increase tribal self-management was the formation of tribal governments. The establishment of a tribal government required majority approval of the adult members of the tribe or adult Indians living on a reservation. Once a majority approved the establishment of a government, the tribe would write a constitution. A majority of the members would then have to ratify the constitution before it became valid. Subsequently, the members of the tribe would elect a governing council. The council retained the power to prevent the sale or lease of tribal property, to hire legal counsel, and to negotiate with government agencies. Additionally, if one-third of the tribal members petitioned the federal government, the government would prepare a charter of incorporation for the tribe. Another majority vote on incorporation

[120]Id. at 27-29.
[121]Id. at 30.
[122]Id. at 9.

was required before a tribe could use the charter to buy lands or issue shares in the corporation in exchange for land.

Termination of the allotment policy is widely considered the most successful component of the Act. By putting an end to both the parceling out of Indian reservations and to the sale of "surplus" land, the IRA successfully reversed a policy that had caused Indian tribes to lose more than 85 million acres of land by 1934.[123] Ending the allotment policy signaled the government's realization that it could not expect Indians to be independent if it allowed the source of that independence to continually be "checkerboarded with plots alternately owned by white settlers, Indians with patented lands, and Indians with land held in trust by the government."[124] In addition to preventing further loss of land, the IRA granted tribes $2 million in funds to acquire and consolidate lands under community ownership.[125] To provide a source of credit to tribal corporations, the IRA also established a revolving loan fund of $10 million with an additional $250,000 a year allocated for loans to Indians seeking higher education.

Despite the success of the IRA land provisions in recovering lands for tribes that had been lost through allotment, the other provisions of the Act, particularly the formation of tribal governments, have been the subject of criticism. The majority of the criticism centers on the conflicting goals of the IRA. On the one hand, the IRA stood for affirmation of tribal self-governance and independence. On the other hand, however, the IRA resulted in a significant increase of bureaucratic control over Indian lands and people.

John Collier, Roosevelt's expert on Indian affairs, often bore the brunt of this criticism. Desiring to preserve tribal cultures, Collier chose what appeared to be an inapposite means of doing so – the imposition of western

[123]Daily, *supra* note 10, at 84.
[124]Id. A Civil Works Administration study conducted in 1933 found that 49 percent of Indians on allotted reservations were landless. Taylor, *supra* note 113, at 7.
[125]Taylor, *supra* note 113, at 6.

governmental structures. The imposition of these structures often caused significant discord between tribal members, tribes, and Indian individuals. In some tribes, for example, mixed-bloods became the majority on the governing council and limited the political opportunities available to full-blooded Indians.[126] In others, single families dominated the councils, excluding other tribal members from the decision-making process.[127]

The most problematic aspect of these new tribal governments, however, was the fact that the form of government called for by the IRA did not necessarily fit historical tribal notions of government. For example, members of many tribes were accustomed to smaller units of government because tribal leaders had traditionally represented individual villages or bands.[128] Although part of the same larger group, these bands operated autonomously and were often divided on many issues.[129] Adding to this confusion was the fact that the government used an arbitrary approach to determine which bands made up tribes and which bands were no longer sufficiently cohesive to be recognized as a tribe.

The approach was arbitrary because it used criteria that did not reflect the reality of the Indian experience. For example, the government required tribes to prove that they had an "unbroken existence" before they were allowed to form governments.[130] In light of the fact that the government had historically combined different ethnic groups for administrative convenience, however, this requirement did not make much sense.[131] Indeed, different native ethnic groups that had become a social unit when the government placed them on the same reservation lands were nevertheless denied the right to develop a tribal government.[132] Similarly, the government required that tribes be political units rather than voluntary groupings, a distinction that

[126]Thomas Cowger, National Congress for American Indians: The Founding Years (University of Nebraska Press 1999), at 20. See also Taylor, *supra* note 113, at 50.
[127]Id. at 25.
[128]Taylor, *supra* note 113, at 80
[129]Taylor, *supra* note 113, at 46.
[130]Miller, *supra* note 14, at 29.
[131]Id.
[132]Marks, *supra* note 13, at 108.

was not always clear given historical blurring of these lines.[133] Arbitrary or not, because both eligibility for government services and recognition as independent governments depended on the federal identification of a group of Indians as a tribe, the stakes for recognition were high.[134]

Of course, many tribes foresaw the problems inherent in adoption of alien government structures, particularly those advocated for by the federal government, and almost one third voted to reject the IRA. Some Indian individuals took the rejection of the IRA a step further and actively lobbied to abolish it and the BIA at the same time. These individuals were proponents of assimilation and did not want to see tribes return to a communal lifestyle and suffer further exclusion from the mainstream.[135]

Like the other New Deal bureaucrats of the time, however, Collier had a national vision for Indian policy, a vision he did not want to see become derailed because of complaints from a minority group or because of internal tribal disputes.[136] In many respects, however, complaints about the implementation of vision, if not the vision itself, were legitimate. Instead of granting the tribes significant power over their own affairs, the IRA gave the Interior Department authority over many of the key provisions of the Act including discretion over tribal constitutions, charters of incorporation, taxes on tribe members and membership guidelines.[137] Moreover, while Collier claimed to want to reduce the coercive and top-down nature of the BIA's relationship with the tribes, he was not afraid to flex the government's regulatory muscle to get what he wanted.[138]

[133]Miller, *supra* note 14, at 29.
[134]Id. at 30.
[135]Cowger, *supra* note 126, at 22.
[136]Daily, *supra* note 10, at 111.
[137]Id. at 113.
[138]A notorious and oft-cited example of Collier's willingness to use his authority as commissioner of Indian Affairs – and to some extent controller of the purse strings – to persuade tribes to accept his policies was the BIA's herd reduction program. The herd reduction program was designed to address the problems of overgrazing and soil erosion on the reservations by forcing the tribes to reduce the number of animals they held. While Collier saw the program as a necessary step to prevent devastation of the land, many tribes were adamantly opposed to it. In a rather deceptive move, Collier told the Navajos that if they would reduce their herds, Congress would grant them more land. The Navajos reduced their herds but Congress never enlarged their reservation. See Daily, *supra* note 10, at 114.

While Collier arguably did not go far enough in his pursuit of a New Deal for Indians, much of the current criticism of his policies seems inapt.[139] When he became commissioner of Indian affairs in 1934, most tribes were living on checkerboard reservations with no opportunity to recover the lands they had lost and limited opportunity to find wage work. Many of their own governmental structures, damaged by assimilation policies that had sought to diminish the authority of traditional chiefs, were in disarray.[140] Nor did American Indians have much voice or power in national or state politics, or even in BIA decision-making processes. This lack of voice contributed to a deep distrust of the federal government.

Despite these obstacles, Collier was able to effect some changes that were not only positive but also sustainable. Recognizing that the effort to preserve Indian culture would be equally doomed by the exclusion of tribes and individual Indians from mainstream social, economic and government structures as it would be by their assimilation into those structures Collier encouraged tribes to act as modern interest groups by forming governments that would be cognizable in the American system.[141] He also encouraged American Indian participation in the government through support for the preferential hiring of Indians.[142]

By creating structures for political participation and increasing the numbers of Indians working in the federal government, Collier's policies promoted the development of a pan-Indian identity and of future Indian leaders.[143] The leaders developed during that time would become instrumental in the fight against termination during the 1950s.

[139]Deloria, Jr., *supra* note 58 at 206.
[140]Fowler, *supra* note 6, at 99
[141]Deloria Jr., *supra* note 58, at 195.
[142]Cowger, *supra* note 126, at 24.
[143]Id at 25.

World War II, Termination, and Relocation

World War II

While setting the groundwork for future advocacy by Indian leaders in the area of health services, the transformation of federal Indian policy that took place during the New Deal was too short-lived to lead to significant advances in Indian health care.[144] Soon after passing the Indian New Deal legislation, Congress cut the appropriations that were necessary for its success.[145] In addition, the institutional prerogative of the BIA to control every aspect of Indian affairs quickly began to dilute the goals of the legislation. As a result, there was little compliance by the BIA with the IRA provision requiring it to consult with the tribes about the use and amount of government appropriations.[146] Moreover, America's involvement in World War II reversed any small gains that might have been made during Collier's early tenure; in fact, as the attention of the American public and government turned towards the war, Indian health did worse than just not improve – it visibly suffered.[147]

In large part, the suffering was due to the high numbers of providers who left the health department of the Bureau of Indian Affairs to join or provide health services to the military. By 1944, the shortage of providers was so great that the government stated that it needed 100 doctors and 188 nurses before it could provide even basic services to the Indian population.[148] Predictably, and perhaps understandably, funding for government provision of health services also dropped dramatically during this time.[149] The rise in prices

[144]Trennert, *supra* note 6 , at 200
[145]Deloria, Jr., *supra* note 58, at 202.
[146]Id. at 202.
[147]The suffering of the Navajo and Hopi became national news in 1947 when severe shortages of food and fuel during the winter exacerbated already poor health conditions. Congress would eventually pass an act to create a rehabilitation program for the two tribes. Donald Fixico, Termination and Relocation: Federal Indian Policy, 1945-1960, (University of New Mexico Press 1986), 13.
[148]Trennert, *supra* note 6, at 201.
[149]Trennert, *supra* note 6, at 205.

and scarcity of supplies contributed to the crisis, leading the government to close 17 Indian hospitals during the war.[150]

Despite these disturbing statistics, the story was not all bad. Restricted in his ability to produce more providers or hospital beds, Collier turned his attention to affirming the viability of traditional healing practices.[151] Advocating for the combination of traditional practices with western medical approaches, Collier hired a psychologist and anthropologist to collaborate on a guide about Navajo healing practices for government providers.[152] The guide identified ways in which western providers could improve their cultural competence.[153] Some of the recommendations included avoiding excessive questioning of native patients, increasing sensitivity to the realities of Indian life on the reservations before prescribing a treatment regimen, and using interpreters.[154]

Support for cultural competence waned in the post-war era as the government became reluctant to provide any health services to Indians. Spurred on by the belief that the tribal structures affirmed during the Indian New Deal prevented Indians from achieving individual development and success, assimilation again became the predominant national and Congressional ideology.[155] Realizing that the government's prior attempts at assimilating American Indians through education, prosleytization and allotment had failed, Congress proposed a new approach – a one two punch of termination and relocation.

Termination

[150]Id.
[151]Davies, *supra* note 9, at 59. See also Trennert, *supra* note 6, at 180.
[152]Id.
[153]Id.
[154]Id.
[155]Fixico, *supra* note 147, at 91-93. Collier was adamantly opposed to termination, arguing that "the ruling purpose... has been to atomize and suffocate the group life of the tribes – that group which is their vitality, motivation, and hope." Id. at 76.

Termination required the government to determine which tribes were ready to function without government assistance. Once it identified tribes ripe for termination, the government would strip the tribes of their legal status as semi-sovereign entities and disclaim its trust responsibility.[156] The retraction of the trust responsibility meant that terminated tribes were no longer eligible for government provided services like health care and education.[157] It also meant that the government no longer held Indian land in trust and therefore could not restrict its transfer.[158] Indians belonging to terminated tribes were therefore free to sell this land, which many did (and later regretted).[159] The withdrawal of the trust responsibility also left the members of terminated tribes at the mercy of state governments who upon termination not only became responsible for providing services to tribe members but also retained jurisdiction over them.[160] Between 1945 and 1960, in the face of opposition from many tribes, Congress terminated the legal status of over 100 tribes in this manner.[161]

The primary criteria for termination was a secure economic status, but the government also considered the "tribe's human and natural resources, limitations, preparedness and management abilities."[162] While many of the tribes the government terminated were financially sound because of successful settlement claims or income from oil or mineral royalties[163], many were unprepared for termination in other respects. For

[156]Id. at 71.
[157]Id. at 95.
[158]Id. at 71.
[159]Id.
[160]Id. at 40
[161]Id. at 110
[162]Id. at 108
[163]The Indian Claims Commission Act, signed by Truman, established a process by which an appointed commission heard tribes' claims for treaty violations. Under the terms of the legislation, the Commission could grant only monetary compensation, excluding interest, for treaty violations that occurred prior to 1946. The intent of legislators was that the tribes would use the money received from the commission to become independent of the federal government through investment in economic projects and in property. Id. at 27. Because the Claims Commission precluded compensation in the form of land grants, however, most of the money received by the tribes was distributed to members on a per capita basis. Since most tribal members usually received about a few thousand dollars each, the awards did little to encourage long-term economic development. Even more problematic was the finality of the settlements; in return for the settlement monies, tribes had to agree to relinquish any future claims for territory. This aspect of the commission would haunt those tribes who accepted settlements only to discover some years later that they had strong bases for establishing a land claim. See Charles Wilkinson, Blood Struggle: The Rise of Modern Indian Nations (W.W. Norton 2005), 223. Many scholars have also criticized the limited jurisdiction of the Claims Commission

example, most tribes were not ready to manage their own finances or negotiate sophisticated oil or mineral extraction deals with private companies.[164]

Despite the obvious potential for problems to arise, particularly for those tribes who had money but did not have a way to manage it, some tribes and many legislators supported termination.[165] Both parties viewed termination as the ideal way to end what they perceived as the government's over-involvement in Indian affairs. They saw the Indian New Deal programs as overly bureaucratic and hierarchical; in other words, a "shadow government" that had been "established to extend federal control over virtually every aspect of Indian life within Indian country."[166] They believed that termination would free Indians – who had been constrained by these federal regulations and programs – to experience true self-determination.

Regardless of the supporters' efforts to distinguish the New Deal bureaucracy from free market termination, however, the two policies were similar in many respects. Both policies were top-down, centrally imposed, and crafted with very little comment from the affected tribes.[167] And while terminationists believed that they were both ending government control over the tribes and ending the government's responsibility for tribal welfare, they were in fact only shifting responsibility for the tribes from the federal government to the

inasmuch as the Claims Commission required all claims to be related to land cessions or to the government's accounting of tribal funds. This meant that there was no forum to address broader claims addressing the government's failure to deal with tribes in good faith or its failure to uphold general trusteeship responsibilities. In *Gila River Pima Maricopa Indian Community, et al. v. United States*, for example, the Court of Claims dismissed the tribe's claim that the government had failed to provide it with adequate education on the ground that the tribe could not point to a specific treaty provision requiring the government to provide education to the tribe. Gila River, 427 F.2d 1194, 1197 (US Ct Cl. 1970). The tribe then argued that by originally asserting its role as guardian of Indian peoples and by affirmatively providing them with services for years, the government had developed a special relationship with and consequent duty toward the Indian people and had thus exposed itself to liability claims. Id. The Court of Claims rejected the existence of a special relationship and stated that regardless of its provision of services over the years, the government had not duty to the Gila River tribe unless there was an underlying contract claim that "expressly obligated the United States to perform these services." Gila River, 497 F.2d at 1198. The Claims Commission was also widely criticized for its delay in resolving claims; more than 22 years after the government established the Commission only about half the docket had been heard. Deloria Jr., *supra* note 58, at 223-225.

[164]Id. at 42

[165]Id. at 98.

[166]Raymond Cross, Symposium: The Indian Trust Doctrine After The 2002-2003 Supreme Court Term: The Federal Trust Duty In An Age Of Indian Self-Determination: An Epitaph For A Dying Doctrine?, *39 Tulsa L. Rev. 369*, 379 (2003).

[167]Fixico, *supra* note 147, at 118.

states.[168] After termination, tribes continued to need educational training, health services, and assistance with managing land and assets if they were to avoid becoming impoverished.[169] As a result, "in the years that followed [termination], most members of terminated tribes would not become middle-class citizens and would have to settle for lower-class status in American society."[170] In fact, some of the first terminated tribes, having mismanaged their assets and income, requested that the federal government restore recognition to their tribes during the 1980s.[171] Once the government re-recognized these tribes, they became eligible for health services again.

The passage of Public Law 280 was another critical piece of the federal government's effort to limit its support for tribes during the termination period. Public Law 280 gave several states, including Arizona, Minnesota, Nebraska, Oregon, and Wisconsin, full criminal and some civil jurisdiction over most reservations in their borders.[172] The law contradicted long-time federal policy, which had required states seeking admittance to the union to insert clauses into their constitution that disclaimed any jurisdiction over the tribal lands within their state and recognized "the absolute jurisdiction and control of Congress" over Indian lands.[173] Despite the existence of these constitutional disclaimers, the Supreme Court would later support states' exercise of jurisdiction over criminal and civil matters by reading the disclaimers as merely prohibiting states from having a proprietary, and not a government interest in tribal lands.[174]

[168]Id. at 98, 169.
[169]Id. at 130
[170]Id. at 133
[171]Id. at 185
[172]David E. Wilkins, *Tribal-State Affairs: American States as Disclaiming Sovereigns* in Brad A. Bays & Erin Hogan Fouberg, eds., The Tribes and the States: Geographies of Intergovernmental Interaction, (Rowman & Littlefield 2002), 18.
[173]This language comes Arizona's constitutional disclaimer which reads in its entirety: "The people inhabiting this state do agree and declare tat they forever disclaim all right and title to the unappropriated and ungranted public lands lying within the boundaries thereof and to all lands lying within said boundaries owned or held by any Indian or Indian tribes, the right or title to which shall have been acquired through or from the United States or any prior sovereignty, and that, until the title of such Indian or Indian tribes shall have been extinguished, the same shall be, and remain, subject to the disposition and under the absolute jurisdiction and control of the Congress of the United States..and no taxes shall be imposed by this State on any lands or other property within an Indian Reservation owned or held by any Indian." Id. at 2.
[174]Despite the federal government's delegation of jurisdiction over criminal and some civil matters on Indian reservations to those states named in Public Law 280, Public Law 280 is rather an anomaly when considered outside of the context of

While touted as an opportunity for independence and self-governance, termination resulted in tribes being cut off from the very resources they needed to develop stable self-governance. In addition, termination did not solve the problems created by the government's heavy-handed involvement in Indian affairs during the New Deal period. Instead, it represented just another federal Indian policy crafted without tribal participation that did nothing to meet serious tribal needs. By causing the government to withdraw from its provision of services to terminated tribes, termination likely reversed gains in health status that those tribes had made during the New Deal period.

Relocation

The government's relocation policy shared many of the same goals and had many of the same effects as the termination policy.[175] For example, the policy arose out of the belief that Indians would eventually prosper if freed from heavy-handed governmental involvement. It also had the similar effect of increasing the health and welfare burdens of American Indians.

Relocation was rooted in the idea that many of the American Indians returning from the war, in addition to those with skills living on the reservations, would benefit from moving to urban areas where there were better economic opportunities and they could more easily integrate into the US population. In the eyes of the federal government, once urban migrants adjusted to city life there would no longer be a need for reservations.[176] Nevertheless, despite the BIA's job training assistance, the unemployment rate of urban Indians hovered around 40 percent twelve years after relocation began. Many Indians had a difficult time

the termination period. While federal-Indian relations do respond to continually changing notions of federalism, the federal government rarely chooses to alter its responsibility for tribes or its supremacy in the area of Indian affairs. Id. at 20.

[175]Fixico, *supra* note 147, at 135.

[176]Fixico, *supra* note 147, at 134.

adjusting to the cities and suffered isolation and loss of morale. Some Indians, however, did find urban life to be less oppressive and poverty-stricken than life on the reservation.[177] Overall, more than 160,000 Indians were forcibly moved from their reservations to cities during this time.[178]

It was perhaps reasonable for the federal government to think that American Indians could adjust relatively easily to urban life; after all, unlike the thousands of immigrants who arrived every year and found a way to adjust to urban life the native population spoke English and held citizenship status. However, not unlike many African Americans who to this day continue to suffer the repercussions of federal policies that encouraged white flight, segregation, and de facto confinement in urban ghettos,[179] many American Indians struggled to bounce back from a history of discrimination and cultural assault to embrace city life and assimilation.[180] Those that were unable to bounce back usually returned to their reservation. Many of the younger Indians, particularly those who had previously been off the reservations, were able to adapt and tended to remain in the cities.[181]

Transfer of Responsibility for Indian Health to the Public Health Service

The third prong of termination after the withdrawal of federal recognition of tribes and relocation of Indian individuals to urban areas was the phasing out of the Bureau of Indian Affairs. The plan for phasing out the BIA centered on the transfer of the services it provided, such as health care, to other government agencies.[182] The transfer of responsibility for Indian health to the Public Health Service (PHS) was the ideal solution

[177]Cowger, *supra* note 126, at 121.
[178]Caryn Trombino, Changing the Borders of the Federal Trust Obligation: The Urban Indian Health Care Crisis, 8 *N.Y.U J. Legis. & Pub. Pol'y 129*, 130 (2004).
[179]Scott L. Cummings, Recentralization: Community Economic Development and the Case for Regionalism, *8 J. Small & Emerging Bus. L. 131*, 141 (2004).
[180]Fixico, *supra* note 147, at 139-40.
[181]Id. at 136-47.
[182]Davies, *supra* note 9, at 69

in the minds of the terminationists who believed that the BIA's ineffectiveness in addressing Indian health problems was a primary reason for continued Indian dependency as well as an obstacle to assimilation.[183] Their disgust for the BIA was perhaps not unwarranted; a former head of the Indian Health told a story about how he had succeeded in getting Congress to earmark $30 million for tuberculosis care only to have the director of the BIA use the money for "other things."[184] Non-terminationists also supported the transfer, not because they hoped for the eventual termination of government services to Indians, but because they believed the BIA had been highly incompetent in its delivery of services.[185]

There were various advantages to transferring the responsibility for health services to the PHS. At the time of the transfer, the BIA was still struggling to deal with the tuberculosis problem on the reservations in spite of its many years of attempts to address it.[186] A strong source of public support for the transfer was the fact that tuberculosis among Indians had become a public problem; between 10 percent and 25 percent of the Indians drafted into the military or employed in defense plants during World War II had had to return to the reservations because of tuberculosis infection.[187] The BIA also struggled to attract and to retain qualified providers; reservation doctors were isolated, poorly paid, and subordinate to the local BIA superintendent.[188]

The PHS, on the other hand, not only was much more successful than the BIA in recruiting physicians but was also much more suited to the job of providing health care to American Indians; in fact, the agency specialized in the treatment and prevention of infectious diseases such as tuberculosis. Their success in recruitment was due in part to the fact that doctors could work with the PHS in fulfillment of their two-year

[183]Id.
[184]Bergman et al., A Political History of the Indian Health Service, *77 The Milbank Quarterly 4* (1999), 580.
[185]Davies, supra note 9, at 69.
[186]Bergman, supra note 184, at 577.
[187]Id. at 578
[188]Id. at 577

service requirement.[189] The better pay and conditions also played a role in the PHS' recruitment success.[190] In spite of resistance from some American Indians who preferred the BIA as the devil they knew, and resistance from the PHS which was initially opposed to taking on responsibility for Indian health, the Indian Health Service became part of the PHS in 1955.[191]

Influenced in part by the machinations of bureaucrats, the decision to transfer the delivery of health services to the PHS was also heavily influenced by the lobbying of various tribes and Indian organizations, especially the National Congress of American Indians (NCAI). Collier's efforts to develop native leaders and to establish a vehicle for their voices came to fruition during this time. It took the shape of advocacy by people like Annie Wauneka, a member of the Navajo tribal council who played an important role in the passage of the transfer legislation.[192] Highly respected by members of her tribe as well as by government officials, Wauneka was central to efforts to expand preventive health efforts on the Navajo reservation.[193]

Members of other tribes also took on leadership roles in the area of health services at the time of transfer. The "Lakota grandmas," a group of women from different Lakota reservations, showed a deep commitment to improving health conditions on their reservations by embracing preventive medicine. However, in addition to working on the prevention of tuberculosis and other infectious diseases, these "grandmas" were not afraid to tackle sensitive topics such as alcoholism, mental health problems, and birth control.[194]

While it could not match the flexibility of these Lakota grandmas in addressing the more taboo health

[189]Id. at 580
[190]Davies, supra note 9 at 69.
[191]Bergman, supra note 184, at 579.
[192]Id. at 582.
[193]Id.
[194]Id.

problems on the reservations, the IHS did respond to criticisms by tribal leaders that the BIA had neglected preventive medicine and had instead focused too heavily on primary care.[195] Taking advantage of the nearly 50 percent increase in Congressional appropriations for American Indian health care that was part of the transfer legislation, the IHS not only allocated more funds to preventive services, it increased its staff numbers, rebuilt the field nursing program, and established health education programs.[196] The IHS also capitalized on its expertise in the area of public health by directing much of its energy toward the improvement of reservation sanitation, sewage, and water supply facilities.[197] In fact, improving sanitation on the reservations became one of the most significant initial IHS achievements inasmuch as it contributed to a dramatic decline in infant and gastrointestinal mortality.[198]

Another important early achievement was the agency's collaboration with a medical team from Cornell.[199] In addition to establishing a very successful clinic on the Navajo reservation, the medical team trained community members to work as field medical assistants.[200] The team thus encouraged American Indians to become actively involved in their own health care delivery.[201] Further encouragement came from the team's emphasis on cultural competence and communication. Limited in its flexibility and in its bureaucratic mindset, the IHS took a little bit longer to develop the kind of enthusiasm for feedback on their performance from American Indians shown by the Cornell team.[202] Nevertheless, by the 1960s the IHS had developed a program whereby representatives from the tribal councils would report to the local IHS service officer about health care needs and developments. The IHS would also adopt many of the Cornell team's practices, including expanding the participation of Indians in their own care.[203]

[195]Davies, supra note 9 at 81
[196]Id.
[197]Id. at 75.
[198]While the improvements in sanitation led to better health, they were still limited in reach. Only 27.6 percent of Navajo homes had indoor plumbing in the mid-1970s. Davies, supra note 9 at 87
[199]Id. at 77.
[200]Id. at 78.
[201]Id. at 79.
[202]Id. at 80.
[203]Id.

Once these lines of communication were open, tribes were not shy about expressing their frustrations with the agency. In addition to insinuating in cartoons and other forms of media that their doctors had no more experience than medical interns, American Indians expressed concerns about the high rates of provider turnover. In most cases, the high turnover was the result of young doctors leaving the reservations after completing their two years of substituted military service with the IHS.[204] Providers also cited the stress generated by the pressure to adapt quickly to a new culture and medical environment as one of the reasons why they left the IHS after just a few years of service.[205] High turnover rates therefore created a vicious cycle whereby the more providers who left, the more stress there was on those who remained, and the more likely it became that those providers would leave. One can hardly blame them: the shortage of providers was so severe that as late as 1975, the Navajo Nation had only 90 physicians per 100,000 patients while the rest of the United States averaged 163 physicians for the same number of patients.[206] In a survey conducted by IHS physician Robert Kane, Navajo patients also complained about the language barriers they faced when trying to communicate with their providers. These issues left some Navajos expressing a desire for the return of the less qualified, but oftentimes more dedicated BIA doctors.[207]

While many of the criticisms lodged against the IHS doctors and services resembled those previously made about the BIA, there was something qualitatively different about the way in which the government delivered health care to Indians after the transfer. Some of the difference was due to the increase in the number and quality of providers, as well as the improvement of facilities and development of community health operations. Nonetheless, the greatest change that occurred was in the government's attitude toward providing services, including a desire to understand better the ways in which Indian people experienced those services. In

[204]Id. at 121
[205]Id. at 127
[206]Id. at 126
[207]Id. at 125

large part, these changes had to do with the different missions of the BIA and the PHS. Whereas the BIA functioned as the "overseer" of the Indian people and subsequently had little interest in their expressed health concerns, the PHS specialized in the improvement of health indicators and therefore had greater interest in listening to concerns. The PHS was also motivated to listen to community members by the results of a study of Indian health that it carried out under Congress' direction in 1957.[208] The conclusions of the study stated that, "all plans for increased utilization of community health resources should be developed in cooperation with the Indians and the community, and will need to be on a reservation-by-reservation basis."[209] Not only did the study make it clear that any real improvement in Indian health would require Indian input, it also emphasized the diversity of the Indian experience and the need to tailor health programs to the needs of the different tribes and reservations.

Ascribing the improved communication between the government and the Indians to the efforts of the PHS alone, however, would be a mistake. Like other bureaucratic agencies left to their own devices, the PHS, while not as likely as the BIA to ignore Indian concerns, had little incentive to encourage and respond to those concerns if the recipients of the services were complacent. Indeed, rhetoric about Indian self-government and management had had its start in the early 1930s. It was at this point, about a decade after the transfer, however, that tribal leaders and members seized upon this rhetoric and sought to make it a reality. One of their efforts involved increasing the numbers of American Indian medical professionals.[210] During this time, American Indian individuals widely took advantage of the opportunities offered by the government to become nurses, doctors and other health professionals.[211] In addition to placing more Indians in health care training programs, tribal leaders sought to become more knowledgeable about the management side of health care. Participating in programs on health management and planning techniques at the training center

[208] Johnson & Rhoades, supra note 5, at 76.
[209] Id.
[210] Trennert, supra note 6, at 222.
[211] Id.

the IHS had built in Arizona, tribal leaders began to envision the potential for an expanded tribal role in the delivery of health services.[212] Released at last from the strictures of the BIA, American Indians began to effectively use the structures of the PHS to make the government more aware not only of the gravity of the health problems they were facing but also of their demand to play a greater role in addressing those problems.

The End of Termination and the War on Poverty

Increased Indian activism in the health care arena was part of a broader movement throughout the 1950s and 1960s to end termination and to expand the participation of Indians in government decision-making processes. An example of this increased activism was the 1961 American Indian Conference in Chicago. The participation in the Conference was so enthusiastic, and included so many groups and individuals that 350 tribal and intertribal meetings, and nine regional meetings, took place before the Conference even got started. The outcome of the conference, the *Declaration of Indian Purpose,* discussed the frequency with which local and state agencies were denying health services to eligible American Indians.[213] The Declaration also highlighted tribal and individual Indian needs in other areas such as education and housing.[214] Despite serving as an important rallying tool for pan-tribal activism and organizing, and laying the groundwork for future sophisticated lobbying and legislative campaigns by Indian organizations, the Declaration had little effect on the federal government's approach to Indian policies.[215]

Tribes were not new to lobbying or to communicating with the federal government. Since the early 1900s,

[212]Johnson & Rhoades, supra note 5, at 76.
[213]Thomas Clarkin, Federal Indian Policy in the Kennedy and Johnson Administrations (University of New Mexico Press (2001),17-19.
[214]Id. at 19
[215]Id.

tribes had sent delegations of officials to Washington to try influence federal Indian policy.[216] All of the tribes in these early years, however, focused their lobbying efforts on either attaining specific benefits for their tribe or demanding federal compliance with treaties. In the 1960s, then, what was new was not that tribes were lobbying, but that they were joining forces and making concerted demands. Because the pan-Indian nature of the movement during the 1960s promised greater strength and greater numbers, it led to greater success than Indian delegations had experienced in the past.[217]

An example of the success of pan-Indian political action was the American Indian Capital Conference on Poverty. Indian groups purposefully planned the conference, intended to "secure cooperative national leadership" on the issue of Indian poverty, to occur at the same time as the hearings on President Johnson's War on Poverty/Office of Economic Opportunity (OEO) initiatives.[218] Conference delegates met with legislators to try to convince them that Indians, initially excluded from the War on Poverty, should be included in Johnson's initiatives. Delegates also attended workshops on health, education, housing, and employment to become better prepared for sustained and sophisticated advocacy on those issues.[219]

Although the conference resulted in the Secretary of the Interior publicly committing to the inclusion of the Indian people in Johnson's antipoverty programs, it did little to alter the paternalistic approach and operation of the BIA.[220] BIA officials saw the antipoverty programs as an infringement upon their jurisdiction over Indian affairs and felt threatened by the establishment of regional offices of economic opportunity on reservation lands. Their defensiveness derived from a fear that another agency might experience greater success than the BIA had, not only in improving poverty and health indicators but also in increasing the economic capabilities and independence of the Indian people.

[216] Fowler, supra note 6, at 46.
[217] Id.
[218] Clarkin, supra note 213, at 113.
[219] Id.
[220] An example of continued BIA heavy-handedness at this time was the Interior Secretary's decision to terminate the Navajo tribe's attorney without the council's permission. While the Secretary believed the action was necessary to protect tribal resources, it created a deep rift in between tribe members and arguably retarded the development of tribal sovereignty. Id. at 150

By bypassing the BIA and making funds directly available to tribes, the OEO programs offered Indian peoples their first opportunity since the federalization of Indian affairs in the 1800s to determine what their priorities were and how they wanted to address them.[221] Indeed, the OEO programs were really the first time that Indians had "the right to be wrong and the right to be right." The Navajo used the funds to create the first school run by a tribe without BIA involvement.[222] Other tribes focused on establishing health centers or Head Start programs. Most importantly, however, the program helped catalyze the development of leaders by offering tribal members the opportunity to move into decision-making and administrative positions. Many of those who took on these administrative and decision-making roles later became tribal council members, leaders in national Indian organizations or political representatives. By offering tribes and individual Indians their first ever "chance to fail," the OEO programs encouraged Indians to begin organizing around increasing their self-determination.

Epitomizing the BIA's negative response to the growing interest in self-determination and consequent rejection of the BIA by Indians at this time was the assertion by the commission of Indian affairs at the end of the Capital Conference that "Indians are better off than Southern Negroes chiefly because of the work of the much criticized Bureau of Indian Affairs. As poor as the Indian people are, the rural nonwhites are much poorer."[223] Not only was this statement factually incorrect, it belied the reality of numerous BIA failures, in particular the mismanagement of trust accounts and natural resources.[224] In addition, it exemplified the tired and narrow vision of the agency; instead of ending the conference with a renewed commitment to

[221] Wilkinson, supra note 163, at 193
[222] Id. at 192.
[223] Clarkin, supra note 213, at 116
[224] The BIA would eventually be brought to task for allow[ing] "federal employees [to squander] Indian natural and financial resources under the guise of trusteeship". It would eventually have to pay $100 million for violation of trust duties. Deloria Jr., supra note 58, at 158. This example demonstrates that the trust relationship is not one-sided; while government officials have legal authority under the trust doctrine to extend federal control over nearly every aspect of Indian existence, it is nonetheless held accountable as a fiduciary, particularly in cases involving its role as trustee of Indian lands and assets. See James Anaya, *International Law and US Trust Responsibility toward Native Americans*, in Native Voices, supra note 30 at 173.

fixing the problems at the BIA and improving the welfare of the Indian people, the commissioner discounted complaints about the BIA. In addition, the commissioner's suggestion that Indians should be content with the poor conditions they suffered because they were better off than rural African Americans illustrates both the BIA's arrogance and the lack of its commitment to its mission.

The Era of Self-Determination

The belief that beggars can't be choosers, or that Indian people did not have the right to demand more and better services so long as the government was paying for them, persisted throughout the 1960s. This belief began to change in the 1970s when the rise of the American Indian Movement, coupled with legislative and executive support for self-determination, led to a reassertion of sovereignty by Indian peoples. Sovereignty promised a new relationship with the federal government wherein Indians – not bureaucratic officials – would manage tribal health care, education and other social service delivery.

While Johnson's inclusion of Indians in his OEO programs had signaled a shift in federal policy from bureaucratic control over Indian affairs to Indian self-determination, the Nixon administration made the shift a reality by declaring that the government was entering a new era of federal Indian relations. In 1970, Richard Nixon gave a speech to Congress in which he asked Congress to "begin to act on the basis of what the Indians themselves have long been telling us... to create the conditions for a new era in which the Indian future is determined by Indian acts and Indian decisions."[225] This new era would be marked by a decline in the jurisdiction of the BIA with tribes able to "take over the control [of federal programs]... whenever the tribal council... voted to do so."[226] Calling termination "morally and legally unacceptable," Nixon

[225]Nixon's Special Message on Indian Affairs, July 8, 1970, www.epa.gov/**indian**/pdfs/nixon70.pdf
[226]Id.

was also the first high-level official to admit that the government's policy was a derogation of the trust responsibility.[227]

Unlike in the pre-self determination days when the federal government designed and implemented its policies without consulting with the Indian peoples, by the Nixon era, Indian leaders who had developed leadership and organization skills during the termination and OEO periods demanded to play a role in shaping legislation and challenging court decisions. In the 1970s, greater tribal control over health care became an important rallying call for Indian leaders. Stemming in part from the HIS' involvement in a few significant health care controversies, the desire for greater tribal control over health care also came from the fact that Indians continued to have disproportionately poor health outcomes. The first IHS controversy centered on evidence that the number of sterilization procedures conducted on the Navajo reservation had skyrocketed between 1972 and 1978.[228] Shocking, these numbers engendered even greater disbelief when one considered them in light of an unrelated study showing that Navajo women rarely chose sterilization if presented with any other options. The increased sterilizations appeared to be due to incompetent IHS direction rather than to a government conspiracy to sterilize Indian women. Nevertheless, the devastating and irreversible effects of such incompetence caused alarm among Navajo people and catalyzed demands for greater control over health services. These demands became stronger when the government took little action to remedy the situation. Indeed, while the government conducted an investigation and the General Accounting Office (GAO) published a report, no other action was taken.[229]

Another controversy that generated greater support for self-determination in health care was the increasing

[227] Wilkinson, supra note 163, at 196
[228] Davies, supra note 9, at 132.
[229] Id. at 133.

numbers of miners and residents who had become ill after exposure to the uranium mines located on the Navajo reservation. One study showed that Navajo miners experienced a lung cancer rate of 148 per 100,000 compared to a rate of 1.7 per 100,000 among non-miners.[230] Most employers had not made the miners aware of the potential dangers of the uranium despite Public Health Service studies showing the link between exposure to radon and cancer.[231] This controversy signaled to the Navajo population not only that that it could not trust the US government to take care of the tribe but that it could and should be more vigilant about the health risks faced by its members.

The cornerstone of Nixon's self-determination policy was the Indian Self-Determination and Education Assistance Act of 1975.[232] The Act called for tribes to take over and administer federal programs if they could show by tribal resolution that the tribe desired to do so. The programs and services that tribes could choose to administer ran the gamut from mental health and drug abuse services to programs for community health representatives to health education programs to facilities construction. The tribes could also choose to administer direct health services. Once they entered into a contract for services, the tribes could administer the programs directly or could contract with outside providers.[233]

The Secretary of the Interior had the ability to decline to enter into self-determination contracts. This Act limited this ability, however, by requiring that Secretary set forth the reasons why the government was rejecting the contract.[234] Furthermore, the Secretary had to assist any tribe with a rejected contract to overcome the reasons for the rejection. The legislation also enabled the tribes to appeal the government's

[230]Id.
[231]Id. at 134
[232]Indian Self-Determination and Education Assistance Act of 1975, Pub. L. No. 93-638, 88 Stat. 2203 (codified as amended in scattered sections of 25 USC)
[233]Rose Pfefferbaum et al., Providing For The Health Care Needs Of Native Americans: Policy, Programs, Procedures, And Practices, *21 Am. Indian L. Rev. 211*, 236-7 (1997).
[234]25 USC §450(f)

rejection of a self-determination contract in federal court.[235] While the BIA was reluctant to relinquish its control and attempted to slow down the contracting process, the tribes refused to take no for answer and continued to submit their applications until their contracts were approved. Leaders simultaneously applied pressure to members of Congress to ensure that the legislation proved to be more than a paper tiger.[236]

Indian leaders had learned from the successful legislative and executive efforts to dilute the effect of the Marshall decisions that they could only secure their interests if they had the support of all three branches of government. Since Nixon clearly favored self-determination, and Congress had acted on his direction in this area by passing the Self-Determination Act, the judiciary became the important target for advancing and securing Indian interests. A group of activist Indian leaders called the American Indian Movement (AIM) worked with traditional indigenous political forces and young Indian lawyers to develop a judicial strategy. The strategy called for the assertion of treaty claims in US and international forums.[237] Leading to favorable court rulings in the area of fishing and resource rights, the assertion of these claims helped to turn self-determination into a reality, rather than just a fancy political expression.[238]

While these decisions were critical to establishing the *de jure* foundations of the sovereignty movement,

[235]Id.

[236]Wilkinson, supra note 163, at 197

[237]Morris, supra note 38, at 118. Some of the early victories included the Winnebagos' win in circuit court over the U.S. Army Corps of Engineers which established their right to their tribal land in Iowa. Another key victory was the return of Blue Lake to the Taos Pueblo. Marks, supra note 13, at 322-33. Other political actions of the Indian groups included boycotting stores that had been racist and protesting against police brutality and substandard education and housing.

[238]In *United States v. Washington*, 384 F. Supp. 312 (1975), Judge Boldt handed down a historic ruling when he interpreted treaty language granting the Northwest Tribes "the right of taking fish, at usual and accustomed grounds and stations. . . in common with all citizens of the Territory" to mean that the tribes had the right to harvest one-half of the salmon in the off-reservation fishing areas. The court of appeals would later affirm the decision. Wilkinson, supra note 163, at 202. Another critical sovereignty decision which exemplified the skillful leadership of Indian leaders and lawyers at this time was *McClanahan v. Arizona,* 411US 164 (1973). In *McClanahan*, a Navajo tribe member and reservation resident challenged the state's withdrawal of taxes from the paycheck she received from a non-tribal bank located on the reservation. In support for her claim that the withdrawal was a violation of tribal sovereignty, she cited the Navajo Treaty of 1868, which stated only that the reservation was set aside "for the use and occupation of the Navajo tribe of Indians." The court, citing *Worcester v. Georgia*, stated that the state tax could not be "reconciled with self-determination." See Id. at 247.

tribes have also been extremely successful in asserting *de facto* sovereignty. One of the areas in which they have had particular success in exercising de facto sovereignty is in contracting with the government for the delivery of health services.[239]

De facto sovereignty is an important complement to *de jure* sovereignty inasmuch as it acts as an "antidote to ambiguous or even contrary *de jure* status." By competently taking on responsibility for their health care, tribes "alleviate concerns that Indian citizens' needs cannot be met by their governments, provide[s] foundation for operational respect for non-Indian governmental counterparts, reduce[s] litigation, provide[s] an "out" for the legal system when overburdened judges seek settlement or dismissal of cases that threaten to bog the system down in the complicated and vacillating area of tribal jurisdiction. . . "[240]

Not only have tribes individually exercised *de facto* sovereignty by running their own health programs, they have formed intertribal organizations that set larger policy goals for Indian health. One example of such an organization is the National Indian Health Board (NIHB).[241] The NIHB developed out of regional health boards originally created by tribal governments who wanted assistance in determining tribal health needs. One of the first national Indian-controlled organizations focused on how to run health-care programs, the NIHB received financial support from the IHS.[242] The NIHB continues to serve as a central clearinghouse for

[239]In addition to using the courts to establish treaty rights, the American Indian Movement demanded changes in IHS and BIA policies. Improvement of Indian health was a main part of their platform with the majority of their criticism focusing on the deficiencies of government funding for Indian health. AIM was not afraid to take on the issue of poor health care for Indians in a radical way. In 1969, when AIM members took over Alcatraz Island to protest the government's failure to honor the terms of treaties, they issued a Proclamation which identified poor medical services and sanitation as an area in which the government had breached its duty to Indian peoples. In 1973, AIM members took over the IHS facility at Gallup Medical Center to demand better services and to insist that the IHS alter the "disrespectful" attitudes of its physicians. AIM also asked IHS to dismiss various hospital officials whom it felt were not performing their duties properly. See Davies, supra note 9, at 129. The radical nature of the AIM enhanced the split between traditionalists and progressives in the movement, particularly with the occupation of Wounded Knee. Marks, supra note 13, at 336-7.

[240]Singer, supra note 40, at 27

[241]National Indian Health Board, `http://www.nihb.org` (last visited April 25, 2005).

[242]Johnson & Emery, supra note 5, at 83

studies and information on Indian health. It also continues to act as a policymaking and lobbying body.[243]

Self-Determination, Self-Governance and Sovereignty: What is the difference?

While I have so far used these terms interchangeably throughout this paper, scholars would argue that each of these terms has a different meaning, or at the very least a different significance. For example, Indian scholar Vine Deloria Jr. rejects the language of self-governance or self-determination. He argues that inherent in these terms is the implication that tribes need, or are seeking, recognition of their governments from the more powerful government, the United States. Deloria Jr. has consequently advocated for the use of the term "nationhood" to describe those tribes that conceive of their exercise of sovereignty and their decision-making as separate from the influence of the United States government or people.[244] To be independent decision-makers, the tribes do not have to sever their relationship with the government. It merely means that tribes take the necessary chances to run their own affairs, build their own government's capacities, and strive to be less dependent on the federal government. It also means not following the government's lead in terms of policy or finances unless the tribe has determined that the lead is truly in their best interest. The exercise of de facto sovereignty, inasmuch as it is tribally determined rather than directed or influenced by the federal government, is central to the development of nationhood.

The question of whether contracting with the government to manage and provide services is better described as part of the process of nation building advocated by Deloria Jr. or as a move toward self-governance endorsed and directed by the federal government will be explored later on in this paper. Either way, tribal achievements in the area of health care have become a key example of the tribes' ability to take advantage

[243]Id at 82.
[244]Morris, supra note 38, at 123

of congressional support and expand upon it through de facto exercise of sovereignty.

The Indian Health Care Improvement Act

Passed by Congress in 1976, one year after the passage of the Self-Determination and Education Act, the Indian Health Care Improvement Act (IHCIA) was grounded in four congressional findings.[245] First, Congress recognized that the federal provision of health services was "required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[246] Second, Congress set out the two goals of the legislation: to provide sufficient services to raise the health status of Indians "to the highest possible level," and to encourage maximum participation of Indians in the provision of these services.[247] Third, Congress noted that the federal government had made progress in reducing the prevalence of disease and death among Indians. Most significant, however, Congress found that despite government provision of services, "the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States."[248] In crafting the IHCIA, Congress conveyed a clear message that improving Indian health care and increasing Indian voice in decision-making processes were national priorities.

The IHCIA enumerated 61 health objectives for Indians living on reservations and in urban areas that the Nation was to meet by the year 2000.[249] The objectives included improvements in Indian health care ranging from reducing cirrhosis deaths to no more than 13 per 100,000 to increasing the proportion of children

[245]Indian Health Care Improvement Act (IHCIA), Public Law 94-437 (1975), 25 USC §1601
[246]Id.
[247]Id.
[248]25 USC §1601
[249]25 USC §1602

who received sealants. In declaring these objectives, Congress reiterated that the Nation had "special responsibilities and legal obligations to the American Indian people" and that one of these obligations was to "assure the highest possible health status" for Indians.[250] Congress stated that it was the Nation's policy "to provide all resources necessary" to effect these obligations and accordingly appropriated $480 million to improve medical services.[251]

Other facets of the IHCIA included the authorization of over $7 million in grants to increase the number of Indians working as health professionals and to provide those Indians currently working as health professionals with opportunities for continuing education.[252] The IHCIA also provided $300 million for the repair and construction of health facilities; to the extent possible, American Indian firms were to complete these repairs.[253] Another important provision of the IHCIA was the establishment of a process whereby Medicare and Medicaid could reimburse the IHS for the services it provided to Indian peoples who were eligible for these government programs.[254] Arguably, however, the most important provision of the IHCIA was the establishment of health services for urban Indians.

Urban Indian Health

Many of the Indians located in urban areas had left reservations as part of the government's relocation program, but most moved because they saw cities as providing better opportunities for employment, housing, and education. Urban Indians composed a diverse group of Indians from many different tribes and therefore did not tend to settle in the same neighborhoods. As a result, migration often resulted in a feeling of loss,

[250]Id.
[251]Id.
[252]See Pfefferbaum et al., supra note 233, at 236.
[253]Trombino, supra note 178, at 139.
[254]Id.

particularly of cultural, familial, and religious ties. This feeling of loss often contributed to the development of health problems such as alcoholism, drug abuse, and depression.[255]

The other loss resulting from migration, a particularly devastating loss considering the struggles with depression and addiction caused by leaving the reservations, was the loss of federally provided health care. While the federal government has a trust responsibility to provide health care to federally recognized tribes,[256] prior to the passage of the IHCIA the IHS only provided services through its reservation facilities or through its facilities located close to reservations. Indians who voluntarily left the reservations for the cities therefore had no access to federal health services even if they continued to be members of their tribe.[257] Members of terminated tribes who relocated to urban areas lost both access and eligibility for services.[258]

Title V of the IHCIA attempted to remedy this loss of services by establishing primarily outpatient health services for urban Indians.[259] Providing for the IHS to contract with non-profit organizations to deliver services such as referral and outreach, the IHCIA did not require the IHS to develop urban facilities. Nor did it require the IHS to provide the same level of services to urban Indians as it provided to American Indians living on the reservations. Despite the disparity in services provided, the extension of services to urban Indians was an important step toward carrying out the intent of the Snyder Act, the first act to authorize

[255]Id.

[256]All tribes with a historical relationship with the federal government that involved treaties or other dealings are federally recognized. Recognition entails entitlement to federal benefits offered to tribes as well as the right to self-government. As explained in the earlier discussion of the termination policy, recognition is double-edged sword. With federal benefits comes Congress's plenary power over tribal existence. In 2000, there were 558 federally recognized tribes and 150 or more tribal entities that were not recognized. The majority of the unrecognized tribes are not terminated tribes. Instead, they are tribes that either chose not to deal with the US government or were too isolated to be affected by the government's actions. See Taylor, supra note 113, at 41. Many of these unrecognized tribes are in the process of requesting recognition of have obtained recognition by the states in which they live. Others were terminated during the 1950s and never requested re-recognition. See Utter, supra note 4, at 62. The IHS provides some level of service to all 558 federally recognized tribes. See Ralph Forquera, Urban Indian Health, (Kaiser Family Foundation 2001), 7.

[257]Trombino, supra note 178, at 139.

[258]IHS eligibility criteria include a confluence of factors. Some of the factors considered are: membership in a tribe, enrollment in a tribe, residence on tax-exempt land, ownership of restricted property, and whether one is regarded as an Indian by the community in which one lives. See Pfefferbaum, supra note _, at 19.

[259]Id. at 147.

health services to Indians, which had called for the provision of services to "Indians throughout the United States."[260]

Since the passage of the IHCIA, migration from reservations to urban areas has increased. In 1970, 25 percent of the Indian population lived in urban areas. In 2000, 61% of the Indian population was urban.[261] Despite the growth in the urban American Indian population, the IHS has made few other efforts, aside from its compliance with the terms of the IHCIA, to expand access to care for urban Indians. For example, the IHS restricts eligibility for contract services purchased from private providers to Indians living on or near reservations in specified contract health services delivery areas (CHSDA).[262] Therefore, Indians who do not live in CHSDAs – primarily urban Indians – cannot receive reimbursement from the IHS if they see a private provider.[263]

Even while restricting eligibility for contract and other services, budget constraints have meant that IHS funding for urban Indian health has not kept up with the increase in the urban Indian population. In 1979, the IHS allocated 1.48 percent of its total budget to urban Indian health. By 2001, the budget allocations for urban health had decreased with the IHS spending 1.15 percent of its total budget, or $29.9 million, on urban Indian health.[264] All of this money went to fund 34 nonprofits, which served 130,000 urban Indians located in 20 states.[265]

[260]Id.
[261]Broken Promises, supra note 2 at 67.
[262]Id. at 62.
[263]Id. Unlike urban Indians, American Indians living in CHSDAs can still receive reimbursement for contract services. Because of budget constraints, however, the IHS will only reimburse those contract services that the IHS cannot directly provide. The high denial rate for contract health services has resulted in a "loss of life or limb" rule whereby the IHS covers only the most urgent care, oftentimes excluding such procedures as gallbladder surgeries, eyeglass prescriptions, and cancer diagnostic services.
[264]Urban Indians and Health Care in America: Hearing on the FY 2004 President's Budget for Indians Programs before the S.Comm. on Indian Affairs, 108^{th} Cong. 4 (2003) (testimony of Kay Culbertson, President, National Council of Urban Health).
[265]Trombino, supra note 178, at 146.

Because IHS funding covers only 22% of their operating expenses, these 34 nonprofits would not able to serve nearly as many people as they do without supplemental Medicaid and Medicare funding as well as funding from state and private sources.[266] The nonprofits' ability to bill Medicare and Medicaid is guaranteed by an IHCIA provision that requires Medicare and Medicaid to reimburse any services that the IHS provides to eligible Indians, regardless of where they live. Even so, because the federal government does not offer the same 100% Medicaid reimbursement rates for services provided by urban Indian health programs that it does for services provided by the IHS on reservations, states are reluctant to establish their own services for urban Indians.[267] The lack of 100% federal reimbursement also renders states reluctant to encourage American Indians to use those state health programs that already exist. Similarly damaging to the stability of urban Indian health programs is the fact that most Medicaid programs have shifted from a fee-for-service to a managed care structure.[268] This means that Medicaid will not reimburse service providers like the nonprofits that provide care to urban Indians because they do not function as managed care organizations.[269]

The rising costs of medical care, combined with the increase in the urban Indian population and stagnant IHS funding have created a situation such that even with the Medicaid, Medicare, State Children's Health Program (S-CHIP) and private dollars, urban health centers require patients to pay a sliding scale fee.[270] Budget constraints also force centers to limit the kinds of services they can provide. Therefore, instead of providing their Indian patients with hospital and specialty services, they can only provide primary care, referrals, and outreach.[271] To receive free emergency service, then, tribe members must travel back to their reservations. "Returning home in time of need" is a rather common practice for urban Indians. Indeed,

[266]Id. at 147.
[267]Id. at 149-150.
[268]Id. at 150-151
[269]Id.
[270]Forquera, supra note 256, at 12.
[271]Id.

IHS Areas[272] that contain large reservations often have high user-to-service population ratios; these ratios reflect the significant number of excess users, most of whom are urban Indians.[273] In addition to placing restrictions on the services that established urban health care programs provide, the limited budget retards the development of programs in new areas. It has been estimated that 18 cities not currently being served by urban Indian health programs have large enough Indian populations to warrant the establishment of such programs.[274] Indeed, the scarcity of urban Indian programs has created a situation whereby 46 percent of all Indians have no access to IHS facilities.[275]

There are many reasons, in addition to a lack of resources, that the IHS has not placed greater emphasis on the development of urban health programs. One reason is the lack of power of urban Indian organizations and individuals compared to tribal governments.[276] The tribal governments are the IHS' main constituency; they are the parties with whom the IHS is used to collaborating and negotiating. They are also the parties that receive the majority of federal government money dedicated to Indian affairs. Moreover, tribal governments, unlike urban Indian organizations, exercise power on a national or statewide level. They donate to both federal and state campaigns, and in some states, they are an important voting bloc and economic presence.[277] Accordingly, the IHS and the larger federal government are unlikely to want to jeopardize the relationship they have with these governments by moving funds away from tribes to individual urban Indians.

[272]IHS Areas refer to the 12 regional offices that make up the decentralized HIS system. Oklahoma is the Area with the largest Indian population while the smallest is the Tucson Area. See History and Organization of Indian Health Services. Depending on regional differences in cost, availability of care, Indian political influence, and the relative mix of direct versus contract care, the Areas receive widely divergent funding. For example, per capita allocation for Indian health care was highest in Alaska at $1906 and lowest in Portland at $525. See 21 Am In L. Rev. 211 Area offices provides administrative and technical aid to the hospitals, clinics and other facilities in its region. See Indian Health Service, "Indian Health Service Area Map," http//www.dsfc.ihs.gov/ihsmap.cfm

[273]Pfefferbaum, supra note 233, at 211.

[274]Id.

[275]Broken Promises, supra note 2, at 67.

[276]Yvette Roubideaux, A Review of the Quality of Health Care for American Indians (Commonwealth Fund 2004), 6.

[277]In New Mexico, for example, the Navajo Nation has a significant impact on reservation border towns like Gallup and Farmington. Navajo voters dramatically affect New Mexico state and local elections. See Mason, supra note 48, at 79.

Since the available funding for reservation health needs is already so limited, the tribes also have little incentive to push for greater allocations for urban Indian health. Tribal governments are only accountable to those members who vote in elections and voting members tend to live on reservations.[278] Without the power of the tribal governments behind them, it is therefore difficult for urban Indian organizations to get attention from the IHS.

In addition to the lack of urban Indian power, another reason for the consistent under-funding of urban Indian health care is the fact that there is very little known about the health status of urban Indians. While the IHS carries out extensive studies of Indian health on the reservations, it does not conduct nearly as many studies of the urban Indian population. Of the few studies that look specifically at urban Indian health, the majority found that health indices of urban Indians were not very different from the health indices of Indians living on reservations or in rural areas.[279]

Nevertheless, while overall health outcomes might be similar, there is a clear disparity between uninsured rural and urban American Indians in terms of their use of health services. Whereas 46 percent of uninsured American Indians without access to IHS facilities did not visit a provider within the year, only 22 percent of those with access to IHS facilities failed to see a provider during that time.[280] This statistic illustrates that the lack of urban health care programs for Indians negatively affects the frequency with which they see providers. Therefore, while some urban Indians return to reservations to receive care, this study demonstrates that many others go without a regular source of care. However, because there are a limited number of studies,

[278]Norman Ration, the head of the National Indian Youth Council, cites the lack of representation for urban Indians before Congress and the IHS as one reason for why funds designated for urban health programs often end up in the hands of tribal health programs. See Broken Promises, supra note 2, at 70.

[279]See e.g., D. Grossman, et al., Health Status of Urban American Indians and Alaska Natives: A Population-Based Study, *271 Journal of American Medical Association 11* (1994); Roubideaux, supra note 276, at 6.

[280]Henry J. Kaiser Foundation, American Indians and Alaska Native, Health Coverage and Access to Care (February 2004).

and because most of the studies conducted do not show that the lack of access has created serious health problems for urban Indians, the IHS has so far been able to follow an "ignorance is bliss" strategy with regard to providing more funding for urban Indian health.

The increasing numbers of Indians relocating to urban areas, coupled with the continued gaps in insurance coverage[281], has recently resulted in some action on the part of the IHS and other organizations to gather more data on the quality of health care for urban Indians. The IHS has begun funding an urban Indian epidemiology center[282] while other organizations have focused their efforts on figuring out the specific health needs of urban Indians. One of the most important recent studies, completed by the Urban Indian Health Institute, found that American Indians living in the 34 urban areas served by the IHS have significantly poorer health than other urban residents.[283] Compared to the general population, these urban Indians experienced 126 percent higher rates for chronic liver disease and cirrhosis, 54 percent higher rates of diabetes, and 38 percent higher rates for accidental deaths.[284]

While more data will certainly assist the IHS in its efforts to determine how best to use the limited resources allocated for urban Indian health, it will not change the three key problems preventing the development of a long-term solution to urban Indian health. These three problems are:

1) the stagnant budget of the IHS, coupled with the rise in the overall Indian population[285], and the rise in the urban Indian population in particular;

[281]Only half of the American Indian population has private health coverage, compared to 83 percent of the white population. More than one-third American Indians are completely uninsured. See Id.
[282]Roubideaux, supra note 276, at 6
[283]Broken Promises, supra note 2, at 69.
[284]Id.

2) the general sentiment at the IHS that because urban Indians can access health services if they really need to, even if they cannot pay for them, the agency should continue to focus on providing services to reservations, particularly to those reservations located in very rural areas where no other providers would locate; and

3) the fact that self-governance compacts are only negotiated with tribes and not with tribal or other Indian groups in the cities.[286]

Reauthorization of the IHCIA

The IHS, like all other health care providers in the current era of rising health costs,[287] is hard-pressed to determine how to allocate its limited resources to obtain the best health care outcomes. Because the annual growth in its budget does not even compensate for inflation,[288] the IHS continually struggles to maintain services at their current level.[289] This is true despite the fact that the government spends twice as much per capita on federal prisoner beneficiaries, and two-thirds as much per capita on Veterans beneficiaries, than it does on American Indians.[290] Maintaining the IHS budget at a level that does not even compensate for

[287]While not within the scope of this paper, the national health care crisis clearly plays a role in the federal government's decisions about how to fund the health care needs of American Indians. Rising health care costs and increasing demands on Medicare and Medicaid not only make it difficult for the government to run IHS direct services, it also hampers the tribes' ability to take over those services without large increases in funding from the government. In addition, the continual decline in the number of private sector jobs offering health care benefits means that even if the employment situation of American Indians improves, they may still be dependent on government health care programs. See Paul Krugman, Ailing Health Care, New York Times (April 11, 2005) (citing Kaiser Family Foundation estimates that there were at least five million fewer jobs with health insurance than in 2001).

[288]As Mim Dixon, a renowned specialist in Indian health care noted, the IHS "is a health care delivery system so underfunded that it would not be able to stay in business in the private sector." See Statement by Mim Dixon to Senate Committee on Indian Affairs, Hearing on Reauthorization of the Indian Health Care Improvement Act (July 23, 2003) `http://indian.senate.gov/2003hrgs/072303hrg/dixon.PDF`.

[289]National Indian Health Board, Testimony of Sally Smith, Chairman on the Fiscal Year 2006 Budget for American Indian and Alaska Natives Programs, 10 at `http://scia.senate.gov/2005hrgs/041305hrg/smith.pdf (last` visited April 25, 2005). See also National Indian Health Board, Tribal Perspectives on Self –Determination and Self-Governance in Health Care Management (1998) at 34 (stating that a combination of inflation and population growth have resulted in less health care spending per Indian person over the past six years).

[290]NCAI Testimony on the Administration's Fiscal Year 2006 Budge Request for Indian Programs, Senate Committee on Indian Affairs (February 16, 2005) at `http://indian.senate.gov/2005hrgs/021605hrg/hall.pdf`.

inflation is also contraindicated by the results of a budget consultation with the tribal leaders which found that $19.7 billion was needed to bring Indian health status to the level of the general population.[291] The disconnect between what tribes believe they need to fully serve their members and what the government is willing to commit to Indian health becomes even more apparent when one considers that the FY 2006 IHS budget is $3.048 billion; this is $16 billion less than what tribes estimate they need.[292]

Various provisions of the Indian Health Care Improvement Reauthorization Act, proposed in 2001 but not still not passed, seek to resolve some of the challenges the government faces in making appropriations for Indian health care.[293] Unlike the 1992 amendments, which are the last amendments made to the IHCIA, the changes proposed by the 2001 Reauthorization Act do not call for specific health care improvements.[294] Instead, the 2001 amendments focus more on improving health care by increasing the enrollment of Indians in entitlement programs such as Medicaid and Medicare, rather than expanding the work of the IHS.[295] For example, the proposed amendments call for increases in funding to hire more eligibility workers to inform Indians about the benefits and requirements for Medicare and Medicaid. In addition to expanding enrollment in entitlement programs, the amendments seek to tailor the entitlement programs to fit Indian health needs and realities.[296] One example of this tailoring is the proposal to eliminate deductibles, co-pays

[291] Testimony of Sally Smith, supra note 289.

[292] Id.

[293] Congress held hearings on reauthorization bills introduced in 2001, 2002, and 2003. However, none of these bills were voted on and there was significant opposition to the mandatory funding provisions included in the proposed amendments. In particular, the Congressional Budget Office found that three added provisions would cost an estimated $5 billion. The IHCIA National Steering Committee has encouraged tribes to support the amendments without these three provisions by stating that even without these provisions, the amendments will achieve numerous improvements. See Broken Promises, supra note 2 at 130-133.

[294] PL 102-573 1992 Amendments to the IHCIA. Some examples of the improvements called for by the 1992 Amendments include increased access to facilities in rural areas, development of better water and waste disposal services, hiring of more personnel, and development of support factors such as housing units for staff. The 1992 Amendments cited some disturbing statistics to support their call for specific improvements such as the fact that 90 percent of the surgical operations needed for otitis media had not been performed. The Amendments stated that without further improvements in these areas, Indian health was "imperiled."

[295] Section 411 of S.556, section 408 of H.R. 2440

[296] Id.

and premiums, the existence of which currently deter Indians from enrolling in Medicare or Medicaid because they can receive Indian health services without paying any out-of-pocket costs.

In addition to tailoring the entitlement programs to meet the needs of the Indian population, the proposed amendments call for the IHS to help the tribes come to terms with the managed care environment. The specific proposal would allow the tribes to use IHS funds to purchase managed care plans or other insurance coverage.[297] Providing further encouragement for the adoption of managed care systems is the provision granting the Secretary of the DHHS, rather than state or local health entities, the right to determine whether the programs meet accreditation standards.[298] These two proposals are particularly important for those tribes who are too small to develop their own direct delivery system of care and who might need more flexibility in finding appropriate managed care coverage.

Overall, the 2001 amendments provide an interesting contrast to previous amendments. Instead of setting out specific health improvements, the amendments look for ways to improve Indian health by doing the utmost possible with available resources, particularly the resources of entitlement programs. The amendments similarly depart from the past practice of treating the IHS as the only important player in health care financing by emphasizing the need for tribes to adapt to modern health care financing structures. While expanding access to entitlement programs ensures that elderly and low-income American Indians will have a more dependable source of care and will not have to deal with the vagaries of IHS funding,[299] the strategies encompassed in the IHCIA amendments do not address the central issue plaguing the government's provision

[297] Broken Promises, supra note 2, at 130-133.
[298] See Testimony of Mim Dixon, supra note 288.
[299] The goal of moving people from dependency on IHS to dependency on entitlement programs is perhaps questionable; the government faces a funding crisis in the provision of Medicare and Medicaid just as it does in the provision of IHS programs. Nevertheless, the very fact that they are entitlement programs makes them inevitably more secure than IHS programs, and the reality is that there are not very many other options.

of health care to American Indians. That central issue is, and always has been, a desperate and persistent lack of money.

The Government's Funding Strategy: Quit While Ahead?

The government has a trust responsibility to the Indian people to provide them with health care. This responsibility, originating in two hundred year old treaties and codified in later statutes, has never been a government priority. One could not claim, however, that the government has completely, or even mostly, reneged on its responsibility to provide health care. In fact, most critics would concede that actions of the IHS have at least contributed to improvements in Indian health care, despite strong obstacles such as limited funding, bureaucratic requirements, and spiraling health care costs.[300] Indeed, since 1973 mortality rates have declined for tuberculosis, injury and poisoning, infant deaths, accidents, maternal deaths and influenza.[301]

Despite some successes, the government's efforts to improve Indian health are consistently incomplete and very often self-serving. In large part this is because the government is neither compelled by law nor by the amorphous trust responsibility to provide Indians with a specified level of services. The government therefore feels it is acceptable to maintain the status quo. Moreover, the fact that there have been significant improvements in Indian health care has added to the government's satisfaction with the status quo. Indeed, instead of allocating funds to meet its goal of bringing Indian health status up to the level of the rest of America, the government is sufficiently complacent to continue to maintain funding at the same levels.[302]

[300] Broken Promises, supra note 2 at 53 (citing interviews with various scholars of Indian health including the executive director of the NIHB and the director of the American Indian and Alaska Native Research Program at UCLA).

[301] Id.

[302] In a hearing on the president's FY 2006 budget request for the Indian Health Service, the Director of the Indian Health Service described the proposed budget as "a continued investment in the maintenance and support of the I/T/U Indian public

It certainly does not have the same impetus to act as it did when there were frequent newspaper and GAO reports about tuberculosis epidemics or extremely high levels of infant mortality on reservations.[303] Indeed, the government has seemingly succeeded in raising Indian health status to a level sufficient for the "Indian problem" to fade into the background.

The government is similarly unlikely to be embarrassed about the fact that urban Indians have limited access to health care. One reason why it is unlikely to be embarrassed by the difficult situation of urban Indians is that the government benefits from the belief shared by most Americans that the only Indians needing services are desperately poor Indians on reservations, rather than those who struggle to make a living in large cities. This tired picture of American Indian needs, combined with the lack of data on specific urban health needs, makes it unlikely that the government will face much criticism about their failure to provide more urban health services. As discussed earlier, the relative lack of political activism around the issue, and the relative weakness of Indian political power likely also play a role in the government's complacency.[304] It is perhaps also true that publicity around successful gaming enterprises has decreased the public's understanding of and sympathy for tribal needs, thus making it less likely that the government will hear from constituents who want to see more money allocated to Indian health care.[305] Contributing to the lack of public empathy

health system." See Statement of Charles Grim before the Committed on Indian Affairs of the US Senate, Hearing on the FY 2006 Budget Request for the Indian Health Service (February 16, 2005) at www.hhs.gov/asl/testify/t050216a.html. This statement is far from an endorsement of an aggressive effort to bring Indian health status up to the level of the rest of the population.

[303]But see Bernardine Healy, The Shame of a Nation, *137 US News and World Report 11*, 54 (October 4, 2004) Healy points out that the health status of the 2.5 million tribal members is worse than that of any other minority group in the US. Criticizing the limited budget of the IHS, Healy states that "money isn't everything, but without it you can't buy healthcare. And without it a dent will never be made in the health disparities of these people to whom the government has given its word." See also Sarah Kershaw, Crisis of Indian Children Intensifies as Families Fail, New York Times, (April 5, 2004) (citing experts' statements that money for health and mental health care on reservations falls far short of demand).

[304]Id.

[305]Indian advocates argue that the belief that gaming has significantly improved the overall status of Indians is misplaced. While Native American gaming encompasses 220 tribes and results in more than $16 billion a year in revenue, only half of all tribes have casinos. In addition, casinos in three states which have only 3 percent of the American Indian population account for more than 44 percent of all casino revenue. Advocates argue that these facts testify to the continued need for health care funding from the government. See Broken Promises, supra note 2, at 89.

for the health care problems of Indians is the fact that 44.7 million nonelderly Americans are currently uninsured.[306]

Another hypothesis about the government's reluctance to expand funding for health care is that it has had to spend much more money than it anticipated on resolving the Cobell litigation. *Cobell v. Norton* is the largest class action lawsuit ever filed against the United States.[307] Filed in 1996, the purpose of the suit was to get an accounting of funds held in trust by the United States government for individual Indians. The funds came from Indian-owned land that the government had leased to private companies for mining, grazing, oil and gas exploration. Reports of the Special Master in the case estimated that Indians were receiving $1/10^{th}$ the amount of money from companies leasing their lands that their non-Indian neighbors were receiving.[308] The trust assets from the land belong to 500,000 individual Indians and are estimated to be worth billions of dollars.

In assessing the liability of the United States for its poor management of the trust assets, a federal judge held that the government had taken part in fiscal and governmental irresponsibility in its purest form."[309] The most recent action taken in the case was a ruling in February 2005 requiring the United States to complete a full accounting of individual trust assets by 2008. Other recent action on the case includes a court-issued injunction on the government's sale of any lands at issue in the case without a fair assessment of the value of the lands and compliance with a thorough disclosure and consent process.[310]

[306]Kaiser Family Foundation, The Uninsured and their Access to Health Care, (November 2004) at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49531

[307]`http://www.indiantrust.com` (explaining the timeline of the lawsuit and posting all relevant court documents).

[308]Id.

[309]Id.

[310]Court in Landmark Indian Trust Suit, Cobell v. Norton, grants restraining order to prevent sale of trust land by Interior Department www.indiantrust.com/index.cfm?FuseAction=PressReleases.

The government has spent many millions of dollars and many years litigating the case. In the words of Judge Lamberth, "Elderly class members' hopes of receiving an accounting in their lifetimes are diminishing year by year by year as the government fights – and re-fights – every legal battle." [311] He adds, "the government has not only set the gold standard for mismanagement, it is on the verge of setting the gold standard for arrogance in litigation strategy and tactics.[312] Nevertheless, while acknowledging that the "Cobell litigation... has shown us the need to examine closely how we manage individual Indian trust land and individual Indian money accounts," the government has not taken full responsibility for the accounting problems.[313] Instead of using a separate set of funds to remedy its errors and complete the accounting, it has treated requests for the funding for the litigation and accounting as just another budgetary request for Indian programs. Accordingly, "reductions have been made in other areas, which has impacted every bureau and office within the Department, indeed perhaps every program."[314]

Self-Governance Compacts

Self-governance compacting arose out of tribal disillusionment with the experience they had contracting with the government under the Indian Self-Determination Act. Under Title I of that Act, tribes could contract with the government to take over the planning and administration of programs from the IHS.[315] Tribes received funding from the government for the programs they contracted to manage and operate.[316] In

[311] Cobell Litigation Team: US District Court Reissues Structural Injunction in Cobell v. Norton Indian Trust Case – Full Accounting to be Completed by January 26, 2008 at http://news.findlaw.com/prnewswire/20050224/24feb2005150233.html.
[312] Id.
[313] Statement of James Cason and Ross O. Swimmer before the Senate Committee on Indian Affairs on the Fiscal Year 2006 President's Budget Request for Indian Programs (February 16, 2005) at http://www.doi.gov/ocl/2005/fy2006budgetforindianprograms021605.htm
[314] Id.
[315] Broken Promises, supra note 2, at 54.
[316] Id.

1987, after complaints from tribal leaders about the way in which the contracts were being carried out and accusations of waste in the federal Indian bureaucracy, the government agreed to allow twenty tribes to test a "self-governance" program.[317] This self-governance program became Title III of the Self-Determination Act when Congress amended the act in 1988.[318]

The tribes rejected the government's original proposal for the self-governance program because it included a provision retracting the government's trust responsibility for any programs assumed by the tribes.[319] Had that version of the self-governance program passed, compacting tribes could no longer have relied on the government to provide financial support for their health care programs.[320] In response to the tribes' resistance to this original proposal, the 1988 amendments contained a clause reaffirming the government's trust responsibility.[321] The 1988 amendments also included an important provision allowing the tribes to recover both the indirect and direct costs of contracting.[322] Had this provision not been included, tribes could have gone through the process of negotiating and contracting only to find that there were no funds left over to provide the actual health services.

Unlike the original Self-Determination Act which required tribes to have the approval of the Secretary of the Interior before altering programs or shifting resources between programs, the 1988 amendments gave tribes almost complete independence in determining the content of their programs. Under the compacting provisions of the self-governance programs, tribes no longer just contract with the government to provide parts of programs or services. Rather, they enter legally binding and mutually enforceable written agreements

[317] Tribal Perspectives, supra note 289, at 2.
[318] "Indian Self-Determination and Education Assistance Act Amendments" Public Law 100-472
[319] Id. at 3
[320] Id.
[321] Id.
[322] Id.

that allow them to take over the entire operation of a health program.[323] Because compacting requires significantly greater expertise, tribes must demonstrate their competence in contracting for three years before the government will allow them to enter into compacts.[324]

Support for the self-governance project continued to be strong throughout the 1990s with Congress providing funds in 1991 for the creation of an office in the Department of the Interior that would deal only with self-governance issues.[325] In 1992, Congress amended the Act again to increase funding for self-governance programs to cover planning, negotiations, implementation, and shortfall expenses. That same year, the governance project was extended to cover an additional ten tribes.[326]

Self-governance got an additional boost from the election of President Clinton in 1992. Whereas Presidents Reagan and Bush were respectively hostile and indifferent to Indian affairs[327], President Clinton embraced the idea of tribal sovereignty and the self-governance compacts. In 1994, he issued a memorandum to the heads of all executive departments and agencies reaffirming the government-to-government relationship with the tribes.[328] This memorandum also required executive departments and agencies to work more closely with tribes and to consult with tribes prior to taking an action that might adversely affect their land or well-being.[329]

[323]Broken Promises, supra note 2, at 54.
[324]Tribal Perspectives, supra note 289, at 3
[325]Id. at 4.
[326]Id.
[327]President Reagan cut funds for Indian welfare from $3.5 billion to $2.5 billion in the first two years of his administration. Marks, supra note 13, at 352.
[328]Memorandum for the Heads of Executive Departments and Agencies, Government-to-Government Relations with Native American Tribal Governments, April 29, 1994 at http://web.em.doe.gov/public/tribal/whletter.html
[329]Id.

In 1994, Clinton also signed the Indian Self-Determination Contract Reform Act which further amended the Self-Determination Act.[330] Seeking to remedy the problems the Department of Health and Human Services faced in writing regulations to implement the 1988 amendments expanding tribal control over health programs, the Contract Reform Act imposed a negotiated rulemaking process on the DHHS.[331] The negotiated rulemaking represented the first time in the history that the tribes would play a role in crafting regulations that affected the way in which they received services. 48 tribal representatives were present for the negotiated rulemaking.[332] The results of the rulemaking were regulations determining how the government was to award contracts and grants under the Self-Determination Act.[333] In 1996, Congress again amended the Self-Determination Act, this time to allow tribes to convert any contracting agreement to a compacting agreement.[334] In creating these new amendments, Congress emphasized its support for self-governance as the ultimate goals of the tribes. The final amendment to the Act in 2000 made self-governance programs permanent at IHS.[335]

The growth in the number of tribes entering into self-governance compacts since 1996 has been phenomenal. From the original 20 tribes, 61 tribes now have self-governance compacts with IHS. These compacts, in addition to the 81 funding agreements entered into between the tribes and the IHS, cover 285 tribes and provide health services to more than 51 percent of tribes.[336] The compacts offer an unprecedented degree of control over programs and services; rather than being supervised and assisted by the IHS like contracting tribes, the only IHS oversight of compacting tribes is an annul audit.[337] One result of limited IHS oversight

[330] "Indian Self-Determination Act Amendments of 1994" , Public Law 103-413 (1994)
[331] Tribal Perspectives, supra note 289, at 4.
[332] Id.
[333] Id.
[334] Id. at 5
[335] Broken Promises, supra note 2 at 55
[336] Tribes who did not choose to compact continue to receive direct services from the Indian Health Service.
[337] Broken Promises, supra note 2, at 55-56.

has been that tribal members have had to figure out how to run programs by themselves; this has consequently increased employment opportunities and opportunities for participation in tribal government.

Tribal governments report that compacting has been a success. Tribes have been able to determine their individual needs and apply their funds accordingly, a change from the days when the IHS would apply the same policies to all tribes regardless of the differences between them. The ability to tailor funds to specific health needs has resulted in a more efficient health delivery system for the compacting tribes. An example of this efficiency is the experience of the Yerington Paiete Tribe. The Tribe transformed an IHS program that provided care only three days a week without a physician to a tribally run program that provided services six days a week with a nurse and physician.[338]

Studies also cite improvements in quality of care as one result of the self-governance compacts. 57 percent of tribal leaders and 84 percent of tribal health directors participating in a survey on the changes created by self-governance compacts reported improvement in the quality of care their tribe members were receiving.[339] Waiting times, types of services, number of people served, and overall health care system all play a role in determining quality of care.

Tribes have also proven to be more efficient than the IHS in terms of billing third party sources such as Medicaid and Medicare.[340] Most significantly, 100 percent of tribally-operated hospitals were accredited by the Joint Commission on the Accreditation of Healthcare Organizations, signaling the tribes overall

[338]Id at 60.
[339]Tribal Perspective, supra note 289, at 108.
[340]Id. at 93.

competency in running their own programs.[341]

Surveys have also identified drawbacks to self-governance compacts. One drawback is the loss of economies of scale. Because tribes are delivering services to a relatively small number of people, they are unable to capitalize on same economies of scale the IHS was able to take advantage of, particularly with respect to the pooling resources on a regional or national scale.[342] Removing the IHS from the picture has also negatively affected efficient data collection; since they began running their own programs, tribes have been less likely to collect and report data on their members' health needs.

Another drawback, perhaps not anticipated in the same way as the other drawbacks, is the division between tribes that has resulted from some tribes choosing to compact and some choosing to remain with the IHS. The division has arisen because there is not adequate funding to support compacting, in addition to contracting and full service delivery.[343] Tribes who are not involved in compacting have labeled those who have chosen to compact as engaging in a "money grabbing scheme."[344] Leaders of these tribes also tend to view compacting as a means for the government to avoid its trust responsibilities.[345] Reinforcing this perception is the fact that compacting tribes have been forced to use tribal resources to compensate for the government's failure to cover all compacting costs.[346]

A Fight Over Contract Support Costs

[341]Id. at 36.
[342]Trombino, supra note 178, at 144-145.
[343]Id. at 145. The greater the number of tribes who choose to compact with the government, the less money the government puts into the IHS administrative structure. This means that fewer direct services are available for those tribes who remain connected to the IHS. In turn, the downsizing of the IHS places pressure on tribes to adopt self-governance compacts.
[344]Tribal Perspectives, supra note 289, at 31
[345]Trombino, supra note 178, at 145-146.
[346]Id. at 146.

The government's failure to cover contract support costs[347] has been a recent focus of litigation. Despite the fact that the 1988 Amendments established a special "ISD" fund to help tribes with the costs of contracting for new or expanded contracts[348], the fund, providing resources on a "first come first served" basis, has been continually under-funded. In 1997, for example, the government allocated only $7.5 million to the ISD fund despite the tribes' request for $36 million. This resulted in a funding shortfall of more than $28 million. The shortfall meant that tribes who were at the bottom of the list either received no funding for support costs or received funding, but only after they had already made cuts to their programs.[349] In March 2004, the Supreme Court decided to consolidate two cases on the matter of deficient contract support funding. In the first case, *Cherokee Nation of Oklahoma v. Thompson*, two tribes filed suit against the United States, the Director of the IHS, and the Secretary of Health and Human Services claiming that the government's failure to fund existing and initial contract support costs had forced the tribe to makes cuts in their health programs.[350] In response, the government asserted that the Self-Determination Act, which states that the "provision of funds... is subject to the availability of appropriations," specifically left the funding decisions to Congress and did not require that all funding needs be met. In further support of its position, the government cited the terms of the model agreement that all contracts between the government and tribes must incorporate. The model agreement specifically provides that funding amounts are "subject only to the appropriation of funds by the Congress of the United States."[351]

[347]The term "contract support costs" is not defined in the Self-Determination Act. In *Ramah Navajo Chapter v. Lujan*, however, the court interpreted the term to mean indirect costs "incurred for a common or joint purpose benefiting more than one contract objective." This definition is contrasted with direct program costs which are tied to a specific program objectives. See Ramah Navajo Chapter, 112 F.3d 1455, 1461 (10^{th} Cir. 1997)

[348]The IHS allocated contract support costs to existing contracts in accordance with recommendations in appropriation committee reports; the allocation was not made out of the special fund.

[349]See Cherokee Nation of Oklahoma v. Thompson, 311 F.3d 1054, 1059 (10^{th} Cir. 2002).

[350]Id.

[351]311 F.3d at 1057

The 10^{th} Circuit agreed with the government, finding that the statutory language was clear, and that unless the IHS wanted to take funds away from other tribal programs, it had no appropriations left over with which to pay ongoing contract support costs.[352] The 10^{th} Circuit further held that the language of the 1996 and 1997 Appropriations Acts which stated that "$7,500,000 shall remain available until expended. . . for the transitional costs of initial or expanded tribal contracts" was also clear; Congress had intended to limit the amount available for new contracts to $7.5 million. See also *Shosone-Bannock Tribes v. Secretary, Department of Health and Human Services*, 279 F.3d 660 (9^{th} Cir. 2002) (holding that tribe had no entitlement to funding for contract support costs beyond the $7.5 million appropriation and that tribe could not claim any contractual right to funding for contract support costs).

Unlike the Ninth and Tenth Circuits which agreed that the $7.5 million appropriated to the ISD was a statutory cap, the Federal Circuit found that the $7.5 million was a carryover provision.[353] As a carryover provision, the $7.5 million could be used in the following fiscal year for contract support costs. The Federal Circuit reasoned that had Congress wanted a statutory cap they would have written the appropriations act to state that the funding was "not to exceed" $7.5 million.[354] In formulating its decision, the Federal Circuit looked to the intent of the Self-Determination Act. Finding that the statute intended tribes to become independent, and that tribes could logically only achieve independence if provided with sufficient funding, the Court determined that Congress could not have intended that the appropriations act would limit funding to a circumscribed amount.[355] Writing for the majority, Judge Timothy B. Dyk explained: "We cannot agree

[352] 311 F.3d at 1065

[353] Thompson v. Cherokee Nation, 334 F3d 1075, 1090 (Fed Cir 2003)

[354] 334 F3d 1075, 1094-95 (Fed Cir 2003)

[355] Various scholars disagree with this assessment of congressional intent. They believe that Congress intended the Self-Determination Act to end the trusteeship between the government and American Indian tribes and that it therefore makes perfect sense that Congress would seek to slowly cut Indian tribes off from government assistance by limiting appropriations. See Elizabeth Glazer, Appropriating Availability: Reconciling Purpose and Text under the Indian Self-Determination and Education Assistance Act, *71 U. Chi. L. Rev. 1637*, 1655 (2004).

that the Secretary had discretion to refuse to reprogram to meet his contractual obligations."[356]

Fearing a negative decision from the Supreme Court, the National Congress of American Indians has begun urging Congress to amend the Self-Determination Act to guarantee full funding for contract support costs.[357] In the meantime, tribes have to use funds from other programs to cover health care costs. In 2004 alone, the shortfall for the contract support costs of tribes managing federal programs was $142 million.[358]

If Congress does not amend the act, and the Supreme Court adopts the Ninth and Tenth Circuits' reasoning that funding for contract support costs is limited to annual appropriations, tribes will have to figure out how to deal with consistent shortfalls in their program management. Given the "first come first served" nature of the funding, tribes will certainly have to compete to be the first to submit budget requests. The implication of such competition is that those tribes who receive the funding will likely experience more success in becoming sovereigns than those tribes who have to move funds from other programs to meet health needs. As the Federal Circuit noted, this would seemingly defeat the purpose of the Self-Determination Act, an Act that envisioned all tribes running their own affairs independently of the US government.[359] On the other hand, if Congress amends the act to state that the IHS can divert funding for self-determination contracts from other areas of the budget to cover shortfalls, it will likely jeopardize the situation of tribes who have chosen to continue to receive services directly from the IHS.

Clearly the solution lies somewhere in between; funding cannot be diverted from one group of needy tribes to another, nor can funding be denied to one group of tribes and at the same time guaranteed to another.

[356]Supreme Court to resolve self-determination dispute (March 23, 2004) at http//www.indianz.com/News/archive/00820.asp
[357]Id.
[358]Id.
[359]334 F3d at 1088

One possible resolution is the increase of funding for both IHS direct services and contract support costs. However, because Congress has continually sought to limit increases in IHS funding, this is an unlikely resolution; incredibly, this is true despite the fact that the federal government has continually exhorted tribes to adopt self-governance compacting. A more likely resolution, then, is an increase in appropriations for contract support costs to a level somewhere in between the amount tribes have requested and the amount Congress has been willing to appropriate. Such a solution will obviously be unsatisfactory to the tribes who have shown that when given sufficient funds, they are more efficient and better at meeting tribal health needs than the IHS.[360]

More important than the dissatisfaction of tribes is the fact that any solution that seeks to "split the baby" will likely fail to address the underlying issues involved in the expansion of tribal sovereignty in the area of health services. Again, the key underlying issue is cost; the government does not want to write tribes a blank check for contract support costs. Part of the government's problem with writing a blank check is that once it establishes its responsibility for providing full support costs to tribes, there is no limit on what they will have to pay, regardless of whether they have other funding priorities. Indeed, even though the government can retract any legislation it might pass, or appropriations it might make, that guarantee its full support for contract costs, its fear that the creation of such a temporary entitlement will likely result in greater litigation and/or greater tribal activism prevents it from making those kind of guarantees. As a result, the government continues to support status quo funding; this not only limits the ability of tribes to take over their own health care programs, but also detracts from the quality and amount of health care provided to those tribes receiving direct care from IHS.

[360] Tribal Perspectives, supra note 289 at 32.

The government's fear and consequent under-funding of its trust responsibilities is nothing new. It in fact has made consistent efforts to confront this fear by trying to limit its trust responsibilities and increase Indian self-sufficiency, first by termination of tribes in the 1950s and arguably again through self-determination in the 1970s. Supporting status quo funding, however, is not a particularly rational response to the government's concerns about runaway trust responsibilities. A lack of substantial funding will only stymie Indian efforts to take over health care, and result not in greater self-sufficiency, as the government would desire, but in a return of tribes to IHS direct services. A failure to fund direct services fully will result in a similar phenomenon; the government will face declines in health status and concomitant increased trust responsibilities.

The failure to fund services fully is only irrational if the government believes that increased funding might eventually extinguish its trust responsibility to provide health care. If the government believes, however, that no matter how much funding it injects into health care, tribes will still request more, then it makes sense to keep the budget at a level just high enough that it does not have to deal with activism and just low enough that it can extend the same funding year after year. The government has followed a similar path in its attempts to address the problems of inner-cities; it consistently funds community economic development at a low enough level to prevent riots or serious crime waves, but does not fund it at a high enough level to make significant improvements in the situation of the residents or the cities themselves.

The difference between city communities and tribes, however, demands that the government use a different approach in dealing with tribes. Tribes are self-governing nations. They have governments whose role it is to improve the health and welfare of its members. They also have a federal right to occupy a land base over which states lack proprietary jurisdiction, in addition to (in some cases) criminal and civil jurisdiction. And while there are divisions within tribes over the direction the tribe should take, and people leave the reservations for urban areas, they are not transient or politically impoverished communities. Instead, they

are communities whose roots go back hundreds of years, and whose members view their reservations as "home" regardless of whether they live there.[361]

It is not only the history and continuity of the tribes that militate in favor of their ability to exercise sovereignty in a way that could eventually lead to self-sufficiency and a lessening of the trust responsibility. It is also the fact that many have already shown their ability to exercise sovereignty successfully by managing their resources, lands, and programs in a manner that has increased economic development and tribal revenues.[362] Contrasting this success to the decades of failure experienced by the federal government in its effort to catalyze tribal economic and social development, Kalt and Cornell note: "In our work, we cannot find a single case of successful economic development and declining dependence where federal decision makers have exercised de facto control over the key development decisions."[363]

An example of the success of tribes in exercising sovereignty through compacting is the following account of the achievements of the Couer d'Alene Tribe in Northern Idaho:

Before 1990, Members of the Couer d'Alene Tribe had two options for medical care: drive 20 miles east down a winding road to St. Maries, or drive 34 north of U.S. Highway 95 to Coeur d'Alene. Limited on-site facilities could not do lab work, and specialists did not visit the reservation. In addition, tribal members had to go through the Indian Health Service's office in Lapwai to get approval for medical treatment. This meant long distance calls and sometimes as long as two years before paperwork was processed. As a result, individuals ran up large unpaid medical bills which were often sent to collection agencies. "We decided it was

[361] An American Indian historian who spoke at the discussion about Charles Wilkinson's book talked about how even those American Indians who never lived on their reservations are so connected to the land where their people came from that they always know where their "home" is. Supra note 286.

[362] Stephen Cornell & Joseph Kalt, Sovereignty and Nation-Building: The Development Challenge in Indian Country Today, *22 American Indian Culture and Research Journal 3* (1998), 209. See also Wilkinson, supra note 163. Due to land acquisition programs, tribes have been able to increase their landholdings by 15% since 1960.

[363] Id.

time to address the health needs of the reservation ourselves," says Tribal Chairman Ernie Stensgar. This sentiment led Stensgar and other Tribal Leaders to build Benewah Medical Center – touted as one of the most successful rural health clinics in the country. Completed in June 1990, the clinic serves the Coeur d'Alene Tribe's 1,300 members, 700 of whom live on the reservation. The clinic is also open to the general public. Non-Indians had the same health care programs as us, so we worked together, says Stensgar. "Community involvement was critical." Funding to build the clinic came from a variety of sources including the BIA, the Department of Housing and urban Development and a grant obtained by the city of Plummer. Construction was made possible by bringing together these disparate funding sources. Multiple sources also account for the clinic's operating funds. HIS funding comprises 85% of the clinic's budget, with other monies coming from insurance payments, reimbursements from Medicaid and Medicare and private dollar. . . ."We are going the Self-Governance route because we were doing it anyway. We have a state of the art facility. We don't want to jump through all the bureaucratic hoops." The Tribes is also in the process of compacting its social services, roads and police.[364]

The best approach, then, is one that requires the government to fund compacting, contracting, and direct services at a high enough level to ensure that tribes continue to extend their exercise of sovereignty and to develop into nations. Instead of seeing the federal trust responsibility as a guarantee, tribes should view the funding as an opportunity for self-sufficiency. The government, however, must recognize that it cannot force self-sufficiency, as it attempted to do with its termination policy. If the government funds exercises of sovereignty but the funding does not lead to self-sufficiency, the government should continue to have a trust responsibility toward the Indian tribes. If, however, the tribes become self-sufficient to the extent that they can support their own health programs, the government should no longer have to support health care costs,

[364]See Tribal Success Stories at http://www.tribalselfgov.org/Red%20Book/For%20the%20SG%20Coordinator/tribal_success_stories.htm

even if tribes later fall on hard times and are not able to support these costs.

The dismantling of the trust relationship described above would reverse hundreds of years of federal Indian policy. However, as long as there are sufficient safeguards to ensure that the government does not terminate the trust relationship before the tribes are capable of improving the health status of their members on their own, dismantling might be the best way to get the government to increase funding for health care compacting.

Sovereignty and Decentralization: Compatible Strategies or an End to the Trust Relationship?

At the heart of the debate about funding contract support costs is the question of who defines sovereignty. Returning to Deloria Jr.'s distinction between nationhood and self-governance, it is unclear whether compacting with the government to manage and provide services is part of the process of nation building or whether it is a government-endorsed expression of tribal self-governance.

Immediately complicating the inquiry is the fact that the federal government retains plenary power to limit the scope of sovereignty whenever it determines that the policy does not serve its purposes.[365] In fact, Congress has the power, if allowed to do by the courts, not only to withdraw funding for services but also to extinguish the legal existence of any federally recognized tribe and its reservation at any time.[366] This is true despite the fact that the federal government has maintained a trust duty toward the tribes since the late 1800s. The government has also consistently funded services for tribes as well as recognized some degree

[365] Wilkins, supra note 43, at 23.
[366] Utter, supra note 4, at 60.

of tribal sovereignty since that time.

The reality is, however, that the government's strongest recognitions of sovereignty have taken the form of executive memorandums or proclamations, rather than the establishment of entitlement programs or other legislation guaranteeing the government's support of the tribes. And while the courts have at times come out strongly for tribal sovereignty and the rights of tribes to determine their own futures, they have not always ensured that the tribes receive the tools to do so. The situation of tribes is therefore such that they "must rely not only on the rule of law, but also on the good faith of the federal and state government to protect their remaining sovereignty rights."[367] Considering the extent of control the federal government exercises over the rights of tribes to exist, it is therefore difficult to conceive of tribal sovereignty as something constructed and advanced wholly, or even mostly, by the tribes. Making this conception of sovereignty even more complicated is the fact that the government has also treated federal Indian policy as an outlet for the expression of its national political and social goals.

Tied into the question of who defines sovereignty, then, are the government's larger political goals, and the way in which the government attempts to achieve those goals through federal Indian policy. Since the policy of self-determination for Indian tribes was first described during the Nixon era, there has been a continual move in the direction of decentralization of government services, not only in the sphere of Indian affairs but in all government affairs. Both Republicans and Democrats have pursued this policy direction; indeed, it was President Clinton who proclaimed in 1992 that the "era of big government is over."[368]

In proclaiming that there would be some changes made to the New Deal structure of top-down social and economic regulation, President Clinton sought to combat a widespread perception of the government as

[367] Wilkins, supra note 43, at 23

[368] Lobel, supra note 103, at 354.

bloated, inefficient, and controlling. In his proposals for an "ownership society" and private social security accounts, President Bush articulates a similar, albeit more activist rhetoric. Some of President Bush's most recent federal court nominees, for example, are so committed to overhauling New Deal structures that they have called for the dismantling of federal environmental and wage regulation.[369]

Efforts to replace those parts of the New Deal structure deemed inefficient or overly centralized have centered on the contracting out of government services to private parties. Another key component has been the decentralization of federal responsibilities to state and local governments. Both of these approaches, described by various scholars as "governance," seek to utilize "a mix of market incentives, soft law norms, and flexible institutional arrangements to produce more effective governance systems."[370] Examples of this phenomenon include welfare reform, the development of school vouchers, and the emphasis on cooperative or self-regulation rather than command and control regulation.[371] The goal of this phenomenon is to make the federal government leaner and more flexible, and to increase the role of states in administering social programs.[372] The Supreme Court has bolstered these changes by issuing various decisions narrowing the definition of the interstate commerce. These decisions have consequently made it more difficult for the federal government to impose its policies on states without the state's agreement.[373]

The views of academics on these developments are mixed. Some scholars have predicted that decentralization will negatively affect democracy. They believe that decentralization will result in a race between states to peel back social and minority interest protections in an effort to attract business. In response to the argument

[369] Jeffrey Rosen, The Unregulated Offensive, New York Times Magazine (April 17, 2005)
[370] See Cunningham, supra note 179, at 135.
[371] Jody Freeman, Private Parties, Public Functions and the New Administrative Law, Working Paper Series, 19 at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=165988
[372] Lobel, supra note 103 at 83.
[373] Brinkley et al., New Federalist Papers: Essays in Defense of the Constitution (W.W. Norton 1997) 20.

that decentralization will facilitate people's access to representatives and their political expression, they claim that decentralization will merely increase the numbers of bureaucracies and officials that people have to deal with.[374] Others, however, have lauded the shift to a governance model, believing it to be the only way to prevent people's alienation from a government that "spends too much of their money and rides roughshod over their most cherished cultural, social, and religious values."[375]

The expansion of tribal sovereignty, particularly in the area of health care, mirrors the shift from a New Deal to a governance model. Tracing the changes in the provision of health care from a dictatorial BIA health service to a less dictatorial but still controlling IHS, and then to self-governance compacting, one can see the move from command and control regulation to contracting out and decentralization of Indian health services. The fact that the government initiated this move (although tribal activism and organization certainly played a large role) might lead one to believe that rather than a step toward nationhood as described by Deloria, Jr., the move toward sovereignty is government influenced and designed. Indeed, tribes have always wanted to control their own affairs, but only got the opportunity to do so after Nixon's statement on self-determination.

In response to the assertion that the move toward sovereignty was government directed, one might wonder why it matters who initiated the move toward sovereignty if it works for both parties. The reason why it matters is that if the government initiated the expansion of sovereignty to achieve its own goals, the government will, when forced with the choice, subvert the goals of the tribes to its own goals. Such subversion would contradict the very nature of nationhood inasmuch as the tribes would still be at the mercy of government influence.

[374]Id. at 19.
[375]Stephen Calabresi, "The Era of Big Government is Over" Book Review: New Federalist Papers: Essays in Defense of the Constitution, *50 Stan. L. Rev. 1015*, 1025 (1998).

The history of the government's Indian policy exemplifies this kind of subversion to government goals. For example, the government initiated policies such as termination, relocation, and Christianization claiming that they would help tribes function better in society and convincing many tribes of the same. In reality, however, the government promoted these policies, not for the welfare of Indians, but in the hope that the tribes would become integrated and drop their demands for fulfillment of trust obligations. More often than not, however, these policies had the opposite effect, diluting tribal identity, increasing poverty, and doing nothing to limit the government's trust obligations.

One nevertheless might argue that the government's sovereignty policy represents its recognition that it failed in its role as overseer of Indian affairs and its endorsement of a sea change in federal Indian policy. One might argue in addition that the government and tribes do not always have to have opposing positions, that while they may not have seen eye to eye on termination and Christianization, they both conceive of sovereignty as offering benefits of self-government and better delivery of services. This argument assumes that the government is comfortable with not only bankrolling Indian sovereignty initiatives but also allowing Indians to operate their own programs without government interference.

I would argue, however, that the government's sovereignty policy, while focused to a certain extent on meeting the goals of tribes, is also a consequence of the government's decentralization agenda, an agenda that does not necessarily contemplate the development of tribal nationhood. Assuming that the government is supporting sovereignty for the same reasons it is supporting the devolution of power to state governments or the privatization of government services, the government believes that the tribes can run their own programs more efficiently because they will have a greater understanding of member needs and can better assess success. This would seem to be the rationale if the government is associating decentralization of services to tribes with decentralization of services to states. Indeed, considering the fact that the government is paying

the costs of both the contracting for and the tribal programs themselves, moving the provision of services to states would seem to be a more apt analogy than privatization to what the government conceives of as the goals for the expansion of tribal sovereignty.

Nevertheless, privatization or contracting out plays some role here inasmuch as the government's failure to cover all costs potentially signals its desire to shift those costs to the tribal providers. Tribal providers who receive funds from the government will often employ private actors to fill their provider and health care needs. Thus, the government has successfully taken itself out of the direct service role and moved its responsibility to privately managed health care organizations or to private physicians and nurses. While this process is not that different from what the government already accomplishes with Medicare or Medicaid providers, the fact that Indian health care is not an entitlement program gives the government a lot more leverage to deny or to control funding. Equating the delivery of Indian health services with Medicare and Medicaid belies the special responsibility the government has for such care and the status of a tribe as a nation, and not just a service provider.

There are various other reasons why equating the tribes with state or private actors is problematic and why significant differences exist between expanding sovereignty for tribes and attempting to decentralize through shifting services to states or to private parties. Unlike states which maintain reserved rights vis-a-vis the 10^{th} Amendment, tribes are dependent upon the courts to validate their sovereignty. While treaty rights do exist, they have largely been subsumed under the trust doctrine or apply to specific areas such as fishing or resource rights. The lack of a constitutional right to tribal existence or to self-governance means that tribes have no defense, as states do, to the federal government's efforts to take away or to add responsibilities.[376]

[376]William Bradford, "Another such Victory and We are Undone": A Call to and American Indian Declaration of Independence, *40 Tulsa L. Rev. 71*, 92 (2004)

For example, whereas courts have the ability to determine the extent of tribal jurisdiction over members and over reservations – and to change that interpretation at will – states can build policies based on the knowledge that they will always have the right to assert police power within their state.[377] In addition, states have wide tax bases from which to support expanded services and develop resources while many tribes have a limited ability to expand revenue through taxation. This means that if tribes receive an "unfunded mandate" to deliver health services to tribes, they do not have the same ability that states have to override their budgets or to get the federal government to deliver more resources.

Treating tribes as the equivalent of private contractors or state governments could ultimately jeopardize the successful expansion of sovereignty by causing an abrogation of the trust responsibility or by fomenting clashes between states and tribes. The abrogation of the trust responsibility might occur as the federal government continues to fail to fund contract and/or program costs in an effort to push tribes to make up for the lack of funds in other ways. And clashes between tribes and states could occur as tribes respond to the government's self-sufficiency message and seek alternative sources of funds such as gaming, which states perceive as drawing away revenues that they might otherwise access.[378]

More significant, however, is something that cuts to the heart of Deloria Jr.'s differentiation between self-government and nationhood; namely that tribes consider themselves separate, independent nations, and not arms of the federal or state governments. Courts have consistently acknowledged the special status of

[377]Singer, supra note 40, at 30.

[378]There is evidence that greater tribal sovereignty has resulted in both greater cooperation and greater conflict with states. Because tribes often provide health services or other services to non-Indians, states perceive compacting as a benefit to them. See Singer, supra note 40 at 28. In the case of tribes who use compacting to assert greater jurisdiction over resources shared with the state, such as access to water or fishing, however, states are less likely to be cooperative. Still, there are examples of state-tribal agreements in these areas. Id. While states have traditionally been angered by the fact that tribes do not pay taxes to the state, many states and tribes have agreements setting out taxation policies. In addition, tribes involved in gaming are required to compact with states and agree on some sort of revenue transfer before they can open up casinos in a state. See Mason, supra note 48, at 64-65.

tribes as sovereign nations. In *Native American Church v. Navajo Tribal Nation*, for example, the court not only asserted the tribe's special status as a sovereign nation but compared this status to that of the states, holding that tribal nations do not share the status of states and in fact "have a status higher than that of states."[379] In finding that tribes are nations possessed of all powers minus those that they have been required to surrender by the US government, the court held that the US Constitution was not binding on the actions of tribal nations.[380] If tribes have a status higher than that of states, the federal government should not view them as vehicles of decentralization. Instead, tribes should own the sovereignty process by using it to make mistakes, and in doing so define and develop their own governing processes; in other words to figure out what nationhood, not just government-influenced sovereignty means to them.

How to develop what Deloria Jr. calls "nationhood" in the context of the paradox of simultaneously demanding greater sovereignty all the while depending on government funds and judicial good-will is the current challenge facing tribes. It is a challenge recently made more difficult by court decisions that have called into questions exercises of sovereignty that already been fought for and won by the tribes.[381] It is also made more difficult by the "legacy of institutional dependency" that results in tribes relying on "someone else's institutions, someone else's rules, someone else's models, to get things done."[382] Nevertheless, it is imperative that tribal governments use compacting to become more than "grants-and-programs funnels attached to the federal apparatus."[383] In using compacting to improve health services and increase the participation of tribal members in their own service delivery, they will not only go further in building their nations, they will ensure that sovereignty is not a policy subject to change in accord with the vagaries of political support for federalism.

[379]See Native American Church v. Navajo Tribal Nation, 272 F.2d 131, 134-5 (10^{th} Cir.1959).
[380]Id. In 1968, Congress passed an Indian Civil Rights Act which applied constitutional requirements to tribal governments.
[381]Cornell & Kalt, supra note 362, at 188. See also Singer, supra note 40, at 3.
[382]Id. at 195.
[383]Cornell & Kalt, supra note 362 at 196.

Conclusion

While federal Indian policy tracks the changes from New Deal to governance, one could argue that Indian tribes should never have been on the federal policy track at all. Since the government holds both the purse strings and the key to tribal recognition, however, tribes have not had much choice in the matter. Tribes should therefore focus on using de facto exercises of sovereignty, first to reduce their dependence on the government, and then to challenge the basis of federal plenary power. When Marshall's description of tribes as "domestic dependant nations," no longer applies, and the government recognizes the vitality and ability of tribal governments in serving the needs of their population, it will be forced to acknowledge Indian nationhood in a more powerful way.

At a minimum, a more powerful Congressional recognition of Indian sovereignty would lead to less unwanted federal and state interference in Indian affairs. Imagining a more radical change, however, it could perhaps lead to some congressional recognition of the need for a "cooperative plenary power" in which the federal government, as the supreme power and the original conqueror, will retain its ability to legislate some aspects of Indian affairs but would be required to negotiate with tribes over others. The aspects of Indian affairs it would be required to negotiate with tribes over would be those aspects in which Indian independence has decreased its trust responsibilities to the point that it has lost the justification for the exercise of plenary power.

Cooperative plenary power would ensure that the tribes and the federal government continue to have a relationship, but that their relationship is more flexible and fluid. By making the federal Indian relationship more flexible and more responsive to federal-state-tribal collaboration, the tribes and the federal government

would be utilizing some of the most successful aspects of governance in a way that guarantees respect for the interests of all three powers. Indeed, governance and decentralization can work successfully with the development of nationhood so long as every party can both protect and promote its interests.

For "cooperative plenary power" to work, then, the government must not view decentralization and governance as a way to get rid of its responsibilities; it must acknowledge that while it is the "superior power," tribes have a status higher than that of states. Tribes can help themselves to gain the bargaining power necessary to support their status by showing that they are indispensable in terms of the efficiency and quality of the services they provide to both Indians and state citizens. They have been successful in demonstrating their indispensability in the political and economic arenas, particularly in states where they have successful gaming or other development projects; there is no reason why they cannot demonstrate the same indispensability in the health care arena.

Therefore, a critical step toward the development of "cooperative plenary power" is the continued exercise of Indian sovereignty in the area of health care compacting. As discussed throughout this paper, full federal funding is required to make the successful exercise of sovereignty in the area of health care a reality. Without such funding, the government will continue to have trust responsibilities and sovereignty will continue to be a government-influenced process. With full funding, however, both the equalization of health status and the *de recto* exercise of sovereignty can become a reality.