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Health Care: An Overview of the Indian Health Service

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HEALTH CARE: AN OVERVIEW OF THE INDIAN HEALTH SERVICE

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At first glance, the Indian Health Service (IHS) seems to be an ideal entitlement program promoting the health of all American Indians. Under an obligation it has assumed for more than a century,[1] the federal government appropriates funding to the IHS for its hospitals and clinics to provide free medical and mental health care[2] to nearly a million eligible Indians.[3] These Indians also are eligible for all other federally aided health programs available to United States citizens.[4] As a result of the combined

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1. SUBCOM. ON HEALTH AND THE ENVIRONMENT, HOUSE COMM. ON ENERGY & COMMERCE, 94TH CONG., 2D SESS., INDIAN HEALTH CARE: AN OVERVIEW OF THE FEDERAL GOVERNMENTS'S ROLE 1-2 (Comm. Print 1984) [hereinafter HOUSE STAFF REPORT]. *Cf.* Rincon Band of Mission Indians v. Califano, 464 F. Supp. 934, 937 (N.D. Cal. 1979). *See generally* Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1, 17-18 (1883). *See also infra* text accompanying notes.

2. Rincon Band of Mission Indians v. Harris, 618 F.2d 569, 573 (9th Cir. 1980). *See, e.g.*, Snyder Act, 25 U.S.C. § 13 (1921) [hereinafter Snyder Act]. The language of this main authorization Act for Indian health care is very similar to that of an entitlement program such as Medicare/Medicaid because it sets no limitations on the length of the authorization or on the amount to be appropriated. The Act also makes no implicit or explicit reference to income criteria for IHS services. *See also* Rincon Band of Mission Indians v. Califano, 464 F. Supp. 934, 939 n.6 (N.D. Cal. 1979) (IHS health care benefits for Indians are "sufficiently similar to welfare benefits to qualify as an 'entitlement' to constitutionally protected 'property interest' as required under Board of Regents v. Roth") (citations omitted). *But see* Gila River Pima-Maricopa Indian Community v. United States, 427 F.2d 1194, 1198 (9th Cir.), *cert denied*, 400 U.S. 819 (1970) (The federal government is generally not obligated to provide particular services or benefits in the absence of a definite provision in a treaty, order, or statute).

3. *See* SENATE SELECT COMM. ON INDIAN AFFAIRS, 98TH CONG., 2D SESS., REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT 183 (Comm. Print 1984), quoting IHS Budget Justification for Fiscal Year (FY) 1985. The IHS is "the primary Federal health resource for 931,000 American Indians and Alaskan Natives" [hereinafter REAUTHORIZATION COMM. pt. 1]. *See also* HOUSE STAFF REPORT, *supra* note 1, at 2. In 1984 the Indian Health Service had the responsibility to provide health care to approximately 909,000 Indians of the 1.4 million total Indian and Alaskan Native population. *See* Public Health Service, U.S. DEP'T OF HEALTH & HUMAN SERV., INDIAN HEALTH SERVICE CHART SERIES BOOK (Apr. 1985), at 3, 11 [hereinafter IHS CHART BOOK] (IHS service population in FY 1984 cited as 937,000 and in FY 1985 as 961,582 American Indians and Alaska Natives).

4. *See* MEMORANDUM OF AGREEMENT: PROVISION OF MEDICAL SERVICES TO INDIANS AND OTHER NATIVE AMERICANS, by Emery A. Johnson, M.D., Ass't Surgeon General

benefits of these various programs, the health status of these eligible beneficiaries has improved dramatically over the last twenty-tive years, a fact proudly pointed out by IHS statisticians.[5]

There are two sides to every coin, however, and a closer look at the IHS will reveal that neither the recipients[6] nor the ultimate sponsors (Congress)[7] are satisfied with the program. In fact, the health status of American Indians remains very poor[8] despite dramatic increases in funding of the IHS over the last decade.[9] Death rates from many diseases are still much higher than those for the average nonminority American,[10] although the differences are less today than twenty years ago.[11] In addition, morbidity rates for Indians remain much higher than nonminorities, especially with respect to curable and preventable diseases.[12] This article will attempt to explain the reasons for these disparities, as well as provide a basic overview of the IHS—its services and eligibility requirements and its duty to provide care to Indians—and an outline of the future and the problems that may confront IHS.

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for IHS (Dec. 17, 1974), *reprinted in* IHS MANUAL [hereinafter Memorandum]. Indians are entitled to equal access to all state, local, and federal programs to which other citizens are entitled.

5. INDIAN HEALTH SERVICE, U.S. DEP'T OF HEW, Pub. No. (HSA) 80-1021, NATIONAL PLAN FOR FISCAL YEARS 1981-1984: THE INDIAN HEALTH CARE IMPROVEMENT ACT 13 (1979) [hereinafter NATIONAL PLAN]. *See also* Presidential MEMORANDUM OF DISAPPROVAL OF S.2166., 42 WEEKLY COMP. PRES. DOC. 1583 (Oct. 22, 1984) [hereinafter Memorandum of Disapproval].

6. R.L. KANE, FEDERAL HEALTH CARE (WITH RESERVATIONS!) 11-21 (1972). *See* STAFF OF AMERICA INDIAN POLICY REVIEW COMM'N, 94TH CONG., 2D SESS., REPORT ON INDIAN HEALTH 12-13 (Comm. Print 1976) (Task Force Six) [hereinafter Task Force Six]. The members of the task force, mainly Indians, cited deficiencies such as inadequate program direction, inadequate appropriations, inadequate delivery mechanisms, and lack of accountability at all levels within IHS. For a list of other citations on Indian dissatisfaction, see NATIONAL HEALTH LAW PROGRAM: AN ADVOCATE'S GUIDE TO INDIAN HEALTH SERVICES 50 n.1 (Jan. 1979) [hereinafter ADVOCATE'S GUIDE].

7. Indian Health Care Improvement Act of 1976, Pub. L. No. 94-437, Findings, codified at 25 U.S.C. §§ 1601-1680 [hereinafter 1976 Act]. *See also* SENATE COMM. ON INTERIOR & INSULAR AFFAIRS, 94TH CONG., 1ST SESS., INDIAN HEALTH CARE IMPROVEMENT ACT (Comm. Print 1975) [hereinafter SENATE REPORT] for a more detailed description of the problems of Indian health care.

8. HOUSE STAFF REPORT, *supra* note 1, at 6; SENATE REPORT, *supra* note 7, at 36.

9. HOUSE STAFF REPORT, *supra* note 1, at 17.

10. *Id.* at 6; IHS CHART BOOK 85, *supra* note 3, at 3.

11. *See* Memorandum of Dissapproval, *supra* note 5. *See also* HOUSE STAFF REPORT, *supra* note 1, at 1; IHS CHART BOOK, *supra* note 3, at 39.

12. *See* Task Force Six, *supra* note 6, at 43-48.

History

The IHS of today is a product of many years of bureaucratic shuffling, equivocable federal policy, and inadequate funding through most of its history.[13] The IHS traces its roots back to the early 1800s when military doctors first began treating reservation Indians in order to contain contagious diseases.[14] Under the War Department's direction, this treatment gradually expanded to provide some crisis care but never any preventive or general health care.[15] Through the years, the federal government periodically expanded its attempts to improve the health status of Indians, but the resulting programs were hardly comprehensive or successful.[16]

The responsibility for providing health care to Indians was shifted from military to civilian control in 1849 when the Department of the Interior and the Bureau of Indian Affairs (BIA) were established.[17] Under their direction, the health status of the Indian population remained poor, mainly because funds appropriated to finance Indian health care were never adequate.[18] The situation remained unchanged and, apparently, unnoticed until the early twentieth century, when a variety of sociological studies brought the appalling conditions to the public eye.[19] Public concern over the plight of reservation Indians eventually pressured Congress into passing legislation directed toward Indian health care needs.[20] The Snyder Act of 1921 established a permanent and open-ended authorization to expend "such moneys as Congress may from time to time appropriate, for the benefit, care and assistance of the

13. *Id.* at 27.
14. *Id.* at 28.
15. *Id.* at 27.
16. *Id.*
17. *See* HOUSE STAFF REPORT, *supra* note 1, at 1.
18. *See* Task Force Six, *supra* note 6, at 30.
19. *Id.* at 29-30. The government sponsored studies by the Public Health Service in 1913 and 1936; the American Red Cross and National Tuberculosis Association in 1922; the American Medical Association in 1929; and most important, the Brookings Institute in 1928. The Meriam Report issued by the Brookings Institute provided the most comprehensive results, showing that Indians had high general death and morbidity rates, inadequate health facilities, deficient diets, inadequate sanitation, and poor general health as a whole. The report also noted that the medical work done by the IHS was below a reasonable standard of efficiency, and was "markedly below the standards maintained by the Public Health Service, the Veteran's bureau, the Army and the Navy and . . . local governments." *Quoted in* Task Force Six, *supra* note 6, at 28.
20. *Id.* at 30.

Indians throughout the United States . . . for the relief of distress and conservation of health,"[21] and marked the true beginning of today's Indian health care programs. The Act still serves as the primary authorization for all Indian health programs, although it provides no definition of the kinds or extent of such services IHS must provide, nor does it adequately define the recipient class of any such services.[22]

Following the directive set by Congress, the federal government began to introduce programs designed to alleviate the problems caused by such curable or preventable diseases as trachoma and tuberculosis.[23] Again, these programs never received adequate funding,[24] and never succeeded in completely repairing the years of deteriorating health conditions among reservation Indians.[25]

The Division of Indian Health under the BIA continued to have problems with appropriations for these programs throughout the 1930s and 1940s, accompanied by a corresponding chronic difficulty in recruiting and retaining qualified personnel.[26] In an attempt to alleviate these problems, a transfer of Indian health care to the Public Health Service (PHS) was adopted in 1955,[27] despite a mixed reaction from federal organizations and Indian tribes.[28]

The IHS remained relatively unchanged under the PHS,[29] although appropriations increased fairly rapidly, until the middle 1970s when authorizations mushroomed.[30] In 1975, Congress pass-

21. *See* Snyder Act, *supra* note 2.

22. *See* ADVOCATE'S GUIDE, *supra* note 6, at 16, 26.

23. *See* Task Force Six, *supra* note 6, at 29-30.

24. *Id. See also* SENATE REPORT, *supra* note 7, at 24.

25. *See* Task Force Six, *supra* note 6, at 30.

26. *Id.* at 30-31.

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

28. *Compare* Task Force Six, *supra* note 6, at 31, *with* F. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 698 (R. Strickland ed. 1982). These widely differing interpretations of TRANSFER OF INDIAN HOSPITALS AND HEALTH FACILITIES TO PUBLIC HEALTH SERVICE: HEARINGS ON H.R. 303 BEFORE THE SUBCOMM. ON INDIAN AFFAIRS OF THE SENATE COMM. ON INTERIOR & INSULAR AFFAIRS, 83D CONG., 1ST SESS. (Comm. print 1954) by the critics and advocates exemplifies the inapposite viewpoints on the subject. One interpretation that has substantial support is that many congressmen who advocated termination approved of the bill, not because it would help Indians but that the transfer was compatible with their efforts to repeal laws that set Indians apart from other citizens. *See* SENATE REPORT, *supra* note 7, at 24; Task Force Six, *supra* note 6, at 31.

29. The Transfer Act created the Division of Indian Health, which was retitled as the Indian Health Service in 1968. *See* SENATE REPORT, *supra* note 7, at 25.

30. From 1955 to 1975, the IHS grew from a budget of $24.5 million and a staff of 3,574 to an annual budget of $226 million and a staff of 8,108. SENATE REPORT, *supra* note 7, at 25.

ed the Indian Self-Determination Act that authorized IHS to make grants to tribes for the planning, development, and operation of health programs.[31] More important, Congress passed the Indian Health Care Improvement Act in 1976 that proposed significant increases in authorizations for IHS over a seven-year period.[32] The 1976 Act declared a policy of "providing the highest possible status to Indians and to provide existing Indian health services with all resources necessary to effect that policy."[33] The 1976 Act also authorized increased funding for modernization of IHS facilities,[34] recruitment incentive programs, educational grants for eligible Indian students,[35] and urban Indian health programs.[36] In addition, the Act authorized IHS to obtain reimbursement from the Medicare-Medicaid programs when they provided covered services to eligible Indians.[37]

The implementation of the 1976 Act was accompanied by a direct appropriations increase of $94,745,000 for fiscal year 1978, accompanied by a staff increase of 477 employees for the IHS.[38] IHS appropriations grew from $226 million in 1975 to $824 million in 1984, while IHS staffing grew from 8,108 employees to 11,400

31. The Indian Self-Determination Act, 25 U.S.C. § 450 (1975), provides additional funding for tribal administrative costs in taking over federal programs.

32. *See* 1976 Act, *supra* note 7. The 1976 Act provided only a four-year authorization, but Pub. L. No. 96-537 extended the legislation through 9/30/84.

33. *Id.*, Declaration of Policy.

34. Subchapter III authorized the appropriation and expenditure of funds, in addition to regular IHS appropriations, for construction and renovation of all classes of IHS facilities, including construction of safe water and sanitary waste facilities. 25 U.S.C. §§ 1631, 1632 (1976). *See also* TITLE II—authorized appropriations in addition to regular IHS appropriations to be used to eliminate backlogs in the provision of services such as patient care, health care, dental care, mental health services, alcoholism treatment, as well as for maintenance and repair of facilities. *Id.* § 1621.

35. TITLE I of the Act created recruitment, scholarship, extern and continuing eduation programs that encourage Indian people to enter health professions. *Id.* §§ 1611-1615; 42 U.S.C. § 234(i)(2) (1976), as amended.

36. TITLE IV authorized the IHS to enter into contracts with urban Indian organizations to establish urban Indian clinics to provide or contract for health care services for both urban and rural Indians. 25 U.S.C. §§ 1652-1657 (1976).

37. *See generally* Title IV, which enables IHS to receive reimbursements for services provided in IHS facilities to Medicare or Medicaid eligible Indians. Generally, if the IHS facility meets Medicare/Medicaid standards (usually JCAH), then the facility becomes eligible for reimbursement for the cost of *direct* care provided to Medicare/Medicaid eligible individuals from the entitlement programs. As a result, Indians who are eligible for Medicare/Medicaid are refused contract care funding by the IHS. *Id.* § 1621 (1976). *See* ADVOCATE'S GUIDE, *supra* note 6, at 14-15; 42 U.S.C. 1396d(b).

38. NATIONAL PLAN, *supra* note 5, at 12 (this figure excludes $75 million advanced in FY 1977 as supplemental appropriations).

employees in 1984.[39] Today, IHS operates as the largest bureau within the Public Health Service[40] and consists of 47 hospitals, 84 health centers, and more than 300 smaller health stations and satellite clinics.[41] IHS also contracts for the operation of four hospitals and 250 health clinics in addition to its "contract care" system from both private and public health care providers.[42]

In 1984, IHS allocated approximately $850 per eligible Indian in the reservation states to provide adequate health care.[43] Despite these fairly large expenditures per capita, Indians remain dissatisfied with both the quality of care received[44] and the inequitable distribution of the funds allotted to provide that care.[45] Many Indian groups, especially those located in areas where care has traditionally not been provided, have successfully argued that a more equitable apportionment of fund is required by law.[46]

Health Problems of the Indian Population

An explanation of the problems faced by IHS is necessary to understand the service as it exists today. Indians are subject to all the usual health problems that affect the general population, as well as many problems that are unique to Indians. Knowledge of these traditional health problems that affect Indians is essential in understanding why their health status has not attained the level of the general population despite dramatically increased appropriations for health care and subsequent increases in services provided by the IHS[47] (see following table):

39. *See* HOUSE STAFF REPORT, *supra* note 1, at 17. *See also* SENATE REPORT, *supra* note 7, at 25.

40. HOUSE STAFF REPORT, *supra* note 1, at 9, 13.

41. *Id.* at 13; IHS CHART BOOK, *supra* note 3, at 7.

42. *Id.*

43. *Id.* at 23; *but see Id.* at 34-35. When compared to the amount spent by the average U.S. citizen, per capita health expenditures for Indians increased about 40 percent from 1977 to 1985; during the same period the per capita expenditure for the U.S. resident population more than doubled.

44. See *supra* note 6 for a list of dissatisfied Indian customers.

45. *See* Rincon Band of Mission Indians v. Califano, 464 F. Supp. 943 (N.D. Cal. 1978). Plaintiffs showed that less than 1 percent of the total IHS budget between 1956 and 1978 was allocated to California, even though 11 percent of the American Indian population resided there, according to the 1970 census. Many of these Indians are members of nonrecognized tribes. *See infra* notes 81-82 and accompanying text.

46. *See Rincon Band*, 464 F. Supp. 943; *Rincon Band*, 618 F.2d at 570. See also *infra* notes 144-169 and accompanying text.

47. See *infra* notes 48-63, 93-105 and accompanying text.

AGE-ADJUSTED MORTALITY RATES FOR INDIANS AND ALASKA NATIVES AND U.S. ALL RACES FOR SELECTED CAUSES—1970, 1975, 1980 (deaths per 100,000 population)

Cause of Death	1970 Ind./U.S. tot.		1975 Ind./U.S./ratio			1980 Ind./U.S./ratio		
Accidents	181.8	53.7	170.5	44.8	(3.8-1)			
Cirrhosis of the liver	56.9	14.7	61.4	13.8	(4.4-1)	41.3	7.5	(5.5-1)
Influenza and pneumonia	46.7	22.1	36.1	16.6	(2.2-1)			
Diabetes mellitis	27.1	14.1	23.8	11.6	(2.1-1)	22.6	10.1	(2.2-1)
Tuberculosis	11.4	2.2	9.9	1.2	(8.3-1)	8.5	0.6	(6.0-1)
Homicide	22.2	9.1	26.5	10.5	(2.5-1)	18.1	10.8	(1.7-1)
Suicide	17.9	11.8	26.0	12.6	(2.1-1)	14.1	11.4	(1.2-1)

(Sources: IHS Trends, *supra* note 45, at 66; House Staff Report, *supra* note 1, at 8. This compilation is not meant to be inclusive. Its purpose is merely to show that the incidence of diseases and accidents among the American Indian population is generally much higher than that of the U.S. population as a whole. If any statistical data was conflicting, the statistic most favorable to the government was used).

As with any statistical data, morbidity and mortality statistics can be manipulated to make programs look better or worse, depending upon who is citing the figures. Some statistics, often proudly cited by the federal government, highlight the fact that the health status of IHS beneficiaries has greatly improved over the last quarter of the century.[48] For example, from 1955 to 1981, the infant death rate per 1,000 Indian live births declined from 62.5 to 11.9; the tuberculosis death rate per 1,000 Indian people declined from 55.1 to 2.[49] Other statistics, not cited nearly as often by government statisticians, show that morbidity rates for the IHS service population have continued to rise despite IHS's consistently

48. Public Health Service, U.S. DEP'T OF HEW, INDIAN HEALTH TRENDS AND SERVICES 3 (1978) [hereinafter IHS TRENDS]. Two separate conglomerations of statistics, one showing the improvements and one showing the problems, exemplify this difference. *See also* NATIONAL PLAN, *supra* note 5, at 13; Public Health Service, U.S. DEP'T OF HEALTH & HUMAN SERV., INDIAN HEALTH SERVICE: A COMPREHENSIVE HEALTH CARE PROGRAM FOR AMERICAN INDIANS AND ALASKA NATIVES 17 (1985) [hereinafter IHS COMPREHENSIVE PROGRAM].

49. IHS CHART BOOK, *supra* note 3, at 17, 36.

increasing budget to offset the rise[50] and are still probably higher than the morbidity rates for any other group in the country.[51]

Among the most alarming statistics are the extremely high rates of alcoholism and drug abuse.[52] Statistics from 1973 show that Indians were dying from alcoholism at a rate almost ten times that of other United States citizens.[53] Morbidity statistics for alcohol-related diseases such as cirrhosis of the liver were also much higher than rates for the population as a whole.[54] While these statistics show improvements in recent years, in 1982 the death rate for Indians due to alcoholism remained five and a half times that of the population as a whole.[55]

Another alarming statistic is the extremely high morbidity and mortality rates for preventable and curable diseases.[56] For example, in 1980 the incidence of tuberculosis among Indian and Alaskan Natives was three times greater than that for the general population, while the age-adjusted death rate was six times greater.[57] Additionally, diseases such as diabetes, otitis media, and trachoma, which are generally viewed as being under control in the population at large, remain problems of epidemic proportion among Indians.[58]

50. For a good example of how statistics can be misleading, see SENATE REPORT, *supra* note 7, at 35-37. Page 35 cites all the improvements and page 36 cites many of the problems plaguing Indian populations that are no longer considered by the population at large. For a more recent overview of problems still existing eight years after the 1976 Act programs began, see SENATE REPORT, *supra* note 1, at 6-7.

51. SENATE REPORT, *supra* note 7. *See also* Task Force Six, *supra* note 6, at 12.

52. SENATE REPORT, *supra* note 7, at 80-86. This history of tribal problems with alcohol and drugs enumerates the unsuccessful attempts by IHS to remedy the situation. Note that the authors of this report feel that the treatment of alcoholism among Indians will never be totally effective until the underlying social, economic, and cultural causes are remedied, over which the IHS has little or no control. *See also* SENATE SELECT COMM. ON INDIAN AFFAIRS, 98TH CONG., 2D SESS., REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT, pt. 2, 53-83 (Comm. Print 1984) [hereinafter REAUTHORIZATION COMM., pt. 2]. (showing the extremely high rates of both alcohol and drug abuse among Pine Ridge Reservation children and teenagers in 1982). *See generally* IHS COMPREHENSIVE PROGRAM, *supra* note 48, at 6 (four of the top ten leading causes of death among Indian people—accidents, chronic liver disease and cirrhosis, suicide, and homicide—are related to alcohol abuse).

53. *See* Task Force Six, *supra* note 6, at 52.

54. *Id. See also* NATIONAL PLAN, *supra* note 5, at 28.

55. IHS CHART BOOK, *supra* note 3, at 34.

56. *See* HOUSE STAFF REPORT, *supra* note 1, at 6.

57. *Id. See also* IHS CHART BOOK, *supra* note 3, at 36 (in 1982, the mortality rate for tuberculosis was 3.3 times as great as that of the white population).

58. *See* IHS TRENDS, *supra* note 48, at 18-22. In 1982 the age-adjusted mortality rate for diabetes mellitus was 2.1 times greater for Indians than for the U.S. population

A related problem also facing Indians is that of inadequate sanitation facilities in many Indian homes.[59] Such severely unsanitary conditions are at least partially responsible for the high incidence of preventable infectious diseases such as bacillary dysentery and infectious hepatitis, illnesses that are generally associated with a lack of running water, unsanitary conditions, and overcrowded housing units.[60] These unsanitary conditions are also partially responsible for the death rate of Indian babies under one year of age, a rate that remains at twice that of the comparable age group in the general population.[61] This statistic remains true despite the fact that through IHS help the Indian infant death rate at birth is similar to that of the population as a whole.[62] As critics of the IHS have pointed out, at least those health problems arising from infectious diseases could be substantially lessened with adequate health care and sanitation, as they have in the population in general.[63]

Indians seeking adequate medical care also face a communication barrier because many older Indians are not fluent in English,[64] and others face a transportation problem because many live either

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as a whole. IHS CHART BOOK, *supra* note 3, at 37. In addition, otitis media and trachoma remain as health problems among Indians, but no statistics are available for the general population of the United States becaues they pose no substantial health problem to the total population. These last two diseases are definitely highly correlated with impoverished living conditions.

59. SENATE REPORT, *supra* note 7, at 118. *See also* IHS TRENDS, *supra* note 48, at 21. *But cf.* IHS COMPREHENSIVE PROGRAM, *supra* note 48, at 6. Since the Indian Sanitation Facilities Act (Pub. L. No. 86-1121) was passed in 1959, the IHS has been instrumental in securing running water and safe waste water disposal in more than 136,000 Indian residences.

60. IHS COMPREHENSIVE PROGRAM, *supra* note 48. In 1972 the incidence rate for bacillary dysentery was 42.1 times greater than the rate for the general population, while the rate for infectious hepatitis was 10.7 times that of the population as a whole.

61. *See* SENATE REPORT, *supra* note 7, at 118. In 1973, 20 percent of patients discharged by IHS and contract hospitals received treatment for infectious diseases (respiratory, other infectious and parasitic and skin diseases) and their residuals.

62. Over the 1979-1980 period, the Indian infant mortality rate was only 11 percent greater than that of the general U.S. population, although it was 28 percent higher than the rate for the white population. HOUSE STAFF REPORT, *supra* note 1, at 6. *See also IHS* CHART BOOK, *supra* note 3, at 17 (in 1982, infant mortality rates for Indian/Alaska Natives and U.S. all races were virtually identical at 11.9 deaths per 1,000 live births).

63. See *supra* notes 57-62. Many factors, such as unsafe water, inadequate sanitary facilities, and lower than adequate nutritional intake, increase the susceptibility of Indians to these infectious diseases. IHS TRENDS, *supra* note 48, at 21.

64. *See* SENATE REPORT, *supra* note 7, at 86.

in remote rural areas or in one of a few large urban areas without "on-reservation" IHS facilities nearby.[65]

As a result of all these factors, "Indian people endure conditions of poor health which are many times worse than those of Americans dwelling in the poorest city ghettos."[66] Understanding why this remains true despite massive appropriations for IHS requires that one look closely into the IHS, its programs, and its regulations.

Eligibility

Eligibility standards for specific benefits are currently governed by two separate and somewhat inconsistent authorities. Recent authorization statutes[67] define eligibility somewhat differently than traditional definitions used under the Snyder Act[68] and the IHS regulations.[69] This inconsistency arose because Congress failed to adequately define the recipient population. The Snyder Act of 1921, still the major authorization legislation governing Indian health care, merely states that appropriations are to assist "Indians throughout the United States."[70] A closer look at legislative history reveals that Congress believed the class of beneficiaries of Snyder Act services was to include all members of federally recognized tribes.[71] Subsequent legislation, such as the Transfer Act of 1955,

65. *Id. See also* ADVOCATE'S GUIDE, *supra* note 6, at 29-30.

66. *See* 3 NATIONAL INDIAN HEALTH BOARD—HEALTH REPORTER 14 (Statement of Senator Dennis DeConcini (Ariz.)) [hereinafter NIHB REP.].

67. Eligibility under the 1976 Act is different from traditional standards for certain programs. See *infra* notes 78-83 and accompanying text.

68. See *infra* notes 70-71 and accompanying text.

69. *See generally* 46 Fed. Reg. 40,692 (1981) (codified at 42 C.F.R. pt. 36) [hereinafter IHS Regs.]. See *infra* notes 75, 77, 109 and accompanying text. In general, IHS regulations allow direct care to be provided to any Indian or Indian descendant as long as he or she belongs to the Indian community served by the IHS facility. Eligibility standards for contract care are stricter in that they require that an Indian reside "on or near" a reservation and not have any alternative resources (Medicare/Medicaid, insurance, state programs, etc.).

70. *See* Snyder Act, *supra* note 2. As a result, there are twenty-six different definitions of "Indian" used by the federal government. Many Indians, especially those in the western states, feel that eligibility for services under the BIA and the IHS should be limited to those who are at least one quarter Indian blood. *See* REAUTHORIZATION COMM. pt. 1, *supra* note 3, at 182-88 (statement of Elmer M. Savilla, Executive Director, National Tribal Chairmen's Association).

71. *See, e.g.*, S. REP. No. 1530, 83d Cong., 2d Sess. (1954), *reprinted in part in* U.S. CODE CONG., & ADMIN. NEWS, 83d Cong., 2d Sess. 2920 (1954): "The Bureau of Indian Affairs is responsible, under present law, for the total health program—both preventive and curative medicine—for all Indians *registered as members of the various tribes in the United States* and Indians and natives of Alaska" (emphasis added).

also failed to provide a more detailed definition by merely mentioning "Indians" in general when referring to beneficiaries.[72] In addition, courts have retained the definition of "Indian" as ordinarily including only members of federally recognized tribes.[73]

Because no further statutory definition exists construing who is an "Indian" for purposes of receiving federal benefits, the IHS has exercised considerable discretion in determining who will receive services. In general, the IHS will provide free direct care services to: "persons of Indian descent belonging to the Indian community";[74] non-Indian women pregnant with an Indian's child during the period of pregnancy through postpartum; certain non-Indian members of an Indian's household if necessary to control a public health hazard; and even non-Indians under emergency conditions.[75] IHS also sets its own eligibility standards for contract care, which are generally more restrictive than the criteria for direct care in that they require the Indian to reside "on or near" a reservation before IHS will fund the services.[76] This is done to help preserve the very limited contract care funds so that funding will be available for emergencies at least.[77]

With respect to certain programs, however, Congress addressed the definition more thoroughly in the Indian Health Care Improvement Act of 1976.[78] This Act created a number of supplemental IHS programs that used a different standard to define the class of eligible beneficiaries.[79] In general, the Act retained the traditional "member of a federally recognized tribe" definition,[80] but for certain programs the definition was expanded to include members of terminated tribes[81] and state-recognized

72. *See* Transfer Act, *supra* note 27.

73. Morton v. Ruiz, 415 U.S. 199 (1974).

74. IHS MANUAL § 2-3.5.

75. IHS MANUAL § 2-3.7.

76. *Id.* at exhibit IV; 42 C.F.R. § 36.23.

77. Task Force Six, *supra* note 6, at 105-97. *See also infra* note 111.

78. *See* 1976 Act, *supra* note 7.

79. See *infra* notes 81-83 and accompanying text.

80. *See* 25 U.S.C. § 1603(c) (1981). "Federally recognized" means that the federal government officially recognizes that tribe as being eligible for services because of their status as a tribe of Indians. The word "tribe" generally includes nations, bands, and other organized groups or communities of either Indians or Alaskan natives. For a more detailed discussion, see ADVOCATE'S GUIDE, *supra* note 6, at 56-57.

81. "Terminated" tribes includes those that were formerly recognized by the federal government as within the scope of federal responsibility, but which are not now within that scope of responsibility and in general, receive no IHS services. For the most part,

tribes.[82] This expanded definition pertained to the health profession recruitment and scholarship program, the alcoholism treatment program, and to services provided to "urban Indians" by urban clinics.[83]

Since some of these programs may be destined for extinction after the authority for the Act's programs terminated in November of 1984,[84] the permanent impact of these newer definitions is yet to be determined. Some Indian advocates think segments of this definition, especially the separate definition of "urban Indian" marked the beginning of a trend toward limiting IHS patient care to federally recognized Indians residing on a reservation.[85] Because

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this responsibility was ended during the "termination years" of the 1950s when many reservations were broken up and the responsibility for services was shifted to the states. Although this breakup was allowed in return for cash grants, Indian belonging to those reservations never adapted to the state's programs and ended up in worse condition than those under IHS supervision. *See generally* ADVOCATE'S GUIDE, *supra* note 6, at 57. *See also* W. BROPHY & S. ABERLE, THE INDIAN: AMERICA'S UNFINISHED BUSINESS (1966). In addition, members of terminated tribes are explicitly excluded from services by the IHS MANUAL, *supra* note 4, § 2-3.7(c).

82. State-recognized tribes and nonrecognized tribes are not recognized by the federal government as "tribes" and do not qualify for IHS aid except under a few specific 1976 Act programs. In addition, they do not qualify for services under the BIA because they are not "federally recognized." Such tribes constitute a large percentage of the total Indian population in the United States, with concentrations in California and North Carolina. *See* HOUSE STAFF REPORT, *supra* note 1, at 3 (listing the service and nonservice populations for each of the twenty-eight reservation states where IHS has the responsibility to provide health care to eligible Indians). *But see* Joint Tribal Council of Passamaquoddy Tribe v. Morton, 528 F.2d 370 (1st Cir. 1975). There the court held that the terms of the Indian Nonintercourse Act, 25 U.S.C. § 177, were applicable even to an unrecognized Indian tribe and that the federal government was required to provide legal representation to the tribe to assist them in protecting their state reservation in a dispute with the state of Maine. The Passamaquoddy Tribe and other nonrecognized tribes could argue that they are eligible for other services on an analogous basis, although this argument has not achieved success in other situations.

83. The 1976 Act's enlarged definition of "Indian" as "including those tribes, bands, or groups terminated since 1940 and those recognized by the State in which they reside "applies only to those four supplemental programs. 25 U.S.C. §§ 1603(c)(3) and (4). For a more detailed discussion on eligibility, see ADVOCATE'S GUIDE, *supra* note 6, at 17-18.

84. President Reagan's veto of the Indian Health Care Amendments of 1984 (S. 2166), the extension of the 1976 Act, on October 19, 1984, is viewed by many critics as marking the beginning of a general reduction or elimination of many of IHS's programs. *See* NIHB REP., *supra* note 66. Although officials at IHS insist that there will be no reduction in existing health care services to Indians after the Sept. 30 expiration of the 1976 Act, critics feel that, at a minimum, no further expansion of services will be possible. For a lengthy discussion of the amendment, the possible reasons for Reagon's veto, and the possible effects of the veto, see *id.* at 1-3, 12-15.

85. *See* ADVOCATE'S GUIDE, *supra* note 6, at 18.

it is the first and only specific statutory definition of an eligible beneficiary, it may become a legislative model for future statutes.[86] Taken in conjunction with tightening restrictions on contract care[87] and other benefits,[88] this could cause catastrophic problems for the nearly 60 percent of the total Indian population not residing on a reservation.[89] On the other hand, proponents insist that IHS funding will continue to be authorized under the Snyder Act, which does not mention this definition, and therefore all the IHS services will continue to be provided to all Indians throughout the United States.[90] In response, critics note that even using the Snyder Act's implied "member of a federally recognized tribe" definition, the IHS will still be excluding approximately a half million Indians who are not federally recognized as "Indian" by the United States government.[91]

Services

The IHS provides three separate types of services to eligible Indian beneficiaries: (1) direct "on-reservation" care; (2) contract care provisions for services by non-IHS, nontribal providers, and (3) urban Indian care for the specially defined group of "urban Indians."[92]

Direct care through IHS may include such services as hospital and medical care, dental care, public health nursing and preventive care, including immunizations,[93] optometrical care, and community/inpatient mental health.[94] The IHS also lists nutrition, laboratory, maternal and child health, physical therapy, environmental health, and health education as other services that may be provided by its hospitals and clinics.[95] It is important to remember that the IHS is not required to provide all of these ser-

86. *Id.*

87. See *infra* notes 111-112.

88. Non-Indian spouses of Indians are no longer eligible for IHS services. Until December 30, 1983, they had been fully eligible for all benefits. 42 C.F.R. § 36.12(a).

89. HOUSE STAFF REPORT, *supra* note 1, at 28.

90. *See* NIHB REP., *supra* note 66, at 2.

91. Approximately 500,000 Indians are considered by IHS as a "nonservice" population who do not receive IHS services. HOUSE STAFF REPORT, *supra* note 1, at 2.

92. *See* ADVOCATE'S GUIDE, *supra* note 6, at 26-29. See *infra* notes 93-125 and accompanying text.

93. 42 C.F.R. § 36.11 (a).

94. 1976 Act, *supra* note 48, at 24-27.

95. *See* IHS TRENDS, *supra* note 48, at 24-47.

vices in each area served.[96] Thus, in many circumstances, the full range of services may not be available. The determination of which services may be available is made by IHS officials and depends upon both the IHS's resources and the facilities of non-IHS sources.[97] For example, a Service Unit director may examine the availability of alternate sources of health care (Medicare/Medicaid, private insurance, state programs, etc.) in deciding which services IHS will provide in that particular Indian community.[98]

Contract Health Services (CHS), the second major type of benefit provided by IHS, allows eligible Indians to receive "free" health care from a non-IHS provider because IHS will reimburse the provider out of its CHS funds.[99] This enables IHS to provide to eligible Indians additional services that are not available through the IHS or tribal delivery systems in that area.[100] Such services are dependent upon the availability of funds, the person's relative medical priority, and the actual availability and accessibility of alternate resources.[101] For example, where the IHS system has sufficient funds but not the resources or technology to treat an eligible Indian,[102] they may refer that person to a previously contracted private provider and pay for treatment. The IHS has contracted with approximately 1,300 health care providers for their services on a regular basis.[103] Additionally, IHS may reimburse noncontract

96. IHS Regs., *supra* note 69, § 36.11(c). After listing the service that "*may be available*," the regulations also state that "[t]he Service does not provide the same health services in each area served."

97. *Id. See also* ADVOCATE'S GUIDE, *supra* note 6, at 26.

98. 42 C.F.R. § 36.11(c). Because this discretion to deny services is so broad, it is fair to say that an Indian cannot demand that any particular service be provided in that area unless the decision was made entirely arbitrarily or contrary to IHS regulations. *See, e.g., Rincon Band*, 618 F.2d at 573.

99. IHS MANUAL, *supra* note 4, § 2-3.7.

100. *See* HOUSE STAFF REPORT, *supra* note 1, at 24-45. Contract health funds may not be expended for services that are reasonably accessible and available at local IHS facilities. IHS MANUAL, *supra* note 4, § 2-3.7 and exhibit IV. IHS will assume financial responsibility for referrals if the patient is eligible under contract health service (CHS) standards *and* is not eligible for or does not have alternative resources. Alternate resources includes Medicare/Medicaid, Vocational Rehabilitation, Veteran's Administration, Crippled Children's Fund, private insurance, and state programs. While the use of alternate resources is mandatory, an individual may not be required to expend personal resources to buy health services. *Id.*, § 2-3.7.

101. *Id.*, § 2-3.7.

102. The eligibility requirements for contract care and for direct care are different. See *infra* note 111.

103. HOUSE STAFF REPORT, *supra* note 1, at 24.

providers for care provided to Indians but only under certain limited circumstances.[104]

Funding for contract care services varies from area to area; consequently, the types of services provided through contract care vary much as they do under direct care service.[105] Generally, once the fixed amount set for contract care is exhausted, IHS will not honor contract requests for that locality until the next fiscal year.[106] Consequently, in many areas where contract care funds are not sufficient to meet the needs of eligible patients, local IHS officials must establish medical priorities in an attempt to ensure funding for emergency treatment.[107] In such areas, even care for medical conditions that are serious but not life-threatening is frequently deferred at least until the beginning of the next fiscal year.[108] In effect, contract care funds are literally limited to "emergencies only" in many IHS areas.[109] This limitation really means that most elective procedures can only be provided through IHS facilities; therefore, an Indian who cannot reach an IHS facility (generally on or near a reservation), will not receive nonemergency treatment through the IHS.

Even with these "emergency only" limits, contract care funds are commonly exhausted before the fiscal year is completed, so other cost-saving measures have been implemented by IHS ostensibly to keep at least enough funds intact for true emergencies.[110] In an attempt to limit the number of recipients, eligibility standards

104. If funds are available, IHS may reimburse noncontracted providers only under emergency conditions or if the provider's total bill for the fiscal year is less than $1,000. Federal Acquisition Regulations. Conversations with IHS officials in Cherokee, N.C. (Apr. 1985).

105. HOUSE STAFF REPORT, *supra* note 1, at 24.

106. *Id.*

107. *See* IHS Regs., *supra* note 69, § 36.23(e); IHS MANUAL, *supra* note 4, ch. 3, § 2-3.7(c). The Services Unit Director (local IHS official) must base his decision on the medical condition of the patient, the ability of the local IHS facility to provide the necessary service, the amount of funds available, and the distance from the IHS facility.

108. *See* Letter from Margaret Heckler to Morris Udall, Chairman, Committee on Interior & Insular Affairs [hereinafter Letter], *reprinted in* HOUSE STAFF REPORT, *supra* note 1, at 102-03, stating that "medical care for many non-life-threatening medical conditions is being deferred unless alternate resources can be located." The letter was written in response to a controversy over whether IHS should provide end-stage renal dialysis and skilled nursing care in the Phoenix area (where traditionally, contract care funds have been inadequate to meet all health care needs).

109. *See* HOUSE STAFF REPORT, *supra* note 1, at 27-29.

110. *See* Task Force Six, *supra* note 6, at 105-07.

are stricter than those for direct care because only Indians residing "on or near" a reservation are eligible for contract care.[111] Therefore, not all Indians eligible for IHS direct care are eligible for IHS-paid contract care.[112] In addition, IHS requires that an individual obtain IHS authorization for all contract care provided.[113] For nonemergency cases in areas with adequate contract care funding, such authorization usually must be obtained prior to receiving care.[114] In emergency cases, such authorization must be obtained within seventy-two hours by the patient or an individual acting on his behalf, or the IHS is not required to pay for the services out of its contract care fund.[115] In one additional attempt to reduce expenditures, IHS will not authorize payment for contract health services to Indians with available third party resources such as Medicare, Medicaid, or private health insurance.[116] For example, IHS will not reimburse for care provided by a private physician if the Indian recipient is eligible, or would be eligible upon application, for an entitlement program's services.

Despite these restrictions, IHS contract care expenditures have increased substantially over the past five years, both in absolute dollar terms and as a percentage of the total IHS budget.[117] In

111. It applies only to Indians who: (1) reside in a contract health service delivery area (CHSDA) and are members of the tribe located on that reservation; or (2) if not on a reservation, must reside near a reservation and within a CHSDA while at least maintaining close economic and social ties with that tribe. In addition, students and transients are eligible for contract care funds if they would be eligible at the place of permanent residence. Other Indians who leave the CHSDA where they are eligible will remain eligible for contract care funds for 180 days after their departure, unless they are foster children placed in an area outside the CHSDA. A CHSDA generally includes a five-county area surrounding each reservation. 42 C.F.R. pt. 36.23(a)-(d) (1978); IHS MANUAL, *supra* note 4, § 2-1.2c. *See also* HOUSE STAFF REPORT, *supra* note 1, at 24.

Although the regulations seem confusing, the actual criteria for the determination of an Indian's eligibility for contract care is commonly referred to as the "on or near" regulation. For all practical purposes, an Indian is eligible only if he resides on a federally recognized reservation, *or* resides near the reservation where his tribe resides. IHS MANUAL, *supra* exhibit IV.

112. *See* Letter from Margaret Heckler, *supra* note 108.

113. 42 C.F.R. § 36.12 (1978); IHS MANUAL, *supra* note 4, § 2-3.8.

114. *Id.*

115. *Id.*; IHS MANUAL, *supra* note 4, ch. 3, exhibit V.

116. 42 C.F.R. § 36.23. *See also* HOUSE REPORT, *supra* note 1, at 25. Note that this is different from direct care under title IV of the 1976 Act providing that Indians, even if eligible for Medicare/Medicaid, can be treated at IHS facilities. In this situation, if the IHS facilities are JCAH accredited, the Medicare/Medicaid programs must reimburse IHS for the expense of the treatment. *See* 1976 Act, *supra* note 7, IV.

117. HOUSE STAFF REPORT, *supra* note 1, at 25.

FY 1984, the IHS spent approximately $194 million, compared to $95 million in FY 1980.[118] A significant part of this increase is attributable to an increasingly larger proportion of available funds being spent for major medical are (hospitalization and other institutionally based services), whose costs per day have increased at an extremely rapid rate.[119]

Finally, IHS offers health care through its Urban Health Services.[120] Originally authorized by the 1976 Act, this program was designed to make health services available to medically underserved Indians in urban areas.[121] Other programs had previously provided some care to these Indians; however, the health status of urban Indians was generally worse than even that of reservation Indians, for a variety of reasons.[122]

In an attempt to remedy the situation, the 1976 Act allowed IHS to contract with urban Indian programs in thirty-seven cities throughout the United States to provide outpatient care as well as referral services to eligible urban Indians.[123] Although huge authorizations were set out in the 1976 Act, actual appropriations have remained constant at $3.25 million per year throughout the life of the program,[124] although they have been supplemented by funding from other sources such as third party reimbursement (Medicare/Medicaid/private insurance), out-of-pocket payments, and grants from the private sector.[125] Even combined, these sources of funding have not been able to raise the health status of urban Indians to the level of the population in general.[126]

Obligation of IHS to Provide Care to Indian People

Without a doubt the federal government has a historical and unique relationship with American Indians that results in a special responsibility for them.[127] Nonetheless, doubts and problems always

118. IHS CHART BOOK, *supra* note 3, at 40. *See also* HOUSE STAFF REPORT, *supra* note 1, at 25.

119. HOUSE STAFF REPORT, *supra* note 1, at 25.

120. 1976 Act, *supra* note 6, tit. V.

121. *Id.*

122. SENATE REPORT, *supra* note 7, at 131-40. For an even more skeptical report of urban Indian health problems, see Task Force Six, *supra* note 6, at 142-49.

123. HOUSE STAFF REPORT, *supra* note 1, at 28.

124. *Id.*

125. *Id.* at 19. *See also* NATIONAL PLAN, *supra* note 5, at 82.

126. A. ORKIN, THE URBAN AMERICAN INDIAN 62-63 (1978); Task Force Six, *supra* note 6, at 148.

127. G. HALL, THE FEDERAL-INDIAN TRUST RELATIONSHIP, 1-3 (1979).

arise when trying to describe the obligation's origins or the exact nature of it. While the scope of responsibility is difficult to determine, three broad areas can be identified: (1) protection of Indian trust property; (2) protection of the Indian right of self-government, and (3) provision of social, medical, and educational services that are essential for the survival of a tribe.[128]

The many origins of the federal government's responsibility are difficult to identify because there is no specific treaty, statute, or case that can be said to establish when this obligation began.[129] Instead, a combination of all three formed what is now commonly recognized as the government's "trust" responsibility.[130]

The earliest responsibilities of the government arose as a result of nearly 650 treaties entered into with Indian tribes.[131] Although their main purpose was to take away rights from the Indians, according to judicial doctrine the treaties are to be liberally construed in favor of the Indians,[132] and some did list rights reserved to Indians.[133] Most did not list any provisions concerning medical care or physicians and none provided for anything more than a hospital, medicines, vaccines, or a physician.[134] In most cases, the government's obligation was phrased as "protection," "security," or care toward Indians.[135] Language of this kind is generally considered as the roots of what is commonly referred to today as the government's "trust responsibility."[136]

Statutes and legislative history constitute another factor in the evolution of this responsibility. They generally acknowledge the existence of a responsibility, although they provide no legal definition of the scope of the relationship.[137] For example, the Snyder Act merely refers vaguely to its purpose of providing for the "relief of distress and conservation of health" without including any provi-

128. *Id.* at 9.

129. *Id.* at 3-8. *See also Task Force Six, supra* note 6, at 33.

130. *See* G. HALL, *supra* note 127, at 3-8.

131. AMERICAN INDIAN LAWYER TRAINING PROGRAM, INC., MANUAL OF INDIAN LAW, J-5 (1979) [hereinafter MANUAL]. For an extensive list of treaties, see G. HALL, *supra* note 127, at 73-83.

132. MANUAL, *supra* note 131, at J-8. *See also* F. COHEN, *supra* note 28, at 222; S. PEVAR, THE RIGHTS OF INDIANS AND TRIBES 33 (1983).

133. Task Force Six, *supra* note 6, at 28.

134. *Id.*

135. *See* G. HALL, *supra* note 127, at 4.

136. *Id. But see* F. COHEN, *supra* note 28, at 220 (noting that the real federal responsibility came mainly from case law).

137 Task Force Six, *supra* note 6, at 33. *See* MANUAL, *supra* note 131, at J-4.

sions defining the scope of services or the class of beneficiaries.[138] The Indian Health Care Improvement Act of 1976 more specifically acknowledged the special federal responsibility regarding Indian health in its Declaration of Policy, which states:

> The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.[139]

Again, no explicit definition of the scope of the "special responsibilities and legal obligation" is provided.

Judicial decisions have provided a more comprehensive explanation of this relationship.[140] The primary cases refers to Indian nations as "domestic, dependent sovereigns" that rely on the United States for protection and support in a way that "resembles that of a ward to his guardian."[141]

This basic legal obligation has been reaffirmed by later courts as well. In 1943 the Supreme Court stated that "the United States assumed the duty of furnishing that protection, and with it the authority to do all that was required to perform that obligation."[142] Decisions like this confirm the existence of a legal obligation; again, however, the nature of the obligation is only vaguely explained.

Looking at this responsibility in a health care context, in general the government programs have been obligated to provide some type of services and to comply strictly with their internal regulations governing eligibility. It should be noted that courts have been hesitant to explicitly define what type of services these programs are obligated to provide under any "trust responsibility" theory. Courts have stated that IHS is obligated to provide primary health care to members of federally recognized tribes who meet IHS's eligibility requirements and that this responsibility can not be arbitrarily breached.[143] In addition, because of its statutory obligation, the

138. Snyder Act, *supra* note 2.

139. 1976 Act, *supra* note 7.

140. *See* G. HALL, *supra* note 127, at 4; M. PRICE, LAW AND THE AMERICAN INDIAN 170 (2d ed. 1983).

141. United States v. Kagama, 118 U.S. 375, 384 (1886); Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1, 17-19 (1831).

142. Board of County Comm'rs v. Seber, 318 U.S. 705, 715 (1943).

143. White v. Califano, 437 F. Supp. 543, 544-45 (D.S.D. 1977) *aff'd per curiam* 581 F.2d 697 (8th Cir. 1978).

IHS cannot arbitrarily deny service to a certain geographical area without a legitimate reason.[144] Beyond these basic responsibilities, little substantive law exists to define what the obligations of IHS are toward its Indian beneficiaries. In other words, no court has explicitly held that a definable trust responsibility to Indians exists, and then gone on to define that obligation.

In one of the primary cases on point, the federal district court of South Dakota, in *White v. Califano*,[145] found that a unique legal relationship or trust responsibility existed so that the federal government (through the IHS) has a statutory responsibility to provide mental health care to Indians if they meet IHS's eligibility requirements.[146] The court referred to the intent of Congress in the 1976 Indian Health Care Improvement Act, while holding that the IHS must follow its own regulations in dealing with Indians.[147]

In *White*, an Indian needing mental health care was refused treatment at IHS facilities.[148] IHS argued that because it was a "residual" supplier of health care services, the states and other federal programs should provide the "primary" care needed.[149] IHS also argued that it was within its discretion to deny services in order to conserve its limited funds for other services.[150] The district court rejected these arguments, relying on statutory policy statements[151] and the Supreme Court's *Morton v. Ruiz* decision finding that the BIA had a duty by statute to provide benefits to unassimilated Indians living near a reservation.[152] In *Morton*, the Supreme Court acknowledged that BIA funds may be inadequate to assist all Indians in that class; it stated that the solution for the BIA was not to withhold services from eligible Indians but to readjust its eligibility criteria if necessary.[153] *White* analogized this to the IHS's situation and stated that IHS officials may exercise their discretion in deciding eligibility rules, but they were bound by those agency regulations.[154] In *White*, the court found that

144. *Rincon Band*, 618 F.2d at 573.
145. *White*, 437 F. Supp. 543.
146. *Id.* at 557.
147. *Id.*
148. *Id.* at 545.
149. *Id.* at 553.
150. *Id.* at 554.
151. *Id.*
152. *Id.* at 555.
153. Morton v. Ruiz, 415 U.S. 199, 230-31 (1974).
154. *White*, 437 F.2d. at 556.

the Indian in question met all eligibility requirements (i.e., the funds were to be spent according to priorities based on medical need, and here the Indian's medical need was extreme) and therefore IHS must provide care.[155] In addition, the court rejected the idea that IHS was a "residual" provider because IHS had repeatedly represented itself to Congress as an agency with "primary responsibility to provide comprehensive health services" to its beneficiaries.[156]

Although cases such as *Morton* and *White* have established that the federal government has an obligation to provide care if all eligibility regulations are met, critics have pointed out that the extent of this duty has never been fully explained.[157] They maintain that a certain level of services should be set out to guarantee a minimum set of benefits ("benefit package"), much as a person enrolled in a Health Maintenance Organization or eligible for Medicare or Medicaid would have.[158] They believe that because the scope of direct and contract services varies considerably among areas, depending on decisions by IHS officials and appropriation hearings, an Indian beneficiary will never be certain that necessary services will be available until such a benefit package is assured.[159]

This view has received some support by the judiciary system as well, in *Rincon Band of Mission Indians v. Harris*.[160] In *Rincon*, the court acknowledged the trust responsibility but also found that IHS had an obligation to distribute the funds in its budget "rationally and equitably" in an effort to provide Indians in California with services comparable to those provided elsewhere in the United States.[161] The court also noted that IHS's present system of funding distributed IHS's budget inequitably.[162]

Rincon arose because the IHS had been distributing less than one percent of the total IHS budget to provide health care to California Indians, who represent approximately 11 percent of the American Indian population.[163] This inequity was present because of IHS's "program continuity" method of budgeting,

155. *Id.*
156. *Id.* at 557.
157. *See* ADVOCATE'S GUIDE, *supra* note 6, at 30; Task Force Six, *supra* note 6, at 33.
158. Task Force Six, *supra* note 6, at 36-37.
159. ADVOCATE'S GUIDE, *supra* note 6, at 30.
160. 618 F.2d 569 (1980).
161. *Id.* at 570.
162. *Id.* at 573 (quoting *Rincon Band*, 464 F. Supp. 934, 937 (1979)).
163. *Id.* at 571.

whereby programs are funded at the same level as they were funded during the previous year.[164] This method allocates funds to program merely because the programs received funds the prior year, regardless of the present needs to the program.[165] This meant that California Indians, many of whom were members of tribes terminated in the 1950s with a corresponding drop in funding levels, could not receive more funds even though the tribes had since been designated as nonterminated. The IHS budgets were based on the previous years totals and failed to take into account that the total number of eligible beneficiaries had increased dramatically.[166]

In an effort to reduce this inequity, Congress established in 1981 an "Equity Fund" to be distributed on the basis of need to help those areas with greatest unmet needs.[167] This fund consisted of $7.9 million in FY 1981, of which 74 percent ($5.8 million) eventually was used to provide health care to California Indians.[168] Although intended as a temporary measure to assist the IHS in implementing the *Rincon* decision, the Equity Fund has remained as the only attempt by IHS to redistribute its services more equally.[169]

Critics of IHS and other government agencies point out that this system has not accomplished its task, mainly because IHS only allocates a very small percentage of its budget through the Equity Fund and continues to distribute about 96 percent of its appropriations on the basis of the program's prior year's funding.[170] The General Accounting Office (GAO), in its comprehensive report of the IHS funding system, found that the Equity Fund by itself will not correct the major problem of inequitable distribution.[171] GAO also addressed IHS's contention that the Equity Fund had significantly improved the distribution by stating that "most of this progress is attributable to IHS's recalculation of tribal re-

164. *Id.*

165. *Id. See also* REAUTHORIZATION COMM., pt. 2, *supra* note 52, at 10-12.

166. *Harris*, 618 F.2d at 570-71.

167. SENATE COMM. ON APPROPRIATIONS: COMPTROLLER'S REPORT TO THE CHAIRMAN—INDIAN HEALTH SERVICE NOT YET DISTRIBUTING FUNDS EQUITABLY AMONG TRIBES 15 (GAO/HRD 82-54, July 2, 1984) [hereinafter GAO REPORT]. *See also* REAUTHORIZATION COMM., pt. 2, *supra* note 52, at 10.

168. GAO REPORT, *supra* note 167, at 15.

169. *See* REAUTHORIZATION COMM., pt. 2, *supra* note 52, at 10. *See also* 4 NATIONAL INDIAN HEALTH BOARD REPORTER 17, (1986) [hereinafter NIHB 1986]. Although congressional appropriations expired in 1984, IHS has continued the program by setting aside approximately $5 million in FY 1985 for the equity health care fund.

170. *Id.* at 11, citing GAO REPORT.

171. GAO REPORT, *supra* note 167, at 15.

quirements . . . rather that to the distribution of the equity fund."[172]

In conclusion, the case law concerning the government's obligation to provide health care to Indians seems to acknowledge the presence of the trust while focusing on either IHS's own statutory obligations or the government's general duty of fairness that prohibits arbitrary denials of benefits to Indians.[173] No court has ever specifically held that the federal government is obligated by their trust responsibility to provide specific services in the absence of an explicit provision in a treaty, executive order, or statute.[174] Indians who feel they have been denied benefits often settle out of court upon receiving the services; thus little or no legal precedent is set for other Indians who are denied benefits.[175]

Modern Developments Concerning Indian Health

Certainly the most important current controversy affecting IHS and its Indian beneficiaries is the Deficit Control Act of 1985 (Gramm-Rudman) which will significantly alter both the appropriations process and the spending levels for several years to come.[176] The law sets budget deficit targets for FY 1986 ($171.9 billion) through FY 1991 ($0) in order to eliminate the deficit by that year.[177] If no plan can be agreed upon by both the administration and Congress to reach those targets, the President is required to impose automatic spending reductions to be applied equally to defense and domestic budgets, except for those programs expressly protected by the Act.[178]

There are two main categories of programs that receive protection from the across-the-board reductions of Gramm-Rudman. The first category includes programs such as Social Security Benefits,

172. *Id.* at 16.

173. See *supra* notes 160-166, 143-156 and accompanying text.

174. *See, e.g.*, Gila River Pima-Maricopa Indian Community v. United States, 427 F.2d 1194, 1198 (9th Cir.), *cert. denied*, 400 U.S. 819 (1970).

175. *See* ADVOCATE'S GUIDE, *supra* note 6, at 31 and nn.127, 128.

176. Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman), Pub. L. No. 99-177, 99 Stat. 1038 (1985) (to be codified at 29 U.S.C. § 901) [hereinafter Gramm-Rudman]. For a brief discussion of this law, see NIHB 1986, *supra* note 169, at 1-3, and 51 NATIONAL CONGRESS OF AMERICAN INDIAN NEWS 1 (1986) [hereinafter NCAI NEWS].

177. Gramm-Rudman, *supra* note 176, at § 201(a)(7)(A).

178. *Id.* §§ 211, 241, 252, 255, 256.

Medicaid, food stamps, and Supplemental Security Income, which are totally exempt from the mandatory reductions.[179]

The second category—which includes Indian health, Medicare, veterans' health, community health, and migrant health—is limited to a maximum 1 percent across-the-board cut in FY 1986 and a 2 percent maximum cut in later years, but the programs are subject to the full 4.3 percent cut in administrative expenditures.[180] Therefore, since the budget for the direct operations of the Indian Health Service and the administrative portions of hospital and clinical programs are considered administrative expenditures, they will not be partially exempt and will be subject to the full reduction.[181]

It should be noted that these protected programs are not exempt from large budget cuts in the regular appropriations process.[182] For example, the President's FY 1987 budget proposal has requested that the IHS budget be reduced by nearly $63 million.[183]

Another important controversy that may affect IHS involves the ineffectual attempts to extend the Indian Health Care Improvement Act of 1976. Amendments of that bill were vetoed by President Reagan in 1984 and failed to proceed past the committee level in 1985.[184] The proposed amendment and its progeny would

179. *Id.* § 255. (listing all the totally exempt programs). *See also* NCAI NEWS, *supra* note 176, at 3.

180. Gramm-Rudman, *supra* note 176, at §§ 256(K), 256(b).

181. *Id.*

182. *See* NCAI NEWS, *supra* note 176, at 3.

183. *Id.* at 1.

184. *See* Memorandum of Disapproval, *supra* note 5, at 1583 (President Reagan vetoed the 1984 version of the amendment). The 1985 versions of the amendment—Indian Health Care Improvement Act of 1985, S-277, 99th Cong., 1st Sess. (1985) and Indian Health Care Improvement Act of 1985, HR 1426, 99th Cong., 1st Sess. (1985) [both bills hereinafter cited as 1985 amendments]—have been placed on hold since May of 1985. Phone interview with Pat Zehl, Senate Select Committee on Indian Affairs April, 1986.

The 1985 amendments are essentially the same as their predecessor, except for the deletion of the controversial "Montana provision" in the 1985 version. This provision would have prohibited IHS from directing indigent reservation Indians to utilize state and local property funded programs (excluding Medicaid) before being considered eligible for IHS services. S.2166, § 204 (1984). The proposed provision would essentially make IHS the primary provider of health care for Indians in the state of Montana, requiring that IHS assume the obligation to pay for medical services now covered by state and local programs. *Id.* Under the provision, the IHS would not be considered a "residual" provider and would have to provide services to eligible Indians regardless of the Indians' eligibility for state and local services. *Id.* For example, if an Indian lived on nontaxable Indian land, and if the local services were funded by state property taxes, the local services (excluding Medicaid) would be excluded from consideration of that Indian's eligibility for IHS services. *Id.* Therefore, if the Indian was eligible for IHS services, IHS could not send him to

have amended and extended the authorizations of the 1976 Act programs, which expired September 30, 1984.[185] In a nutshell, the amendment also would have established the following programs: (1) an Indian Health Care Improvement Fund to be used to improve substandard IHS service units by expanding emergency medical services, accident prevention programs, and Community Health Representative Programs;[186] (2) a Catastrophic Health Emergency Fund designed as additional appropriations to help individual IHS service units meet extraordinary costs associated with the treatment of Indian disaster victims;[187] (3) an extension of IHS's current authority to be reimbursed by Medicare for all IHS funds spent in IHS hospitals, skilled nursing facilities, home health agencies, and rural health clinics that meet Medicare conditions and requirements for payment.[188] In addition, the amendment proposed removing the IHS from its present placement in the bureaucratic hierarchy and elevating it to a higher level within the Public Health Service.[189]

Proponents of the reauthorization amendment point out that the extension of authorizations would be necessary for IHS to continue to provide needed services for Indians, while the critics note that even without the 1976 Act, the Synder Act provides an open-ended authorization for IHS.[190] Indeed, in 1985, the Director of IHS promised that "there will be no disruption of existing programs" even without the Amendment.[191]

Despite such statements, many Indian advocates remain skeptical about the future of many IHS programs because they realize that decisions concerning IHS's budget will be made automatically by

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be cared for by a state agency (funded by property taxes) until all IHS appropriations were spent. *Id.* The provision came about as a result of pressure by Montana legislators who felt that their state and local programs should not have to provide care to on-reservation Indians who do not pay state property taxes to support such programs. *Id.* For a detailed discussion of this provision, see NIHB REP., *supra* note 66, at 12-13.

185. Memorandum of Disapproval, *supra* note 5, at 1583.

186. S.2166, 98th Cong., 1st Sess. § 201 (1984); S.277, 96th Cong., 1st Sess. (1985). This section listed generous authorizations for patient care, field health, dental care, mental health, alcoholism treatment, and maintenance and repair.

187. *Id.* Twelve million dollars were to be authorized to be distributed to IHS areas that had to fund costly disaster treatment. *See also* NIHB REP., *supra* note 66, at 15.

188. *Id.*

189. *Id.* For an overview of this elevation and the problems associated with it, see NIHB REP., *supra* note 66, at 13-14.

190. *Id.* at 2.

191. *Id.* at 2, citing Dr. Everett Rhoades' statements made in a memorandum issued to IHS area directors.

Gramm-Rudman or by OMB, not by officials within the IHS.[192] They also believe the 1984 veto may be the first step by a conservative administration to eventually "eliminate everything that is not clinical care" while reducing the IHS to the limited "on-reservation" system that existed before the Public Health Service assumed control in 1955.[193]

Conclusion

The IHS is a unique organization whose function of providing adequate health care to almost a million Indians is a commendable one. The IHS undoubtedly provides quality care to many Indians and the health status of American Indians is much higher than it was twenty-five years ago. Yet the goal of the IHS to "elevate the health status of Indians and Alaska Natives to the highest level possible" has not been reached and may never be,[194] as exemplified by the appalling conditions still existing on many reservations.[195] Skeptics can point to the present administration's policies and inefficient management within IHS as reasons why they feel the IHS's goal is unattainable.

Considering the Reagan administration's position concerning domestic welfare programs, it is easy to see why critics feel that IHS will never be funded on a sufficient level to fulfill its ambition. Reagan's "new federalism" policies, which propose to shift the burden of domestic programs to state and local governments, run directly counter to any increase in federal funding for health care to Indians. In light of these policies, it is no wonder that the creation of new programs or reauthorization of generous old programs, such as those proposed under the Reauthorization of the Indian Health Care Improvement Act, is viewed as "totally unacceptable."[196] In fact, rather than asking what new programs are to be created for IHS, a more realistic question would be to ask which programs are to be eliminated. While this view seems overly pessimistic, critics note that budget cuts in the true entitlements (Medicare/Medicaid), which have even greater lobbying power and provide care to much larger numbers of beneficiaries, are forebearers of bad tidings to IHS.

192. *Id.* at 2.
193. Statement of former IHS director Dr. Emery Johnson, *quoted in id.* at 14.
194. IHS TRENDS, *supra* note 48, at 1.
195. See *supra* notes 47-65 and accompanying text.
196. Memorandum of Disapproval, *supra* note 5, at 1584.

Although it is relatively easy for critics to blame the administration for the present woes of the American Indian, a second factor must also enter into the equation. Critics of the IHS contend that the IHS is inefficiently managed and immersed in a mass of bureaucratic layers, frustrating any attempt to improve this situation. Even its former director, Dr. Emory Johnson, feels that the IHS is a multimillion-dollar program "still largely managed like a 'mom and pop' grocery store."[197] Statements like this make even the uninformed public wonder what is going on within the IHS and, more important, why nothing is being done to correct it.

In addition to the two criticisms of the IHS noted by commentators, rapid inflation in the health care industry is an important factor to be considered in the ability of IHS to provide quality care to Indians on IHS's budget. It is well known that health care costs are inflating at more than 10 percent per year. As a result, it is important to remember that even if appropriations for IHS remain at the same level, fewer real dollars will actually be available to provide health care to Indians. This factor, taken in combination with the other problems already mentioned, makes it easy to see why many knowledgeable commentators are so skeptical about the future of health care for American Indians.

One important point to remember is that no single factor generated this problem, and no single remedy will cure it. A combination of factors could conceivably correct the problems already mentioned, but perhaps the surest way for American Indians is for them to begin planning for ways to at least supplement the residual care provided by IHS. At the tribal level, tribal members must be educated concerning all the alternatives to IHS care. Tribes who are financially stable should begin thinking of ways to encourage their members to provide for all or at least part of their own care to reduce the burden on the IHS. At some time in the future, means testing by income, cost sharing, and stricter eligibility requirements (only recognized tribal members over one-fourth Indian blood) are going to become issues and tribes should begin preparing now for them.[198]

197. REAUTHORIZATION COMM. pt. 1, *supra* note 3, at 72-37.

198. *See* NIHB 1986, *supra* note 169, at 3, 24. The Department of Health and Human Services is allegedly readying a proposed rule limiting IHS services to those who are one-quarter degree or more federally recognized Indian blood. Additionally, critics of the Gramm-Rudman Act feel that the Act will place even more pressure to eliminate funding for "nonclinical" programs, as well as encourage the IHS to redefine some of their basic policies such as available health benefits, third party collections, and eligibility. *Id.* at 3.