# Taking Health Care Into Their Own Hands: Why The Federal Government Should Encourage Tribes To Independently Operate Their Health Care Services

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Two Chosen Course Goals: 1) Increase students' substantive knowledge about the people, places and policies that relate to Indian Country in the contemporary era; 2) Deepen students' understanding of the central role that tribal sovereignty plays in directing, illuminating, and responding to contemporary events in Indian Country;

In 2017, the United States Government Accountability Office put the Indian Health Service (IHS) on its high-risk list – identifying the service as one that provides "critical services to the public", yet has "serious weaknesses". The IHS has since remained on this list, for its inability to "efficiently administer Indian… health care programs". Taking Sioux San Indian Health Service Hospital, in Rapid City, South Dakota, for example. In an article titled "Fed Up With Deaths, Native Americans Want to Run Their Own Health Care" by the New York Times, Mark Walker highlights, "five government investigations have found that patients have died at Sioux San from inadequate care, are often given wrong diagnoses and are treated by staff members who have not been screened for hepatitis and tuberculosis". The same article details the story of patient six-month-old James Ladeaux, who was turned away from Sioux San as a doctor assured his mother, Robyn Black Lance, that his second upper respiratory infection in a month was just a common cold. Twelve hours later James was struggling to breath, so Ms. Black Lance rushed him back to the hospital, where doctors, citing their lack of capacity to treat him, transferred him to Rapid City Regional Hospital. There, James was diagnosed with a life-threatening case of respiratory syncytial virus (RSV) and spent a week and a half being (successfully) treated in the intensive care unit. This case became the subject of another federal review.

Another investigation found that in 2011, a 57-year old woman showed up at the Sioux San emergency room complaining that she had trouble breathing and felt faint. The medical staff did not immediately examine her. She collapsed outside the emergency room, minutes later, hitting her head on the floor. The woman went into a seizure and died soon after. Another patient died the day after he was discharged from Sioux San, but the hospital had no records indicating

what was wrong with him. Because of this chronic mismanagement, Sioux San's emergency room and inpatient unit were shut down by the IHS and Congress in 2017, leaving the members of the Sioux, Cheyenne, Shoshone, Arapaho, Crow, and Flathead tribes, that had relied on Sioux San for their care, even if substandard, with only an understaffed urgent care clinic.

Sioux San is far from the only Indian Health Service hospital with these issues though. The U.S. Government Accountability Office found that over 60% of IHS medical buildings are in sub-par condition. A report prepared for the Department of the Interior found that "the number of doctors, nurses, and dentists is insufficient". Roll Call identifies the "seemingly intractable problems" that American Indian healthcare remains plagued by, including: "underfunding, quality deficiencies, a lack of agency leadership, and inattention in Washington". Of the 46 hospitals that the IHS runs or funds, most have fewer than 50 beds, and are understaffed by about 20%. Most of these hospitals are in remote areas, so they struggle with recruiting healthcare professionals. Additionally, Walker found that in 2017, the federal government spent $12,829 per Medicare patient, $7,789 per Medicaid patient, $8,602 per federal inmate, and only $3,332 per IHS patient. The IHS has clearly proved itself incapable of providing proper service to Indian Country. The service is grossly underfunded, under led, and under resourced, and Native American communities are paying for these deficits with their lives.

This issue runs deeper than IHS and extends to the question of why the federal government is responsible for providing tribal health reservations with specific, separate healthcare? Afterall, aren't they independent sovereign states? The answer to these questions relies on the acknowledgment of their persisting tribal sovereignty, from before America's founding. On July 8th, 1970, Richard Nixon, in an address that would mark the beginning of the era of self-determination in federal Indian Affairs, affirmed,

> "The special relationship between Indians and the federal government is the result of solemn obligations that have been entered into by the United States government. Down through the years, through written treaties and formal and informal agreements, our government has made specific commitments to the Indian people. For their part, the Indians have often surrendered claims to vast tracts of land and have accepted life on government reservations. In exchange, the government has agreed to provide community services such as health, education and public safety—services that would presumably allow Indian communities to enjoy a standard of living comparable to that of other Americans. This goal, of course, has never been achieved. But the special relationship between the Indian tribes and the federal government that arises from these agreements continues to carry immense moral and legal force."

Similarly, in "Remarks to Native Americans and Native American Tribal Leaders" in 1994, Bill Clinton vowed to "respect your right to remain who you are and to live the way you wish," "to honor and respect tribal sovereignty based upon our unique historic [government-to-government] relationship," and "to fulfill the trust obligations of the federal government." The sovereignty of tribal nations was acknowledged by the founders of the United States, and enshrined in treaties derived from traditional European legal theory, which were drafted upon the same diplomatic respect that the founding fathers afforded to foreign nations. Tribal nations were regarded as "nations within a nation" or "domestic dependent nations". The treaties obligate the federal government to protect tribal self-governance, tribal lands, assets, and resources, according to the National Congress of American Indians (NCAI). Resources include social services such as education, housing, and healthcare. This responsibility is referred to as the "trust obligation" and is premised on "the fact that American Indians and Alaska Natives had aboriginal claims to all land in America", yet are now restricted to small fractions of that by way of reservations. Between 1887 and 1934, the U.S. government forced tribal nations to cede 90 million acres of their traditional lands, at the authority of the Dawes Act. Currently, 56 million acres of land are held in trust by the federal government for the 334 Indian land areas administered as federal Indian reservations, the rest of the acreage having been sold to private owners. Cession treaties

often listed medical care as partial compensation for the land. Congress also acknowledged the trust responsibility via the Snyder Act of 1921, and allocated funds to the Bureau of Indian Affairs for the "the relief of distress and conservation of health" of Native Americans.

In 1955, the Indian Health Service was established as a bureau of the U.S. Public Health Service to carry out the government's trust obligation to provide health care services. This obligation is regarded by the Supreme Court as "a moral obligation of the highest responsibility and trust" (Seminole Nation v. United States, 1942). Rear Adm. Michael Weahkee, a member of the native Zuni Tribe and top official in the IHS, told Walker, "I don't think the federal government has fulfilled its treaty obligations for providing health care because it has not provided I.H.S. with the resources to do so," aligning with the consensus of many tribal leaders and members. We are failing our Native American population, not just by violating the trust agreement, but by neglecting a vulnerable population of Americans. In states with IHS hospitals, Native Americans are three to five times more likely than the rest of the population to die from preventable diseases, such as alcohol-related illnesses, diabetes, and liver disease. According to Roll Call, they are also 60 percent more likely to commit suicide and twice as likely to die during childbirth. On average, Native American life expectancy is five years shorter than that of the rest of the US population. Despite the poor health outcomes and rampant underfunding, Congress has consistently declined to increase the IHS's funding, or "overhaul the way Native Americans get health care", Walker explains. This issue is largely stagnant.

Presently, care from IHS operated facilities is often the only affordable option for many tribal residents, as expenses incurred outside the IHS are not often covered by the federal government. Trips to private hospitals to receive quality care can be extremely pricey and tribal members must petition the IHS for reimbursement for such bills. Between 2016 and 2019, the

IHS was forced to decline 500,000 of these petitions, due to their own pre-existing financial struggles, saddling the patients with more than $2 billion in medical debt. Dr. Brook Eide, an emergency room doctor at Rapid City Regional Hospital, near the former Sioux San Hospital, tells Walker, “It is sad to see the impact on patients. The impact emotionally and financially. It’s devastating.”

Native Americans are fed up and some tribes have begun taking matters into their own hands, assuming control of their hospitals. Acoma-Cañoncito-Laguna hospital was a joint hospital between the Pueblos of Acoma and Laguna, and the Cañoncito Navajos. In early 2021, the Pueblo of Laguna decided to take its share of the hospital’s budget and start its own independent clinic. In another Times article, titled “Native Americans Reliant on Hospital Feel Abandoned by U.S. During Pandemic”, Gov. Wilfred Herrera Jr. of the Pueblo of Laguna tells Mark Walker that “the people of Laguna had long been frustrated with the care they received from the hospital.” The Indian Self-Determination and Education Assistance Act (ISDEAA), passed by Congress in 1975, also known as P.L. 93-638, enabled the Pueblo of Laguna to make such a move. Under “638”, tribes have the option to administer or “assume control over health care programs and services that the IHS would otherwise provide” – using IHS funding to take over their health care management. Unfortunately, the IHS was not financially equipped to fully support the Acoma-Cañoncito-Laguna hospital without Laguna’s share. Walker explains that “the health service was caught between the desire of one constituency to take control of its own health care and the need of another to keep a well-established hospital operating.” With reduced funding, the IHS proceeded to close the hospital’s emergency room, women’s services and inpatient critical care units. Over half of the full-time employees would be let go.

Understandably, the Pueblo of Acoma and the Cañoncito Navajos who were still reliant on the hospital "felt abandoned by the federal government during an acute public health crisis."

Native Americans suffered disproportionately high infection and death rates during the COVID-19 pandemic. This slashing of services effectively created a health desert during a public health emergency, and the local tribal residents felt defenseless. Wendy Sarracino, a community health representative for the Acoma people, said to Walker, "that was kind of our lifeline…an awareness needs to be made that people do live in rural New Mexico and we need health care." Yolanda Sanshu, lifetime resident of the Acoma Pueblo, told Walker that her best option for health care is now an hour away in Albuquerque. Zelda Seymour, cancer patient at Acoma-Cañoncito-Laguna hospital put the issue perfectly to Walker, "There's already so much loss that we have to deal with in terms of the unavailability of goods and services because we live on the reservation, so basically we are fighting to keep whatever we can because at this point the health of our community isn't great enough to sustain itself on it own."

The Pueblo of Laguna is one of an increasing number of tribes that have had enough with the federal government's mismanagement of their healthcare, opting to take their portion of IHS funds and operate their hospitals independently, believing they can do a better job of running them. As are those that relied on Sioux San. In 2019, two years after the IHS shutdown the emergency room and inpatient unit, the nonprofit Great Plains Tribal Chairmen's Health Board took over the hospital's operations. The Great Plains Tribal Chairmen's Health Board represents 18 tribal communities across South Dakota, North Dakota, Nebraska, and Iowa. They developed a plan to "reopen the inpatient hospital and the emergency room, recruit more qualified doctors and health care workers, and upgrade equipment", as reported by Walker in 2019. However, establishing and maintaining these systems without IHS infrastructure can be financially

burdensome. To bring this costly plan to fruition, the Plains Health Board would need to secure millions of additional dollars in the coming years. Lacking sufficient casino revenue, they pursued additional federal grants beyond the Indian Health Service, and worked to increase their funding from Medicaid and Medicare to finance the needed hospital upgrades.

The most successful example of self-determination by way of independent health care operation is the Alaska Native Tribal Health Consortium (ANTHC). The ANTHC split off from the IHS in 1998. Since then, per their executives, alongside their allotment from the IHS, they fund their clinics by "aggressively seeking grants", billing Medicaid and Medicare, and partnering with the Department of Veterans Affairs. Charmaine White Face, a member of the Oglala Sioux expressed her doubts in Sioux San's new management, "In order to be successful like in Alaska, the tribes, or the native organization, has to have a lot of other resources, and the tribes here in the Great Plains do not. We are too poor here."

Alaska has a unique system of self-determination and sovereignty for their Natives. Alaska is largely organized in a "corporation model", in contrast to the traditional reservation model in the lower 48. There is one land-in-trust reservation in Alaska, but the majority of the land is owned by Alaska Native shareholders, split into regions by the 229 tribal nations that make up the corporations. The Alaska Native Claims Settlement Act of 1971 created this system to address aboriginal land claims of the Alaska Native community. The NCAI explains, "ANCSA allotted [over] 40 million acres of fee simple land, divided among 12 for-profit regional Native corporations and 220 village corporations, established to manage Alaska Native lands and resources. A thirteenth corporation was formed in 1975 to represent Alaska Natives residing outside the state… ANCSA and Alaska state corporate law regulate these corporations."

The corporation model, where shareholders own the land in fee-simple and must turn a profit through economic development, is quite different from the reservation model in the lower 48, but the health care arrangement largely works the same. However, as corporations have more financial independence than reservations, transitioning to an independently operated health care system is easier. Prior to ANCSA and P.L. 638, the Bureau of Indian Affairs opened the Anchorage Medical Center to provide Alaska Natives with healthcare; the IHS assumed management of the center in 1955. In 1994, Alaska Native Tribes, and consortiums of tribes, formed the Alaska Tribal Health Compact (ATHC) to operate their healthcare independently, and define their relationship with the IHS. About 99% of the IHS Alaska Area budget is allocated to the ATHC, which provides care for the ~242,000 Alaska Natives. This budget supports hospitals located in Anchorage, Barrow, Bethel, Dillingham, Kotzebue, Nome, Sitka, and Wrangell, 72 tribal health centers, 148 tribal community health aide clinics, and five residential substance abuse treatment centers across the state. Alaska Native Tribal Health Consortium is an example of one of the co-signers of the compact, and it was founded in 1997. As mentioned previously, IHS funds alone cannot support this scale of operations, and such a wide range of services, so the consortium secures revenue from other sources such as billing Medicare, Medicaid, and private insurance, as well as state, federal, and private grants.

The ANTHC was founded to prioritize local decision-making. “Our health in our hands”, an ANTHC informational campaign on the history and current status of tribally managed health care in Alaska, highlights the establishing principles of self-determination and self-governance of the consortium. According to the campaign, “Leaders felt it was essential for Alaska Native communities to take an active role in managing health care problems and solutions, rather than being treated as passive recipients of federal services.” Vivian Echavarria, the vice president of

professional and support services for the ANTHC, emphasized the unique needs of Alaskans, and expressed that national priorities did not always align with Alaskan priorities. Echavarria says, "'I'm not trying to knock down Indian Health. It's just that Indian Health is a government entity that has its governance from people in Maryland. You are banking [on] the decisions from people that may not have a clue as to what the real health care concerns are of the [local] people.'" For example, she recalls nationwide IHS programs to prevent hantavirus – a disease that, while relevant in areas like the Four Corners, which have a large population of Native Americans, has zero reported cases in Alaska.

This model of independent health care management, as exemplified by Alaska, offers tribal residents higher quality care, more personalized to the community. Lynn Malerba, chief of the Mohegan Tribe and former chairwoman to the Tribal Self Governance Advisory Committee, an advisory body to the IHS, found that the tribes managing their own healthcare systems, and are able to overcome such financial obstacles, tend to see healthier, more satisfied citizens. Studies conducted by the Alaska Native Tribal Health Consortium found the following: Since 1984, life expectancy at birth has steadily increased for Alaska Native people statewide, from 67.0 years to 70.4 years. Among the same population group, the age-adjusted all-cause mortality rate per 100,000 people has decreased from 1,207.3 to 1,077.7. From 1987 to 2019, Infant Mortality Rate per 1,000 live births has decreased from 16.4 to 10.3 Age-Adjusted Heart Disease Mortality Rate per 100,000 people has decreased from 274.4 people to 183.3 people. There are many variables that go into these trends, most of them likely unmeasurable, but improvements in the access to quality health care in a community cannot be discounted as having a significant impact on that population's health and wellbeing. Though patient satisfaction survey results are

not publicly available, one could generally assume that these positive trends go hand in hand with improved patient experiences.

Along with improving health outcomes, independent clinics can better address the aforementioned “unique needs” of indigenous populations. Many tribes still practice their ancestral rituals, ceremonies, and prayers to restore balance and harmony between the body, mind, and spirit. Historical oppression and forced assimilation has resulted in “deference for such traditions” within Western medicine, according to the National Indian Council on Aging. However, more and more doctors are beginning to recognize the importance of holistic medicine in promoting a patient's overall wellness by connecting them with, and affirming, their cultural, ethnic, and religious identities. Mental and physical health often go hand in hand. An article in the Tribal College Journal titled "Hogans in Hospitals: Navajo Patients Want the Best of Both Worlds" describes the holistic care services available to patients at Chinle Indian Health Service Hospital. Most notably, the hospital constructed a “healing room” in the shape of a Navajo Hogan, where medicinemen can perform ceremonies and prayers over the patients. For example, these rituals are performed to “[prepare] Navajos for the birth of their children, entry into womanhood, cleansing of returning soldiers, and preparation for stepping into the next world.” Dr. Joseph Jacobs, a Mohawk and director of the Office of Alternative Medicine for the National Institutes of Health, asserts,

> “‘It’s very important for the physicians and nurses and other health care providers to try to understand and work with the traditional healers of the communities. If you don’t consider the belief systems of people, then you can’t adequately integrate Western medicine into the care of indigenous people. It’s foolish not to do it.’”

Senior director of community health services for ANTHC, Tina Woods, emphasizes that, “‘Promoting Alaska Native traditions such as Native language, storytelling, songs and dances, traditional foods and plants are the best medicine for treating our people in a holistic manner.’”

This kind of above-and-beyond care is only feasible with Independent health care operation. According to Woods, the ANTHC strives to "'take a culturally responsive approach to promoting wellness in a way that was not imaginable prior to self-governance'". Holistic medicine, informed by indigenous tradition, goes hand-in-hand with a concept called "culturally competent care". Culturally competent care sees the patient as an individual, and includes social determinants of health in their care plan. For example, socio-economic conditions such as poverty and limited access to healthcare or education can play a part in physical (and mental) health. Native Americans have experienced unique environments, cultures, histories, and circumstances as a population – the acknowledgement of which is "fundamental to improving health outcomes and reducing longstanding disparities and inequities", according to the U.S. Department of Health and Human Services' Office of Minority Health.

It is clear that independently operated health care services better serve our Native American populations, providing both better tangible physical health outcomes and quality of care. Through the perennially struggling and run-down Indian Health Service, the federal government is failing to uphold its treaty obligations. A shift in health care strategy by the federal government to encourage tribes to take advantage of their rights granted by P.L. 638 and assume control over their health care could improve these outcomes more broadly. Such a move though should not only shift the IHS funding but also bring it up to levels more comparable with other federal programs. Longer term financial infusions into Native American health care of our is critical for the health and survival of this at risk population. First, these funds should be put towards recruiting healthcare professionals who will stick around. Rural hospitals all struggle with high rates of turnover. A study from Massachusetts General Hospital finds that healthy doctor-patient relationships, ones founded on the sort of trust and loyalty that result from

longer-term employee retention, “can produce health effects as beneficial as some common treatments, such as taking a daily aspirin to prevent heart attack.” To encourage this employee retention, the federal government needs to provide tribes with the money to offer salaries that are competitive with urban hospitals. Additionally, according to the Association of American Medical Colleges, “medical students who grow up in small communities far from urban centers are much more likely to return to them to practice, research shows.” The federal government should invest in talent programs to encourage young Native Americans, and residents of rural communities in general, to go into medicine. There is already some headway with this initiative: the IHS runs a scholarship program to provide Native Americans with the “opportunity to establish an educational foundation for a career in health care and serve medically underserved Indian health programs throughout the country.” This scholarship was founded in 1978, and has since awarded nearly 7,000 students. Finally, funds must also be used to upgrade facilities and invest more money into each patient per year – possibly a rate comparable to that of Medicare patients. Former Senator of North Dakota, and chairman of the Senate Committee on Indian Affairs, Byron Dorgan dismayedly expressed to Walker in an interview, “These were the first Americans and they have been getting second-class health care, if any at all.” The trust obligation is predicated on the preexistence of tribal sovereignty, and the provision of health care is part of this obligation. Any changes in federal Indian policy must strive to uphold the trust responsibility and be for the betterment of Native lives on and off the reservations, if not because of what we owe the First Peoples, than because of what we owe our fellow American citizens.

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