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## ***Healthcare Policy for American Indians Since the Early 20th Century***

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## **Abstract**

Healthcare policy for American Indians cannot be understood apart from the US government's Indian policy more generally, and neither Indian policy in general nor healthcare policy in particular has been consistent over the past century or more. Moreover, they have often appeared to be inconsistent in their aims.

From the late 19th century to the 1930s, the emphasis of Indian policy was on the assimilation of Indians into the larger US society, and their abandonment of tribalism. With the coming of the New Deal in the 1930s, policy shifted to what would now be called self-determination. By the early 1950s, however, self-determination had been abandoned in favour of assimilation, manifested in the government's attempt – successful in several instances – to terminate the special trust status of Indian tribes. By the late 1960s, that policy had been abandoned and self-determination was once again the stated policy.

The consequences for health policy have been paradoxical. Despite the concern to create better health services responsive to the needs of Indians during the New Deal of the 1930s, for instance, quality and access did not improve noticeably. On the other hand, in the 1950s, when termination of Indians' special status had become the goal, it became evident that, without a significant improvement in health status, they would be unable to assimilate adequately. Thus, services were improved significantly, with beneficial consequences for health.

That improved system of health services became the target of criticism by many who believed that it was insufficiently responsive to community needs. Changes in federal legislation in the 1970s allowed tribal governments and other entities to assume responsibility for the management and provision of services without, however, providing a mechanism for financial support to grow as the costs of care increased. Thus there has been little increase in financial support for services over the past 20 years or so, and the result has been that both preventive and curative services have suffered, and the mortality rate of Indians has increased.

**Keywords:** American Indians, Health care, Health policy, Self-determination, Mortality.

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## Introduction

In the English-speaking liberal democracies of North America and Oceania, European contact with indigenous peoples caused catastrophic population losses initially, and recovery only relatively recently. In addition, policies with respect to the treatment of the original indigenous inhabitants have been broadly similar, moving from subjugation to assimilation to self-determination.<sup>1</sup> In all four of these settler societies, (Australia, Canada, New Zealand and the United States), policies for the past generation or so have favoured greater autonomy and self-determination for the indigenous people.

The reasons for this convergence have to do with both diffusion of influences among them, and broadly similar socio-economic changes within each country. Each has become increasingly urban, and as the bulk of each population has become less involved in farming and extractive industries, they have become increasingly removed from contact and conflict with indigenous people, and increasingly sympathetic to the claims for the restitution of land rights and protection of the environment.<sup>2</sup> Members of the settler societies, whose interests still conflict with those of indigenous people, tend to be far less sympathetic to their claims to land, fishing rights and natural resources.

Within these very broad similarities, however, there are great differences among countries that are shaped by their histories of contact and by the differences among and within both the settler and the indigenous societies. For ease of exposition, I shall deal only with policy changes in the United States since the late 19th century.

## American Indians and African Americans

Because much has been written about the consequences of slavery and continuing discrimination for the health of African Americans,<sup>3</sup> this paper deals with a smaller minority group in the United States, namely American Indians and Alaska Natives. There are, however, some illuminating similarities and differences between them that are worth mentioning briefly. An important similarity has to do with the importance of federalism.

In the United States there has historically been tension between those who would centralise power in the federal government and those who would de-centralise it to the states. This was built into the structure of the government at the founding of the republic and continues to be a live issue into the present. Typically,

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<sup>1</sup> Kunitz, S.J. (1994). *Disease and Social Diversity: The Impact of Europeans on the Health of non-Europeans*. New York: Oxford University Press.

<sup>2</sup> Kunitz, S.J. (2000). 'Globalization, states and the health of indigenous peoples'. *American Journal of Public Health*, 90, 1531-1539.

<sup>3</sup> See for instance Kunitz, S.J. with Pesis-Katz, I. (2005). 'Mortality of white Americans, African Americans, and Canadians: The causes and consequences for health of welfare state institutions and policies'. *Milbank Quarterly*, 83, 5-39.

liberals are said to support centralisation and 'big government' and conservatives decentralisation and small government, but the dividing line is not as clear as the conventional wisdom suggests. It was conservatives who advocated passage of the 18th amendment to the Constitution, which made the sale of alcoholic beverages a federal offence instead of a local option. And it was under a liberal administration that community control of services in poor neighbourhoods was supported during the 1960s.

Nonetheless, with regard to the rights of minorities, it has generally been the federal government that has been cast in the role of protector, often only with great reluctance, whereas states have generally been less willing protectors. In the case of both African Americans and American Indians, local and state interests have supported the interests of whites and have resisted the intrusion of the federal government on behalf of minority populations, especially with regard to the civil rights of African Americans and the protection of Indian land rights and natural resources. Because state interests are well represented in the federal government, particularly in Congress, such resistance has often been effective. For instance, in the 1930s southern congressmen were able to exclude many African Americans from the benefits of New Deal legislation, and as we shall see, similar differences between state and federal agencies have been important in Indian health policy throughout the 20th century.

On the other hand, an important difference between the situations of African Americans and American Indians has to do with tribalism. Though the slaves who were brought from Africa were members of many different tribes, those differences were vaporised in the crucible of slavery. In contrast, because many Indian tribes, especially west of the Mississippi, have been able to retain land (even if much diminished) since the time of early contact with Europeans, tribal diversity and cultural differences have remained important, as have differences in access to political influence, economic opportunities, and services, including health services.

One result has been significant regional and tribal differences in health, a vast topic about which too little is known. What is known, however, suggests that the relative size of Indian populations in a state often has a very significant impact on that state's congressional delegation and the willingness of representatives and senators to work on behalf of their Indian constituents. For example, Alaska Natives represent a large proportion of the population of Alaska and control important natural resources. This is not unrelated to the relatively generous federal funding of healthcare for Alaska Natives compared to the funding of services for indigenous people in the lower 48 states. These issues, too, are important with respect to Indian health policy.

## **Health policy for American Indians**

Policy with respect to health services for American Indians has been embedded within, and responsive to, Indian policy more broadly. And Indian policy has in its turn been responsive to political, economic and cultural forces that have their sources well beyond Indian country. As in the other Anglophone countries mentioned above, policy has swung between the poles of assimilation and tribalism or nationalism. Assimilation refers to the incorporation of Indians into the larger population, based upon the assumption by Indians of the individualism and acquisitiveness that have been important characteristics of American

society. Claims to land and natural resources as the property of tribal entities were to be foregone as Indians assumed the rights and obligations of citizenship. On the other hand, tribalism or nationalism, now called self-determination, refers to the maintenance of distinct tribal entities, considered domestic sovereign nations with treaty rights to land, natural resources, and services, maintaining their own cultures, and controlling services and economic development on their own territory.

Until the 1870s, tribes were dealt with as collectivities and treaties were agreed upon, or more often forced upon them after military defeat. In 1871, however, Congress deprived Indians of the right to enter into treaties but did not at the same time grant them citizenship.<sup>4</sup> Moreover, rights to land and resources were eroded by subsequent legislation, perhaps the best known of which was the General Allotment Act of 1887, better known as the Dawes Severalty Act. This Act, and others like it, allotted reservation land to individual Indians. The land that remained was then thrown open to acquisition by non-Indians. This was clearly a way of dispossessing Indians and making their resources available to others. The rationale was that once Indians owned land as individuals, they would be on their way to assuming the values of the larger society.

## Assimilation

Justifying this policy was the social evolutionism that pervaded much western thought, including ethnology, in the late 19th century.<sup>5</sup> The development from savagism through barbarism to civilisation was believed to be a universal process. John Wesley Powell and his colleagues at the Bureau of American Ethnology did not think that savages and barbarians were physically or mentally different from civilised people, but that culturally and technologically they were far less advanced. Thus, while they liked and respected many of their Indian informants, an attitude that distinguished them from many other Anglo-Americans, they shared the widely held belief that Indians must ultimately give way to a higher civilisation.<sup>6</sup> It was therefore one of the tasks of ethnology to salvage whatever could be learned of the languages and cultures of the indigenous peoples of the United States,<sup>7</sup> both to help with policy making and administration, and to justify and explain the higher claim of Europeans to Indian lands. Ethnologists believed that one world community would evolve, with separate races disappearing, but with the descendants of the most advanced dominating. William Henry Holmes, a colleague of Powell's, wrote:

In the inevitable course of human history the individual races will probably fade out and disappear, and the world will be filled to overflowing with a generalized race in which the

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<sup>4</sup> Jorgensen, J. (1978). 'A century of political economic effects on American Indian society, 1880-1980'. *The Journal of Ethnic Studies* 6, 1-82, pp. 10f.

<sup>5</sup> Hinsley, C.M. (1981). *The Smithsonian and the American Indian: Making a Moral Anthropology in Victorian America* (Chapter 5). Washington, DC: Smithsonian Institution Press.

<sup>6</sup> Worster, D. (2001). *A River Running West: The Life of John Wesley Powell* (pp.112-113, 262, 266). New York: Oxford University Press.

<sup>7</sup> Gruber, J.W. (1970). 'Ethnographic salvage and the shaping of anthropology'. *American Anthropologist* 72,1289-1299.

dominating blood will be that of the race that today has the strongest claim, physically and intellectually, to take possession of all the resources of the land and sea. The resultant race will not have of the native American blood even this one three-hundredth part, because they are decadent as a result of conditions imposed by civilization.<sup>8</sup>

Powell himself believed that government policy had been for the most part benign and administered by honourable men. Writing not long after passage of the Dawes Allotment Act in 1887, he claimed that at the time of Columbus, Indians in what became the United States numbered between 500,000 and one million. By the 1890s they numbered about 250,000. The decline had been caused by warfare with whites, as well as between tribes, and by 'the presence of civilization itself', for 'the diseases of the lower classes of the white race were introduced among the Indians.' However, Powell continued, an army of missionaries and teachers had accomplished much, though impediments to progress remained. The most important of these were: Indian religion and the resistance of the 'shamans' found in every tribe who were 'believed to be endowed with wonderful powers of sorcery'; Indian reluctance to engage in the civilised arts; 'tribal organization', which, being based upon kinship, discouraged individual ownership and inheritance of land; and the great number of different languages spoken by Indians. All of this would change, he wrote. Land was being purchased from Indians at fair prices; warfare had almost entirely ceased, largely replaced by farming and industry; and 'in a generation or two the pristine tongues will all be gone'. Indeed, with wise and humane administration, 'for two generations more, the problems will be solved; the remnant of the Indians will be saved and absorbed in modern enlightenment.'<sup>9</sup>

Washington Matthews, a military physician who wrote the first ethnographic studies of Navajo Indians, who was a colleague of Powell's at the BAE, and who wrote about the impact of consumption (tuberculosis) on the Native American population, observed:

Nowhere in this or other papers do I speak of the actual possession of civilization as injurious to the Indian, ... but I refer instead to the evils that result from 'contact with civilization', from 'the influences of civilization' etc. The policy hitherto pursued by our people toward the Indians has resulted in maintaining a certain large and representative portion of them and their mixed descendants as isolated communities of barbarous aliens in the midst of a civilized population, too busy with other matters to try to understand them, and generally too selfish to consider their weakness. The means of leading a successful healthy savage life has been taken away from them, never again by any possibility to be restored, while the means of leading a successful civilized life has not been furnished them instead.<sup>10</sup>

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<sup>8</sup> Quoted in Hinsely (1981), *op cit.*, p. 113.

<sup>9</sup> Powell, J.W. (1893). 'Are our Indians becoming extinct?' *Forum* 15, 343-354, 346, 348, 352, 354. See also Worster, *op cit.*, pp. 542-543.

<sup>10</sup> Matthews, W. (1888). 'Further contributions to the study of consumption among the Indians'. *Transactions of the Fifth Annual Meeting of the American Climatological Association*, Philadelphia, 136-155, 154.

Matthews believed that more specialised schools for Indians, like Carlisle and Santee, were required, schools that educated young people who never thereafter returned home but blended into the larger society. This was, he recognised, a policy of extermination. 'Any policy which tends to assimilate the Indian to the white population is, in one sense, but not a cruel sense, a policy of extermination.'<sup>11</sup> Nonetheless, given the realities of the situation as he saw it in the 1880s, it seemed the most humane solution. Indeed, it was the same solution – called 'Americanisation' – espoused by many reformers of the time as they considered the situation of immigrants to rapidly growing urban slums.<sup>12</sup> So widespread, indeed, was the assumption of the disappearance of American Indians that even Franz Boas, a critic of Powell's social evolutionism, believed that ethnology at the BAE would cease to exist as its subjects became extinct in 20 years' time.<sup>13</sup>

This was not an unreasonable assumption. While there is no agreement about the size of the indigenous population of the western hemisphere at the time of first European contact,<sup>14</sup> there is unanimous agreement that the native population experienced a dramatic decline subsequently. As noted above, the same sort of decline was observed in Australia and Polynesia, but not on the Eurasian landmass or in Africa.<sup>15</sup> The differences in economic development between the regions where the indigenous populations collapsed and where they did not, have been commented upon by others.<sup>16</sup> There is little doubt that where 'good' institutions and economic development occurred, the environment was relatively safe for Europeans. It is just as clear, however, that Europeans were detrimental to the health of the indigenous peoples of those regions, for the populations that declined had no history of exposure to many of the diseases imported by Europeans and subsequently by African slaves, and hence they were especially susceptible. In addition to disease, warfare and dispossession had equally profound consequences, so much so that by the late 19th century, when the indigenous population of the United States reached its nadir, many observers – whether they believed in social evolution or not – could assume that Indians would disappear entirely. Indeed, economic development and 'good' institutions took root where the indigenous peoples had been exterminated, or nearly so.

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<sup>11</sup> Matthews, *ibid*, p. 155.

<sup>12</sup> Elliott, M.A. (1998). 'Ethnography, reform, and the problem of the real: James Mooney's *Ghost Dance Religion*'. *American Quarterly* 50, 201-233. Prucha, F.P. (1973). *Americanizing the American Indians: Writings by the 'Friends of the Indian' 1880-1900*. Cambridge, MA: Harvard University Press.

<sup>13</sup> Hinsley (1981), *op cit.*, p. 277. See also Gruber, *op cit.*, p. 1297.

<sup>14</sup> Henige, D. (1998). *Numbers from Nowhere: The American Indian Contact Population Debate*. Norman, OK: University of Oklahoma Press. See also Livi Bacci, M. (2008). *Conquest: The Destruction of the American Indians*. Cambridge, UK: Polity Press.

<sup>15</sup> McNeill, W.H. (1988). *Plagues and Peoples*. New York: Anchor Books.

<sup>16</sup> E.g. Bayly, C.A. (2008). *Indigenous and Colonial Origins of Comparative Economic Development: The Case of Colonial India and Africa*. Policy Research Working Paper 4474. Development Research Group, Poverty Team. Washington, DC: The World Bank. Acemoglu, D., Johnson, S.A. and Robinson, J.A. (2001). 'The colonial origins of comparative development: An empirical investigation'. *American Economic Review* 91, 1369-1401.

## Communitarianism from the 1920s to the 1940s

And yet Indians did not disappear. While mortality was high in the late 19th and early 20th centuries<sup>17</sup> and has continued to be higher than in the rest of the US population, and though census data are very far from perfect, there is convincing evidence that throughout the 20th century the Indian population increased, though at different rates and for different combinations of reasons in different tribes. From 248,000 in 1890, the population increased to 524,000 in 1960, an increase of 1.1 percent per year, the result of very high mortality and fertility. By 1990 the population had increased to 1,959,000, implying an impossibly high average annual growth rate of 4.3 percent since 1960, the result of reduced mortality, continuing high fertility, and rapidly changing self-identification on the part of respondents to the Census.<sup>18</sup> Despite changing self-identification, the dramatic increase was real and is substantiated when particular tribal populations are considered more closely.<sup>19</sup> Without doubt the most dramatic growth has been in the past 40-50 years.

The reasons for the slow rate of increase in the pre-World War II period were poverty and substandard living conditions, virtually non-existent economic growth, the continuing expropriation of Indian resources, and abysmal health services.<sup>20</sup> In 1921 the Snyder Act (PL 67-87) was passed, providing 'such monies as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States,' including 'for relief of distress and conservation of health',<sup>21</sup> and in the 1930s a significant change in Indian policy did take place. Despite these changes, it is very difficult to believe that they led to changed practices resulting in dramatic improvements in the health status of the population. Descriptions of services available to Indians on various reservations in the 1930s invariably describe overcrowded facilities, insufficient and inadequately trained staff, and low morale.<sup>22</sup>

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<sup>17</sup> Shoemaker, N. (1999). *American Indian Population and Recovery in the Twentieth Century*. Albuquerque, NM: University of New Mexico Press. Hacker, J.D. and Haines, M.R. (2006). 'American Indian mortality in the late nineteenth century: The impact of federal assimilation policies on a vulnerable population'. Working paper 12572. Cambridge, MA: National Bureau of Economic Research.

<sup>18</sup> Passel, J.S. (1996). 'The growing American Indian population, 1960-1990: Beyond demography'. In Sanderfur, G.D., Rindfuss, R.R. and Cohen, B. (Eds.), *Changing Numbers, Changing Needs: American Demography and Public Health* (pp.79-102). Washington, DC: National Academy Press.

<sup>19</sup> Shoemaker (1999), *op. cit.* Trafzer, L.E. (1997). *Death Stalks the Yakama*. East Lansing, MI: Michigan State University Press.

<sup>20</sup> Meriam, L. and others (1928). *The Problem of Indian Administration*. Institute for Government Research. Baltimore, MD: The Johns Hopkins Press. See also Kunitz, S.J. (1983). *Disease Change and the Role of Medicine: The Navajo Experience*. Berkeley, CA: The University of California Press; Trennert, R.A. (1998). *White Man's Medicine: Government Doctors and the Navajo, 1863-1955*. Albuquerque, NM: University of New Mexico Press; and Davies, W. (2001). *Healing Ways: Navajo Health Care in the Twentieth Century*. Albuquerque, NM: University of New Mexico Press.

<sup>21</sup> The Snyder Act, PL 67-87, Nov. 2, 1921. Available on the website of the Department of Health and Human Services, Indian Health Service, Congressional and Legislative Affairs Office: [http://www.ihs.gov/AdminMngrResources/legislativeaffairs/legaffairs-key\\_acts.asp](http://www.ihs.gov/AdminMngrResources/legislativeaffairs/legaffairs-key_acts.asp). Accessed 1 February 1 2008.

<sup>22</sup> See for instance Kunitz, S.J. (1996). *Disease Change and the Role of Medicine*, *op. cit.*, pp. 146-148. Abel, E.K. and Reifel, N. (1996). 'Interactions between public health nurses and clients on American Indian reservations during the 1930s'. *Social History of Medicine* 9, 89-108.



The policy supported by President Roosevelt's New Deal Administration in the 1930s emphasised the importance for native peoples of having viable tribal communities. It was, according to one historian of the period, an 'assault on assimilation'.<sup>23</sup> Despite dilution by Congress of the original bill,<sup>24</sup> the Indian Reorganization Act of 1934 allowed for the purchase and consolidation of Indian lands, the creation of tribal governments, and the establishment of schools on reservations. The Bureau of Indian Affairs, under its commissioner, John Collier, also hired anthropologists to do studies among various tribes in order to improve the understanding by bureaucrats of the people they were supposed to be serving,<sup>25</sup> a policy that was derided by many career BIA employees as 'the anthropological approach.' Despite anthropological research, and despite the fact that democratic decision-making on the part of tribes was the goal, the administration of the BIA tended to be heavyhanded and top down. Moreover, resources for significant tribal enterprises such as cattle ranching were not made available, although the federal government did provide such support to non-Indian agricultural enterprises.<sup>26</sup>

Nonetheless, compared to the previous period, the Collier years represented a distinct improvement for Indians. Indeed, federal policy was understood by many non-Indian westerners and their congressional delegations to be a threat to the acquisition of Indian land and natural resources, and when the Republicans regained the White House with the election of Dwight Eisenhower, Indian policy once again emphasised the dismantling of Indian reservations and the assimilation of Indians into the larger US population.

### **Termination in the 1950s<sup>27</sup>**

When Harry Truman became president upon the death of Franklin Roosevelt, one of his major concerns was to reorganise the government. He believed that his predecessor had not been a good manager and that the executive branch required rationalisation. At the same time, the Republican-dominated Congress, which was elected in 1946, wanted to trim the Executive Branch for the purposes of 'economy and efficiency' and, many Democrats feared, to undo the reforms of the New Deal.<sup>28</sup>

The result was legislation that empanelled a bipartisan Commission on Reorganization of the Executive Branch of the government under the chairmanship of former president Herbert Hoover. 'There is no

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<sup>23</sup> Kelly, L.C. (1983). *The Assault on Assimilation: John Collier and the Origins of Indian Policy Reform*. Albuquerque, NM: University of New Mexico Press. See also Philp, K.R. (1977). *John Collier's Crusade for Indian Reform, 1920-1954*. Tucson, AZ: University of Arizona Press; Taylor, G.D. (1980). *The New Deal and American Indian Tribalism: The Administration of the Indian Reorganization Act, 1934-1945*. Lincoln, NE: University of Nebraska Press.

<sup>24</sup> *A Report of the Special Committee on Investigation of the Select Committee on Indian Affairs. A New Federalism for American Indians*, 101st Cong., 1st sess., 1989, pp. 51-52.

<sup>25</sup> Kunitz, S.J. (1972). 'The social philosophy of John Collier', *Ethnohistory*, 18, 213-229. Kelly, L.C. (1980). 'Anthropology and anthropologists in the Indian New Deal'. *Journal of the History of the Behavioral Sciences* 16, 6-24.

<sup>26</sup> Jorgensen (1978), *op cit.*, pp. 17-22.

<sup>27</sup> The next several paragraphs are based upon Kunitz, S.J. (1996). 'The history and politics of health care policy for American Indians'. *American Journal of Public Health*, 86, 1464-1473.

<sup>28</sup> Moe, R.C. (1982). *The Hoover Commissions Revisited* (pp.23-24). Boulder, CO: Westview Press.

doubt', one observer wrote, 'that the Commission's ultimate plan was to have been keyed to a Republican Administration which everyone, except Truman and some 23,000,000 Americans who voted for him, anticipated in November, 1948. The Commission's findings and recommendations for changes in executive organizational structure were to have been the grand overture of a new Republican era.'<sup>29</sup> Despite the fact that the Republicans did not win the presidential election of 1948, the commission's recommendations were of enormous significance, for they had not been forgotten when the Republicans under Eisenhower did win four years later.

The Hoover Commission's Task Force on Indian Policy advocated the integration of Indians into the larger US population, a policy completely antithetical to the one pursued by the Bureau of Indian Affairs under John Collier in the 1930s and early 1940s. The members recommended that, '[P]ending achievement of the goal of complete integration, the administration of social programs for the Indians should be progressively transferred to State governments.'<sup>30</sup> This was to include, of course, all health services, and it became federal Indian policy during the Eisenhower years. It involved terminating the federal recognition of Indian tribes; encouraging the relocation of Indians from reservations to cities; transferring responsibility for Indian affairs and services from the Bureau of Indian Affairs to states and counties, or to other federal agencies; and weakening, with the hope of ultimately dismantling, the Bureau entirely.

It was recognised, however, that termination of federal oversight of many tribes could not occur overnight. The economic, educational and health status of many Indians was so inadequate compared with that of the rest of the US population, that in many instances services would have to be improved before the government could withdraw entirely.<sup>31</sup> Moreover, state and county governments were simply unwilling to shoulder the responsibilities recommended for them by the task force. Thus, instead of becoming a state responsibility, the onus of responsibility for Indian health was transferred from the Bureau of Indian Affairs to the US Public Health Service (another federal agency) in 1954 as authorised by PL 83-568. The purpose was to both weaken the Bureau of Indian Affairs organisationally and to improve health services and thus the health status of Indians. The assumption was that the commitment was finite, for once health had been improved sufficiently, the federal government could withdraw and Indians would assume their place in the mainstream of American life.

Testimony in the hearing before the bill was passed indicated several important differences of opinion about its desirability. Indian tribes were themselves divided on the issue. Some expressed fear that the result would be hospital closures, decreasing access to healthcare, and discrimination in non-Indian facilities; others believed that the level and quality of healthcare provided by the Bureau of Indian Affairs were simply inadequate and that a professional corps of commissioned officers would be more numerous

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<sup>29</sup> *Ibid*, p.24.

<sup>30</sup> US Commission on Organization of the Executive Branch of the Government (1949). *The Hoover Commission Report* (pp.465-473). New York: McGraw-Hill Book Company. The full text of the recommendations regarding health services is reprinted in US Public Health Service (1957). *Health Services for American Indians* (271-273). PHS publication 531. Washington, DC: US Government Printing Office.

<sup>31</sup> This was, in fact, a position that assimilationists had taken before – notably, Lewis Meriam in the Brookings Institution Report of 1928: Institute for Government Research (1928). *The Problem of Indian Administration* (p.51). Baltimore, MD: The Johns Hopkins Press. For a more recent example, see Krug, J.A. (1948). *The Navajo: A Long Range Plan for Navajo Rehabilitation*. Washington, DC: Bureau of Indian Affairs, Department of the Interior.

and better trained, would have access to more resources, and would provide better care. Professional opinion was decidedly in favour of the transfer for the same reasons.

The Department of the Interior under a Republican administration now favoured the transfer of responsibility, although Oveta Culp Hobby, Secretary of the Department of Health, Education and Welfare, had what were perceived to be primarily administrative objections and resisted transfer to her department. Her concerns were dismissed. Nonetheless, the Indian Health Service has always occupied a somewhat marginal place in the Department of Health Education and Welfare, now the Department of Health and Human Services.<sup>32</sup>

Senator Edward Thye of Minnesota, who introduced the bill into the Senate, had said that the purpose was several-fold:

1. '1. To improve health services to our Indian people;
2. To coordinate our public health program; and
3. To further our long-range objective integration of our Indian people in our common life.'<sup>33</sup>

The authors of the legislative history of the bill were equally clear as to its purpose:

The proposed legislation is in line with the policy of the Congress and Department of the Interior to terminate duplicating and overlapping functions provided by the Indian Bureau for Indians by transferring responsibility for such functions to other governmental agencies wherever feasible, and [to enact] legislation having as its purpose to repeal laws which set Indians apart from other citizens.<sup>34</sup>

## The Indian Health Service

The system of care that was developed by the Public Health Service may be characterised as 'hierarchical regionalism', a term one writer has used to describe the attempts by reformers to reorganise the entire American healthcare system.<sup>35</sup> The Indian Health Service (or Division of Indian Health, as it

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<sup>32</sup> See comment of Forest Gerard quoted in Bergman, A.B. , Grossman, D.C., Erdrich, A.M., Todd, J.G. and Forquera, R. (1999). 'A political history of the Indian Health Service'. *The Milbank Quarterly* 77, 571-604, 597.

<sup>33</sup> Edward J. Thye comments. US Senate, *Hearings of the Subcommittee of the Committee on Interior and Insular Affairs, on HR 303, 83rd Cong., 2d sess., An Act to Transfer the Maintenance and Operation of Hospital and Health Facilities for Indians to the Public Health Service*, 28 May 1954, 12.

<sup>34</sup> They listed three, all enacted August 15, 1953: PL 83-277, repealing federal statutes prohibiting the use or possession by or the sale and disposition of intoxicants to Indians; PL 83-280, conferring civil and criminal jurisdiction over Indians upon certain states; and PL83-281, repealing statutes applicable only to Indians having to do with personal property, the sale of firearms, and the disposition of livestock. S. Rept. 1530 to accompany HR 303, 83rd Congr., 2d sess., June 8, 1954, 2919.

<sup>35</sup> Fox, D.M. (1986). *Health Policies, Health Politics: The British and American Experience, 1911-1965*. Princeton, NJ: Princeton University Press. Among the most influential reformers were members of the Committee on the Costs of Medical Care who, in the 1920s and early 1930s, proposed a plan to organise services in the United States; this plan has had continuing influence on healthcare reformers ever since. The connection between the committee and

was then known) was highly integrated, in terms of both services and administration, with field stations linked to general hospitals and referral centres. Service units (catchment areas) reported to area offices, which in turn reported to headquarters in Washington. A Public Health Service document published shortly after transfer stated, 'Indian health services on the reservation should be tied in more closely to a regional pattern so that services of larger medical facilities would be available for diagnostic, consultative and treatment services for complicated cases.'<sup>36</sup>

The healthcare system that was created had both strengths and weaknesses. Indeed, one implied the other. The strengths derived from its high level of organisation and integration, efficiencies of scale, much improved access to services, and an emphasis on public health programmes, such as tuberculosis control and increased availability of clean water sources both in homes and at protected well sites. The result was a distinct improvement in mortality rates.<sup>37</sup> It is no accident that, as noted above, it was in the 1960s that the great increase in the Indian population began, due largely to a rapid decline in mortality from infectious diseases.

The very organisational characteristics that made the Indian Health Service effective, however, also worked to weaken it. On the one hand, in the early years innovative experiments in healthcare delivery and medical interpreting had been encouraged, and yet there was great bureaucratic resistance to institutionalising the innovations.<sup>38</sup> As healthcare was recognised to be increasingly effective, utilisation grew and crowding and long waiting times became a serious problem. Insensitivity and ignorance on the part of insufficiently trained healthcare providers often led to misunderstandings. Paperwork and planning often consumed excessive time. And, like many large service organisations, the Indian Health Service was often unresponsive to the demands of local communities despite its stated goals.<sup>39</sup> All these very real problems became grounds for criticism in the 1960s and 1970s.

## **Self-determination since the 1960s**

The demand for community control, which originated in the civil rights movement of the 1960s, enshrined 'maximum feasible participation' of the poor in the Economic Opportunity Act. The result was the increased hiring of Indian paraprofessionals, the creation of community health boards, and the beginning

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the Public Health Service's reorganisation of Indian healthcare was embodied in the person of Haven Emerson, Professor of Public Health at Columbia University and member of the New York City Board of Health, who had signed the committee's majority report and was also President of the Association of American Indian Affairs and an advocate of transfer from the Bureau of Indian Affairs to the Public Health Service. Committee on the Costs of Medical Care (1932). *Health Care for the American People*. Chicago, IL: University of Chicago Press.

<sup>36</sup> Public Health Service, *Health Services for American Indians*, *op cit.*, pp.118-119.

<sup>37</sup> Rubenstein, A., Boyle, J., Odoroff, C. and Kunitz, S.J. (1969). 'Sanitary facilities and infantile diarrhoea in a Hopi Village'. *Public Health Reports*, 84, 1093-1097.

<sup>38</sup> Adair, J. and Deuschle, K.W. (1970). *The People's Health: Anthropology and Medicine in a Navajo Community*. New York: Appleton-Century-Crofts.

<sup>39</sup> Kane, R.L. and Kane, R.A. (1972). *Federal Health Care (With Reservations!)*. New York: Springer Publishing Company, Inc.

decentralisation of what had begun as a highly centralised system. The Community Action Programs of the Office of Economic Opportunity (OEO) were meant to fund community organisations directly, bypassing other government agencies, both local and federal. They had a profound impact in Indian reservation communities, where tribal organisations received funds free of the control of the Bureau of Indian Affairs.<sup>40</sup>

These first meaningful efforts to support self-determination were begun under a Democratic administration, during Lyndon B. Johnson's War on Poverty, but decentralisation and community control accelerated throughout the 1970s after President Nixon specifically rejected the policy of 'forced termination', which had been instituted when he was Vice President during the Eisenhower administration. In a message to Congress he wrote, 'The policy of forced termination is wrong, in my judgment, for a number of reasons. First, the premises on which it rests are wrong.' He said that federal responsibility was not simply an act of generosity towards a 'disadvantaged people' that could therefore be discontinued 'on a unilateral basis whenever [the federal government] sees fit.' The relationship rests on 'solemn obligations' – that is to say, on 'written treaties and through formal and informal agreements.' Second, 'the practical results [of forced termination] have been clearly harmful in the few instances in which [it] has actually been tried.' And third, forced termination has made Indians suspicious:

the very threat that this relationship may someday be ended has created a great deal of apprehension among Indian groups and this apprehension, in turn, has had a blighting effect on tribal progress... In short, the fear of one extreme policy, forced termination, has often worked to produce the opposite extreme: excessive dependence on the Federal government.<sup>41</sup>

The policy his administration was to pursue was to steer a middle course.

I believe that both of these policy extremes are wrong. Federal termination errs in one direction. Federal paternalism errs in the other. Only by clearly rejecting both of these extremes can we achieve a policy which truly serves the best interests of the Indian people. Self-determination among the Indian people can and must be encouraged without the threat of eventual termination. In my view, in fact, that is the only way the self-determination can effectively be fostered.

This, then, must be the goal of any new national policy toward the Indian people: to strengthen the Indian's sense of autonomy without threatening his sense of community. We must assure the Indian that he can assume control of his own life without being separated involuntarily from the tribal group. And we must make it clear that Indians can become independent of Federal control without being cut off from Federal concern and Federal support.<sup>42</sup>

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<sup>40</sup> Castile, G.P. (1998). *To Show Heart: Native American Self-Determination and Federal Indian Policy, 1960-1975* (Chapter 2). Tucson, AZ: University of Arizona Press.

<sup>41</sup> Nixon, R.M. (1979). 'Message from the President of the United States transmitting recommendations for Indian policy'. 91st Cong., 2d sess., July 8. H. Doc. 91-363, 2-3.

<sup>42</sup> Nixon, *ibid*, p.3.

The Nixon administration's Indian policy was embodied in two central pieces of legislation passed during the very brief Ford administration: the Indian Self-Determination and Education Assistance Act (PL 93-638), passed in 1975, and the Indian Health Care Improvement Act (PL 94-437), passed a year later. Title I of PL 93-638 created mechanisms whereby tribes could, if they wished, contract with the Secretaries of Interior and of Health, Education and Welfare to develop new services or assume control over services previously provided by the federal government.<sup>43</sup>

President Nixon's assistant, John Erlichman, said the President was interested in Indians for several reasons: 'First, he was a 'strict constructionist', who believed that treaties were meant to be observed. Second, he believed that because they were relatively few in number, Indians were a 'manageable minority' and that their problems could be addressed by the government. Finally, he was favourably disposed towards Indians because of his high regard for his football coach at Whittier, 'Chief' Newman'.<sup>44</sup> He failed to mention the confrontations at Wounded Knee and Alcatraz, the Trail of Broken Treaties, and other events that also had a substantial impact on the Administration. Indeed, historians of the period have argued that self-determination was a cynical ploy to co-opt and destroy grass roots and activist Indian movements and to create and install as leaders tribal chairmen who would acquiesce in the federal government's plans to dispose of Indian water rights, land, natural gas and oil for the benefit of large corporations.<sup>45</sup>

Whatever the intentions of the Administration and the Congress, the new Indian policy was welcomed by people at all points on the political spectrum. Among many American Indians, as well as among non-Indians on the political left, people who were critical of professional and administrative dominance welcomed greater community control of health and social services, as well as of resources and economic development. On the political right, which included some Indians,<sup>46</sup> were those who believed that big government was the problem, not the solution, and that a 'new federalism' was required, of which Indian nations, like states, counties and private enterprises, would be the beneficiaries. In this atmosphere, assertions of incompetence and corruption on the part of government officials charged with responsibility for Indian affairs were not uncommon.<sup>47</sup>

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<sup>43</sup> Kunitz, S.J. (1983). *Disease Change and the Role of Medicine* (pp. 47-48). Berkeley and Los Angeles, CA: University of California Press; Urban Associates, Inc. (1974). *A Study of the Indian Health Service and Indian Tribal Involvement in Health*, published as an appendix to the Hearing on Indian Healthcare before the Permanent Subcommittee on Investigations of the Committee on Government Operations. 93rd Congr., 2d sess., September 16.

<sup>44</sup> Quoted in A.B. Bergman, et. al. (1999), *op cit.*, p. 589.

<sup>45</sup> Forbes, J. (1981). *Native Americans and Nixon: Presidential Politics and Minority Self-Determination 1969-1972*. Los Angeles, CA: American Indian Studies Center, University of California.

<sup>46</sup> Swimmer, R.O. (1989-90). 'A blueprint for economic development in Indian Country'. *Journal of Energy Law* 13,13-31. See also Cook S.R. (1996). 'Ronald Reagan's Indian policy in retrospect: Economic crisis and political irony'. *Policy Studies Journal* 24, 11-26.

<sup>47</sup> Statement of Sen. John McCain before the Senate Committee on Indian Affairs (1994). *Hearings to accompany S. 2036, the Indian Self-Determination Contract Reform Act*, June 15. See also (1989). *A Report of the Special Committee on Investigation of the Select Committee on Indian Affairs. A New Federalism for American Indians*, 101st Cong., 1st sess.

These converging views from left and right on the inadequacy of federal programmes are very similar to the converging views about the ineffectiveness of healthcare and the medical profession that also surfaced more broadly in the 1970s.<sup>48</sup> In each instance, a libertarian and anti-authoritarian ideology animated the attack on dominant professional or government institutions. Despite the similarity, however, the underlying premises of right and left were fundamentally different. For the left, individuals and communities were victims of an oppressive social system and medical establishment. For the right, individuals and communities were responsible for their situations. The political left assumed that government support – for instance, in the form of national health insurance – should be available, but that access to care should not be controlled by the medical profession. The political right assumed that government support is intrinsically bad, creating dependency and sapping initiative, and that privatisation is the appropriate response. The result of this convergence during the Nixon years was that national health insurance failed and what was put in place was privatised corporate healthcare.

The same ideological differences seem to me to underpin much of the advocacy of self-determination for American Indians. Many Indians, and the non-Indian left, assumed that the federal government has a continuing obligation to provide an adequate, and increasing, level of support for services that will be managed by tribal entities free of excessive government control. The political right has accepted for the moment the idea that Indian tribes should be able to exercise self-determination, but this means only a minimal level of government commitment and survival in the marketplace.<sup>49</sup> As with the provision of healthcare more generally, which version of self-determination is ascendant will have profound consequences for the future of Indian sovereignty and the accessibility and quality of health services for American Indians.

### **Self-determination and/or self-termination**

There is widespread agreement that, as President Nixon wrote, the Federal government has a legal obligation to protect American Indian tribal sovereignty and to provide support for social and health services. But, as Timothy Westmoreland has observed in a personal communication:

The more important question is 'Is there an enforceable obligation?' No. There's a legal maxim that 'There's no right without a remedy,' meaning that you don't really have the right if you can't enforce it. That is, I think, the AI/AN [American Indian/Alaska Native] dilemma. Those promises sure look like some moral obligations to me. But can they be enforced? No.

He goes on to say:

As far as I know, all Indian health laws are limited by the general phrase (paraphrased here): 'Subject to the availability of appropriations', which means that the high-sounding opening

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<sup>48</sup> Kunitz, S.J. (1987). 'Explanations and ideologies of mortality declines'. *Population and Development Review* 13, 379-408; Kunitz, S.J. (1991). 'The personal physician and the decline of mortality'. In Schofield, R., Reher, D. and Bideau, A. (Eds.), *The Decline of Mortality in Europe*. Oxford, UK: Oxford University Press; and Kunitz, S.J. (2006). *The Health of Populations: General Theories and Particular Realities* (pp.22-23). New York: Oxford University Press.

<sup>49</sup> Castile, G.P. (2006). *Taking Charge: Native American Self-Determination and Federal Indian Policy, 1975-1993* (pp.74-76). Tucson, AZ: University of Arizona.

language and authorized services are limited by however much the Congress decides to spend on them. No money, no service. The magic phrase for true mandatory spending is something like: 'This constitutes budget authority in advance of appropriations.' That's not in any of the AI/AN [American Indian/Alaska Native] laws I've looked at.<sup>50</sup>

This is important. It means that government spending on Indian programmes, including health programmes, is not an entitlement for Indians in the way that Social Security, Medicaid, and Medicare are for the beneficiaries of these programmes. It is not part of the government's mandatory spending, and it does not increase automatically each year, but is part of the discretionary budget, voted on annually.<sup>51</sup> It is this that jeopardises health programmes, whether managed by the Indian Health Service or tribal entities. In either case, every study agrees,<sup>52</sup> the money allocated for health services, even when the amount recoverable from Medicare, Medicaid and private insurers is added, has been far less than is available to non-Indian citizens.<sup>53</sup> This means that resources for healthcare, whoever controls and provides it, are inadequate unless additional funds can be obtained. Some Indian tribes have been able to obtain additional funds, often from successful tribal enterprises, the most dramatically visible of which are gambling casinos.<sup>54</sup> Others are unlikely to be successful.

There has been debate about the desirability of treating the Indian Health Service budget as an entitlement. Some believe that if healthcare were an entitlement, there would be a cap on the amount of money that would be available, and that public health services (e.g. sanitation) might be excluded. Others argue that effectively there is a cap now, that it set too low, and that only if healthcare is considered an entitlement will adequate and stable levels of support be achieved.<sup>55</sup> This is an important debate, for on

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<sup>50</sup> Westmoreland, T.M. (2007). Personal communication, September 5.

<sup>51</sup> Westmoreland, T.M. and Watson, K.R. (2006). 'Redeeming hollow promises: The case for mandatory spending on health care for American Indians and Alaska Natives'. *American Journal of Public Health* 96, 600-605.

<sup>52</sup> See for instance two studies by the US Commission on Civil Rights: (2003), *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*. Washington, DC: US Commission on Civil Rights; and (2004), *Broken Promises: Evaluating the Native American Health Care System*. Washington, DC: US Commission on Civil Rights.

<sup>53</sup> See, for example, Indian Health Service (2004). *Trends in Indian Health 2000-2001*. Washington, DC: US Department of Health and Human Services, Indian Health Service, Office of Public Health, Office of Program Support, Division of Program Statistics, US Government Printing Office; as well as Westmoreland, T.M. and Watson, K.R. (2006), *op cit.*

<sup>54</sup> Taylor, J.B. and Kalt, J.P. (2005). *Cabazon, The Indian Gaming Regulatory Act, and the Socioeconomic Consequences of American Indian Governmental Gaming, A Ten-Year Review*. Cambridge, MA: Malcolm Wiener Center for Social Policy, John F. Kennedy School of Government, Harvard University: The Harvard Project on American Indian Economic Development. See also US Commission on Civil Rights, *Broken Promises, op. cit.*, p. 90.

<sup>55</sup> US Commission on Civil Rights (2004), *Broken Promises, op cit.*, pp. 107-108; and Vogt, D.U. and Walke, R. (2006). *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*. Washington, DC: Congressional Research Service, The Library of Congress, September 12, p. CRS-32f.



its outcome hinges the level and stability of funding of clinical and community services, possibly for years to come.

The recent legislative history of the Indian Health Care Improvement Act illustrates the problem. Recall that it was originally passed in 1976 to provide an infusion of money for health services. It has been renewed and expanded regularly since then, until 1998.<sup>56</sup> Since 1998 it has proven impossible for the Congress and the Administration to agree on the support of new services and as recently as 22 January 2008, the Administration was threatening a veto of the bill (S. 1200), which among other things would provide additional funds for urban health and would not require renewal for ten years.<sup>57</sup> Funding for services has been appropriated year to year under the Snyder Act (PL 67-87) of 1921. The bill has now (in early March 2008) been passed by a large majority and awaits reconciliation between the two houses of Congress and then the President's signature – or veto. Its details need not detain us. The point is that with a government divided over what the level of its commitment to Indian health should be, and in the context of a large deficit and declining economic performance, support of programmes that would even come close to achieving parity with the rest of the population have a very difficult time being funded at adequate levels.

Given the issues surrounding the adequacy of funding, it is no surprise that tribes have responded differently to the opportunities for managing their own services. Between 1980 and 1995, the tribes that assumed control of services were those that had had to deal with regional Indian Health Service offices that had proven unresponsive to their needs. They also tended to have had lower levels of poverty than tribes that did not take over services.<sup>58</sup>

These differences in tribal decisions mirror differences of opinion among Indian healthcare professionals on the desirability of tribal management of health programmes. A study by the National Indian Health Board concluded that tribal management of programmes was working successfully, but that it could work even better in the future. And while the Indian Health Service would likely play a less integrative role in the future, Indian health boards would increasingly assume that role.<sup>59</sup> This would include everything from health policy to disease surveillance, to bulk purchasing of pharmaceutical and medical supplies.

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<sup>56</sup> See the legislative history, available on the website of the Department of Health and Human Services, Indian Health Service: <http://www.ihs.gov/AdminMngrResources/IHCIA/ihcia-437-history-index.asp> Accessed February 3, 2008.

<sup>57</sup> See summaries of the bill and amendments provided by both the Senate Democrats ([http://democrats.senate.gov/dpc/dpc-new.cfm?doc\\_name=lb-110-2-4](http://democrats.senate.gov/dpc/dpc-new.cfm?doc_name=lb-110-2-4)) and Republicans (<http://rpc.senate.gov/files/L46S1200IndianHealth012208AC.pdf>), as well as the Administration's position (Statement of Administration Policy [SAP], Indian Health Care Improvement Act, S. 1200, ([www.whitehouse.gov/omb/legislative/sap/110-2/saps1200-s.pdf](http://www.whitehouse.gov/omb/legislative/sap/110-2/saps1200-s.pdf))). All are dated January 22, 2008. Accessed February 3, 2008.

<sup>58</sup> Adams, A. (2000). 'The road not taken: How tribes choose between tribal and Indian Health Service management of health care resources'. *American Indian Culture and Research Journal* 24, 21-38.

<sup>59</sup> Dixon, M., Shelton, B.L., Roubideaux, Y., Mather, D. and Smith, M. (1998). *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management*. Vol. 2. Denver, CO: National Indian Health Board. Published as an appendix to Amending the Indian Self-Determination and Education Assistance Act to Provide for Further Self-Governance by Indian Tribes, and for other Purposes. 106th Congress, 1st session. US

On the other hand, Everett Rhoades, a former director of the Indian Health Service, believed that:

erosion of the federal role is bound to continue. A great redistribution or rearrangement is happening, with a shift of resources to the...wealthier tribes. They will continue to do better, and the poorer tribes will continue to do worse.<sup>60</sup>

There are examples to support each view. On the optimistic side, there are regional Indian health boards that do serve an integrative function, for instance with regard to disease surveillance, epidemiology, and health service planning and management. On the pessimistic side, there is the example of the closure of an urban Indian Health Service hospital, as a result of a demand for funds by nearby tribes that wanted them to manage their own health service on their reservations.<sup>61</sup> A large number of urban Indians thus were left without accessible care. In this case, competing claims to an already limited amount of money have had negative consequences for some and positive consequences for others.

This example also illustrates the problems faced by American Indian migrants to metropolitan areas.<sup>62</sup> Because Indian healthcare benefits are not portable, they do not attach to individuals and are not usable wherever they happen to be. With more than half of self-identified American Indians now living in metropolitan areas, many of them poor and without health insurance, this is clearly a major problem that has been only partially dealt with by the Indian Health Service, which has allocated only a very small proportion of its budget to urban programmes, in part because Indian reservation leaders fear the money will be diverted from their programmes. The current Bush Administration has attempted to remove even this small amount from the budget, and it is one of the reasons the President threatened to veto the Indian Health Care Improvement Act. Indeed, it is the Administration's view that the Indian Health Service was meant to serve only Indians living on and near reservations. Once they migrate to cities, as 50 percent or more now have, they should obtain care as other citizens do. This is an accurate reading of the purpose of the original legislation creating the Indian Health Service, which was to terminate the special status of American Indians, but it is a policy that was repudiated 20 years later.

### **Health consequences of recent policy changes**

As observed previously, acceleration in the growth of Indian population after World War II coincided with, and in part resulted from, the great improvement in health services that followed transfer of responsibility

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Senate, Report 106-221. Much of the evidence for success produced in this study was based upon surveys of tribal officials and health directors. Unfortunately, response rates were low, on the order of 30 percent, thus vitiating the strength of the findings.

<sup>60</sup> Quoted in Bergman, A.B. et. al. (1999), *op. cit.*, p. 600.

<sup>61</sup> Dinsdale, N. and Frosch, D. (2006). 'Nowhere to turn: Increasing numbers of Native Americans are out of luck when it comes to finding health care'. *Santa Fe Reporter* December 13-19.

<sup>62</sup> Pfefferbaum, R.L., Pfefferbaum, B., Rhoades, E.R. and Strickland, R.J. (1997). 'Providing for the health care needs of Native Americans: Policy, programs, procedures and practices'. *American Indian Law Review* 21, 211-258, 248. Urban Indian Health Commission (2007). *Invisible Tribes: Urban Indians and Their Health in a Changing World*. Seattle, WA: Urban Indian Health Commission.

from the Bureau of Indian Affairs to the US Public Health Service.<sup>63</sup> The death rate declined from the time of transfer in the mid-1950s to the mid-1980s, and it was the so-called avoidable conditions – those amenable to intervention by the healthcare system – that declined most rapidly.<sup>64</sup> Then the decline stagnated and reversed slightly. Over the same period, mortality rates for the non-Indian population continued to decline.<sup>65</sup>

This seems to have been the result of several factors. The decline was largely the result of the decline of infectious diseases, including gastroenteritis, tuberculosis and childhood pneumonia and diarrhoea. As they declined, however, non-infectious conditions began to increase in both relative and absolute importance. Among the most important were diabetes, heart disease and smoking related conditions such as lung cancer. Diabetes accounted for about 50 percent of the increase from the mid-1980s to the late 1990s; smoking-related conditions for about ten to 20 percent of the increase.

One can debate how much of the increase in deaths due to these conditions was avoidable had there been timely preventive and treatment interventions by the healthcare system, but it is generally agreed that healthcare systems do have something to offer with respect to both prevention and treatment. That there has been an increase in death rates suggests, then, that the healthcare system has not been as effective as it should have been. There are no adequate data available to determine whether programmes managed by tribal entities performed better or worse than those managed by the Indian Health Service, and of course there may well be non-health-related reasons for favouring tribal management of health systems, such as capacity building, but what limited information is available suggests that there was no great difference between them that is not better explained by median household income.<sup>66</sup> It appears, rather, that the low level of spending, perhaps 50-60 percent per capita of what is spent for non-Indians; the stagnant budget for more than ten years; and difficulties recruiting healthcare professionals to many remote locations, have all affected health programmes managed both by the Indian Health Service and by tribal entities.

## Conclusion

Termination has been called a 'failed detour' on the way to self-determination.<sup>67</sup> This is not entirely accurate. It was neither a detour nor was it a complete failure. That it was an abrogation of treaty

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<sup>63</sup> Watson, T. (2006). 'Public health investments and the infant mortality gap: Evidence from federal sanitation interventions on US Indian reservations'. *Journal of Public Economics* 90,1537-1560.

<sup>64</sup> Hisnanick, J.J. and Coddington, D.A. (1995). 'Measuring human betterment through avoidable mortality: A case for universal health care in the USA'. *Health Policy* 34, 9-19.

<sup>65</sup> Indian Health Service (2004). *Trends in Indian Health 2000-2001*, *op cit.*, p. 156. See also Kunitz, S.J. (2008). 'Changing patterns of American Indian mortality'. *American Journal of Public Health*, 98, 404-411.

<sup>66</sup> Kunitz, S.J. (2004). 'The history and politics of health care for Native Americans'. In Healy, J. and McKee, M. (2004). *Accessing Health Care: Responding to Diversity*. Oxford, UK: Oxford University Press.

<sup>67</sup> Shelton, B.L. (2001). 'Legal and historical basis of Indian health care'. In Dixon, M. and Roubideaux, Y. (Eds.), *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century* (p.22). Washington, DC: American Public Health Association.

obligations and catastrophic for some tribes and many individuals is certain, but at the same time it did lead to improved health services and to improved health. In that limited but important sense, it was not a failure. Nor was it a detour because, despite the oscillations in policy described at the outset, the overall trajectory of Indian policy has been to loosen the government's commitment to tribal governments and to individuals.

Thus, in the 1930s the legislation drafted by John Collier's administration was much weakened by the time it passed through Congress, and by the early 1940s Collier's position had been weakened by western Congressmen, who opposed the Bureau of Indian Affairs' attempt to protect Indian rights. Shortly after, the entire policy of self-determination was reversed and termination became policy.

Termination as a policy was officially abandoned in the mid-1970s, but because the budget for Indian health is not treated by Congress as an entitlement, it has suffered compared to programmes that are treated as entitlements. As a result, even without a stated policy of termination, and even if no-one truly wanted termination, the effect has been to weaken health programmes, especially for immigrants to cities and for tribes that do not have alternative sources of revenue. In fact, the current Administration's policy implies *de facto* if not *de jure* termination, at least of health services, for Indians who move to cities. As I have already observed, this is consistent with the intent of the original legislation that created the Indian Health Service in the first place. It was not an entitlement but a finite commitment, meant to last only as long as Indians were not fully integrated into the larger American society, and this is the policy the Bush Administration has pursued.

But what of those people who remain on or near their reservations? They are the ones for whom the Administration claims Indian Health Service funds are meant. However, the level of support they receive continues to be inadequate and thus must be supplemented by other sources, including various forms of third party and government support, and tribal revenues. The result is that tribes may receive very different levels of services because there are differences in the success of their business ventures. Indeed, according to the Senate Republican Policy Committee, an amendment to the Indian Health Care Improvement Act was under consideration which required means testing for Indian beneficiaries of the Indian Health Service, so that tribes with large revenues from gambling casinos would have to pay for services currently provided by the Indian Health Service, thus making more money available for tribes without resources.<sup>68</sup> If implemented, this would be a further erosion of the government's commitment to Indians.

Different degrees of success and failure of tribal enterprises are explained partly by location, partly by the larger economies in which tribes are embedded, and partly by internal organisational features over which tribes do have control.<sup>69</sup> For example, there are 19 Pueblo Indian tribes in New Mexico, with populations

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<sup>68</sup> Senate Republican Policy Committee (2008), *op. cit.*, <http://rpc.senate.gov/files/L46S1200IndianHealth012208AC.pdf>

<sup>69</sup> Cornell, S. and Kalt, J.P. (2003). 'Reloading the dice: Improving the chances for economic development on American Indian reservations'; and 'Sovereignty and nation-building: The development challenge in Indian Country today'. Joint Occasional Papers on Native Affairs, Numbers 2003-02 and 2003-03. Cambridge, MA: The Harvard Project on American Indian Economic Development, Malcolm Wiener Center for Social Policy, John F. Kennedy School of Government, Harvard University, and Tucson, AZ: The Native Nations Institute for Leadership, Management, and Policy, Udall Center for Studies in Public Policy, University of Arizona.

ranging in size from 500-600 to 8,000-9,000. Eleven of them have gambling casinos, the gross revenues of which during the first six months of 2007 ranged from about \$6 million to over \$80 million.<sup>70</sup> The variation in revenues is inversely correlated with the distance from the major metropolitan area, thus illustrating the importance of location, which is one very important source of differences among Indian populations, even in the same state.

The question is whether access to adequate health services should be held hostage to the success or failure of tribal enterprises, and whether a means test should be imposed for services that are understood to be a treaty right. Should the federal government acknowledge and meet its obligation to provide adequate services, no matter what the success or failure of tribal enterprises?<sup>71</sup> In light of the experience of the past 100 years, it is unlikely that all or part of the budget for Indian health and other programmes will be made mandatory.<sup>72</sup> For conservatives who support self-determination are likely to believe that such a guarantee would promote dependency and discourage privatisation and integration of Indian communities into the larger economy, and they may well prevail.

The issue is not whether self-determination is inherently a good or bad policy as far as health is concerned. As usual, the devil is in the details. For the policy of termination led to the creation of a programme that had very beneficial results, and the policy of self-determination has, so far at least, had at best equivocal results. The issue is how programmes are funded and supported. With adequate support, it is likely that self-determination can be very successful, resulting in health programmes that are responsive to the particular needs of individuals and communities. Without such support, however, it seems likely that the growing inequality that has characterised the United States generally will also increasingly characterise Indian country.

More broadly, this case study suggests two points. First, politically attractive and unattractive labels can be misleading. The content of programmes – how they are funded, and how effectively, equitably, and efficiently they serve the people they are meant to benefit – is what is important.

Second, it is an unspoken assumption that it was necessary for the building of the ‘good’ institutions that have made economic development so successful in the United States and the other Anglophone liberal democracies<sup>73</sup> that the virtual extermination of the indigenous people of each country should occur. Whether necessary or not, it happened, and the legacy has been the continued marginalisation and relative poverty and ill health of those who have survived. One manifestation of marginalisation is the relative lack of influence of American Indians on health and development policies that affect them, at least until recently. And what influence they have even now is limited, for despite the existence of treaties

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<sup>70</sup> State of New Mexico Gaming Control Board, <http://www.nmgcb.org/tribal/revsharing.html>. Accessed January 7, 2008.

<sup>71</sup> Vogt and Walke (2006), *Indian Health Service: Health Care Delivery*, *op. cit.*, pp. 32-33.

<sup>72</sup> G.P. Castile (2006), *Taking Charge*, *op. cit.*, p. 117.

<sup>73</sup> Acemoglu, D., Johnson, S.A. and Robinson, J.A. (2001). ‘The colonial origins of comparative development: An empirical investigation’. *American Economic Review* 91, 1369-1401.

and the support of many non-Indians, the right to self-determination exists at the sufferance of the federal government and can be taken away or rendered meaningless unilaterally. Indians and other indigenous peoples may lobby, demonstrate, seek redress in the courts, complain to the United Nations, and engage in what has been called the politics of embarrassment,<sup>74</sup> but in the end they are considered by many people both within and outside government to be just one more interest group,<sup>75</sup> unique in some ways but not entitled to any special consideration. In 1832 Chief Justice Marshall described Indian tribes as dependent domestic nations, a concept that Indian legal scholars reject,<sup>76</sup> but that unfortunately is still an accurate description of the true state of affairs.

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<sup>74</sup> Kunitz, S. J. (200), 'Globalization, states, and the health of indigenous peoples', *op. cit.*

<sup>75</sup> The recent scandals surrounding bribes solicited from casino-owning tribes by a Republican Party lobbyist, Jack Abramoff, is a recent example that fuels such views. Democrats have also been implicated, for Bruce Babbitt, Secretary of the Interior during the Clinton Administration, is alleged to have done something similar.

<sup>76</sup> Newcomb, S. (2008). 'Rejecting domestic dependent nationhood'. *Indian Country Today*, <http://www.indiancountry.com/content.cfm?id=1080574522>. March 29. Accessed March 7, 2008.

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