

A Political History of the Indian Health Service

ABRAHAM B. BERGMAN,
DAVID C. GROSSMAN,
ANGELA M. ERDRICH, et al.*

*Harborview Medical Center; University of Washington;
Seattle Indian Health Board*

FEW BRIGHT SPOTS EXIST IN THE SHARED HISTORY OF the American Indians and the federal government. (Throughout this paper, the term "Indians" will refer to American Indians and Alaskan Natives.) A notable exception is the sustained campaign by a little-known agency, the Indian Health Service (IHS), to improve the health of this population. Except for the intractable problems associated with the abuse of alcohol, the health status of Indians has been raised to approximately the level attained by the rest of the U.S. population. This achievement is amazing when one considers the appalling poverty and harsh physical environment in which many Indians live.

We do not mean to present a rosy picture. New problems related to lifestyle changes, such as trauma, and chronic diseases, such as diabetes and obesity, have emerged. The physical and mental health problems associated with alcohol abuse are rampant in Indian communities. Unemployment, poor housing, and limited education remain all too common. We wish to emphasize, however, that, given their isolation and harsh living conditions, many health status measures of Indians are better than might be expected, in large measure owing to the efforts of the IHS.

*Coauthors are John G. Todd and Ralph Forquera.

The campaign responsible for these improvements is an inspiring one that is virtually unknown among health professionals, public policy makers, and the general public. What makes the story even more remarkable is that the advances occurred in the face of both chronic underfunding and scant support from the Department of Health, Education, and Welfare (HEW), where the IHS is lodged. (We use the original name, rather than Health and Human Services [HHS], which the department adopted in 1980.) We believe that the significant improvements in Indian health came about primarily because of the combination of vision, stubbornness, and political savvy of the agency's nonconformist physician-directors, who in turn were supported by a handful of tribal leaders and powerful allies in the Congress and the White House.

The history of health services for Indians has been well described elsewhere, most recently in an excellent article by Kunitz (1996). We will focus here on the tenures of the first five IHS directors, beginning in 1955 when the health services were transferred from the Bureau of Indian Affairs (BIA) to the Public Health Service (PHS), and concluding in 1994 when the current director took office. We will describe the critical role of certain politicians and tribal leaders, outline the legislation governing Indian health, and review the persistent efforts of midlevel officials in HEW and the Office of Management and Budget (OMB) to "rein in" the new agency and slow the movement toward self-determination and tribal management of health programs.

IHS Achievements

Because multiple factors affect health status, which has improved for all Americans since 1955, the ameliorated health of Indians cannot be solely ascribed to the IHS. Kunitz points out that Indians' death rates were already at a "relatively low level" by the time the Public Health Service assumed responsibility for their health care (Kunitz 1983, 180). Nevertheless, from 1955 to 1994 the disparity between the health of Indians and other U.S. population groups greatly narrowed, an accomplishment for which the IHS deserves some credit. In 1955 life expectancy was fully nine years lower for Indians (Rhoades, D'Angelo, and Hurlburt 1987). Infant death rates, often a seminal indicator of health status, were nearly three times higher than among other races, and a quarter of all deaths occurred among infants under one year of age. Maternal deaths associated

with childbirth were also three times higher than among whites (Indian Health Service 1996, 40). Because infectious diseases were an important source of morbidity and mortality, the early programs concentrated on the areas of environmental health, sanitation, and immunization. Rates of death from diarrhea and dehydration were 300 percent higher among Indians (McDermott, Deuschle, and Barnett 1972). Tuberculosis was prevalent among Indian people, partly because of the lack of an effective public health infrastructure to identify and treat cases and contacts (Rhoades 1990). Other infectious diseases, like chlamydial eye infections, were far more common on reservations than in the surrounding areas (Lawler, Biswell, Sharvelle, et al. 1970).

In the first 25 years of the program, infant mortality dropped by 82 percent, the maternal death rate decreased by 89 percent, the mortality rate from tuberculosis diminished by 96 percent, and deaths from diarrhea and dehydration fell by 93 percent (Rhoades, D'Angelo, and Hurlburt 1987). The improvement in Indians' health status outpaced the health gains of other disadvantaged U.S. populations. For example, between 1980 and 1992 infant mortality was nearly halved for Indians, whereas it decreased by 25 percent among African Americans (Indian Health Service 1996, 40).

Since the inception of the IHS, the disparity between the health status of Indians and the rest of the U.S. population has decreased for most conditions. For example, from 1972 to 1974 infant and maternal mortality rates were 25 percent and 82 percent higher, respectively, among Indians than during the period 1991 to 1993, when they were only 4 percent higher for infants and 12 percent *lower* for mothers than for all U.S. residents (table 1).

Mortality from diarrhea and dehydration was 138 percent higher in those earlier years, dropping to 15 percent higher in the early 1990s. Despite the improvement, some conditions still have considerable excess mortality. For unintentional injuries, the excess mortality has dropped from 264 percent (1972–74) to a still alarming 184 percent (1991–93) above the U.S. rate (Indian Health Service 1996).

Statistics aside, the IHS developed into a superb system of regionalized health care to meet the needs of a mostly rural, impoverished population. In Alaska, for example, care was coordinated between a regional medical center in Anchorage, six smaller hospitals, twelve primary care health centers, and specially trained community members in the smallest villages. Table 2 lists some important events in the history of the IHS.

TABLE 1
Health Improvements among American Indians/Alaskan Natives from 1972 to 1992

Death rates ^a	1972-74			1991-93		
	Indian	U.S.	Excess mortality ^b (%)	Indian	U.S.	Excess mortality ^b (%)
Infants	22.2	17.7	+25	8.8	8.5	+4
Maternal	22.7	15.2	+82	6.9	7.8	-12
Pneumonia and in uenza	40.8			19.2		
Tuberculosis	10.5	1.5	+600	21	0.4	+425
Gastrointestinal diseases	6.2	2.6	+138	1.5	1.3	+15
Unintentional injury	188.0	51.7	+264	83.4	29.4	+184

^aRates expressed as per 100,000 population. Infant and maternal death rates expressed as per 1,000 live births.

^bExcess mortality is defined as the percentage difference between the mortality rate among Indians and in the U.S. population.

Sources of data: Centers for Disease Control, Wonder database, mortality data; Indian Health Service (1996).

TABLE 2
Important Events in the History of the Indian Health Service

Date	Event
1954	PL 83-568 (The Transfer Act") Transferred responsibility for Indian health services from the Department of Interior to the Department of Health, Education, and Welfare.
1959	PL 86-121: Passage of Indian Sanitation Facilities Construction Act.
1965	Funds from the Office of Economic Opportunity (OEO) led to the initiation of the Community Health Representative Program at Pine Ridge, the first step toward tribal control of health affairs.
1970	President Richard Nixon's White Paper on Indian Policy, proclaiming an end to the policy of termination and the beginning of the policy of Indian self-determination.
1972	OEO provides funds for urban Indian clinics in Minneapolis, Rapid City, and Seattle.
1975	PL 93-638: Passage of the Indian Self-Determination and Educational Assistance Act, changing an executive proclamation into the law of the land.
1976	PL 94-437: Passage of the Indian Health Care Improvement Act, spelling out the federal government's responsibilities for Indian health.
1988	PL 100-713: Encouraged by the passage of the Indian Health Care Amendments, tribal and urban organizations increasingly administer their own programs, and the role of the IHS in providing direct health services diminishes.

Methods

Written descriptions of events in modern political history, if they exist at all, may be self-serving and/or inaccurate. In the preface to his magnificent biography of Huey Long, historian T. Harry Williams explains why tape-recorded interviews of active participants, rather than reliance on written documents, are necessary to preserve the history of the recent past:

I found that the politicians were astonishingly frank in detailing their dealings, and often completely realistic in viewing themselves. But they had not trusted a record of these dealings to paper, and it would not have occurred to them to transcribe their experiences at a later time. Anyone who heard them would have to conclude that the full and inside story of politics is not in *any* age committed to the documents. (Williams 1970, ix)

TABLE 3
Persons Interviewed for Oral History

Former IHS directors	
James (Ray) Shaw	1989 (VT); 1996(P)
Emery Johnson	1996
Everett Rhoades	1997
Former White House staff	
Bradley Patterson	1996 ^a
John Ehrlichman	1996 ^a
Former congressional staff	
William VanNess	1997
Forrest Gerard	1996
Franklin Ducheneux	1998 ^a
Former HEW of cial	
Robert Graham	1997 ^a
Indian Health advocates	
William Byler	1996
Charles Trimble	1998 ^a

^aInterviewed by telephone.

Abbreviations: VT, videotape; P, in person.

Although we have reviewed the existing written material, primarily letters and congressional hearing records, we have relied mostly on the oral histories of participants who are still alive. In 1989, one of us (JGT) conducted videotape interviews with all four former IHS directors. In 1997, two of us (ABB and AE) conducted additional interviews with three former directors, two whom have since died. Interviews were also conducted with 14 other participants in the events we chronicle; their names are listed in table 3. Unless otherwise noted, the quotations are derived from these interviews. We lay no claim to the truth³; our views and those of the interview subjects are obviously subjective. We would not expect our main sources of information, the former IHS directors, to adopt a detached view of their tenures. It should be obvious that the targets of their criticisms have not had an opportunity to respond.

Birth of the IHS

Federal health services for Indians were established within the War Department in 1824. At that time, the federal Indian policy was primarily oriented toward military containment. As early as 1802 Army physicians

took emergency measures to curb contagious diseases among Indian tribes in the vicinity of military posts. The first large-scale smallpox vaccination of Indians was authorized by Congress in 1832, probably more to protect U.S. soldiers than to benefit Indians.

The military control of Indian Affairs and its organizational entity, the Bureau of Indian Affairs (BIA), ended in 1849, when the administration was shifted to civilians under the newly created Department of the Interior. Within this federal environment the Indian health care system evolved until its transfer in 1955 to the Public Health Service (PHS).

During the 20 years of discussion that preceded the transfer of BIA to PHS, the Bureau faced more difficulties in recruiting and retaining qualified physicians than comparable career services like the military, the Veterans Administration, and the Public Health Service. The pay was terrible, the doctors were isolated, they had bad facilities, no books, no continuing medical education, and worst of all, they were subordinate to the local BIA superintendent," says James R. (Ray) Shaw, who was detailed by the PHS to the BIA and was later to become the first director of the IHS.

Emery Johnson, another IHS director, describes working as a physician for the BIA:

After finishing my one year rotating internship, I started at White Earth, Minnesota on June 30 1955, the last day before the transfer. I found that a new stove that had been ordered for the medical officer's residence had been "requisitioned" by the BIA Superintendent, the "official boss" of the reservation. For most of my time at White Earth I was the only physician; we had to go 25 miles to make a long distance telephone call. When I got there I was immediately inundated with patients with eclampsia, motor vehicle and gunshot trauma, diarrheal dehydration, appendicitis, and pneumonia. The stove was not all that was missing from my quarters. There was no laboratory equipment, even for hemoglobin determinations. Most of my surgery was performed with local nerve blocks, but I also used spinal, or drop ether.

However logical the merger seemed to the small band of health professionals, it was stymied by inertia and active opposition until 1954, when transfer legislation was finally introduced.

Shaw reports:

It was the rampant spread and high mortality rate of tuberculosis among Indians that brought the matter to the fore. During World War II, between 10% and 25% of Indians drafted into the Armed

Services had to be sent back to their reservations because of active TB. Thousands of them also left the reservations for the first time to be employed in defense plants. Huge numbers were found to have active tuberculosis and returned to the reservations. This situation was seen as a scandal and seemed to crystallize the attention of public health workers on the general problem of Indian health. The Indians were approximately three generations behind the rest of the country, due primarily to culture, language, and attitudinal problems, as well as economics, isolation, and above all, lack of service.

In his marvelous history of health care on the Navajo Reservation, Robert A. Trennert writes: Between 1946 and 1949 the mortality rate for tuberculosis for the general population dropped from 40.1 to 34.6 per 100,000, while the Indian rate remained somewhat over 200" (Trennert 1998).

Transfer Legislation

The debate about transfer should be viewed in the context of "termination," which was the dominant Indian issue of the 1950s. This policy, espoused by the Eisenhower administration and many members of Congress from both political parties, called for terminating the special legal status of Indians and assimilating them directly into the national mainstream in exchange for giving up their lands. William VanNess, former chief counsel of the Senate Interior Committee, says: "The prevailing political philosophy in the 1950's, even by many who felt themselves to be friendly to Indian interests, was that the best interests of Indians would be served by assimilation into the general society."

In 1954, when the transfer legislation was introduced, the only organized support came from the Association of State and Territorial Health Officers, the National Tuberculosis Association, and the Association on American Indian Affairs (AAIA), none of which possessed much political clout. A formidable array of organizations, on the other hand, was opposed. HEW and its Public Health Service did not want to take on the responsibility for Indian health. President Eisenhower's Budget Bureau likewise felt that the merger was not justified "on the basis of economies, improvements in efficiency, or more effective administration" (U.S. Public Health Service 1957, 95). Most Indian tribal leaders were opposed as well. However much the Indians distrusted the BIA, it was their"

agency and they were familiar with it. Also, most tribal leaders believed that the transfer would be a step toward the termination policy that they dreaded.

The legislation was introduced by two Republican legislators from Minnesota: Senator Edward Thye and Representative Walter Judd. Other congressional actors were Senators Carl Hayden, a Democrat from Arizona, and Arthur Watkins, a Republican from Utah. The Minnesota legislators were recruited by that state's long-time health officer, A.J. Chesley, a national leader in TB control.

Senator Hayden, chairman of the Appropriations Committee and a friend of Dr. Shaw, was mainly concerned about the lack of tuberculosis treatment for Indians in his state. Senator Watkins was motivated by a different consideration. As an ardent supporter of termination, he viewed the transfer as a step toward ending the benefits that set Indians apart from other citizens. Judd's reasons were more idealistic. He was a physician who had worked as a medical missionary in China and was genuinely concerned about the health problems of Indians. The lobbyist who orchestrated the transfer legislation was the late Noble Swearingen, representing the National Tuberculosis Association.

Thus, an incongruous coalition of advocates—on the one hand, for terminating reservation status and, on the other, for improving health services for Indians—pushed through the Transfer Act¹ on August 5, 1954. In 1955 the Division of Indian Health (since renamed the Indian Health Service) was created within the PHS, with Ray Shaw as its first director.

Ray Shaw's Priorities

A better choice of director could not have been made. Shaw was familiar with Indian health issues and possessed abundant political savvy. Trained in internal medicine and cardiology, he joined the PHS in 1933 "mostly because there were not too many paying jobs available." In the late 1930s he was stationed in Washington, D.C., primarily to provide medical care to Coast Guard and PHS families, but he was also on call for the White House. During World War II Shaw was chief medical officer for the Coast Guard in southern California, where he came to know a number

¹PL 83-568.

of politicians. One of them, Senator Hayden, turned out to be his most powerful ally.

After the war, Shaw was detailed from the PHS to head the BIA's Indian Health Service. He was strictly an advisor to the director of the BIA and had no authority. Shaw recalls one particularly galling episode that turned him into a passionate advocate for the transfer:

Soon after I got over to the BIA I got Senator Hayden to put up \$30 million to treat Indians with TB in off-reservation facilities. The money was never used for that purpose. The director of BIA told me he needed the money for other things." I never forgot that.

Shaw's three priorities when he took the reins were to improve the quality of clinical care, to expand prevention programs, and to bridge the gap between tribal members and the health facilities.

Improving clinical care meant recruiting from a wider pool of well-trained physicians. This was facilitated by the doctor draft." Starting with the Korean War in 1950, physicians were required to fulfill a two-year service obligation, a requirement that could be satisfied by joining the PHS. A pool of young physicians who tended to be dedicated and to possess excellent clinical skills thus became available, but their presence was a mixed blessing. Tribal members tended to be suspicious, viewing the physicians as mere conscripts. Some of the young physicians, on the other hand, were hurt at not being embraced by the reservation residents and bridled at what they perceived as the rigidity of the career administrators (Kane and Kane 1972). Other young doctors, however, thrived in the reservation milieu and stayed in the IHS throughout their careers. The quality of medical care steadily improved. New hospitals and clinics were built. The grim scenario at White Earth described by Emery Johnson became a rarity. Laboratory and radiology examinations could be performed. Dentists, nurses, pharmacists, and other health professionals arrived on the scene and, through the mechanism of contract care, it became possible to make referrals to specialists outside the IHS.

Prevention centered on infectious disease control practices. TB and diarrheal dehydration, the two major public health problems, were addressed by early case finding, health education, deployment of public health nurses, and most critically, by improved sanitation. According to Shaw, sanitation on the reservations was especially bad:

The BIA would drill water wells for livestock, but not for human consumption. There were no outhouses, toilets, or any other sanitary facilities on reservations. Indians often had to carry buckets of water for many miles, and that water usually came from contaminated sources.

Improvement came in 1959 as a direct result of the Indian Sanitation Facilities Construction Act² (Rubenstein, Boyle, Odoroff 1969). According to Johnson, "The sanitation program had a greater impact on the health of Indians than any other measure since smallpox vaccination."

The sanitation legislation was another product of Ray Shaw's deft political touch. Senator Alan Bible, a Democrat from Nevada and an influential member of the Appropriations Committee, was receiving complaints from some white constituents in Elko about contamination of their water supply by runoff from tribal lands, so he asked Dr. Shaw what was needed to remedy the situation. The resulting law addressed far more than the sanitation problems of Elko residents.

Bridging the Gap

Shaw describes how he tried to improve relations with the agency's clients:

Many Indians believed in traditional healers, who were banned from federal facilities. When I took over I set up tribal health committees at every facility to, among other things, try and bridge the gap between traditional and modern healing practices.

Trennert writes:

Non-Indian medical specialists often opposed the continuation of traditional healing practices because their existence appeared to threaten the 'civilization' program they represented. Thus the type of health care utilized by the Navajo peoples symbolized far more than their physical welfare; it became involved with the government's determination to destroy native culture and replace it with the values of white America. (Trennert 1998, 1)

²PL 86-121.

The new emphasis on preventive measures required the support of the Indian people, who, as a group, had little reason to trust the IHS. The best-known health ambassador” was the late Annie Dodge Wauneka, the first woman elected to the Navajo Tribal Council.

The traditional dress of Annie Wauneka—blanket over her shoulder, turquoise beads, long skirts, and velveteen blouse—belied her sophistication and excellent English. Mrs Wauneka could have been an articulate, effective and dedicated leader in any American town . . . but [she] lived a real reservation life with feet well planted in her home community. She was able to convey the essential points to the community as she, more than any other Navajo, had a comprehensive knowledge of tuberculosis and its treatment. (Adair, Deuschle, and Barnett 1970, 56)

Another group that spearheaded the campaign for preventive health was of cially called the Lakota TB and Health Association, but the members were better known as the Lakota grandmas.” William Byler, long-time director of the Association on American Indian Affairs (AAIA), recalls:

Four of the grandmas,” Phoebe Downing at Standing Rock, Eunice Larrabee at Cheyenne River, Alfreda Janis-Bergin at Pine Ridge, and Irene Groneau at Sisseton-Wahpeton, banded together to track down a notorious person who was spreading active TB across the reservations. The Lakota grandmas” served as a nucleus for local tribal health committees that first were advisory to the IHS, and later took over the operation of the health programs. Not being bound by government strictures, the grandmas could take on controversial issues, like mental health and alcoholism, that were not then within the purview of the IHS.

In the 1960’s, the Lakota TB and Health Association decided to branch out into birth control. The IHS becameustered, fearing that they would be accused of fostering genocide. The grandmas, however, maintained that big families were not traditional and that in the old days Lakota women nursed longer as a natural form of birth control. They would say, “After all, you could only afford as many children as you could pack up quickly.” A few years later, I was surprised to see a vast assortment of birth control devices on display at one of the community meetings.

Employing the Iron Triangle

Iron triangle” is a term used by political scientists to describe the links between midlevel bureaucrats in a cabinet department, powerful legislators and their staff members, and outside beneficiaries of the government program (Edwards, Wattenberg, and Lineberry 1999). Some examples would be the following: the military industrial complex” (Officials, military equipment contractors, and members of the Armed Services committees); the medical research establishment (officials of the National Institutes of Health, members of the academic research community, voluntary health organizations, and legislators serving on the health and appropriations committees); and the highway lobby” (manufacturers of highway building materials, the Teamsters, and officials of the Department of Transportation) (Strickland 1972). Every U.S. president is tormented by iron triangles because of official Administration policies, especially in the budgetary category, are ignored or circumvented by unelected bureaucrats” (Kristol 1993). The IHS directors skillfully employed the triangle; if they had not, it is doubtful that the organization would have remained intact. In the beginning, the tribal leaders did not play a major political role; it took almost a decade before they claimed ownership” of the IHS. The program’s most important advocate was the Association on American Indian Affairs. Founded in the 1920s and supported solely through private contributions, the AAIA gave out small grants and lobbied in Washington, D.C. All the IHS directors had close ties to the AAIA and its director, Bill Byler. A favorite tactic of the AAIA was to convene a conference of well-known experts to discuss a particular issue, like trachoma or health manpower recruitment. These experts would then carry the conference consensus to administration officials and legislators in Washington.

On the AAIA’s board of directors were Cornell Medical School faculty members Walsh McDermott, Carl Muschenheim, and Kurt Deuschle, who, along with John Adair, an anthropologist from San Francisco State College, established an experimental health program at Many Farms on the Navajo Reservation. The contributions of the Cornell group helped to validate the shift in attention from the medical care of individuals to the health care of a community (McDermott, Deuschle, and Barnett 1972). McDermott’s reputation as one of the nation’s most eminent internists facilitated his lobbying efforts on behalf of Indian health.

Another of Shaw's masterful moves was to compile health statistics, which were continuously updated. The IHS directors were thus able to supply legislators on the appropriations committees with estimates of, for example, the number of cases of trachoma or deafness that would be prevented by the expenditure of a certain sum of money. As Shaw pointed out, "If you can't tell what you accomplished, you can't sell your program to anyone."

New Leadership

Ray Shaw retired in 1962 to take a teaching job at the University of Arizona School of Medicine. In his seven years as director, the IHS had evolved into a large, organized rural health system with hospitals, clinics, allied health personnel, environmental health services, and a \$60 million annual budget. Management skills, however, were lacking, and that weakness was tackled by his successor, Carruth Wagner, an orthopedic surgeon. During his relatively brief tenure (1962–65), Wagner focused on training personnel to administer the wide-ranging activities of the agency. Although the IHS trained Indian practical nurses and sanitarian aides, both the scope of the training and the number of trainees were now greatly expanded. Wagner established medical and dental residencies, registered nurse, nutrition and dietetics, environmental health, dental and other health professional training programs during his time in office.

The next director, E.S. (Stu) Rabeau, who served from 1966 to 1969, brought different talents to the job. Trained as a surgeon, he had come up through the ranks at the service unit, area, and headquarters levels. His two most notable accomplishments were the training and deployment of community health representatives (CHRs) and the use of research findings to plan and evaluate intervention programs. An example of the latter was the cohort study performed by the Arctic Research Center of 600 infants in 27 Alaskan villages to learn about the causes of infant mortality. Infections in the postneonatal period were identified as the greatest problem, one that was exacerbated by poor nutrition, crowded housing, closely spaced pregnancies, and lack of early treatment.

Rabeau believed as strongly as Shaw in the importance of using scientific data to "sell" his programs. Another of his contributions was the assembling of a group of bright professionals to develop and promote the data system used in the IHS. Rabeau stepped down as director in 1969

to found the Office of Research and Development in Tucson. He retired from the PHS in 1981 and returned to Alaska to become the director, and then the deputy director, of the Alaska State Health Department, an office he held until his death in 1984.

Emery Johnson

When Emery Johnson (1969–81) assumed the IHS directorship, the civil rights movement and the “War on Poverty” were in full swing. Nothing could have better suited this passionate believer in Indian self-determination. From the day he became director until the day he retired, *every* action Johnson took was predicated on preparing the tribes to manage their own health affairs. Until the late 1960s, services for Indians were conducted on their behalf but without their involvement. The influence of the civil rights struggle, launched by African Americans, soon spread to other ethnic groups. Younger Indians, disenchanted with their political leadership, formed the militant American Indian Movement (AIM), which engaged in high-profile confrontations like the 19-month occupation of Alcatraz Island (1970–71) and the occupation of a settlement at the Oglala Sioux Pine Ridge (South Dakota) reservation in 1973, also known as the Second Battle of Wounded Knee (Smith 1996). In 1964 the Office of Economic Opportunity (OEO) was instituted by President Johnson and empowered to bypass traditional government channels in order to make grants available to grassroots community organizations serving the poor. “Maximum feasible citizen participation” had to be demonstrated in order to obtain money. This proved to be a boon to the IHS. Mental health, alcoholism treatment, and family planning programs, which did not receive appropriations through regular channels, could be sponsored by individual tribes.

The most far-reaching innovation and the first step toward tribal control of health matters, however, was the OEO-funded training and deployment of community health representatives (CHRs), first instituted at Pine Ridge, South Dakota, in 1965. Emery Johnson says:

Several factors led to the initiation of this [CHR] program. Transportation and communication on most reservations were primitive at best. Patients had great difficulty in reaching clinics and hospitals, and telephones were rarely available. If these patients were to be able to

access the health system, someone in the system had to be convenient to the Indian home. Considering the hundreds of small Indian communities, it was unrealistic to expect to provide physicians or nurses on a real-time basis in most Indian communities. The only feasible approach seemed to be to have members of each community trained as part of the health team. They were trained by the IHS in such skills as principles of health, sanitation, communication, first aid and home nursing.

The first CHRs at Pine Ridge were directly supervised by an IHS employee, a public health nurse. The second program, instituted a few months later on the Northern Cheyenne Reservation in Montana and also funded by OEO, took a different tack. John Woodenlegs, president of the Northern Cheyennes, proposed that the CHRs be selected and supervised by the tribe. Johnson, then the area director in Billings, agreed. Describing what was to become his characteristic style, Johnson said, "I didn't ask headquarters, but neither did I tell." This CHR program was the first formal assumption by an Indian tribe of an IHS-supported health program, and it became a national model. In 1968 Congress provided funds in the IHS budget for CHR training and deployment.

The impact of the CHRs was mostly felt in large, remote land areas. The marked reduction in mortality from diarrheal dehydration was largely due to improved sanitation. However, the sanitation education and oral rehydration treatment provided by the CHRs also played an important role (Hirschhorn, Cash, Woodward, et al. 1972; Nutting, Strotz, Shorr, et al. 1975). Likewise, the dramatic decrease in childhood deafness caused by chronic otitis media in Alaska was achieved through early treatment of acute otitis by village health aides (Kaplan, Fleshman, Bender, et al. 1973).

Gaining Political Support of Tribes

Whereas Ray Shaw's political skills were superior, Emery Johnson's were legendary. He played the iron triangle like a virtuoso. He already had established close ties to key legislators, the most important being the chair of the House Interior Appropriations Subcommittee, Representative Sidney Yates, a Democrat from Illinois, who oversaw the IHS budget. The most active, and from the IHS perspective, valuable

member of the White House staff was Bradley Patterson, special assistant to the President from 1969 to 1976. Brad Patterson was magnificent," says Johnson. He had a sense of our mission, and saw his job as helping to further that mission. Whenever the pressure from the OMB and HEW officials got too bad, I could pick up the phone and call Brad, and know that I could then get on with my job." Patterson returns the compliment: Emery Johnson was a capable professional running a good operation. He did not call us very often, but when he did, we tried to be helpful. This was in contrast to the BIA that had weak leadership and almost weekly crises. I considered the BIA a 'weak sister' to the IHS."

A greater political challenge was gaining the trust of the tribal leaders. Johnson says:

As the quality of medical care on the reservations improved, Indian tribal leaders slowly began to have a reasonable expectation that the IHS was on their side, open to their ideas, and would be supportive of their initiatives. This sense of ownership" by the tribes led to an effective "triangular" mechanism (i.e., tribes, IHS, legislators) for funding IHS programs, whereby leaders lobbied their own congressional delegations.

The most significant "hook" in obtaining tribal involvement was the requirement in the Indian Health Care Improvement Act that each tribe identify its own health needs and design a comprehensive plan to meet those needs. Over 90% of the tribes accepted this challenge and their plans became the basis of the Secretary's National Plan for the Indian Health Care Improvement Act, which was transmitted to the Congress in April, 1980.

Johnson made sure that consumer-driven health advisory boards operated at every service unit, which in turn led to the formation in 1972 of the National Indian Health Board. In 1970 Johnson encouraged Everett R. Rhoades, then an infectious disease specialist and professor of medicine at the University of Oklahoma Medical School, to help form a national organization of Indian physicians. Rhoades, a member of the Kiowa tribe, sent invitations to all known Indian physicians. With financial support from the IHS, 15 physicians attended the organizational meeting of what came to be known as the Association of American Indian Physicians (AAIP), which has since reached a membership level of 379.

The Golden Era

Momentous political achievements occurred during Johnson's tenure as director. Charles Trimble, a member of the Oglala Sioux tribe, who served as executive director of the National Congress of American Indians from 1972 to 1978, calls those years, the golden era of Indian politics." He identifies Richard Nixon and Henry Jackson as the two politicians who had the greatest effect on Indian policy."

After the era of treaty-making ended in 1871, Nixon was the only American president to demonstrate any particular interest in Indians. On July 8, 1970, he submitted a policy statement to Congress that dramatically ended discussion about termination and launched the policy of self-determination":

The first Americans—the Indians—are the most deprived and most isolated minority group in our nation. On virtually every scale of measurement—employment, income, education, health—the condition of the Indian people ranks at the bottom The time has come to break decisively with the past and to create the conditions for a new era in which the Indian future is determined by Indian acts and Indian decisions. (Nixon 1970)

Emery Johnson says:

Nixon's Indian policy statement turned Federal/Indian relations on its [sic] head. At one fell swoop a colonial system was brought into the modern world. His concept of a business deal, i.e., land from the Indians in exchange for federal services, gave credibility to our position that the tribes had purchased a prepaid health care plan in perpetuity.

The support of the Nixon White House for Indian causes was not confined to broad policy issues but was continuous and sustained. Did this support for the IHS emanate from the President himself or from sympathetic White House staff members? Both, according to two former staff members.

Bradley Patterson says:

There was a trail of interested support for Indians at the White House from the top down. The origins of the President's Indian message lay in the enthusiasm of Nixon's former law partner Leonard

Garment. Garment was influenced by a book by Edgar Cahn [1969] detailing the government's perdy in dealing with Indians. He received the support of the president's domestic advisor John Ehrlichman to draft a new initiative in Indian policy and proceeded to do so.

When asked about Nixon's personal involvement, Ehrlichman, who died in February, 1999, responded:

Nixon did have a personal interest in Indian issues. There were three 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 favorably disposed towards Indians because of his high regard for his football coach at Whittier, Chief Newman.

In his own memoirs, Richard Nixon writes:

I think I admired him more and learned more from him than from any man I have ever known aside from my father. Newman was an American Indian, and tremendously proud of his heritage. There is no way I can adequately describe Chief Newman's influence on me. He drilled into me a competitive spirit and the determination to come back after you have been knocked down or after you lose. He also gave me an acute understanding that what really matters is not a man's background, his color, his race, or his religion, but only his character. (Nixon 1978, 19–20)

Henry Jackson and Forrest Gerard

Henry (Scoop) Jackson, who served in the Senate from 1953 until his death in 1983, is best known for his activities in the fields of national security and environmental policy. However, according to William Byler, "What is not generally recognized is that Jackson was responsible for more far reaching legislation benefiting Native Americans than any politician in history." Emery Johnson comments: "President Nixon issued a policy statement on federal-Indian relations; Senator Jackson made it the law of the land."

Jackson was the prime sponsor of, among other things, the Alaska Native Land Claims Act,³ the Menominee Restoration Act⁴ (reversing a historic termination action), the Indian Self Determination and Education Assistance Act,⁵ and the Indian Health Care Improvement Act.⁶ Jackson's sympathy for Indian causes, however, dawned relatively late. During the Eisenhower years he supported termination, even introducing legislation to close down Washington State's Colville Federated Tribes.

Jackson's "conversion" to supporter of Indian causes coincided with his appointment, in 1971, to the Interior Committee, where he met Forrest Gerard, the professional staff member for Indian Affairs. The modest and soft-spoken Gerard, a member of the Blackfeet tribe, grew up on his reservation in Montana. After graduation from the University of Montana, he worked for the Wyoming TB Association and then joined the edgling IHS in 1957 as its tribal relations officer. After completing a congressional fellowship in the mid-1960s, Gerard worked in congressional relations, first for the BIA and then for HEW, before joining the Interior Committee staff.

William VanNess says:

It was clear that Sen. Jackson needed an Indian on his professional staff to advise him, and Forrest filled the bill perfectly. All of us who came in contact with him were impressed by his knowledge, and his calm, pragmatic approach. Forrest would trade off all the spouting of ideology and war feathers in favor of a balanced clinical approach. Because of this he was subjected to abuse by radical Indian groups throughout his career. However Jackson and I viewed him as the ideal commodity. He was discreet, had vision, worked hard, and thus was given full leeway.

Everett Rhoades adds to this portrait: "Forrest had class and style; he broke so much new ground." The result was the historic spate of Indian legislation that emerged, all sponsored by Henry Jackson and crafted by Forrest Gerard. The other key player on Capitol Hill was Gerard's counterpart in the House of Representatives Subcommittee on Indian Affairs, Franklin Ducheneaux, a member of the Cheyenne River Sioux Tribe of South Dakota. "Forrest was my mentor," says Ducheneaux.

³PL 92-203.

⁴PL 93-197.

⁵PL 93-638.

⁶PL 94-437.

We worked as a team.” Trimble says: Gerard and Ducheneaux were so effective shepherding Indian legislation through Congress because they were both capable and did not call attention to themselves.”

The Indian Health Care Improvement Act (IHCIA)

The most far-reaching legislation on Indian health was the Indian Health Care Improvement Act of 1976. Previously, the only statute authorizing health services for Indians was the Snyder Act of 1921,⁷ which simply called for the BIA to expend such money as Congress may from time-to-time appropriate for the benefit, care, and assistance of the Indians throughout the United States . . . for the relief of distress and conservation of health.” The mandate was broad enough—the IHS was allowed to engage in health promotion and disease prevention activities—but the vague mission statement restricted long-term planning and subjected Indian health programs to the vagaries of the yearly appropriations process. Rationed medical care was a way of life for the IHS. When the money appropriated each year for medical care ran out, there was no more forthcoming.

The IHCIA was unique in several respects. First, so that there would be no confusion about the intent of Congress, there was an emphatic statement of findings:

The Congress finds that: a) Federal health services to maintain and improve the health of Indians are consonant with and required by the Federal Government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people, and b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.⁸

Second, the law made clear that the authorization of more than \$1 billion was intended to supplement, not supplant, the regular IHS appropriation:

⁷42 Stat. 208.

⁸U.S. Senate. Findings: PL 94-437, §2, ll. 3–8; 94th Cong., 1st sess., 1976.

As such funds which are appropriated pursuant to this Act are to eliminate health services backlogs, they shall not be used to offset or limit the appropriations required by the Service to continue to serve the health needs of Indian people during and subsequent to such fiscal-year period, but shall be in addition to the annual appropriations required to continue the health services to the Indian people.⁹

The comprehensive package authorized the following programs: health professional scholarships for Indian students; specific health benefits similar to those contained in most insurance programs; funds for construction and renovation of facilities; permission for the IHS to collect and retain Medicare, Medicaid, and private insurance benefits from eligible clients; construction of safe water and sanitary waste disposal facilities; and, for the first time, the establishment of facilities and outreach programs to serve urban Indians under IHS auspices.

Urban Indians

When first conceived, the IHClA was modest in scope—its purpose was simply to extend IHS services to Indians living in urban areas. In 1975 an estimated 1.2 million Indians were living in the United States, roughly half on reservations and half in urban areas. Not surprisingly, lack of education and separation from their land and families resulted in the lot of urban Indians being no better than that of their reservation kinfolk. Additionally, they were cut off from federal services, including health care. Indians who left the reservations were no longer considered by the government to be Indians. This policy might have been “stretched” to include them, but the leaders of the organized tribes, who in unceded federal practices, did not view themselves as representing the interests of those who had left reservations. A more compelling reason, however, was the chronic lack of funding for the IHS, which never allowed the agency to meet its obligations on reservations, let alone expand into new areas of responsibility. A number of urban Indian health programs developed in the late 1960s in conjunction with antipoverty initiatives. Johnson tried to support several urban programs indirectly. The first IHS money for urban Indian health, in 1972, took the form of grants to programs in Minneapolis and Rapid City to conduct needs assessments.” However, no money was available for clinic operations.

⁹U.S. Senate. PL 94-437, §201, 1976.

In 1972, Bernie Whitebear, a member of the Colville tribe, who was director of the Kinatechitapi Indian Clinic in Seattle, approached the lead author, Abraham Bergman, a pediatrician at the University of Washington Medical School, to discuss how IHS funds might be obtained to help support his operations. (Because he is both one of the authors and a participant in these events, Dr. Bergman is referred to in the third person for the sake of clarity.) Bergman was a friend of Washington's two senators, Warren Magnuson and Henry Jackson. The Seattle clinic operated during evening hours in a second-floor clinic of the Public Health Service Hospital and was staffed by volunteer physicians, dentists, and nurses. Struck with the worth and neediness of the Seattle Indian Clinic, Bergman spoke with Senator Jackson about extending the mandate of the IHS to include urban Indians. Bergman describes the subsequent events:

Jackson knew Bernie Whitebear and admired the work of his clinic, so it took him less than 30 seconds to agree. "Go see Forrest," he said, "and work it out." That was my hunting license."

When I later sat down to meet with Gerard, I was surprised to find Emery Johnson present. Surprised, because when I was involved with the legislation that created the National Health Service Corps, the HEW officials who would be called upon to carry out the program were our most energetic opponents. In this case it was clear that Johnson had a close working relationship with Gerard, and as I came to learn, every other person on Capital Hill who had influence on Indian health.

Gerard made it clear from the beginning that my "hunting license" from Sen. Jackson would not be limited to helping urban Indians. Such a restrictive bill, he explained, would draw the opposition of the tribes and have little chance of passage. What I later learned was that Gerard and Johnson envisioned a "system upgrade" before IHS programs were turned over to tribal control. They knew that no rational tribal leader would wish to take over under-funded and understaffed health program operating in dilapidated buildings.

With Johnson supplying the technical expertise, and Gerard weaving the pieces together, the IHCA was crafted to remedy that situation.

The Legislative Contest

The greatest threat to the legislation came from two sources, both on the left side of the political spectrum. Senator James Abourezk, a

Democrat from South Dakota, chaired the Indian Affairs Subcommittee of the Senate Interior Committee and wanted to be seen as the author of health legislation. Abourezk, however, was a maverick who was not well liked in the Senate, especially by Scoop Jackson. As chairman of the full committee, Jackson could assume legislative responsibility for any issue he wished, which he deftly did by means of the following letter to Senator Abourezk:

Dear Jim,

This is to apprise you of a major proposal that is being drafted for my introduction that I believe will do much to improve the current status of the health of American Indians. It is my hope that you will join me as a major co-sponsor of the bill at the time of its introduction.

By way of background, I was contacted early in this session of Congress by Dr. Abraham Bergman a physician on the staff of the Children's Hospital in Seattle. Dr. Bergman assisted Senator Magnuson and me in the development of legislation which led to the establishment of the National Health Service Corps.

Dr. Bergman suggested to me at the time of our initial discussion earlier in the year that I consider legislation to deal with the urban Indian health problems. However he agreed with my position that it would be difficult to single out that category of Indian concern and not address attention to Indians living on Federal reservations and Indian communities.

I note that you recently held two days of hearings before the Subcommittee on the question of Indian Health Service's recruitment problems of medical personnel. I am certain that the record for those hearings will prove useful in the development of legislation that is now under way. (Jackson 1973)

The more serious threat came from Senator Edward Kennedy, a Massachusetts Democrat, or more accurately, from Senator Kennedy's staff. As chair of the Health Subcommittee, Kennedy asked to share jurisdiction over the Indian health legislation. Aside from the jurisdictional issue, Kennedy's staff members, who advocated universal health insurance, were opposed to incremental steps for any group, as they believed that the momentum for a universal solution would be diluted. VanNess says: "If Kennedy had shared jurisdiction, support from the conservative Republicans would have vanished, and the bill would have died." Gerard and Johnson sent out alarm signals to tribal leaders, who asked for a personal meeting with Senator Kennedy. Gerard recalls: "To the

disappointment of his ambitious staff members, Kennedy, who had always allied himself with Indian causes, told the tribal leaders that he would follow their wishes in this matter. They asked that he drop his claim of jurisdiction, which he did.”

Courting the Conservatives

Another danger came from the right side of the political spectrum. On the face of it, the prospects of passing a bill during a Republican administration that would authorize the spending of \$1.6 billion to benefit a group with little political clout appeared to be minimal. This thinking, however, did not reckon with the “transideologic sponsorship” that emerged. Redman points out that the support of legislators from both the far right and far left of the political spectrum designates a bill as being “safe” and thus passable (Redman 1973, 79).

Paul Fannin, a former governor of Arizona, was the principal Senate cosponsor. Senator Fannin brought not only his impeccable conservative credentials but also the services of his aide, Rick Lavis. Working as a smooth team, Gerard dealt with the Democrats, Lavis with the Republicans. On the House side, by a stroke of good fortune, Representative Lloyd Meeds, a Jackson protégé from Everett, Washington, chaired the subcommittee on Indian affairs. Lavis met every two weeks with the staff assistants of Republican senators. He continually stressed that the bill was not the antipoverty legislation so dreaded by Republicans but rather was a way of meeting treaty obligations.

In explaining the strong support for the bill from his boss, Lavis says:

Paul Fannin was one of the most scally conservative politicians I knew. I never thought he would go along with the huge authorization. However as governor of Arizona he came to view the Indian reservations as “impoverished islands in a sea of plenty,” and became especially interested in Indian education. “Let’s go with the bill,” he said; “we’ve got to get ‘em healthy.”

For similar reasons, there was also strong support from the Republican leader of the House, Representative John Rhodes of Arizona, whom Lavis recruited to testify. The flavor of this support can be experienced in the

testimony of Mr. Conservative” himself, Senator Barry Goldwater, also from Arizona, before the House Indian Affairs Subcommittee:

I have lived with the Indians of my state all my life, not just knowing them, but living intimately with them, operating a trading post on the Navajo Reservation for a number of year and I have seen the whole history of neglect unfold. In fact, Mr. Chairman, I can recall when I operated this post, the nearest health service available was 90 miles over a road that took 5 hours to drive.

Though we in Congress may have appropriated yearly increases for the IHS, we have merely sustained a status quo health delivery system for the Indians which is less than substandard to the white man’s health care. Over 7 years, \$1.6 billion is not that much to ask for when considering the disgraceful condition that the Indians and the IHS have had to put up with for so many years. (U.S. Congress 1975)

On the House side, Franklin Ducheneaux was as adept as Gerard in dealing with members and their staffs. I never sensed much opposition to the bill,” he said. There was a sense that this (Indian health) was a problem that we should do something about.”

With such broad-based support, the bill sailed through the Senate and House and landed on the desk of President Ford, where its fate was uncertain. A frantic campaign took place to influence the president. Both HEW and OMB recommended a veto. Patterson, however, still worked in the White House and recommended that the bill be signed. Another influential supporter was Dr. Ted Marrs, a physician who previously had worked in the Defense Department. He came to the White House as a special assistant to President Nixon and stayed on with President Ford; thus he was familiar with Indian issues. Ford listened to these two insiders,” and on September 30, 1976, he signed PL 94-437 into law.

Bureaucratic Pressure

From its inception in 1955, the greatest threat to the survival of the IHS came neither from lack of funding nor from enemies of Indian welfare, but rather, in the view of the individuals we interviewed, from midlevel officials in HEW and OMB. The reasons pertain both to the tensions that are inherent in large bureaucracies and to the unique issue of how the government should relate to Indians.

OMB makes the directors of most programs unhappy. They all think they need more money; it is the job of OMB to cut back on wish lists in order to serve the "greater good" of the Administration. It is not difficult, therefore, to imagine how the IHS directors who ignored the chain of command and worked the "iron triangle" would have disconcerted their nominal superiors. For example, Administrators are supposed to support the President's budget once it is submitted to Congress. The IHS directors never did. They viewed the chairs of the House Interior Appropriations Subcommittee as more important than the director of OMB or the secretary of HEW. Everett Rhoades says: Emery was a master at disregarding administrative direction. I think he actually enjoyed tweaking the tails of the bureaucrats."

This insubordination," however, should be seen in the context of budgets that never came close to meeting needs. The money for the rationed medical care was substantially less per capita than that spent on the rest of the U.S. population (Kunitz 1996). Construction money was rarely requested. New facilities appeared only when Congress, at the public behest of the tribes and the private urging of the IHS, added additional money. Forrest Gerard says this about the reasons for the tension:

Because the PHS was opposed to the transfer in 1955, they put the IHS into the lowest possible level in their gigantic bureaucracy. To this day I believe that one of the major problems the IHS has faced within HEW is the difficulty that the policy makers and long-term careerists have had in accepting the unique relationship that the Indian tribes maintain with the US government. They see the Indians as just another minority that they have to serve. Another source of discomfort for the HEW bureaucrats has been the source of the IHS Appropriations. Doubtless as a result of Congressional pride, when the functions of the IHS were transferred from the BIA to the PHS, funding for the program was left in the hands of the Interior Appropriations Subcommittees of the House and Senate.

In his book describing the expanding role of the White House staff, Patterson provides this explanation for the failure of government officials to support President Nixon's new policy on Indian self-determination:

Departmental officials are not usually scheming miscreants, plotting to undermine the chief executive, though most presidents often think so. On the contrary, they are almost always honorable men and

women—political and career alike—acting according to established professional traditions. What they fail to realize is that presidents are tradition-*breakers*. For White House staff who see the president beleaguered on so many fronts . . . departmental reluctance translates into insubordination. (Patterson 1988, 61).

Johnson was bothered both by the failure of many officials in HEW and OMB to share his view that Indians were entitled to health care because of treaties and by what he perceived to be their insensitivity to Indian culture. He cites the following example:

The Hopi Service Unit is geographically located in the middle of the Navajo Reservation, but operationally has reported to the IHS area office in Phoenix. The OMB budget examiners were always telling me that for the sake of efficiency, I should have the Hopi Service Unit report to the Navajo Area office. And each time I would have to patiently explain that because the Navajos and Hopi's were traditional enemies there were good reasons for keeping their affairs separate.

The Tenure of Everett Rhoades

Johnson's final challenge before his retirement was to identify his successor, and he describes how he made his choice:

There was little question that the new IHS director should be an Indian, but at the time the pool of qualified candidates was limited. It was important that the first Indian director not fail. We had to find a physician of stature who had already distinguished himself. Everett Rhoades was the obvious choice.

Getting Rhoades to take the job was another matter. He was a professor of medicine at the University of Oklahoma and had scant desire to give up his academic career and/or move his family to Rockville, Maryland. However, Johnson's persuasive powers, combined with Rhoades's own desire to give something back to his people, brought him into the fold.

Rhoades's tenure (1981–93) was not easy. He says: "the wisest decision Emery Johnson ever made was picking the right time to retire." By that time, Brad Patterson had left the White House and Ronald Reagan and his budget director, David Stockman, began to cut the size of the government. Robert Graham, who headed the Health Resources

Administration in which IHS was lodged, describes the situation faced by Rhoades:

Appropriations Subcommittee Chairman Yates had fewer degrees of freedom to apply money to problems, and as more health programs were turned over to the tribes, there was increased tribal competition for fewer dollars. Some tribal leaders took their frustrations out on Everett. The fact that he was an Indian did nothing to deflect their criticisms.

The departure of Johnson, with his abundant connections and political skills, also meant that HEW tightened its grip on the reins. The IHS director was no longer allowed to testify alone before the appropriations subcommittees. Rhoades says, "I was under strict orders by my superiors in the Department not to talk to anyone on 'the Hill' and more or less followed those orders." On one occasion Rhoades lapsed. Not satisfied with the testimony of Graham before his subcommittee, Chairman Yates began to direct his questions to Rhoades, who was sitting amidst a group of HEW officials. "My frank answers were not appreciated by my superiors," said Rhoades.

The harassment turned from the annoying to the vicious when a story appeared in the *Washington Post* on June 26, 1985, accusing Rhoades of influencing the IHS minority student recruitment program to provide scholarship aid for his daughter to attend Harvard College. Rhoades was summoned to the office of the HEW Secretary Margaret Heckler, whose staff director, C. MacLain Haddow, waxed indignant about this supposed ethical lapse and demanded his immediate resignation. "I was absolutely stunned," said Rhoades, "but something inside told me to not give in. The first thing I did was call Emery and ask his advice." Johnson quickly contacted his old comrades, Gerard and Byler, who made the rounds of Capitol Hill and mobilized enough support to keep Rhoades from being fired. Nevertheless, from July to December 1985, while an investigation of the episode by HEW's inspector general took place, Rhoades was reassigned to an office in the Parklawn Building and not allowed to provide any direction to the IHS. Eventually the charges were determined to be totally unfounded, and he returned to the director's chair, where he remained until he retired in 1993.

A footnote can be appended to the tawdry affair: In 1987 Haddow, who had lectured Everett Rhoades about ethics in government, pled guilty to improperly pocketing \$55,300 in foundation and government

funds while working in HEW. He was fined and sentenced to a year in federal prison (*New York Times*, December 16, 1987).

The IHS Today

Although a detailed examination of the present-day IHS is beyond the scope of this paper, some comments are in order. In 1988 the status was upgraded on the organization chart of the Department of Health and Human Services to that of an "agency." One result was that the director of the IHS was appointed by the President and confirmed by the Senate. In 1994 President Clinton appointed Dr. Michael Trujillo, a member of the Laguna Pueblo in New Mexico, who had joined the IHS in 1978, to become the sixth director of the IHS.

The tribes have increasingly taken over their own health operations with mixed consequences. Kunitz says:

Since 1955 the Indian Health Service has evolved from a highly centralized, regionalized service in its first 20 years to an increasingly decentralized service in its second 20 years [A] related initiative undertaken by the administrations is what has been called "compacting," which is a looser arrangement than contracting, and gives the tribes more flexibility in their use of government funds. Contracts require that tribes provide the same level and types of services as were provided by the BIA and IHS programs they replace. Compacts give them much more latitude to use the money for a wide variety of purposes [However,] as tribes have been given increasing responsibility for managing their own health and other services, and as the costs of those services rise, the inadequacy of government appropriations has become increasingly evident. Tribes are thus being encouraged to provide resources to supplement the government appropriations, which accounts, in large measure, for the epidemic of casino gambling that has swept through Indian country in recent years. (Kunitz 1996)

Rhoades, who has returned to the University of Oklahoma, provides this pessimistic view:

The erosion of the federal role is bound to continue. A great redistribution or rearrangement is happening, with a shift of resources to the compacted (wealthier) tribes. They will continue to do better, and the poorer tribes will continue to do worse. Though it is a terrible term, I share the concern of some other Indian people that a possible ultimate

outcome of self-determination and now self-governance will be termination." Whereas the leadership in the Administration could take pride in the accomplishments of the IHS they continue to this day to view the IHS with disdain, or worse, not view the IHS at all. The overwhelming tone among the health establishment in the country towards the IHS continues to be how terrible things are. There is little appreciation of the program's magnificent accomplishments. And I fear this general misperception colors so much of the Departmental and White House attitudes. Before my retirement I had a chance to brief the new Secretary, Donna Shalala. I wanted her to know how proud she could be of one of her agencies. I didn't even get a chance to open my mouth before she went on about what to do about the awful IHS."

Reflecting nostalgically on his long career as a lobbyist for Indian causes, William Byler says:

In those years—the 60's and 70's—we could beat anyone. It used to be that moral persuasion could get things done. It did not matter who the Goliaths were; we could bring 'em down. Now there is indifference in the congressional offices where before people would have been keenly aware of the issues.

Conclusion

Webster defines politics as "the art or science of government." We conclude that the politics of the IHS involved considerably more art than science. Mirroring the history of relations between Indians and the federal government, its administrators continued to fall into two camps: those who felt that Indians were just one of several disadvantaged minority groups to be dealt with" and those who agreed with this statement of Senator Inouye: "Over 100 years ago, the Indian people of this nation purchased the first pre-paid health care plan, a plan that was paid for by the cession of millions of acres of land to the United States" (Inouye 1993). The first group had more numbers and greater political power. Those in the second group were fewer in number but possessed abundant measures of idealism and political skills.

A number of lessons can be learned from this story. Had the IHS directors not utilized the "iron triangle" but had chosen instead to adhere strictly to the orders of their superiors in HEW and OMB, the IHS, if it existed at all, would presumably look quite different. Many readers will

be surprised to learn that, among politicians in the modern era, Richard Nixon and Henry Jackson had the greatest effect on Indian policy. Or that conservative icons like Senators Barry Goldwater and Paul Fannin were champions of Indian health. The importance of a "transideologic" coalition in achieving legislative victories is illustrated by the Indian Health Care Improvement Act. Finally, tribute should be paid to staff aides like Bradley Patterson in the White House, Forrest Gerard in the Senate, and Franklin Ducheneaux in the House of Representatives. To be successful at their jobs, they had to be anonymous to the public. Their achievements on behalf of Indians are huge. Despite its imperfections, and despite the sizable health problems that still exist among American Indians and Alaskan Natives, the IHS is an example of one federal program that has worked.

References

- Adair, J., K.W. Deuschle, and C.R. Barnett. 1970. *The People's Health: Medicine and Anthropology in a Navajo Community*. New York: Appleton-Century-Crofts.
- Cahn, E.S. Ed. 1969. *Our Brother's Keeper: The Indian in White America*. Washington, D.C.: New Community Press.
- Edwards, G.C., M.P. Wattenberg, and R.L. Lineberry. 1999. The Federal Bureaucracy. *Government in America: People, Politics, and Policy*, 8th ed, Longman Online: chap. 15. <http://occ.awlonline.com/bookbind/. . . chapter98/medialib/edvisch15.html>.
- Hirschhorn, N., R.A. Cash, W.E. Woodward, and G.H. Spivey. 1972. Oral Fluid Therapy of Apache Children with Acute Infectious Diarrhea. *Lancet* 2 (766):15-18.
- Indian Health Service. 1996. *Trends in Indian Health*. Rockville, Md.
- Inouye D. 1993. Perspectives on Indian Health Care. Remarks to the National Summit on Indian Health Care Reform, March, Washington, D.C. Oakland, Calif.: American Indian Resources Institute.
- Jackson, H. M. 1973. Papers. Archives of University of Washington Library, Seattle.
- Johnson, E.A. 1985. *The Health of American Indians/Alaska Natives: Progress, Problems, and Potential*. Report to the Robert Wood Johnson Foundation. (Unpublished.)
- Kane, R.L., and R.A. Kane. 1972. *Federal Health Care (with Reservations)*. New York: Springer.

- Kaplan, G.J., J.K. Fleshman, T.R. Bender, C. Baum, and P.S. Clark. 1973. Long Term Effects of Otitis Media: A Ten Year Cohort Study of Alaskan Eskimo Children. *Pediatrics* 52:577-85.
- Kristol, W. 1993. Breaking Up the Iron Triangle. *Harvard Journal of Law and Public Policy* (winter):95-100.
- Kunitz, S.J. 1983. *Disease Change and the Role of Medicine: The Navajo Experience*. Berkeley: University of California Press.
- Kunitz, S.J. 1996. The History and Politics of US Health Care Policy for American Indians and Alaskan Natives. *American Journal of Public Health* 86:1464-73.
- Lawler, D.J., R. Biswell, D.J. Sharvelle, and O.B. Carreno. 1970. Trachoma among the Navajo Indians. *Archives of Ophthalmology* 83:187-90.
- McDermott, W., K.W. Deuschle, and C.R. Barnett. 1972. Health Care Experiment at Many Farms. *Science* 175:23-31.
- Nixon, R.M. 1970. Recommendations for Indian Policy. Message to the 91st Congress, second session, July 8. House Document 91-363. Washington, D.C.
- Nixon, R.M. 1978. *The Memoirs of Richard Nixon*. New York: Grosset and Dunlap.
- Nutting, P.A., C.R. Strotz, G.I. Shorr, and L.E. Berg. 1975. Reduction of Gastroenteritis Morbidity in High-Risk Infants. *Pediatrics* 55:354-8.
- Patterson, B.H. 1988. *The Ring of Power: The White House Staff and Its Expanding Role in Government*. New York: Basic Books.
- Redman, E. 1973. *The Dance of Legislation*. New York: Simon and Schuster.
- Rhoades, E.R., A.J. D'Angelo, and W.B. Hurlburt. 1987. The Indian Health Service Record of Achievement. *Public Health Reports* 102:356-60.
- Rhoades, E.R. 1990. The Major Respiratory Diseases of American Indians. *American Review of Respiratory Diseases* 141:595-600.
- Rubenstein, A., J. Boyle, C.L. Odoroff, and S.J. Kunitz. 1969. Effect of Improved Sanitary Facilities on Infant Diarrhea in a Hopi Village. *Public Health Reports* 84:1093-7.
- Smith, P.C. 1996. *Like a Hurricane: The Indian Movement from Alcatraz to Wounded Knee*. New York: New Press.
- Strickland, S.P. 1972. *Politics, Science, and Dread Disease*. Cambridge, Mass.: Harvard University Press.
- Trennert, R.A. 1998. *White Man's Medicine: Government Doctors and the Navajo, 1863-1955*. Albuquerque: University of New Mexico Press.

U.S. Congress. 1975. Testimony of Senator Barry Goldwater before the House Subcommittee on Indian Affairs of the Committee on Interior and Insular Affairs, September 15, 94th Congress. Serial no. 94-22. Washington, D.C.

U.S. Public Health Service. 1957. *Health Services for American Indians*. PHS pub. no. 531. Rockville, Md.

Williams, T.H. 1970. *Huey Long*. New York: Knopf.

Address correspondence to: Abraham Bergman, MD, Harborview Medical Center, Box 359774, 325 9th Avenue, Seattle, WA 98104 (e-mail: oscarb@u.washington.edu).