The History and Politics of US Health Care Policy for American Indians and Alaskan Natives

ABSTRACT

This paper traces the development of the US federal government's program to provide personal and public health services to American Indians and Alaska Natives since the 1940s. Minimal services had been provided since the mid 19th century through the Bureau of Indian Affairs of the Department of the Interior. As a result of attempts by western congressmen to weaken and destroy the bureau during the 1940s, responsibility for health services was placed with the US Public Health Service. The transfer thus created the only US national health program for civilians, providing virtually the full range of personal and public health services to a defined population at relatively low cost. Policy changes since the 1970s have led to an emphasis on self-determination that did not exist during the 1950s and 1960s. Programs administered by tribal governments tend to be more expensive than those provided by the Indian Health Service, but appropriations have not risen to meet the rising costs, nor are the appropriated funds distributed equitably among Indian Health Service regions. The result is likely to be an unequal deterioration in accessibility and quality of care. (*Am J Public Health.* 1996;86:1464–1473)

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Introduction

The history of health services for American Indians is unknown to most public health workers. This is a pity because the provision of both public and personal health care for Native Americans and Alaska Natives represents a major, unique, and largely successful experiment in this country, and one that seems to be coming to an end. It is embedded, of course, in Indian policy in particular but also in much larger political, economic, and ideological currents, some of which are described in this brief essay.

Provision of Care by the Federal Government

Since the early 19th century, the federal government has provided health care to American Indians, both as a treaty obligation and as a consequence of its role as trustee.[1] Care was first provided by military doctors until 1849, when the Bureau of Indian Affairs was transferred from the War Department to the newly created Department of the Interior.

The Department of the Interior has always been in a difficult position with regard to Indians. On one hand, it is charged with acting as trustee for Indian rights and resources. On the other hand, federal legislators, primarily those from western states whose constituents covet Indian resources, often subject it to intense pressure not to be too zealous in its defense of Indian rights and resources. Moreover, presidential administrations that were unsympathetic to Indians have often appointed as secretaries of the interior and commissioners of Indian affairs, people who themselves had other interests than the Indians' at heart. It is a fair generalization that non-Indians in states with substantial Indian populations often resent the presence of Indians and the role of the federal government in awarding them what are perceived to be special privileges and services.

Thus, the Department of the Interior has often been less than zealous in protecting Indian rights and resources. During the 1930s, however, under Secretary Harold Ickes and his commissioner of Indian affairs, John Collier, the department was unusually protective of Indian rights—so much so, indeed, that a number of western legislators attempted to have the Bureau of Indian Affairs abolished and its responsibilities moved to other federal agencies or levels of government. But Collier was adamant that all responsibility should remain with the bureau; in 1936, for example, he resisted an attempt to move the health care function to the US Public Health Service.[2] The bureau remained intact as long as the Democrats were in the White House, but major changes began to occur in the 1950s.

The First Hoover Commission

When Harry Truman became president upon the death of Franklin Roosevelt, one of his major concerns was to reorganize the government. He believed that his predecessor had not been a good manager and that the executive branch required rationalization. At the same time, the

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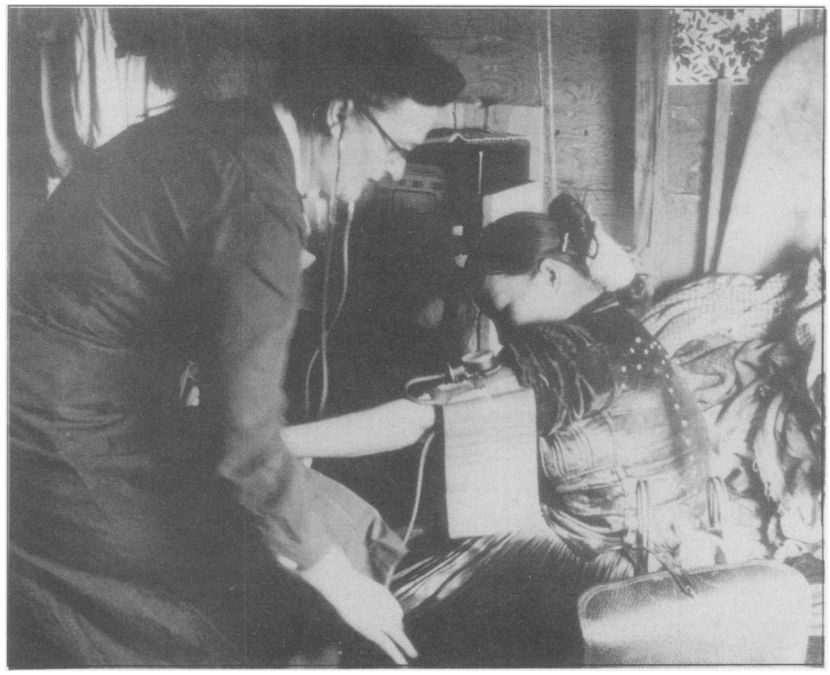
Editor's Note. See related comment by Jorgenson (p 1362) in this issue.

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.[3]

The result was legislation that empaneled a bipartisan Commission on Reorganization of the Executive Branch of the Government under the chairmanship of former president Herbert Hoover. "There is no 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."[4] 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 did win 4 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."[5] This was to include, of course, all health services. The policy of assimilation and the steps to achieve it did become federal Indian policy during the Eisenhower years. This involved terminating the federal recognition of Indian tribes, encouraging the relocation of Indians from reservations to cities, and weakening and ultimately dismantling the Bureau of Indian Affairs.

It was recognized, however, that termination of federal oversight 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.[6] Moreover, state and county governments were simply unwilling to shoulder the responsibilities recommended for them by the task force. The result was that when legislation was introduced into both houses of the 82nd Congress in 1952 to transfer responsibility for Indian health from the Bureau of Indian Affairs to the US Public Health Service, it was defeated. However, it was later passed in 1954 by the 83rd Congress as PL 568.



A visiting nurse checks the blood pressure of a Navaho Indian woman. Courtesy of the National Library of Medicine.

Testimony in the hearings 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 health care, and discrimination in non-Indian facilities; others believed that the level and quality of health care provided by the Bureau of Indian Affairs were simply inadequate and that a professional corps of commissioned officers would be more numerous and better trained, would have access to more resources, and would provide better care. Professional opinion was decidedly in favor of the transfer for the same reasons. Indeed, the sponsor of the House bill, Rep Walter Judd from Minnesota (himself a physician), claimed that the original idea had come to him from the American Public Health Association after its annual meeting in 1951. And of course there were the assimilationists, many of whom wished to weaken the Bureau of Indian Affairs, the primary guardian of Indian rights and resources.

The Department of the Interior under a Republican administration now favored the transfer of responsibility. Asst Secy Orme Lewis wrote to Sen Hugh Butler, chairman of the Senate Committee on Interior and Insular Affairs, "For over 100 years the Indian has had a relationship to the Bureau which has resulted in dependency for certain services. The Department believes that a new relationship with the need to work out problems and services through normal community and agency facilities will be worth any administrative difficulties which may be encountered."[7] Oveta Culp Hobby, secretary of health, education, and welfare, had what were perceived to be primarily administrative objections and resisted transfer to her department. Her concerns were largely dismissed.

Thus, the bill passed both houses of Congress. Sen Edward Thye of Minnesota, who introduced the bill into the Senate, had said that the purpose was severalfold: "1. to improve health services to our Indian people; 2. to coordinate our public health program; and 3. to further our long-range objective of integration of our Indian people in our common life."[8] 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

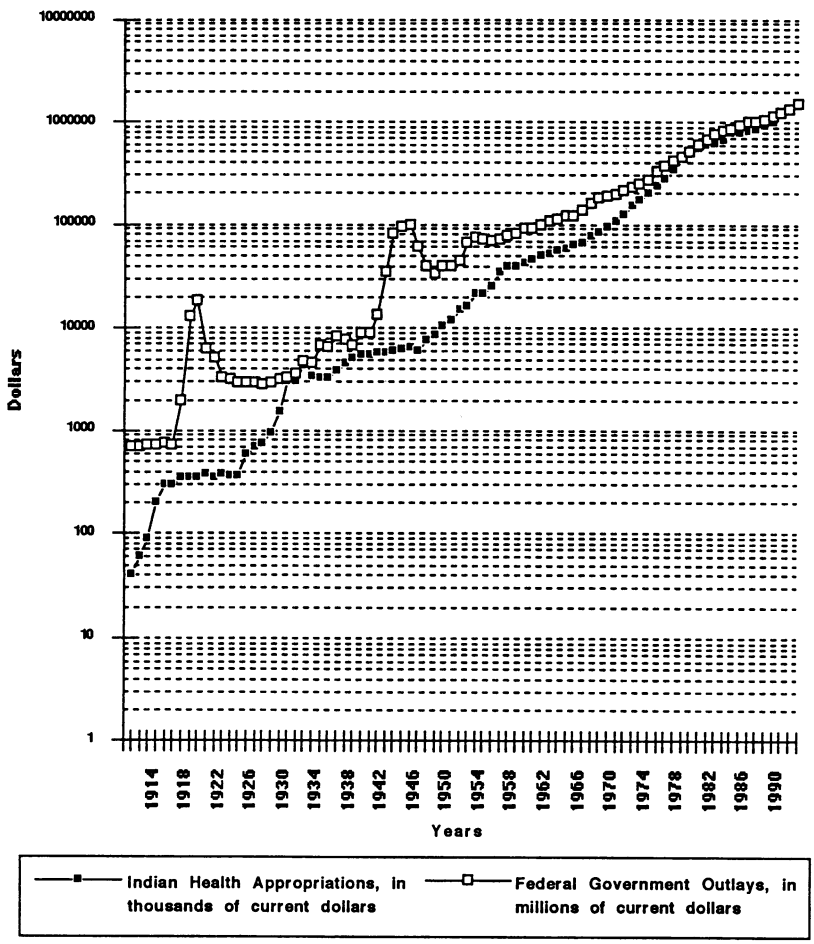


FIGURE 1—Federal outlays and Indian health appropriations for services, 1911 to 1992, semilog scale.

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."[9]

The result of the transfer was to create the only truly national health service for civilians in the United States, one that provided nearly the full range of public and personal services to a defined population. In the 40 years that have passed since the transfer was made, many Indians and non-Indians have come to see this program as an entitlement, something owed to Indians as a result of treaty rights and trust obligations. That is not how the government regarded it at the time of its creation, however, and it does not seem to be how many regard the program now.

The Indian Health Service

The system of care that was developed by the Public Health Service may be characterized as "hierarchical regionalism," a term one writer used to describe the series of attempts by reformers to reorganize the American health care system.[10] The Indian Health Service (or Division of Indian Health, as it was then known) was highly integrated in terms of both services and administration, with field stations linked to general hospitals and referral centers. Administration followed the same chain of command, with service units (catchment areas) reporting to area offices, which in turn reported to headquarters in Washington. A Public Health Service document that was published at the time the Division of Indian Health was created, stated that "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."[11]

This highly integrated regionalized system dominated by White professionals (some Public Health Service career officers, some individuals serving 2-year military obligations, some civil servants) began to change significantly within 2 decades of its establishment. 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 beginnings of decentralizing what had begun as a highly centralized system.

Decentralization 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 toward 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."[12]

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

TABLE 1—Indian Health Service Area Allocations and Hospital Utilization, 1992 and 1993

Indian Health Service Area	Allocation/User, $ (1993)	Allocation/Person Enumerated, $ (1993)	Users/Service Population, % (1993)	Hospitalization Rate/10 000 Service Population (1992)	Average Length of Stay in Days (1992)	Proportion of Hospitalizations in Indian Health Service Facilities (1992)
Aberdeen	976	1223	122.0	1089	4.3	66
Alaska	1908	1906	99.8	1476	5.4	53
Albuquerque	867	915	105.6	829	4.4	80
Bemidji	888	838	94.5	490	3.6	32
Billings	922	1091	118.2	1004	3.8	47
California	1000	562	56.3	163	4.2	0
Nashville	1322	831	62.8	840	5.5	39
Navajo	608	717	117.9	888	4.1	87
Oklahoma	575	534	92.9	631	4.3	58
Phoenix	1002	886	88.4	1041	5.0	85
Portland	946	525	55.5	291	4.3	0
Tucson	1051	799	76.1	466	6.2	74

Source. Services allocation data are from Indian Health Service Budget Justification to the Congress, fiscal year 1995. Population estimates and hospitalization data are from Indian Health Service, *Regional Differences in Indian Health, 1994* (Rockville, Md.: U.S. Department of Health and Human Services, 1994).

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.[13]

The Nixon administration's Indian policy was embodied in two central pieces of legislation: 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 health, education, and welfare to develop new services or assume control over services previously provided by the federal government.[14] Contracting was limited to health and social service programs; it did not extend to natural resource management.

There does not appear to be any reason to believe that the Nixon administration was anything but sincere in advocating the policy of self-determination without termination.[15] One observer wrote, however, that the paradoxical results were an intensification of "tribal competition for federal support" and a narrowing of "political concerns to the managerial problems of social service programs. Rather than assisting tribes by expanding options of self-reliance, self-determination policy has deepened tribal dependence on central government funding and possessions. At the same time, the power of the BIA [Bureau of Indian Affairs] to represent tribal interests has declined, producing an overflow of tribal-specific conflicts in the courts."[16]

These conflicts were exacerbated by the failure of federal expenditures for the Bureau of Indian Affairs to increase substantially in the years after 1974: in constant (1974) dollars, funding for the bureau went from $411 million in 1974 to $416 million in 1988. On the other hand, the Indian Health Service fared much better. Direct program outlays increased (in 1974 dollars) from $217 million to $398 million over the same period.[17]

In fact, since the program's inception in 1955 and until the last couple of years, appropriations (in current dollars) for Indian health services have consistently increased, although at varying rates.[18] Figure 1 displays on a semilog scale both total federal government outlays and annual appropriations for Indian health from 1911 through 1992. During the two world wars and most of the 1930s, Indian health appropriations were virtually constant from year to year. In the immediate post-World War II decade just prior to the transfer of responsibility to the Public Health Service, these appropriations increased to a greater extent than did total federal outlays. From the late 1950s to the late 1960s, the increases were essentially parallel. From the late 1960s until the late 1970s, the rate of Indian health appropriations increased more rapidly than that of all federal outlays. This was a result, first, of the Great Society programs and, second, of increased appropriations from the Indian Health Care Improvement Act. Since about 1978, the rates of increase have been essentially the same for both total federal outlays and Indian health.

Despite the increases, however, the amount spent per capita on health services is substantially less than that spent on health for the entire US population. Excluding construction and research costs, the per capita expenditure on health for the entire US population in 1990 was $2629[19]; the Indian Health Service appropriation for American Indians, excluding facilities, was $976 per capita ($1052 if Medicare/Medicaid and private insurance reimbursements received by the Indian Health Service are included). If one adds about another $600 per capita for out-of-pocket expenditures by Indians, the average increases to about $1600 ($1700 including Medicaid, Medicare, and private insurance), or between 60% and 65% of the national figure.[20]

These average figures blur very considerable variations in allocations among the 12 Indian Health Service area offices (see Table 1). In 1993 these allocations

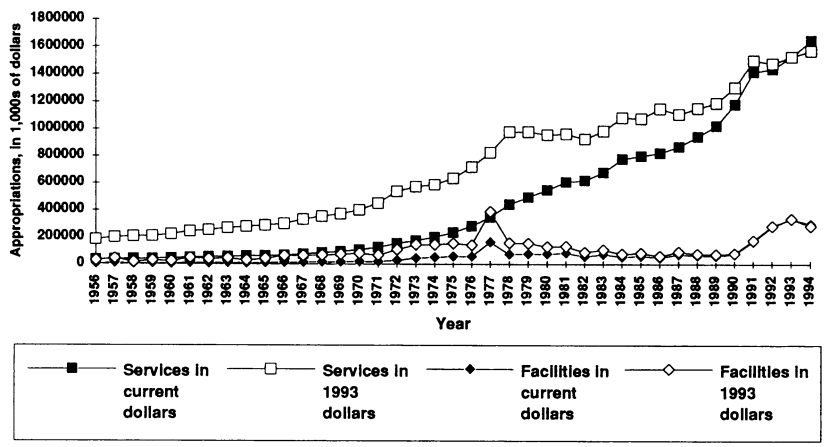


FIGURE 2—Indian Health Service appropriations, 1956 to 1994.

ranged from $1908 in Alaska to $575 in Oklahoma per Indian Health Service user (defined as anyone who has used program services in the 3 previous years), and from $1906 in Alaska to $525 in Portland, Ore, if the program (census-defined) population is used. There is a high correlation between the two measures ($r = 0.77$), but the differences are important. There have been complaints about the inequitable allocations, some of the reasons for which are based on historical precedent, regional differences in cost and accessibility to care, the different ways that services are provided (e.g., whether in Indian Health Service or contract facilities), and the relative influence that Indian tribes and Alaskan Native corporations have with their states' congressional delegations.

There is a strong correlation ($r = 0.83$) between the allocation per person in the service population of each area office and the hospitalization rate (in Indian Health Service, tribal, and contract facilities) of the area population. Yet there is a weak correlation ($r = 0.48$) between the allocation per user across areas and the hospitalization rate. This appears to be because in some areas, the user population is as much as 20% greater and in other areas the user population is almost 50% less than the census-enumerated service population.

The areas where the ratios are more than 100% are those where large reservations exist and where the Indian Health Service has historically focused the bulk of its attention. It is likely that many of the excess users are people originally from those areas who have migrated to places like California and Texas, where program services are either not available at all or not readily accessible; who have no health insurance because of the kind of jobs they are able to find; and who return home in times of need. That may be why there is a strong correlation ($r = 0.66$) between the user to service population ratio and the proportion of hospital days that are spent in Indian Health Service facilities compared with tribal or contract facilities. Migrants to areas without Indian Health Service care who have health insurance are likely to be cared for in community general hospitals rather than in Indian Health Service, tribal, or contract facilities. They would not appear in the Health Service data system at all, and thus they contribute to the very low hospitalization rates in the California and Portland areas. Moreover, the fact that the ratio of user-to service population is essentially 1:1 in Alaska suggests that when Alaska Natives do migrate, they are most likely to do so within Alaska itself rather than to another area, unlike what seems to occur among Indians in the contiguous 48 states. These differential migration and health care patterns appear to contribute significantly to the differences between the correlation coefficients reported in the previous paragraph.

Providers and tribal governments in those areas where care is provided to more people than are in the enumerated service population are likely to feel that they are getting a smaller allocation than they deserve. On the other hand, those in the California and Portland areas, which have no accessible Indian Health Service hospitals and the lowest user-to–service population ratios, are likely to feel they do not get the same range of benefits as Indians elsewhere. And the Alaska Native groups that manage most of their hospitals and clinics on Indian Health Service contracts are likely to justify their relatively high allocations by the long distances and greater costs of living there than in the contiguous 48 states. Indeed, Alaska Natives have by far the highest hospitalization rates and about the longest average lengths of stay of any of the area populations. Presumably this is because people in Alaska are flown from remote villages to hospitals earlier in the course of an illness than are people whose geographic access to hospital care is greater. Whatever the reason for the disparities among regions and regardless of whether the method of allocation is equitable, the fact is that even those areas with the highest allocations per person get considerably less than does the average US citizen.

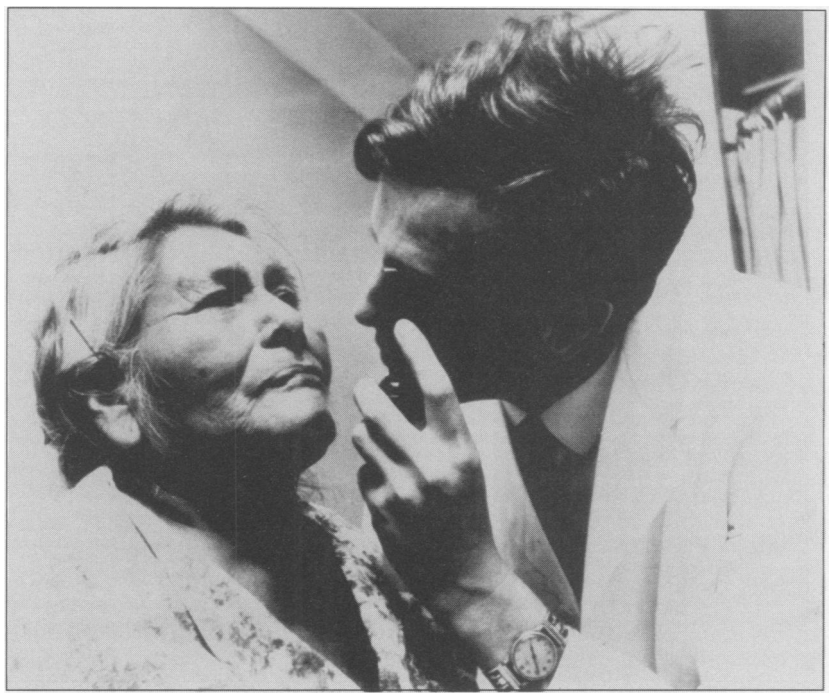
One consequence of this low level of expenditure has been that Indian Health Service hospitals provide a more limited range of services, both diagnostic and therapeutic, than community hospitals in general. Thus, they have shorter average lengths of stay and lower occupancy rates. Because a full range of services is not provided in Indian Health Service facilities or even the major referral centers, an increasing proportion of services must be provided by non–Health Service personnel, paid for with contract funds and costing more than such services would if they were provided internally. The reason for high costs is twofold: The Indian Health Service has failed to negotiate aggressively with private providers; and in some areas where private providers are scarce, there is not sufficient competition to force them to lower their prices.[21]

Moreover, low levels of funding are exacerbated by the contracting mechanism created by P.L. 93-638, whereby tribes receive money from the Indian Health Service to manage certain services themselves. This often involves subcontracting with non–Health Service providers. The Indian Health Service has benefited from economies of scale, which are unlikely to be achieved when individual tribes contract for services.

Finally, since the military draft of physicians ended on June 30, 1973, the number of physicians applying for the Indian Health Service has declined and the number of unfilled positions has increased. These various factors have conspired to make contracting tribes and

the Indian Health Service itself increasingly dependent on non–Health Service personnel and facilities, the result being that limited dollars do not go as far as they would in a system that is more highly integrated and provides a fuller range of services internally.

Since 1955, then, 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. In the face of low levels of expenditure and increasing costs, however, decentralization has raised serious problems, not simply for the institutional survival of the Indian Health Service, but also for the continuing provision of adequate services. These problems became increasingly obvious through the 1980s. The advent of the Clinton–Gore administration in 1992 promised relief since their campaign had spent considerable effort successfully wooing the Indian vote, small though it is. But the hopes raised by their victory have never been realized. On the contrary, the problems faced by the Indian Health Service and the Indian people have actually grown worse.



A physician examines the eyes of a Pima Indian women. Courtesy of the National Library of Medicine.

Indian Health Care in the 1990s

One of the planks of the Clinton–Gore platform had been "reinventing government," which meant reducing the federal bureaucracy and regulations. Like the Hoover commission almost 50 years ago, this initiative was meant to make government more efficient, more economical, and less intrusive in the lives of citizens. As part of the Department of Health and Human Services, the Indian Health Service was particularly vulnerable because, despite assurances to the contrary in testimony at the time of transfer, it has always been something of a stepchild in the department. This marginal status has been attributed by at least one knowledgeable observer to the fact that oversight of the Indian Health Service has remained with the Committee on Indian Affairs rather than with the committee that oversees the rest of the department.[22] Thus, when cuts were to be made, it was the marginal agency that suffered disproportionately. From fiscal year 1994 to fiscal year 1995, the reduction was to be 2.2% of full-time equivalents from the entire department, yet the Indian Health Service took a 7.7% cut.[23] Indeed, as Figure 2 indicates, since 1991 the Indian Health Service appropriation for services has scarcely increased at all.

The proposed disproportionate reduction in personnel was to be accompanied by a reduction in the Indian Health Service budget of 13% ($247 million) from fiscal year 1994 to fiscal year 1995. The rationale for this was evidently twofold: first, the president's proposed Health Security Bill for national health insurance would more than compensate for these reductions; and second, optimistically high reimbursements from Medicare and Medicaid were assumed.[24]

At a meeting with the president in April 1994, Indian leaders protested the reduction. In testimony before the Senate Committee on Indian Affairs in June 1994, Dr Jo Ivey Boufford, principal deputy of the assistant secretary for health, described the administration's response: "We ... are aware of the frustrations the Indian tribes have over the staffing and funding levels in the FY 1995 Budget. In response to those concerns, a budget amendment was submitted to provide an additional $125 million for the Indian Health Service."[25] The "additional" $125 million meant that the reduction was only 6%, not 13%. Informants say it came from other agencies within the Department of Health and Human Services, thus gaining the Indian Health Service no additional friends at a time when it had already become marginalized.

A related initiative undertaken by the administration is what has been called "Compacting," which is a looser arrangement than contracting and gives tribes more flexibility in their use of government funds.[26] Contracts require that tribes provide the same level and types of services as were provided by the Bureau of Indian Affairs and Indian Health Service programs they replace. Compacts give them much more latitude to use the money for a wide variety of purposes. Both the Indian Health Service and the Bureau of Indian Affairs have been criticized by federal legislators and tribal leaders for exercising excessively microscopic oversight of contracts and thus stifling tribal initiative. For instance, Sen John McCain (R, Ariz), currently the chairman of the Senate Committee on Indian Affairs, said in 1994:

> [T]his administration like its predecessor is committed to reducing federal regulatory burdens. I can think of no better place to start to reduce the crippling effect of regulations than in the area of Indian self-determination. It is time that the BIA and the IHS [Indian Health Service] get the message. Self-determination is not simply another federal program and it is not an

An Indian Health Service nurse demonstrates chest x-rays, part of the tuberculosis control program. Courtesy of the National Library of Medicine.

> excuse for federal officials to continue seeking domination over the affairs of tribal governments. In this instance, the BIA and the IHS suffer from the delusion that tribal programs can only be operated in the way that the BIA or IHS have operated them. To the contrary, self-determination requires a diminishment of the federal presence in tribal affairs. This includes reducing the federal work force and minimizing regulatory interference. Since the BIA and IHS seem unable or unwilling to accomplish these goals, I believe it has become necessary to repeal their authority to promulgate regulations under the Self-Determination Act.[27]

Compacting is said to be a mechanism to reduce just such allegedly excessive regulation. In the future, it may also raise serious questions about accountability for the use of federal funds, which is at least as great a cause of regulatory proliferation as the bureaucratic hunger for control.

Indian and Alaska Native corporations and tribes differ widely in their willingness to sign contracts and compacts with the Indian Health Service. Some have done a great deal in this regard; others, very little. The Navajo Tribe is one that has been reluctant to engage in contracting:

> The Navajo Nation is aware of its option to request that an entire program like the dental department become a "638" contract. However, the Navajo Nation views contracting as a problematic option because there is no available "pool" of contractors in the area. Contracting for clinical services or medical professionals can cost 2 to 3 times as much as an IHS employee. The problem of inadequate resources to meet growing needs will not be solved by transferring the operating responsibility while continuing to fund the program at 1/8 the national rate of expenditure.[28]

The problem for the Navajo Tribe and others like it is that they are being forced by events to undertake contracting and compacting. If they do not, the limited money available in the Indian Health Service budget will be absorbed at an increasingly disproportionate rate by those that do contract and compact, and they fear they will be left with very little. Thus, while contracting is supposed to be a matter of choice for tribal governments, they are being forced to do it or risk losing what services they have.[29]

One result seems to have been that competition between tribes for relatively less and less money to pay for increasingly expensive services has led to a vicious cycle in which more tribes are forced to compete, driving up costs to the system even further while the available money fails to keep pace. The problem is exacerbated by the highly unequal baseline from which negotiations must begin, as Table 1 indicates.

As a result, competition has increased not only between tribes but, in some instances, within tribes as well. On the Navajo Reservation, for example, service units are increasingly autonomous and responsible for their own budgets. In at least one instance, a local board is contemplating contracting with the Indian Health Service to manage health care. While this may sound attractive, it risks creating a patchwork, unintegrated, and expensive system in which previously integrated facilities will now have to bill each other for services provided to Navajos from other service units. Indeed, Navajo patients are already being turned away from facilities in other service units than the one in which they live. Moreover, to transfer money to the tribes, the Indian Health Service is having to shed personnel,[30] creating the very real risk that important public health and integrative functions will no longer be able to be carried out.[31]

Finally, as tribes have been given increasing responsibility for managing their own health and other services[32] 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.

All of this has happened under an allegedly friendly Democratic administration, which has probably prompted Indians to wonder whether they need enemies. Needed or not, the congressional election of November 1994 created the possibility of even more devastating changes in Indian policy. In an address to the Executive Council of the National Congress of American Indians shortly after the election, Sen Daniel K. Inouye (D, Hawaii), vice chairman of the Senate Committee on Indian Affairs, said:

> There is an important trend that is the subject of much debate in the Congress these days—the move to consolidate federal programs and block-grant them to the state governments. . . .
>
> Under several of the pending bills that propose the block grants to states approach, there is no provision made for the administration of federal programs by tribal governments.
>
> There is no reference to tribal self-determination contracts nor [to] self-governance compacts.

These bills do not address the constitutionally based and statutorily implemented relationship between the United States and Indian nations.

These bills are silent on the matter of treaty rights and the United States' trust responsibilities.

This, I believe, is a movement that holds the potential for a far more serious impact on Indian country than almost anything that is contained in the president's budget request.[33]

The senator is right to be worried for, as noted previously, state governments have not generally been friendly to their Indian citizens, whom they often regard as noncontributing members of society standing in the way of economic development.[34] If block grants go only to state governments and not directly to tribal governments, the so-called government-to-government policy—that is, the direct relationship between the federal and tribal governments—of the Clinton and previous administrations will become even more empty than it has been under the impact of the current budgetary restrictions.

A White Earth Indian Reservation Nurse, making a home health call. Courtesy of the National Library of Medicine.

Changes in Indian Health

Despite difficulties enumerating Indians and tabulating vital rates, there is little doubt that since 1955, Indian mortality has declined and life expectancy has improved substantially—from about 60 years at birth in the 1950s to 73.2 years at birth in 1989/91. The most recent figures are 2 years less than those for all US races and 3 years less than those for US Whites in 1990.[35]

Not unexpectedly, the major improvements have been in infant and child mortality, and the major declines have been in infectious diseases. Among Indian peoples, deaths from tuberculosis, gastroenteritis, and pneumonia-influenza have dropped significantly. In addition, homicide, other deaths due to violence, and alcohol-related deaths have also declined. On the other hand, deaths due to non–insulin-dependent diabetes are unusually high and rising, compared with those among non-Indians. Neoplasms, which are less common among Indians than among non-Indians, are also rising.[36]

These data suggest that the Indian Health Service has been effective in reducing preventable and treatable conditions such as infectious diseases but that it has not yet had an impact on certain chronic conditions such as diabetes and some cancers—most notably, perhaps, cervical cancer. Alcohol abuse has been the focus of much tribal and Indian Health Service attention, which may have contributed to the decline in alcohol-related deaths.[37] Thus, while some very important preventable problems remain, it is clear that, overall, the Indian Health Service has contributed significantly to the improvement of Indian health.

The question is whether it will be able to continue to do so, or whether the new health care delivery systems that are replacing it will be similarly successful. It seems unlikely that they will, for the increasing costs of care in the face of stagnant budgets will probably mean that clinical functions will be protected as best they can while public health and prevention programs are retrenched.

Conclusions

This brief history raises a number of issues and questions. It exemplifies the century-long debate in this country between assimilationism and pluralism (now called multiculturalism). Indians are, of course, different from other racial and ethnic groups inasmuch as they did not ask to be invaded, and many have treaties that give them a unique status in the eyes of the law. This unique status is perhaps why many conservatives have been supportive of Indian self-determination with federal support when they might not support similar claims by other ethnic groups.

This history also suggests, however, that self-determination is a double-edged sword. If supported adequately, it may in fact permit the freedom to develop locally unique and responsive programs. But if supported inadequately, as seems to be the case at present, it may lead instead to fragmented, expensive programs that will require the expenditure of tribal resources that might be better used elsewhere for other purposes.

Clearly, self-determination is a highly problematic concept. As generally used, it derives from the attempts after World War I "to make state frontiers coincide with the frontiers of nationality and language."[38] For the most part, this has turned out to be impossible to accomplish in more than a handful of nations. Indian reservations are among the few places where boundaries often do encompass one self-identified ethnic or linguistic group, although such groups are not sovereign nations as the term is usually understood. It is important to recognize that the concept is most readily applied to a territorially bounded group, not to individuals. Thus, it makes some sense to talk about self-determination of reservation populations. The issue becomes more problematic when applied, for instance, to people from many tribes who live scattered throughout Los Angeles County, people who may be as different from one another as any of them is from non-Indians.

It can be argued, of course, that it is "Indianness" rather than tribal identity that is important. This raises issues that go

well beyond the scope of this paper but are nevertheless important because, with growing intermarriage and mobility, it becomes increasingly difficult to determine who is an Indian and is entitled to federal and tribal benefits, and who is not. Recall that the transfer of responsibility for Indian health services was part of a larger policy that also included relocation of many Indians to urban places. The migration of the past 40 years means that, at present, about 50% of Indians live in metropolitan areas. There has been an ongoing debate between Indian urban and reservation leaders about the support of health services to urban residents. Urban leaders understandably consider health benefits to be an entitlement that ought to be portable; reservation leaders just as understandably fear the loss of support for reservation health programs. In fact, urban programs receive only a small fraction of the Indian Health Service budget: $22.8 million out of a total appropriation of $1.94 billion in 1994.[39] This simply shows that health services for Indians are not an entitlement—that is, a package of fixed benefits for each individual simply by virtue of membership in a federally recognized tribe. The level and distribution of services are shaped by annual appropriations.

Policy and demographic changes have thus worked to alter profoundly both the Indian Health Service and the care available to Indians. Self-determination is forcing Indians into the expensive private market for health care without increasing appropriations to cover the costs equitably across Indian country. This will likely result in a deterioration of services on many reservations. And the massive movement from reservations to cities will require urban residents to depend increasingly on the same sources of health care as the rest of the population. The policy of integration that gave birth to the Indian Health Service almost 50 years ago seems to be coming to fruition. □

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24. It is worth noting that until the passage of the Indian Health Care Improvement Act, the Indian Health Service as a federal agency was unable to receive reimbursement from Medicare or Medicaid. In explaining the change in policy to allow such reimbursement, the Senate Committee on Interior and Insular Affairs stated in its report on the act, "It is the intent of the Committee that any Medicare and Medicaid funds received by the Indian Health Service program be used to supplement—and not supplant—current IHS appropriations. In other words, the Committee firmly expects that funds from Medicare and Medicaid will be used to expand and improve current IHS health care services and not to substitute for present expenditures." *S. Rept. 93-1283 of the Committee on Interior and Insular Affairs, together with additional views to accompany S. 2938, the Indian Health Care Improvement Act,* 93d Cong., 2d sess., 1974, 114. In fact, the Indian Health Service has not been especially effective in collections from third parties, largely because of the lack of billing clerks.
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