Seattle Journal for Social Justice

Volume 20 | Issue 2 Article 15

3-15-2022

Death by Apathy: Tolerance of the Government's Failure to Fund Promised Healthcare Causes Loss of Native American Lives

Lia Maria Fulgaro

Death by Apathy: Tolerance of the Government's Failure to Fund Promised Healthcare Causes Loss of Native American Lives

Lia Maria Fulgaro*

I. INTRODUCTION

In 2015, Indian Health Services (IHS), the federal agency responsible for providing Native Americans[1] with promised healthcare, closed Rosebud Hospital Emergency Department in South Dakota due to lack of compliance with basic safety and sanitation guidelines.[2] In response, the local Rosebud

* J.D. Candidate, Seattle Univ. School of Law; Boston Univ. (Paralegal Studies); California State Polytechnic Univ., Pomona (B.A., English Language and Literature). The author would like to thank Director of Seattle Univ. School of Law's Center for Indian Law and Policy Brooke Pinkham (Nez Perce); Hon. Mark W. Pouley; Thomas P. Schlosser; and Geoffrey D. Strommer for their generous and valuable input and guidance on this topic. The author would also like to thank friends, family members, colleagues, and the SJSJ team for their support and feedback.

[1] The author notes that in referring to Indigenous people, within what is now known as the United States of America, there are different preferences of terminology. The author here uses "Native American" for consistency with contemporary literature unless the specificity of another term is needed. This is not meant to communicate any disrespect, nor is it meant to exclude other termed groups within labeling such as "American Indian and Alaska Native" and "Indigenous Peoples." The author recognizes the inherent difficulties with this terminology and notes this reference is not intended to convey that Native Americans are one homogenous group, as the term refers to many different groupings of tribes and individuals that have their own identities, cultures, and views. The author refers to the demographic in the aggregate here for lack of a better way to address the issue in relation to all of these individuals and groups, but that use is not to be seen as a flattening of Native American tribal and individual identities into one simplified label. The terms "Indian" and "Indian Country" also sometimes appear as these have specific meaning in federal Indian law and they are present in older legislation and rulings. No disrespect in any of these references is ever intended, and the author asks the reader's patience and understanding.

[2] Rosebud Sioux Tribe v. United States, 450 F.Supp.3d 986, 992 (2020); Acee Agoyo, *Indian Health Services Faulted for Closure of Rosebud Sioux Emergency Room*, INDIANZ.COM (July 22, 2019), https://www.indianz.com/News/2019/07/22/indian-health-service-faulted-for-closur.asp [https://perma.cc/PL2X-9XS7].

Sioux Tribe sued IHS in an effort to keep the emergency department open because the substandard, out-of-compliance facility was the best and only healthcare accessible to most of the tribal community.[3] In the seven months it took for the emergency department to reopen, at least nine people died while being transported to hospitals farther away from the reservation.[4] As dangerous as the IHS facility was, having it closed was worse for the community.[5]

In Montana, Anna Whiting Sorrell, a member of the Confederated Salish and Kootenai Tribes, received her hernia surgery partially covered through IHS, but her follow-up care was denied.[6] It took her years to finally obtain the proper follow-up care for the surgery.[7]

In March 2020, when the Seattle Indian Health Board sent out a request for more personal protective equipment supplies during the early days of the COVID-19 pandemic, the federal government sent them body bags instead.[8] This action mirrored the federal government's ongoing devaluation of Native American lives and brought board member Abigail Echo-Hawk[9] to tears.[10]

---

3 Agoyo, *supra* note 2.
4 *Id.*
5 *Id.*
6 Eric Whitney, *Native Americans Feel Invisible in U.S. Health Care System*, NPR (Dec. 12, 2017), https://www.npr.org/sections/health-shots/2017/12/12/569910574/native-americans-feel-invisible-in-u-s-health-care-system [https://perma.cc/L2FF-QRHK].
7 *Id.*
8 Nicole Pasia, *When They Gave Her Body Bags Instead of PPE, She Used Them to Make a Healing Ribbon Dress*, THE SEATTLE TIMES (Apr. 1, 2021), https://www.seattletimes.com/life/when-they-gave-her-body-bags-instead-of-ppe-she-used-them-to-make-a-healing-ribbon-dress/ [https://perma.cc/F8Q8-2L5Q].
9 Abigail Echo-Hawk is a registered member of the Pawnee Nation of Oklahoma. *Id.*
10 *Id.*

A. Crisis in Native American Healthcare

Dishonored promises and destructive federal policies have caused a largely unacknowledged crisis for the Indigenous population of what is now known as the United States.[11] The federal government took Native American lands in exchange for provision of services.[12] That taking, coupled with early federal policies severely undermining Native American societal structures and economies,[13] has caused Native Americans to be uniquely reliant upon the federal government to provide necessary healthcare.[14] Instead of properly fulfilling this obligation, the federal government has consistently underfunded the systems in place to provide Native Americans with the promised healthcare, often significantly delaying or denying them basic care and leaving them without remedy.[15]

Native Americans suffer from disproportionately poor levels of health and education in the United States.[16] The true depth of this crisis is often sidelined as Native Americans are frequently marginalized, and tribal relations are an often-overlooked aspect of the United States' legal, federal, and healthcare systems.[17] The life expectancy for Native Americans born today in the United States is 4.4 years less than the United States' general population.[18] In some states, the life expectancy of Native Americans is 20

---

[11] Anna Lindrooth, *Discretionary Deaths in Indian Country: Ensuring Full Funding for Tribal Health*, 26 FED. CIR. B.J. 277, 278 (2017).

[12] Daniel I.S.J. Rey-Bear & Matthew L.M. Fletcher, *"We Need Protection from Our Protectors": The Nature, Issues, and Future of the Federal Trust Responsibility to Indians*, 6 MICH. J. ENV'T. & ADMIN. L. 397, 402 (2017).

[13] *See* discussion, *infra* Section II.

[14] *Id.*; Timothy M. Westmoreland & Kathryn R. Watson, *Redeeming Hollow Promises: The Case for Mandatory Spending on Health Care for American Indians and Alaska Natives*, 96 AM. J. PUB. HEALTH, no. 4, at 601 (Apr. 2006).

[15] *See generally* Westmoreland & Watson, *supra* note 14, at 600.

[16] Rey-Bear & Fletcher, *supra* note 12, at 398.

[17] *See, e.g.,* Libby Smith, *Impact of the Coronavirus and Federal Responses on Indigenous Peoples' Health, Security, and Sovereignty*, 45 AM. INDIAN L. REV. 297, 299–300 (2021).

[18] Mary Smith, *Native Americans: A Crisis in Health Equity*, 43 ABA HUM. RTS. MAG., no. 3,

years shorter than the national average.[19] Native Americans die at a higher rate than other Americans in many categories of causes, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault or homicide, intentional self-harm or suicide, and chronic lower respiratory diseases.[20] The tuberculosis rate in 2019 was almost 7 times higher for Native Americans than for the white population.[21] Native Americans have also been disproportionally affected by the COVID-19 pandemic, with Native Americans being 3.5 times more likely to contract the disease and 1.8 times more likely to die from it than white people.[22] These disparities are caused, in large part, by the barriers Native Americans often face in obtaining adequate healthcare.[23]

Arguably, the most significant barrier Native Americans face in obtaining adequate healthcare is lack of funding for IHS.[24] That lack of funding is in direct violation of a legally established responsibility that the federal government must provide Native Americans with adequate healthcare.[25] Additional barriers of remoteness, poverty, racism, and

---

https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/native-american-crisis-in-health-equity/ (last visited Feb. 21, 2022).

[19] Whitney, *supra* note 6.

[20] INDIAN HEALTH SERV., INDIAN HEALTH DISPARITIES (Oct. 2019), https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf [https://perma.cc/A5UP-ARQK].

[21] U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF. MINORITY HEALTH, *Profile: American Indian/Alaska Native* (Mar. 2018), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62 [https://perma.cc/ZW4U-FDXX].

[22] *See* Pasia, *supra* note 8; J. Arrazola et al., *COVID-19 Mortality Among American Indian and Alaska Native Persons – 14 States, January–June 2020*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a3.htm?s_cid=mm6949a3_w [https://perma.cc/6EER-XJJL].

[23] *Id.*

[24] *See, e.g.,* Smith, *supra* note 17, at 305–07.

[25] *See* discussion, *infra* Section II-A.

bureaucratic red tape are all exacerbated by this lack of funding.[26] Economic factors further limit Native Americans' abilities to afford or reach healthcare resources.[27]

According to the 2010 Census, approximately 22% of Native Americans and Alaska Natives live on reservations or other trust lands.[28] These lands are often more isolated or rural, further heightening Native American communities' vulnerability to being ravaged by events like the COVID-19 pandemic and other health issues as available healthcare resources are scarce.[29] Available healthcare facilities often require Native Americans to travel great distances to reach them.[30] The only available facilities for Native Americans may also be out of compliance with basic health and sanitation standards.[31] Because of insufficient funding, an IHS facility can also be more likely to deny care altogether simply because the resources are not there.[32] The scarcity of funds, lack of access to adequate healthcare resources, and clear disparities in quality and length of life are particularly concerning given the trust responsibility of the federal government to provide adequate healthcare for the tribes.[33]

This failure of the federal government to make adequate provisions for Native American healthcare as promised in treaties, statutes, and caselaw disproportionally causes Native American deaths.[34] The status quo allows the government to enjoy the benefits of the land acquired through these promises while continually failing to provide what it promised the tribes in

---

[26] *See generally* Holly E. Cerasano, *The Indian Health Service: Barriers to Health Care and Strategies for Improvement,* 24 GEO J. ON POVERTY L. & POL'Y 422 (2017).
[27] Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 246–48 (1997).
[28] U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF. MINORITY HEALTH, *supra* note 21.
[29] Pfefferbaum et al., *supra* note 27, at 222.
[30] *See, e.g.,* Lindrooth, *supra* note 11, at 279.
[31] Lindrooth, *supra* note 11, at 279–80.
[32] *See, e.g.,* Whitney, *supra* note 6.
[33] Pfefferbaum et al., *supra* note 27, at 221.
[34] *See id.*

return, with little to no consequence for such a breach.[35] This status quo can no longer be tolerated. Congress must clarify these healthcare obligations to hold the government accountable and to provide Native Americans with effective legal recourse for these breaches of duty. Likewise, the judicial system must properly enforce the duty owed to Native Americans and provide appropriate avenues for remedy.

B. Roadmap

This publication will (1) explain the duty the federal government has to provide adequate healthcare to the tribes and show how failure to uphold that duty has left Native American healthcare in crisis; (2) examine the current framework to fulfill this duty and how that falls short of the federal government's obligation; (3) urge Congress to enact legislation to change the budgetary designation of IHS analogous to Medicare in order to remedy these problems; (4) demand the courts properly enforce the legal rights with regard to healthcare; and (5) address and rebut potential criticisms of this proposal.

II. BACKGROUND: FOUNDATIONS OF DUTY AND CRISIS

The federal government's responsibility to provide adequate healthcare to Native Americans is supported by treaties, federal legislation, and caselaw.[36] Though the foundations of this duty are clear,[37] the history of that relationship is fraught with breaches by the federal government that underpin the health crisis Native Americans experience to this day.[38]

---

[35] *See* discussion, *infra* Section II.
[36] Beverly Graleski, *The Federal Government's Failure to Provide Health Care to Urban Native Americans in Violation of the Indian Health Care Improvement Act*, 82 U. DET. MERCY L. REV. 461, 464 (Spring 2005).
[37] *See* discussion, *infra* Section II.
[38] *Id.*

A. A Clear Duty to the Tribes Exists

The trust relationship between the federal government and tribes was first established through treaties entered into from approximately 1778 to 1871.[39] Treaties between tribes and the federal government are contracts securing peace with tribes in exchange for land cessions.[40] It is "beyond question" that the United States has reaped significant benefits from these cessions,[41] yet the federal government has consistently failed to honor its obligations to the tribes in return.[42]

Prior to European contact, Native Americans maintained thriving, complex, culturally diverse societies—many with their own independent governments—throughout what is now known as the United States.[43] Tribal governments, both then and now, exercise the authorities and responsibilities of a nation-state, including protecting the health and welfare of their citizens.[44] Throughout the late 1800s and early 1900s, the federal government engaged in several different policy approaches regarding tribes that largely resulted in cultural and economic devastation.[45] Among these policies were removal and termination.[46] Tribes were removed from their original territories to reservation lands—often desolate areas and far from

[39] WILLIAM C. CANBY, JR., AMERICAN INDIAN LAW IN A NUTSHELL 13–14, 20 (6th ed. 2015); Dennis Wagner & Wyatte Grantham-Philips, *'Still Killing Us': The Federal Government Underfunded Health Care for Indigenous People for Centuries. Now They're Dying of COVID-19*, USA TODAY (Oct. 26, 2020), https://www.usatoday.com/in-depth/news/nation/2020/10/20/native-american-navajo-nation-coronavirus-deaths-underfunded-health-care/5883514002/ [https://perma.cc/X3UZ-M5GD].

[40] Rey-Bear & Fletcher, *supra* note 12, at 402.

[41] *Id.*

[42] *See, e.g.,* discussion, *infra* Section II.

[43] *See, e.g.,* Smith, *supra* note 17, at 299.

[44] Aila Hoss, *Securing Tribal Consultation to Support Tribal Health Sovereignty*, NE UNIV. L. REV. (forthcoming).

[45] *See, e.g.,* CANBY, *supra* note 39, at 15–33; Smith, *supra* note 17, at 299–300.

[46] *Id.*

their homelands.[47] This separated tribes from natural resources they had structured their diets and medicines around, impairing their ability to obtain proper nutrition and medicine.[48] Then, in the 1950s, the government terminated many tribes' federally recognized statuses in order to further deny tribes the treaty protections and promised compensation owed to them.[49]

Throughout this time, the government promoted the idea that Native Americans should be "civilized" via destruction of their own cultures and assimilation into the general U.S. population.[50] In the nineteenth century, the federal government and courts repeatedly characterized the government's relationship as a guardian-ward relationship, with the tribes being "wards of the [United States]" in a "state of pupilage" to the government.[51] While part of the foundations of the current trust relationship, the government frequently used this characterization to improperly further U.S. federal interests at the cost of Native Americans.[52]

By the last third of the twentieth century, the federal government began acknowledging that these policies had caused great harm to Native American communities.[53] Tribes' economic and societal structures had been upended, centuries of cultural knowledge had been obscured, and both the spiritual and physical health of many Native Americans had been

[47] *Id.; see, e.g.,* Smith, *supra* note 17, at 300; Wagner & Grantham-Philips, *supra* note 39.
[48] *See, e.g.,* CANBY, *supra* note 39, at 15–30; *Indian Reservations*, HISTORY (Mar. 18, 2019), https://www.history.com/topics/native-american-history/indian-reservations [https://perma.cc/J974-73F4].
[49] *See, e.g.,* Smith, *supra* note 17, at 301–02.
[50] CANBY, *supra* note 39, at 15–33.
[51] Cherokee Nation v. Georgia, 30 U.S. 1, 17 (1831); United States v. Kagama, 118 U.S. 375, 384–85 (1886).
[52] *See, e.g.,* Smith, *supra* note 17, at 300–01.
[53] CANBY, *supra* note 39, at 30–33.

negatively impacted.[54] There was also a growing awareness in public, legal, and political spheres that the characterization of the federal trust relationship with tribes as a guardian-ward dynamic was problematic, offensive, and patronizing.[55] The characterization had its roots in the offensive, inaccurate, and racist assumption that the federal government was the more civilized and sophisticated entity that had a moral obligation to guide and shape the uncivilized Native American.[56]

Not only is the belief that the federal government had a moral obligation to "civilize" tribes morally repugnant, but it is also a policy slant that caused harm on a practical level.[57] Because the federal government operated under the flawed assumption that it was the more civilized and mature in the relationship, it failed to consider input from tribes on what tribes themselves believed would best benefit them.[58] That lack of consultation with tribes was a significant reason why many of the federal government's policies in the late 1800s and early 1900s had devastating consequences for tribes.[59]

Against this backdrop of admitted policy failures and the emerging civil rights movement of the 1960s came a shift in policy toward Native American self-determination.[60] Congress and the executive branch began to adjust policies to favor tribal self-development, acknowledging that tribes often both knew what was best for them and, as sovereign nations, were entitled to the autonomy of choosing the same.[61] In addition to the treaties,

---

[54] *See, e.g.,* Delaney Perl, *Mitigating Disparities in Access to Healthcare Among Native American Communities Through Telehealth*, 30 ANNALS HEALTH L. ADVANCE DIRECTIVE 247, 247 (2021); Smith, *supra* note 17, at 299–300, 302.
[55] CANBY, *supra* note 39, at 30–33, 56–57.
[56] Raymond Cross, *The Federal Trust Duty in an Age of Indian Self-Determination: An Epitaph for a Dying Doctrine?* 38 PUB. LAND & RES. L. REV. 209 (2017).
[57] CANBY, *supra* note 39, at 30–33.
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] *Id.*

the Snyder Act of 1921,[62] the Indian Self-Determination and Education Assistance Act of 1975[63] (ISDEAA), and the Indian Health Care Improvement Act of 1976[64] (IHCIA) established clear intent from Congress for a rehabilitation of Native American healthcare and are key pieces of legislation that mandate the responsibility of the federal government to provide adequate healthcare for tribes.[65] The Snyder Act of 1921 instructs federal agencies to "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for" among other things, "relief of distress and conservation of health" of Indians throughout the United States.[66] When passing ISDEAA, Congress specifically noted the past inadequacies in Native American healthcare and reaffirmed the government's intention to involve tribes in healthcare programs through self-governance.[67] In enacting the IHCIA and its amendments, Congress found that the government's unique relationship with and resulting responsibility to Native Americans required the federal government to provide health services to Native Americans to maintain and improve their health.[68] In fact, the intent of the statute is clear that a major national goal of the federal government is to provide "the quantity and quality of health services which would permit the health status of Indians to be raised to the highest possible level."[69]

In keeping with the policy shift toward self-determination, the federal government also explicitly acknowledged intent to encourage participation

---

[62] 25 U.S.C. § 13.
[63] Indian Self-Determination Act, Pub. L. 93-638, 88 Stat. 2206 (codified generally in 5 U.S.C. and 25 U.S.C.) (1987).
[64] 25 U.S.C. § 1601.
[65] Holly T. Kuschell-Haworth, *Jumping Through Hoops: Traditional Healers and the Indian Health Care Improvement Act*, 4 DEPAUL J. HEALTH CARE L. 843, 846 (1999).
[66] Rosebud Sioux Tribe v. United States, 9 F.4th 1018, 1020–21 (8th Cir. 2021) (citing 25 U.S.C. § 13 (1994)).
[67] Kuschell-Haworth, *supra* note 65, at 846.
[68] Pfefferbaum et al., *supra* note 27, at 221.
[69] BRIAN D. SMEDLEY ET AL., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 533 (2003).

of Native Americans in the planning and management of these health services.[70] As of 2020, roughly half the Indian Country healthcare programs are tribally operated.[71] However, the federal government's ongoing failure to provide the funding owed continues to undercut tribes' efforts.[72]

Congress reaffirmed its obligations under the IHCIA when enacting the Patient Protection and Affordable Care Act (ACA) in 2010.[73] The ACA included certain exemptions for Native Americans from payment of health insurance deductibles and co-payments as a progressive way to help fulfill federal trust and treaty obligations in Indian Country[74] (though many tribal members remained unable to access these exemptions).[75] While the ACA's provisions do not begin to address the funding deficiencies in IHS, the legislation does add to the body of treaties and law affirming the federal government's duty to provide adequate healthcare to Native Americans.[76]

B. Federal Native American Healthcare Today: Framework and Inadequacies

Under the established authority, Native American tribes are entitled to adequate healthcare provisions from the federal government.[77] While there is a framework currently in place for these provisions in the form of IHS, it consistently falls far short of what is required under the trust duty, often leading to situations illustrated in the Rosebud Sioux Tribe's emergency department case.[78] The ongoing breach of the trust duty coupled with the judicial system's reluctance to provide relief have led to an appalling crisis

---

[70] *Id.*
[71] Wagner & Grantham-Philips, *supra* note 39.
[72] *Id.*
[73] *See* Andrew W. Baldwin et al., *Special Health Care Provisions for Indians in 'Obamacare' in Need of Protection*, 40 MONT. LAW. 18 (Sept. 2015).
[74] *Id.*
[75] *Id.* at 19.
[76] *See* Baldwin, *supra* note 73, at 18.
[77] *See* discussion, *supra* Section II-A.
[78] Rosebud Sioux Tribe v. United States, 9 F.4th 1018 (8th Cir. 2021); *see* discussion *infra* Section II-B-3.

in Native American healthcare that has only been intensified by the COVID-19 pandemic.

1. Structural Overview of IHS

IHS is the agency responsible for administering federally funded healthcare for Native Americans pursuant to the established trust responsibility.[79] IHS is overseen by the U.S. Department of Health and Human Services,[80] and the Bureau of Indian Affairs (BIA) oversees appropriations made by Congress for the establishment of health programs for Native Americans through IHS.[81] BIA is the primary instrument for carrying out the federal trust responsibility to tribes, and IHS is the principal federal healthcare provider and health advocate for Native Americans.[82] While healthcare funding and administration ultimately comes via IHS, local programs can be managed by IHS, tribes, or urban programs.[83] IHS serves 2.56 million American Indians and Alaska Natives across 574 federally recognized tribes in 37 states.[84]

In line with the IHCIA and ISDEAA, the declared mission of IHS is "to raise the physical, mental, social, and spiritual health of the American Indians and Alaska Natives to the highest level."[85] Unfortunately, IHS is often more of a bureaucratic barrier than aid for Native Americans trying to access adequate healthcare.[86] Congress has long failed to allocate enough money to meet Native American health needs, despite the obligation of the

[79] Kuschell-Haworth, *supra* note 65, at 845.
[80] *About IHS,* INDIAN HEALTH SVCS., https://www.ihs.gov/aboutihs/ [https://perma.cc/T8LJ-43KB].
[81] *See* CANBY, *supra* note 39, at 50–51.
[82] *See Mission Statement*, BUREAU OF INDIAN AFFAIRS, https://www.bia.gov/bia [https://perma.cc/D2YP-AFAT].
[83] SMEDLEY ET AL., *supra* note 69, at 536.
[84] Wagner & Grantham-Philips, *supra* note 39.
[85] *Id.*
[86] Whitney, *supra* note 6.

federal government to do so.[87] This inadequate funding results in IHS health facilities not having enough resources, IHS health facilities not being maintained in a safe or sanitary way, Native Americans having to travel great distances to reach an IHS provider, and Native Americans being denied treatment altogether because funding has simply run out.[88] The shortage of funds is so well known that there is a familiar sardonic joke in Indian Country that tribal members had better hope if they are going to get sick that it happens by mid-year, because after that the funds will have run out.[89]

Because of low pay and remote locations, staffing shortages and high turnover are also often prevalent at IHS facilities.[90] These shortages and high turnover rates result in fewer healthcare providers available to treat Native Americans and no stability or consistency in care as would come from being able to stay with the same treating provider(s) over the years.[91] While IHS offers some scholarships and loan repayment awards for potential healthcare employees to try to attract and keep hires longer term, the limited funds IHS has are nowhere near enough to properly mitigate the staffing shortage.[92]

Under ISDEAA, with its emphasis on tribal self-determination, tribes can assume control over the management of their healthcare by negotiating "self-determination contracts" with IHS, through which they can contract for needed services[93] that IHS continues to fund.[94] While the incorporation of these contracts has been successful in increasing Native American participation in delivery and management of their healthcare, neither IHS

---

87 *Id.*
88 *See, e.g.,* Pfefferbaum et al., *supra* note 27; Rosebud Sioux Tribe v. United States, 9 F.4th 1018 (8th Cir. 2021).
89 Whitney, *supra* note 6.
90 Cerasano, *supra* note 26, at 421, 432.
91 *Id.*
92 *Id.*
93 *Id.* at 424.
94 *Id.*

nor tribes can directly provide sufficient health services needed by the beneficiary population.[95] To help fill this gap in service, IHS can purchase health services from other health facilities when no IHS direct care facility exists, when the existing facility is incapable of providing the type of care needed, or when supplementation of alternate resources such as Medicare or private insurance is required to provide comprehensive care to beneficiaries.[96]

IHS's purchasing of health services from other health facilities under these conditions is done via the Contract Health Services Program (CHS).[97] The underfunding of IHS is often felt most severely in the area of CHS.[98] Funds for CHS are far from sufficient to fill the gap in supplemental services needed by Native Americans, even in areas where the services are needed most.[99] Because of insufficient funding, IHS also has strict limitations on who can access services via CHS and when they can do so.[100] Most urban programs do not receive CHS funding at all.[101] Without access to proper CHS services, which itself attempts to fill essential gaps in healthcare, Native Americans are cut off from receiving life-changing services to which they are entitled.

2. IHS Compared to Similar Federal Programs

Comparing IHS to other federal healthcare programs provides valuable insight into both how IHS functions and the funding discrepancies between programs. While IHS shares many overlapping goals and functions with Medicare and Medicaid, IHS is not a type of health insurance.[102] Instead,

---

95 *Id.*
96 *Id.* at 425.
97 *Id.*
98 *Id.*
99 *Id.*
100 *Id.*
101 SMEDLEY ET AL., *supra* note 69, at 536.
102 Cerasano, *supra* note 26, at 422–23.

IHS is a federally funded health services provider that provides health services to beneficiaries directly or in conjunction with Native American tribes.[103] IHS does not offer a standard set of medical benefits and services at all IHS locations.[104] Services vary greatly by type depending on location and the funding available to the facility in question.[105]

IHS is currently more analogous to the Veteran's Health Administration (VHA) in function, but the similarities end quickly.[106] While IHS is discretionary funding, VHA is split into mandatory and discretionary funding, with a substantial portion of the appropriation dictated by statute.[107] VHA thus has protections for ensuring funding that IHS does not.[108] VHA also differs from IHS in overall quality of service, with many evaluations finding that by most measures VHA care is equal to and sometimes better than care provided in the private sector.[109]

More substantial than IHS's structural differences from Medicare, Medicaid, and similar federal programs is the disparity in funding between IHS and similar federal programs.[110] The federal government spends less per capita on Native American healthcare than on any other group for which it has this responsibility, including federal prisoners.[111]

---

[103] *Id.* at 423.
[104] *Id.* at 424.
[105] *Id.*
[106] Whitney, *supra* note 6.
[107] Memorandum from U.S. Gov't Accountability Off. to the Comm. on Appropriations Subcomm. on Interior, Env't, and Related Agencies (Dec. 10, 2018) (on file with author) [hereinafter GAO Memo]. Discretionary funding is discussed in more detail in Section III-A-1.
[108] *See* discussion, *supra* Section II-B-1.
[109] *See, e.g.*, *Evaluating the Capacity of the VA to Care for Veteran Patients: Hearing Before the H.R. Comm. On Veterans' Aff.*, 113th Cong. 2 (2014) (statement of Hon. Corrine Brown); Carten Cordell, *Rand Study Finds VA Care Equal or Better Than Private Sector,* FED. TIMES (July 18, 2016), https://www.federaltimes.com/management/leadership/2016/07/18/rand-study-finds-va-care-equal-or-better-than-private-sector/ [https://perma.cc/F4W4-M64S].
[110] GAO Memo, *supra* note 107; Westmoreland & Watson, *supra* note 14, at 600.
[111] Lindrooth, *supra* note 11, at 278–79.

The disparities between the discretionary funding of IHS compared to the funding of Medicare, Medicaid, and other federal mandatory spending programs are glaring.[112] Between 1980 and 2002, spending per capita for Medicare grew at an average rate of 7.8% per year, Medicaid grew at an average rate of 6.9% per year, and IHS spending grew at an average rate of only 4.8% per year.[113] In monetary representations, this means that during a period where Medicare spending grew by $5,200 per person, appropriations per person for IHS grew by only $1,121.[114] On an average annual basis from 1980 to 2002, the gap between IHS per capita spending and Medicare per capita spending grew from $569 to $4,448, leaving IHS far behind.[115] The spending difference is also illustrated by the gap between Medicare funding and IHS funding, which was 90% the size of IHS per capita spending in 1980, but by 2002 was 250% of IHS per capita spending.[116] That disparity has only continued to worsen. A 2018 study by the U.S. Government Accountability Office found that the per capita spending for IHS from 2013–2017 was 50% or less of the per capita spending for Medicaid, Medicare, or VHA.[117] Specifically, in 2017, IHS per capita spending was $4,078 compared to $8,109 for Medicaid, $10,692 for VHA, and $13,185 for Medicare.[118] Put plainly, the funding allocated for IHS per person is severely less than any other similar federal healthcare program, and that gap has only continued to grow over time.

IHS is legally responsible for providing healthcare to Native Americans, and congressional appropriations for IHS are premised on that fact.[119] Namely, IHS is seen as a payor of last resort, meaning that when Native

---

112 Westmoreland & Watson, *supra* note 14, at 600.
113 *Id.* at 600, 602.
114 *Id.*
115 *Id.* at 603.
116 *Id.* at 602.
117 GAO Memo, *supra* note 107.
118 *Id.*
119 *See, e.g.*, *Agency Overview*, INDIAN HEALTH SVCS., https://www.ihs.gov/aboutihs/overview/ [https://perma.cc/77L4-Q4NK].

Americans qualify for healthcare from other sources such as Medicare, Medicaid, and private insurance, these alternative sources are to be utilized first.[120] However, access to Medicare or Medicaid remains a problem for many tribal members, in part because they often may not have a driver's license or be able to verify a current address.[121] A 1995 report from the Health Care Financing Administration found that Native Americans were the least likely of all racial groups to access Medicaid, with only 65% of eligible Native Americans at that time having Medicaid coverage compared with 82% for African Americans, 83% for Asians and Pacific Islanders, and 91% for Hispanics.[122] Although the ACA expanded coverage available to Native Americans, the disparity has remained.[123] (In a more recent research analysis of these disparities, Native Americans were not even included for consideration as a statistical group—the study's purview included only Black, white, and Hispanic people).[124] Even if tribal members secure Medicaid coverage, that coverage does not guarantee access to medical services as many providers refuse to accept Medicaid patients.[125] Native Americans are often unable to secure or afford private insurance, with Medicare and Medicaid being the norm when there is alternative health insurance coverage at all.[126] For many Native Americans, the services

---

[120] *Requirements: Alternate Resources*, INDIAN HEALTH SVCS., https://www.ihs.gov/prc/eligibility/requirements-alternate-resources/ [https://perma.cc/G5Z2-6HKL].
[121] SMEDLEY ET AL., *supra* note 69, at 536.
[122] *Id.* at 536–37.
[123] Jesse Cross-Call, *Medicaid Expansion Has Helped Narrow Racial Disparities in Health Care Coverage and Access to Care*, CTR. ON BUDGET & POL'Y PRIORITIES (Oct. 21, 2020), https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and [https://perma.cc/L7K4-MTD9].
[124] *See generally* Hyunjung Lee et al., *Medicaid Expansion and Racial and Ethnic Disparities in Access to Health Care: Applying the National Academy of Medicine Definition of Health Care Disparities*, 58 J. HEALTH CARE ORG., PROVISION, & FINANCING 1 (2021).
[125] SMEDLEY ET AL., *supra* note 69, at 536.
[126] *Id.* at 545.

provided through IHS are essential, so the consequences are significant when IHS services are inadequate or unavailable.[127]

3. "I Am Not Talking About Unpainted Walls"[128]

The lack of adequate funding for IHS has a very tangible impact on the state of Native American healthcare; it means medical centers funded by IHS often lack the equipment, facilities, and staff required to provide Native Americans with standard healthcare.[129] Significantly, the inadequacies cited in Native American healthcare do not merely refer to aesthetics or healthcare that is slightly substandard; these inadequacies frequently indicate healthcare that is at best, dangerously incompetent, and at worst, fatal.

At a Senate hearing in 2016, witnesses to the state of Native American healthcare begged the federal government to properly fund IHS.[130] Victoria Kitcheyan, treasurer of the Winnebago Tribe, stressed in her testimony at the hearing that she was not talking about "unpainted walls or equipment that is outdated," but rather about a facility which employs emergency room nurses who do not know how to administer basic drugs, employees who do not know how to call a Code Blue or locate a defibrillator when a human life is at stake, and a facility with a track record of sending patients home with over-the-counter drugs only to have them airlifted from the Reservation later in a life-threatening state.[131] Kitcheyan's aunt, Debra Free, died in the Winnebago Hospital in northeastern Nebraska in 2011 after she

---

[127] *See, e.g., Rosebud Sioux Tribe*, 9F.4th 1018 (2021).
[128] From a quote by Victoria Kitcheyan, treasurer of the Winnebago Tribe, in her testimony at a 2016 Senate hearing. Maggie Fox, *Care at Native American Health Facilities Called "Horrifying and Unacceptable" in Senate Hearing*, NBC NEWS (Feb. 3, 2016), https://www.nbcnews.com/health/health-care/care-native-american-health-facilities-called-horrifying-unacceptable-senate-hearing-n510826 [https://perma.cc/GP9H-SFTX].
[129] Smith, *supra* note 17, at 305.
[130] Fox, *supra* note 128.
[131] *Id.*

was left on the floor of her hospital room, overdosed by poorly trained staff.[132] After hearing witness after witness speak to similar occurrences, Wyoming Senator John Barrasso admitted that the state of IHS healthcare "is simply horrifying and unacceptable."[133]

Five-year-old Ta'Shon Rain Little Light in Montana was told at multiple visits to an IHS facility that she was depressed when in fact she had cancer.[134] Her stomach pain and difficulty eating and walking rapidly worsened over several months.[135] It was only after her lung collapsed and she was airlifted to a children's hospital in Denver, Colorado that the cancer was properly diagnosed.[136] Shortly after, in September 2006, she told her mother she was sorry for being so sick before passing away in her mother's arms.[137] Ta'Shon Rain Little Light was a bright, precocious child who loved to dance,[138] and she might be alive today had she received better care.[139]

Stories like these are frighteningly commonplace for Native Americans.[140] Less abrupt but equally insidious deficiencies are also prevalent. At the Gallup Medical Center in New Mexico, where IHS funding levels are 49% of what would be equitable using national health expenditure data as a benchmark, there is no dialysis center even though

---

[132] *Id.*
[133] *Id.*
[134] *In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area: Hearing Before the S. Comm. on Indian Affairs*, 111th Cong. 8 (2010) (statement of Sen. Dorgan, Chairman, S. Comm. on Indian Affairs) [hereinafter *Critical Condition*].
[135] Mary Clare Jalonick, *PROMISES, PROMISES: Indian Health Care's Victims*, THE SAN DIEGO UNION-TRIB. (June 15, 2009), https://www.sandiegouniontribune.com/sdut-us-health-cares-forgotten-061509-2009jun15-story.html [https://perma.cc/Y3W5-W7AY].
[136] *Id.*
[137] *Critical Condition*, *supra* note 134.
[138] *Ta'Shon Rain Little Light*, BILLINGS GAZETTE, https://www.legacy.com/us/obituaries/billingsgazette/name/ta-shon-little-light-obituary?id=28387063 [https://perma.cc/447V-6Y7Z].
[139] *Critical Condition*, *supra* note 134.
[140] *See, e.g.,* Lindrooth, *supra* note 11, at 278.

adult tribal members suffer from diabetes at nearly three times the rate of white non-Hispanics.[141] IHS has employed dozens of doctors with histories of medical mistakes and regulatory sanctions, often because IHS simply did not bother to make basic inquiries about physicians' backgrounds.[142] These are deficiencies that should not exist at any hospital in the U.S.;[143] they pose an immediate risk to patient safety and have led to multiple patient deaths.[144] Where tribal members should be receiving the life-saving treatment they are entitled to from the government, they too often receive life-threatening treatment instead.[145]

This ongoing crisis has only been exacerbated by the COVID-19 pandemic. Tribes have experienced disproportionately greater infection rates, more suffering, and more deaths in the COVID-19 pandemic as a result of years of inadequate healthcare funding.[146] As of mid-2021, IHS had only 625 hospital beds to serve the members of the 574 tribes.[147] When Congress passed a $2.2 trillion economic stimulus package to help the country survive the beginning of the pandemic, only $714 million was earmarked for the Navajo Nation.[148] That amounts to $4,552 per each Diné[149] on the reservation, compared with $6,703 per capita in stimulus funding nationwide.[150] IHS estimated it would cost $700 million alone just to obtain safe drinking water and basic sanitation for everyone on the

[141] Wagner & Grantham-Philips, *supra* note 39.
[142] Patrick A. Thronson, *Legal Accountability for the Abysmal Medical Care Provided to Tribal Communities*, TRIAL REP. (MD.) 56, 57–58 (Fall 2020).
[143] Fox, *supra* note 128.
[144] *Id.*
[145] Thronson, *supra* note 142, at 57.
[146] *See, e.g.,* Smith, *supra* note 17, at 308; Wagner & Grantham-Philips, *supra* note 39.
[147] Smith, *supra* note 17, at 309.
[148] Wagner & Grantham-Philips, *supra* note 39.
[149] The people of the Navajo Nation refer to themselves as the Diné. *Id.*
[150] *Id.*

reservation.[151] (Thirteen percent of Native American homes still do not have safe drinking water or adequate waste disposal systems).[152]

These stark deficiencies, as well as tribes enduring disproportionately higher infection rates, suffering, and deaths in the COVID-19 pandemic, are a result of systemic racism and generations of neglect, from historical subjugation to contemporary poverty.[153] The ongoing failure of the federal government to fulfill its obligation to properly fund Native American healthcare continues to have devastating ramifications, and it cannot be tolerated any longer.

4. U.S. Courts Provide No Reliable Remedy

While the state of Native American healthcare in the U.S. is undisputedly appalling,[154] there is little proper recourse for Native Americans in the judicial system. Theoretically, the judicial system is free of bias, furthering justice for all. Unfortunately, the U.S. court system has not always conducted itself so fairly with regard to federal Indian law cases.[155]

Two main problems with the courts relevant to this discussion are as follows: First, the courts have historically failed to properly enforce Native American rights, including rights regarding healthcare.[156] Second, federal Indian law has a deeper problem in the form of tangled, unethical precedent that still holds immense sway.

When Native Americans have prevailed in court, the U.S. federal and state entities have not always respected the ruling. In 1832, the Cherokee Nation prevailed against the state of Georgia in a Supreme Court case[157] regarding white missionaries imprisoned for helping the Cherokee Nation

---

[151] *Id.*
[152] Smith, *supra* note 17, at 309.
[153] Wagner & Grantham-Philips, *supra* note 39.
[154] *See, e.g.*, discussion, *supra* Section II.
[155] *See, e.g.,* Smith, *supra* note 17, at 300–01.
[156] *See* discussion, *infra* Section II-B-4.
[157] Worcester v. State of Ga., 31 U.S. 515 (1832).

resist the state's hostilities.[158] In response to the ruling, President Jackson allegedly quipped, "[Justice] Marshall has made his decision, now let him enforce it."[159] Georgia likewise disregarded the Court's decision, effectively ending the Cherokee's hope of resistance for the time.[160] Not long after, many members of the Cherokee Nation were forced to remove to Oklahoma, with approximately one in four members dying along the march.[161]

Courts also are not effectively enforcing congressional mandates as to the funding of IHS. In 2005, the Supreme Court held that IHS was liable for failing to provide sufficient funding for Contract Support Costs (CSC)—funding for reasonable administrative costs in the healthcare programs—in the years before Congress capped CSC spending.[162] Although the funding deficiencies for CSC had been addressed in both the legislature and the judiciary, the BIA continually failed to provide sufficient funds.[163] Despite the Court's ruling, lower courts continued to hold that, after Congress capped CSC expenditures, agencies were protected from liability.[164] In 2012, the Supreme Court held that the government cannot back out of its contractual promise to pay each Tribe's full contract support costs, even if Congress failed to allocate sufficient funds.[165] Regardless, tribes still face

[158] Adam Crepelle, *Lies, Damn Lies, and Federal Indian Law: The Ethics of Citing Racist Precedent in Contemporary Federal Indian Law*, 44 N.Y.U. REV. L. & SOC. CHANGE 529, 545 (2021).
[159] *Id.* at 545.
[160] *Id.* at 545–46.
[161] *Id.*
[162] Cherokee Nation of Oklahoma v. Leavitt, 543 U.S. 631 (2005); Smith, *supra* note 17, at 306–07.
[163] Smith, *supra* note 17, at 307.
[164] *Id.*
[165] Salazar v. Ramah Navajo Chapter, 567 U.S. 182, 192 (2012); Libby Smith, *supra* note 17, at 307.

shortages in their funding.[166] There was little enforcement of the mandate.[167]

A current circuit split between the Eighth and Ninth Circuit courts helps to illustrate the tangled web of ineffectual precedent regarding IHS funding. In *Quechan Tribe of the Fort Yuma Reservation v. United States*, the Ninth Circuit opined that "[n]either the Snyder Act nor the [IHCIA] contains sufficient trust-creating language on which to base a judicially enforceable duty."[168] The Ninth Circuit decision stated that both statutes speak about Indian health "only in general terms," and neither requires the U.S. to provide a specific standard of medical care.[169] The Ninth Circuit ineffectively tried to evade both the commonsense, contractually established obligations of the federal government and Congress' expressed intent for fulfillment of the same by construing the statutory language as vaguely insufficient. In contrast, the Eighth Circuit correctly concluded there is a duty created by the applicable Treaty and reinforced by the Snyder Act and the IHCIA to provide competent, physician-led healthcare to the Tribe and its members.[170] The Eighth Circuit's finding, however, came after the lower court in *Rosebud Sioux Tribe* opined that the statutory language was merely a nice expression of an aspirational goal rather than anything intended to be actually binding or legally enforceable.[171] The attempts to reconstrue and dismiss this obligation as a largely empty, nice idea to be experimented with at the federal government's whim and convenience are unsettling and destructive.

---

[166] *See generally Broken Promises: Continuing Federal Funding Shortfall for Native Americans*, U.S. COMMISSION ON CIVIL RIGHTS (Dec. 2018), https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf [https://perma.cc/F762-K9SH].
[167] *See id.*
[168] Quechan Tribe of the Fort Yuma Indian Reservation v. United States, 599 F. App'x 698, 699 (9th Cir. 2015) (unpublished).
[169] *Id.* at 699 (quoting Lincoln v. Vigil, 508 U.S. 182, 194 (1993)).
[170] *Rosebud Sioux Tribe*, 9 F.4th at 1026.
[171] *Rosebud Sioux Tribe*, 450 F.Supp.3d at 1002.

Courts have historically found creative ways to help the federal government disenfranchise Native Americans.[172] This has led to a body of caselaw that at turns both acknowledges Native American rights and bears the stain of startlingly bigoted, flawed reasoning.[173]

Federal Indian law is fundamentally colonial law, which is ethically problematic from the outset.[174] Many key decisions in federal Indian law precedent are so bigoted and, at times, inaccurate that they violate the Model Rules of Professional Conduct (MRPC) used to guide legal ethics.[175] In *Johnson v. M'Intosh*,[176] a land dispute in which no Native American was even a party to the case, the Supreme Court took the case for the purpose of deciding whether Native Americans have ownership rights to their land.[177] Justice Marshall's opinion asserted that European nations were justified in taking the land from the country's Indigenous people because "the character and religion" of the Indians contrasted with "the superior genius of Europe,"[178] and Indian inferiority meant that it was necessary to impair their rights.[179] Justice Marshall also claimed that Native Americans were warlike, fierce savages and hunters in contrast to the civilized white men who were "agriculturalists, merchants, and manufacturers."[180] These statements were known falsities: as an educated Virginian, Justice Marshall would have known the Native Americans in the area had demonstrated great hospitality and were adroit farmers.[181] Instead, the lies were used as a basis to justify depriving Native Americans of their land rights.[182] Despite flagrant racism

[172] *See generally* Crepelle, *supra* note 158.
[173] *See, e.g.*, Crepelle, *supra* note 158.
[174] Crepelle, *supra* note 158, at 573.
[175] *Id.* at 156, 533, 575.
[176] Johnson v. M'Intosh, 21 U.S. (8 Wheat.) 543 (1823).
[177] Crepelle, *supra* note 158, at 543.
[178] *Johnson*, 21 U.S. at 573.
[179] Crepelle, *supra* note 158, at 542.
[180] *Id.* at 542–43.
[181] *Id.* at 542.
[182] *Id.* at 541–44.

and factual errors, *Johnson v. M'Intosh* is one of the most influential cases in Supreme Court history and remains binding law.[183] In fact, all land tenure in the U.S. can be traced directly to it, and the current trust status of Indian land is a direct consequence of *Johnson v. M'Intosh.*[184]

In another example, *United States v. Rogers,*[185] Justice Taney actively derided Native American rights and claimed the Cherokee Nation only occupied the land through an act of benevolence by the federal government.[186] Next, the Justice conceived of Congress' unbridled plenary power over Native Americans based on what he cited as Native Americans' "racial inferiority."[187] The case remains binding law today.[188]

Similarly, the Court in *Ex parte Crow Dog* asserted that Indians were unable to understand the "white man's morality," noting the "savage nature" of Native Americans.[189] *Crow Dog* remains one of the most influential cases in the history of federal Indian law.[190]

Courts have also improperly attempted to rewrite history and established authority in caselaw. The 2015 decision in *Quechan Tribe*[191] is one of the latest in this vein, attempting to rewrite the federal government's obligations to Native Americans as to healthcare. In *Tee-Hit-Ton Indians v. United States*, the Court held the Tee-Hit-Ton did not have a takings claim against the U.S. for the federally authorized plunder of the tribe's timber because, "[e]very American schoolboy knows [...] it was not a sale but the conquerors' will that deprived [the Indians] of their land."[192] The Court

[183] *Id.* at 543.
[184] *Id.*
[185] United States v. Rogers, 45 U.S. (4 How.) 567 (1846).
[186] Crepelle, *supra* note 158, at 547.
[187] *Id.* at 548.
[188] *Id.*
[189] *Ex parte* Crow Dog, 109 U.S. 556 (1883).
[190] Crepelle, *supra* note 158, at 551.
[191] Quechan Tribe of the Fort Yuma Indian Reservation v. United States, 599 F. App'x 698, 699 (9th Cir. 2015) (unpublished).
[192] 348 U.S. 272 (1995); Crepelle, *supra* note 158, at 555–56.

went on to say that any "generous provision" the federal government gave Native Americans was "a matter of grace, not because of legal liability."[193] These statements are false[194] and stand in stark opposition to both the reality of the contract-like treaty agreements that took place between two sovereign nations and the legal principles of the same. Rewriting history like this can have widespread consequences, such as eroding the foundation for Native American rights and the federal government's obligations to tribes. Jarringly, *Tee-Hit-Ton* was decided within a year of *Brown v. Board of Education*[195]—a monumental victory for racial equality under the law.[196] *Tee-Hit-Ton*, however, remains precedential in federal Indian law today. It has been cited in at least 129 court cases, including one as recently as September 2020.[197]

Paradoxically, these rulings are often bound up in precedent that helps form the foundation for rights Native Americans have reclaimed through the courts. This makes it difficult to untangle the prejudice from the progress. For example, while the "Marshall trilogy," a trio of Supreme Court decisions from the 1800s, preserved some important tribal rights, including tribes' limited sovereignty and right to self-governance, it also legitimized the expropriation of Indian lands and began the process of stripping tribes of other rights.[198]

The often ethically troubling, revisionist portions of caselaw that remain "good" law in federal Indian law have complicated proper acknowledgment of the obligations the federal government owes to tribes. Left unaddressed, these stumbling blocks will continue to hamper IHS facilities from

[193] 348 U.S. 281–82 (1995); Crepelle, *supra* note 157, at 556.
[194] Crepelle, *supra* note 158, at 556.
[195] Brown v. Bd. of Educ., 347 U.S. 483 (1954).
[196] Crepelle, *supra* note 158, at 556. (Crepelle notes that Justice Jackson also died during this time, which may have been a factor in the court's shift).
[197] *Id.*
[198] Smith, *supra* note 17, at 300–01.

receiving the healthcare funding to which they are entitled and that they so desperately need.

III. URGENT STEPS NEEDED TO SAVE LIVES

The problems and shortcomings of the federal government's handling of IHS and the services regarding healthcare to Native Americans are widespread and severe.[199] Because this issue involves various layers of tribal authorities, healthcare providers, members of the public, and the federal government, this is a complex and intimidating issue. However, because there has been a history of conflicting messages from the federal government and the courts in addition to a tendency to neglect duties owed to Native Americans,[200] it is essential to address the issue now.

Both moral and legal duties mandate that these issues be properly addressed, and the COVID-19 pandemic illuminates how urgent action is needed to remedy the disparities in Native American healthcare.[201] Throughout the pandemic, tribal members have been at a significantly increased risk of sickness and death largely in direct correlation to the

---

[199] *See, e.g.,* Anna Wilde Mathews & Christopher Weaver, *Six CEOs and No Operating Room: The Impossible Job of Fixing the Indian Health Service*, THE WALL ST. J. (Dec. 10, 2019), https://www.wsj.com/articles/six-ceos-and-no-operating-room-the-impossible-job-of-fixing-the-indian-health-service-11575993216 [https://perma.cc/GHV5-DE4C]; Smith, *supra* note 18; Andrew Siddons, *The Never-Ending Crisis at the Indian Health Service*, ROLL CALL (Mar. 5, 2018), https://www.rollcall.com/2018/03/05/the-never-ending-crisis-at-the-indian-health-service/ [https://perma.cc/K3N8-KCFP].

[200] *See generally* Lindrooth, *supra* note 11; Westmoreland & Watson, *supra* note 14; Wagner & Grantham-Philips, *supra* note 39.

[201] *See, e.g.,* Sarah M. Hatcher et al., *Morbidity and Mortality Weekly Report: COVID-19 Among American Indian and Alaska Native Persons - 23 States, January 31–July 3, 2020*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 28, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6934e1.htm [https://perma.cc/RG8T-73GS]; Wagner & Grantham-Philips, *supra* note 39; Mark Walker, '*A Devastating Blow': Virus Kills 81 Members of Native American Tribe*, N.Y. TIMES (Oct. 8, 2020), https://www.nytimes.com/2020/10/08/us/choctaw-indians-coronavirus.html [https://perma.cc/S8T7-W3AS].

federal government's consistently severe underfunding of IHS.[202] This increased risk does not take into consideration that deaths among the United States' Native American population are likely underreported.[203] While 80% of state health departments record race as part of their COVID-19 statistics, approximately half are not including Native Americans—simply labeling them as "other" instead.[204] Chillingly, this means that as high as the number of reported Native American deaths is as currently recorded, the actual amount is still higher. Even after the more acute phase of the pandemic passes, Native American individuals and tribes will still need proper resources to aid in recovering from the emotional and psychological trauma of loss,[205] and those who survive the virus may need help with long-term health impacts[206]—all this on top of an already-existing healthcare crisis long overdue for remedy.[207] This is no mere academic concern but quite literally a matter of life and death.[208]

The current emergency must be addressed with a two-prong approach: (1) Congress must strengthen and clarify legislative authority for adequate funding of Native American healthcare in fulfillment of the trust duty, and (2) the courts must properly enforce this duty and provide appropriate

---

[202] *See, e.g.,* Hatcher et al., *supra* note 201; Wagner & Grantham-Philips, *supra* note 39; Walker, *supra* note 201.
[203] Ruth Hopkins, *Deaths Among Natives are Underreported. It's Time for State Health Departments to Step Up*, THE APPEAL (May 26, 2020), https://theappeal.org/covid-19-infections-and-deaths-among-natives-are-underreported-its-time-for-state-health-departments-to-step-up/ [https://perma.cc/H9ZT-NNUL].
[204] *Id.*
[205] Ana Sandoiu, *The Effects of COVID-19 on the Mental Health of Indigenous Communities*, MED. NEWS TODAY (July 6, 2020), https://www.medicalnewstoday.com/articles/the-effects-of-covid-19-on-the-mental-health-of-indigenous-communities#Mental-health-impacts-of-the-pandemic [https://perma.cc/8G9Q-9UVQ].
[206] *Coronavirus Disease 2019: Long-Term Effects*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 16, 2021), https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects.html [https://perma.cc/VRD8-9RTK].
[207] *See, e.g.,* Hatcher et al., *supra* note 201*;* Wagner & Grantham-Philips, *supra* note 39; Walker, *supra* note 201.
[208] Lindrooth, *supra* note 11, at 277 (quoting Sen. Bryon L. Dorgan).

remedy. Throughout, it is vital that tribes are comprehensively involved in the planning and implementation of any policy or course of action.[209] Native Americans have continuously been marginalized and denied a voice in decisions that directly impact their lives, often at great cost to them.[210]

A. Congress Must Act

Congress can and must take action to provide adequate healthcare via IHS facilities in a way that ensures tangible results. Designating IHS funding as mandatory using a statute similar to the statute enacted for Medicare will help guarantee IHS is timely and adequately funded each year.

1. Changing the Budgetary Designation

Congress' first major step should be to change the budgetary designation of IHS funding to mandatory. Currently, the IHS budget request and subsequent funding is categorized as "discretionary."[211] As a discretionary program under the current structure, funding is never guaranteed and depends on annual allocations from Congress.[212]

IHS's current designation as discretionary spending stands in stark contrast to other federal healthcare programs such as Medicare, which are

---

[209] CANBY, *supra* note 39, at 32–34.

[210] *See* discussion, *supra* Section II-A.

[211] W. Ron Allen, *Indian Health Services Can't Be Fixed Overnight*, INDIAN COUNTRY TODAY (Aug. 12, 2016), https://indiancountrytoday.com/archive/indian-health-services-cant-be-fixed-overnight [https://perma.cc/47YC-E7R5].

[212] This takes place through 302a allocations that pass down from Congress to twelve subcommittees in both houses. These subcommittees then split the 302a allocated funds into twelve pieces called 302b allocations. The IHS budget request is reviewed by the Subcommittee on Interior, Environment and Related Agencies and the Senate Committee on Indian Affairs. *See, e.g., A Brief Guide to the Federal Budget and Appropriations Process*, AM. COUNCIL ON EDUC., https://www.acenet.edu/Policy-Advocacy/Pages/Budget-Appropriations/Brief-Guide-to-Budget-Appropriations.aspx [https://perma.cc/RH25-KAX3] [hereinafter *Guide*]*; Annual Budget*, INDIAN HEALTH SERV., https://www.ihs.gov/aboutihs/annualbudget/ [https://perma.cc/76TN-U2BT].

all designated as mandatory.[213] Mandatory program funding increases with population growth, new technologies, and inflation.[214] A mandatory designation means the funding each year is ensured on a statutory basis.[215] For example, the authority for the mandatory program Social Security benefits ultimately stems from the Social Security Act of 1935.[216] The Social Security Act (along with subsequent amendments) guarantees workers will receive benefits after they have retired and set up a trust fund.[217] This is funded by payroll taxes and is used to pay out the benefits.[218] A similar trust fund approach for IHS has recently been proposed.[219] Because Indian Health is not designated as mandatory, it is often left far behind and is particularly susceptible to budget cuts or a complete lack of funding.[220] There does not appear to be any significant reasoning for the difference in IHS's funding status as opposed to similar federal programs designated as mandatory.[221]

Any such reclassification should contain a form of automatic annual adjustment to consider increasing costs over time and a fluctuating number of eligible people.[222] Without such an automatic increase, any improvements in funding are at risk of being overcome by inflating costs or increases in needs over time.[223] This problem would again have little to no swift recourse.[224] To avoid that dilemma, Congress could construct an

---

213 Allen, *supra* note 211; Westmoreland & Watson, *supra* note 14, at 602.
214 Allen, *supra* note 211.
215 Westmoreland & Watson, *supra* note 14, at 602.
216 Social Security Act, Pub. L. No. 74-271, 49 Stat. 620 (1935) [hereinafter Social Security Act]; Kimberly Amadeo, *Current Federal Mandatory Spending*, THE BALANCE (Mar. 3, 2020), https://www.thebalance.com/current-federal-mandatory-spending-3305772 [https://perma.cc/5JJW-46C7].
217 Social Security Act, *supra* note 216; Amadeo, *supra* note 216.
218 *Id.*
219 Lindrooth, *supra* note 11, at 281.
220 Westmoreland & Watson, *supra* note 14, at 603.
221 *Id.*
222 *Id.* at 604.
223 *Id.*
224 *Id.*

inflator for IHS funding to mirror the change in Medicare or Medicaid spending per person.[225] This would function as a baseline for individual cost-of-care and could then be adjusted as necessary from a Native American specific cost-of-care index to be developed with further study[226] (or by using other such numbers from tribes for guidance). This would ensure that funding of IHS keeps up with inflation and offers better protection for Native American healthcare over time.

Increased funding would also allow IHS to increase the number of scholarships and loan repayment awards it provides to healthcare workers. These additional scholarships and awards would create incentives that would help with staffing issues and available healthcare services in more remote areas.[227] This in turn would increase the number of providers able to serve and stay in remote locations where they are needed.[228] The resulting improved access and stability would be especially meaningful to the high percentage of Native Americans living in remote areas.[229]

Tribal governments have expressed support for a mandatory spending designation for IHS.[230] While the federal government has promised in treaties, doctrine, and current law to provide adequate healthcare to the tribes,[231] the current discretionary designation of funding for IHS has

---

[225] *Id.*
[226] *Id.*
[227] *See* discussion, *supra* Section II-B.
[228] *Id.*
[229] *Id.*
[230] NAT'L CONG. OF AM. INDIANS, RECLASSIFICATION OF IHS BUDGET TO MANDATORY SPENDING PROGRAM, RESOLUTION, #MKE-17-011 (Oct. 2017), https://www.ncai.org/attachments/Resolution_thbeyXcTCPBgWtaTvCBqdQcRMdVBbsGXIQtquUiHULHCmnGstmf_MKE-17-011%20final.pdf [https://perma.cc/KYW8-YUPK]; Allen, *supra* note 211; Smith, *supra* note 17, at 307.
[231] NAT'L INDIAN HEALTH BD., THE WAY INDIAN HEALTH IS FUNDED PUTS THE HEALTH OF AMERICAN AND ALASKA NATIVES AT RISK, https://www.nihb.org/docs/05062015/Indian%20Health%20one%20page%20leave%20behind%20FINAL.pdf [https://perma.cc/CP7N-DVKU] (citing The Snyder Act of 1921, Indian Health Care Improvement Act of 1976, and Patient Protection and Affordable Care Act).

subjected those promises to the annual will of Congress and the president to provide sufficient funds.[232] This reliance on discretionary spending for Native American healthcare has produced a system that is insufficient, unreliable, and associated with stark health disparities.[233] A mandatory classification of IHS would elevate and cement the federal government's promise in a way that ensures results instead of just words.[234]

2. Medicare as a Model

To designate IHS as a mandatory budgetary item to rectify the spending disparity between IHS and like programs, Congress should enact a statute similar to Medicare.[235] Medicare's establishment and provisions present a useful reference point for Congress in drafting legislation regarding IHS. Congress should also use the opportunity of the drafting process to clarify the language of the existing authority so that authority can help guarantee proper funding in the interim as well as swift recourse if such funding is not provided.

a) Aspects to Keep

Congress can begin with the statute that established Medicare: H.R. 6675. This would be a useful foundation, and Congress should also look to the various amendments and revisions to the Medicare system since H.R. 6675's enactment. Primarily, Congress should mirror the budgetary designation and funding of Medicare in drafting its IHS legislation.

Like Medicare, the legislation for IHS should establish IHS as a mandatory budgetary designation. As discussed, this one aspect alone would ensure IHS receives more appropriate funding each year.[236] Congress

[232] Westmoreland & Watson, *supra* note 14, at 602.
[233] *Id.* at 600.
[234] *Id.*
[235] *See, e.g.*, H.R. 6675, 89th Cong. (1965).
[236] *See* discussion, *infra* Section IV-A.

should follow a similar funding structure for IHS[237] and should include language in the legislation that allows the designated amount for IHS to increase proportionally with inflation.[238]

Congress should also structure IHS funding like Medicare's Supplemental Medical Insurance (SMI) Trust Fund. The SMI receives its permanently-authorized, annual appropriations from general federal tax reserves.[239] In contrast, the trust fund used to fund Social Security depends on the strength of the economy for revenue.[240] The trust fund for Social Security appropriates the amount of funding depending on the size of collected taxes; however, with Medicare, Congress is instead statutorily required to appropriate an actuarially determined amount sufficient to fit the actual needs.[241] This approach protects the Medicare fund from facing the threat of reserve depletion as the fund for Social Security currently does.[242]

b) Aspects to Change

While the structure of Medicare serves as a useful model, Congress should modify several components of the Medicare legislation to better suit funding of IHS. Three such changes are: (1) revising the appeals system, (2) strengthening and streamlining the role of telemedicine in Native American health services, and (3) including provisions respecting traditional tribal healing practices.

First, the appeals system in Medicare is highly inefficient and burdensome, often stalling payments and coverage for months and creating challenging barriers for beneficiaries to obtain the care they need.[243] To address this systemic problem in new IHS legislation, Congress should shift

---

[237] Westmoreland & Watson, *supra* note 14, at 603–04.
[238] *See* discussion, *supra* Section III-A-2.
[239] Lindrooth, *supra* note 11, at 295.
[240] *Id.* at 295.
[241] *Id.* at 294–95.
[242] *Id.* at 295.
[243] Cerasano, *supra* note 26, at 433.

the burden of appeal from the beneficiary to the federal government. If a payment is in dispute (perhaps with certain conditions met), the federal government must cover the cost during the appeal. This would not only relieve the beneficiary of a potentially wrongful economic burden during weeks to months of appeal, but it would also create incentive for the federal government to move the appeal process along at a more efficient pace.

Next, the COVID-19 pandemic forced many professions to find creative ways to continue operating, often through video conferencing services.[244] This has normalized the use of telemedicine services, previously considered fringe.[245] The increased normalization of telemedicine type services during the pandemic can be utilized to strengthen and streamline the role of telemedicine as a resource for Native American healthcare services. Because the VHA is a recognized national leader in telemedicine,[246] Congress can look to the current telemedicine processes in place at VHA for important insight on what would strengthen the field of telemedicine for IHS.

Lastly, traditional tribal medical practices are an important aspect of Native American culture and well-being that cannot be overlooked in discussions regarding Native American healthcare.[247] For centuries, Native Americans have looked to their tribal healers to prevent or cure physical and spiritual ailments through both complex pharmacology and ceremony.[248] Traditional practices will likely vary depending on the tribe and the individual,[249] but Congress should acknowledge the importance of

[244] Rashid Bashshur et al., *Telemedicine and the COVID-19 Pandemic, Lessons for the Future*, 26 TELEMEDICINE & E-HEALTH 571, 571 (2020).
[245] Johanna D. Hollingsworth, *Is There A Doctor in the House?: How Dismantling Barriers to Telemedicine Practice Can Improve Healthcare Access for Rural Residents,* 62 HOW. L. J. 653, 669 (2019).
[246] INST. OF MED., THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 99 (The National Academies Press 2012).
[247] Kuschell-Haworth, *supra* note 65, at 843.
[248] *Id.*
[249] *See generally id.* at 845.

traditional tribal medical practices in the new legislation to ensure traditional practices can be properly incorporated into and covered under federal healthcare for Native Americans. Doing so will ensure adequate holistic healthcare is available to Native Americans and will help promote the cultural practices of tribes.[250]

B. The Courts Must Exercise Proper Accountability

In addition to action from Congress, the judicial system must address the responsibility it bears for the healthcare crisis. Discriminatory precedent and decisions unjustly disenfranchising Native Americans in U.S. courts have been major contributors to the problem at hand.[251] Judicial players must commit to renewed integrity and accountability in these matters, and federal Indian law must be reevaluated. While precedent generally should be given due respect and weight, the judiciary also must recognize when precedent is too polluted or compromised by prejudice to reign. Because progress for Native Americans is bound up and entangled in the problematic precedent, separating the bigotry from the progress is a complex but vital process.

Lawyers practicing in federal Indian law or citing federal Indian law cases should be required to note the precedent's historical context and racist tone wherever applicable.[252] As Adam Crepelle, an Assistant Professor of Tribal Law, notes, "a case's holding may no longer seem sound if one discovers the Court reached its conclusion because it viewed [Native Americans] as racially or culturally inferior to whites."[253] Lawyers should also become more comfortable in challenging ethically troubling precedent when arguing federal Indian law cases.[254] While contesting precedent is

[250] *Id.* at 853.
[251] *See, e.g.,* discussion, *supra* Section II.
[252] Crepelle, *supra* note 158, at 576.
[253] *Id.*
[254] *Id.* at 575.

unlikely to bring about sudden results, it will shed light on the inherent flaws in contemporary federal Indian law and help to bring it out of its dark past.[255] Though a difficult and complex endeavor, it is necessary to reckon with this past in order to create a better future.

The 2020 Supreme Court decision in *McGirt v. Oklahoma*[256] is a significant example of how this wrestling with and righting of unethical past decisions in caselaw is both possible and powerful. In *McGirt*, the Court addressed a jurisdictional issue under the federal Major Crimes Act (MCA) turning on whether the lands certain crimes had been committed on were Indian Country. Critically at issue was whether the lands, reserved for the Creek Nation in treaty and legislation since the 1800s, were still Indian Country despite decades of broken congressional promises and Oklahoma unlawfully treating the lands as state land.[257] Oklahoma courts rejected any suggestion that the lands in question remained a reservation, while the Tenth Circuit reached the opposite conclusion.[258] The Court held that, for MCA purposes, the lands were indeed still Indian Country, and just because the land had wrongly not been properly acknowledged as Indian Country for so long did not mean that this error erased or nullified the truth.[259] The Court opined that in any event, "the magnitude of a legal wrong is no reason to perpetuate it," and, significantly, the Court held the federal government to its word.[260]

More decisions like *McGirt* are needed. However, because of the enmeshment in the caselaw of bigoted principles with precedent that Native Americans rely on for protections today, both the judiciary and Congress should exercise due consideration when addressing these issues within the context of established law. Federal Indian law has historically been used to

[255] *Id.* at 576.
[256] McGirt v. Oklahoma, 140 S. Ct. 2452 (2020).
[257] *Id.* at 2460–74.
[258] *Id.* at 2460.
[259] *Id.* at 2480.
[260] *Id.* at 2459, 2480.

inflict "structural violence" on Native American communities and tribes.[261] Structural violence is "invisible, embedded in ubiquitous social structures, normalized by stable institutions and regular experience" and "occurs whenever people are disadvantaged by political, legal, economic, or cultural traditions."[262] Frequently, the very language and forms of discourse used to discuss Native American histories and issues have contributed to structural violence and harm as well.[263] The structural violence in federal Indian law has led to inequitable health outcomes for Native American communities,[264] denying them the adequate healthcare they are entitled to by law. Accordingly, in addition to listening to Native voices, legislative and judicial players should use an evaluative framework when considering any federal public health policy regarding tribes and Native American communities in order to avoid harm or perpetuating structural violence.[265]

For example, Assistant Professor of Indian law and health law Aila Hoss proposes five inquiries to make when performing such an assessment.[266] These five inquiries center tribal sovereignty and prompt reflection on the

---

[261] Aila Hoss, *A Framework for Tribal Public Health Law,* 20 NEV. L.J. 113, 133, 135 (2019).

[262] *Id.* at 132–33.

[263] *See, e.g.*, GREGORY YOUNGING, ELEMENTS OF INDIGENOUS STYLES: A GUIDE FOR WRITING BY AND ABOUT INDIGENOUS PEOPLES (2018); Eve Tuck, *Suspending Damage: A Letter to Communities*, 79 HARV. EDUC. REV. 409 (2009). (This author is still learning how to best avoid inadvertently perpetuating structural violence or harm in this respect, and the author urges readers to pursue resources such as these that explore ways of discussing Indigenous Peoples and associated issues and offer guidelines to help improve this in future scholarship and discourse).

[264] Hoss, *supra* note 261, at 133.

[265] *Id.* at 135.

[266] The five inquiries proposed by Hoss are: (1) whether the tribal sovereignty is respected and promoted and explored strategies that can be implemented relying on tribal inherent authority; (2) whether any federal Indian laws are implicated by the issue; (3) whether tribal law tools have been considered or utilized to address the issues; (4) whether legal strategies proposed would perpetuate structural violence against a tribe or Native American communities; and (5) whether actions by local, state, and federal actors include tribal engagement and consultation. *Id.* at 136.

possible consequences of any actions.[267] Crepelle proposes a contextual test for whether precedent in federal Indian law may be ethically problematic.[268] Crepelle suggests that the ethical issue arises when the old cases are weaponized to attack tribal sovereignty without indicating the cases were decided on principles long rebuked by the U.S.[269] Alternatively, when such cases are used to protect Native American rights despite the bigoted principles the cases contain, the use can be empowering.[270] Evaluation of possible moves using inquiries like these is an important consideration in addressing the current crisis in a constructive, ethical way.

C. Tribal Control Versus "Consultation"

Since the passage of the ISDEAA, tribal consultation has been increasingly emphasized in order to respect tribal sovereignty and address issues in the most effective manner.[271] Consultation is a formal, government-to-government process that requires federal and state governments to consult with tribal governments before taking actions that would impact tribes.[272] The federal government has already acknowledged that attempts to implement policy regarding Native Americans without consulting the tribes have typically been unhelpful and destructive.[273] Unfortunately, while consulting with tribes about federal policy decisions for Native Americans has been increasingly encouraged, consultation systems have been largely ineffective in practice to date.[274]

Tribal control of programs, in contrast, has proven incredibly effective. The efficiency of increased tribal control has been examined within the

[267] *See id.*
[268] Crepelle, *supra* note 158, at 577.
[269] *Id.*
[270] *Id.*
[271] *See* discussion, *supra* Section II-A.
[272] Hoss, supra note 44
[273] *Id.*
[274] Hoss, *supra* note 261, at 135.

scope of the tribal legal system.[275] A 2015 Indian Law & Order Commission Report found that when tribal law enforcement and courts are supported in taking primary responsibility over the dispensation of local justice, they are often more effective in providing justice in Indian Country than their non-Native counterparts.[276] After the Tulalip Tribes took control over their jurisdiction in criminal matters from Washington State in 2001, for example, criminal filings dropped from 1,172 in 2003 to 435 in 2007.[277] The Tribes accomplished this by developing their local criminal justice systems, and they clearly did so swiftly and efficiently.[278] With control over programs and proper government funding, tribes will be equipped to achieve similar results in their healthcare.

Many tribes have already mobilized to better their healthcare in this current crisis—remarkably, considering the present limitations.[279] With the current system, however, there is only so much that tribes can do to mitigate the healthcare crisis.[280] Given a better foundation, proper resources, and more control, tribal actors and organizations are key players in finding the best way forward.

This does not mean the concept of tribal consultation should be discarded entirely. Tribal governments need to be consulted and should have an active role in the process. In addition to increased control for tribal governments, consultation must be revised to be more effective.[281] Not only does this

---

[275] *See generally* INDIAN L. & ORDER COMM'N, A ROADMAP FOR MAKING NATIVE AM. SAFER: REP. TO THE PRESIDENT & CONG. OF THE U.S. (2015).
[276] *Id.*
[277] *Tribal Courts and the Administration of Justice in Indian Country: Hearing Before the S. Comm. on Indian Affairs*, 110th Cong. 2 (2008) (statement of Hon. Theresa M. Pouley, Tulalip Tribal Court; President, Northwest Tribal Court Judges Association).
[278] *Id.*
[279] *See, e.g.,* Wagner & Grantham-Philips, *supra* note 39.
[280] Mathews & Weaver, *supra* note 199.
[281] Aila Hoss proposes revisions to consultation in a forthcoming publication. *See* Hoss, *supra* note 44.

respect tribal sovereignty,[282] but it is integral on a practical level as tribal governments often know best.[283] It is irresponsible and inefficient to attempt any solution without taking tribes' input into account,[284] especially in situations where tribal control may not yet be a ready option. In addition to offering essential information on what is needed on a practical level, tribal involvement and self-advocacy promotes tribal agency, resiliency, and emotional well-being.[285]

The importance of tribal consultation cannot be overstated, but consultation mandates to date have largely failed in their objective. Focus should therefore instead be on increasing tribal control of programs in addition to exploring ways to reinforce and revise the consultation requirements. Adequate funding by the federal government remains an important prerequisite for tribes to mobilize this control effectively toward solutions.

IV. CRITIQUES AND RESPONSES

Critiques of this proposal include citing lack of available federal funds, the belief that litigation alone will resolve the issue, claims that the issue is too logistically complex to properly address, and mistaken perceptions of Native American healthcare as a charity cause. These challenges fail upon closer examination, and none cancel out the seniority of the federal government's obligation to provide adequate healthcare to tribes.[286]

---

[282] Nadia B. Ahmad, *Trust or Bust: Complications with Tribal Trust Obligations and Environmental Sovereignty*, 41 VT. L. REV. 799, 851 (2017); Pfefferbaum et al., *supra* note 27, at 213.
[283] CANBY, *supra* note 39, at 33.
[284] *Id.*
[285] Kirsten Matoy Carlson, *Lobbying as a Strategy for Tribal Resilience*, 2018 BYU L. REV. 1159 (2019).
[286] *See, e.g.,* Graleski, *supra* note 36, at 463.

A. Lack of Available Federal Funds is Not an Adequate Excuse

With the general financial strain of the recent pandemic on the United States and with long-running concerns over the size of the federal government deficit,[287] it can seem like additional funds are simply not available for IHS. This line of reasoning, however, does not hold up.

It is naive to think that budgetary decisions at the federal level are simple or that endless reserves of funds are available—neither, of course, is true.[288] However, the provision of adequate healthcare to Native Americans is a treaty right and a trust obligation of the United States.[289] The obligation goes back to the 1800s, is grounded in legal principle and statute, and is arguably one of the most senior obligations of the federal government.[290] It is also one that has rarely, if ever, been properly fulfilled.[291] Adding to this imperative for the federal government to finally fulfill its trust obligations to tribes, the disparity between what IHS receives in funding and what other federal healthcare programs receive in funding is staggering, further casting doubt on the argument that the funds simply are not available.[292]

It is likely that an increase in spending up front to ensure adequate services are provided will reduce overall spending in the long run.[293] Such severe shortages and underfunding often lead to complications and individuals not obtaining medical care until they are much sicker than they initially were.[294] These circumstances can also ultimately lead to

---

[287] Alan Rappeport, *U.S. Budget Deficit Hit $3.1 Trillion Amid Virus Spending Surge*, N.Y. TIMES (Oct. 16, 2020), https://www.nytimes.com/2020/10/16/us/politics/federal-deficit-31-trillion.html [https://perma.cc/RE3G-WLAJ].
[288] Rappeport, *supra* note 287; *Guide*, *supra* note 212.
[289] NAT'L INDIAN HEALTH BD., *supra* note 231.
[290] *See* Graleski, *supra* note 36, at 463.
[291] Lindrooth *supra* note 11, at 277, 282; Westmoreland & Watson, *supra* note 14, at 600; Wagner & Grantham-Philips, *supra* note 39.
[292] NAT'L INDIAN HEALTH BD., *supra* note 231 (citing the 2014 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita).
[293] Pfefferbaum et al., *supra* note 27, at 211.
[294] Allen, *supra* note 211.

lawsuits.[295] If better healthcare were more readily available, the costs associated with complications and negative ramifications would lessen.[296] This would also improve quality of life for Native Americans and would help raise the lower life expectancy of Native Americans relative to the general population.[297]

The United States established a trust relationship with tribes and an underlying duty to provide certain funding and services in exchange for tribal lands when it signed treaties with tribes in the late 1700s and 1800s.[298] Because adequate healthcare via IHS is a trust obligation, IHS must be fully and adequately funded.[299] The seniority and seriousness of the obligation to provide adequate healthcare to tribes, as well as the great disparity seen between the federal government's funding of other similar programs in comparison to IHS, accentuates that this remedy is necessary and possible.

B. Leaving This Issue Solely to the Courts Wastes Time and Resources

While it may be tempting to believe that the courts will eventually resolve the issue, that belief is misplaced. While litigation and court decisions are a necessary step in many scenarios, relying solely on litigation to establish a better way forward for Native American healthcare is neither a prudent nor complete solution.

Although courts have consistently agreed on the existence of an obligation or duty on the part of the federal government, decisions to date have kept the exact parameters of those duties vague and in dispute.[300] Already, Native Americans in the United States tend to enter the healthcare

[295] *See, e.g.,* Rosebud Sioux Tribe v. United States, 450 F. Supp. 3d 986 (D.S.D. 2020).
[296] Pfefferbaum et al., *supra* note 27, at 211; Allen, *supra* note 211.
[297] Pfefferbaum et al., *supra* note 27, at 211; Allen, *supra* note 211.
[298] *See generally Rosebud Sioux Tribe*, 450 F. Supp. 3d; CANBY, *supra* note 39, at 13–14, 20; Allen, *supra* note 211.
[299] Allen, *supra* note 211.
[300] *See, e.g., Rosebud Sioux Tribe*, 450 F. Supp. 3d; Allen, *supra* note 211.

system late and with higher acuity needs due to chronic underfunding and severe barriers to care.[301] These needs and expenses only grow more acute as litigation stalls resolution.[302] As these cases work their way through the courts, the human and monetary costs often increase significantly on all sides.[303]

The combination of these factors frequently means that both the federal government and already struggling tribal members are stymied for months or years in litigation where the costs run high and the definitive answers are slim.[304] With lack of clarity as to whether aspects of these cases are based on a legally enforceable duty rather than a moral duty, legal remedies may not even be available in these cases.[305] Not only is this further neglecting to provide proper care—amid a pandemic that has only intensified that need[306]—but it is also simply a waste of precious resources for both sides on a practical level. It is a straightforward cost and life-saving option for Congress to enact a statutory basis for IHS as mandatory spending and clarify existing authority to avoid the delays and price of litigation altogether.

C. Long-Term Benefits Outweigh Short-Term Logistical Complexities

Congress streamlining and clarifying existing language and drafting legislation regarding the federal trust relationship to tribes and the associated duty to provide healthcare accordingly may give rise to logistical challenges. Properly confronting the problematic precedent in federal Indian law is likewise complex. However, just because these issues may be complex does not mean Congress and the judicial system should put them

---

[301] Allen, *supra* note 211.
[302] *See, e.g., Rosebud Sioux Tribe*, 450 F. Supp. 3d.
[303] *See id.*
[304] *Id.*
[305] *Id.*
[306] *See, e.g.,* Hatcher et al., *supra* note 201; Wagner & Grantham-Philips, *supra* note 39; Walker, *supra* note 201.

off. The template provided by Medicare, the use of the evaluative framework discussed above, and increased tribal consultation and control all aid in overcoming these potential obstacles. Taking the time to adequately address the problem, Congress can put a framework in place that will greatly reduce time and resources currently wasted on litigation. In the courts, there must be a reckoning with the problems brought on by bigoted precedent. The 2020 *McGirt* decision shows that this is both possible and powerful. The larger body of caselaw that is built upon this cracked foundation, the more difficult it becomes to address. Especially given the current crisis, the U.S. must grapple with these issues sooner rather than later.

D. This is No Charity Case

Any belief that the funding of Native American healthcare is a charity case or a request for a handout should be quickly put to rest. There is a pervasive public perception that Native Americans live "on the public dole."[307] The opposite is true—Indigenous Americans actually get fewer federal dollars for services than other Americans because they lack political clout.[308] Centuries after the federal government obtained land in exchange for healthcare and other services for sovereign Native nations, federal officials spend nearly 3 times as much per person on non-Indian medical care than on health services for Indigenous people.[309] Adequate funding of Native American healthcare in fulfillment of the federal government's trust duty is no charity case; this is compensation duly owed.

To date, Native American communities have shown resilience, determination, and commitment to their communities in overcoming the disadvantaged position the federal government has put them in with

[307] Wagner & Grantham-Philips, *supra* note 339.
[308] *Id.*
[309] *Id.*

generations of abuse and neglect.[310] Native Americans today are descendants of people who persevered through colonization, smallpox, massacres, and resettlement.[311] When the COVID-19 virus peaked in May 2020, Navajo Nation employees were buying supplies with their own money, making personal protective equipment on their days off, and delivering provisions to tribal members in remote areas.[312] Often, tribes' responses to the crisis created by the federal government are accurately described as "nothing short of heroic."[313] Without the promised, proper funding from the government, though, tribal efforts are limited.[314]

Additionally, while acknowledging the competency of tribes is important, at heart this issue is one of due compensation. The established law indicates the U.S. agreed to provide services, including adequate healthcare, in exchange for cessations from Native Americans. The federal government has failed to provide what it promised, though it makes free use of Native American lands. This is no charity case. This is a duty owed and a debt long deferred.

IV. CONCLUSION

As highlighted most recently by the COVID-19 pandemic, it is clear there is an ongoing crisis in Native American healthcare. The federal government's continual failure to uphold its promise to fund adequate healthcare for Native Americans continues to lead to unnecessary Native American deaths and lessened quality of life. Current legal precedent leaves tribal members and communities with little avenue to require the federal government to provide what it promised. Access to adequate healthcare is essential, and Native Americans are clearly entitled to such provisions from

310 Smith, *supra* note 17, at 325–26.
311 Wagner & Grantham-Philips, *supra* note 39.
312 *Id.*
313 *Id.* .
314 Smith, *supra* note 17, at 325.

the federal government under law that is supported by treaty authority, contract law principles, international law doctrines, explicitly and implicitly expressed Congressional intent, legislation, historical context, and caselaw. Congress must act now in enacting legislation to change the designation of IHS and address key aspects of Native American healthcare. Existing authority both enables and compels Congress to do so. While Congress has the clearest directives toward implementing a solution, the courts bear substantial responsibility as well. Given the ongoing history in the courts of devaluing and disempowering Native Americans, the courts must show new commitment to righting the wrongs of the past.

Swift remedy to this longstanding crisis is necessary, especially given how the COVID-19 pandemic has so severely increased the intensity. Because the healthcare owed to Native Americans was promised in exchange for their lands, the federal government essentially has a choice: provide the proper funding and work to rectify the damage done by centuries of breached duty or give the land back.[315] In the words of Dr. Mary Owen, president of the Association of American Indian Physicians and a member of Alaska's Tlingit band, "Everybody says, 'You have to make do with what you got.' Do we? Really? Well, then, give us back those lands."[316]

[315] Frankly, this author is of the opinion that certain lands should be given back in addition to the provision of the long-overdue funding.
[316] Wagner & Grantham-Philips, *supra* note 39.