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Self-Determined Health: Reevaluating Current Systems and Funding for Native American Health Care

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For years, the federal government has failed to uphold its promises to provide health care to Native Americans. These promises are echoed in treaties, the Constitution, and judicially-created law. As a result of this breach of promise and chronically underfunding, there are significant health disparities between indigenous populations and other Americans. In a recent 2020 case, McGirt v. Oklahoma, the U.S. Supreme Court held that both the federal government and individual states must follow the terms of a treaty made with a tribe, encouraging the possibility of direct health care funding. This reform, however, means little without tribal sovereignty and self-determination, which give dignity and decisionmaking capabilities back to a group that has long been without them. This Note explores two examples of self-determination in Native American health care, the Alaskan Native health care system and the recent vaccine rollout, proposing a framework for increasing self-determination in health care to provide support for funding reform, which becomes increasingly necessary as Native Americans continue to struggle to access health care.

I. INTRODUCTION

Native Americans[1] have a long history of negative health outcomes: high rates of chronic liver disease, rates of cardiovascular disease twice the national average, and the highest rate of Type 2 diabetes in the world, among many others.[2] In light of the unique relationships tribes share with the federal government, federal departments and laws have been established over time to provide the care promised in treaties between federal and tribal governments and by the Constitution.[3] Federal responsibility for Native American

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[1]In this Note, the term "Native American" is used interchangeably with the term AI/AN ("American Indian/Alaska Native") unless indicated otherwise. When the term "Indian" is used, it is necessary as a part of either a title or a quotation.

[2]U.S. Comm'n on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans 66 (2018).

[3]U.S. Const. art. I, § 8, cl. 3.

health care was codified in the Snyder Act of 1921 and the Indian Health Care Improvement Act ("IHCIA") of 1976, which together form the legislative authority for the federal agency known today as the Indian Health Service ("IHS").[4]

For years, the government has failed to satisfy the promise made by the Snyder Act and the IHCIA. Many tribes are dismayed with the quality of their health care and are looking to take control.[5] Although the Indian Self-Determination and Education Assistance Act ("ISDEAA") provides a contractual method by which tribes can make efforts to gain control of their own health care, it still forces tribes through the IHS system, which is underfunded and inefficient.[6] This Note proposes that Congress provide mandatory funding for tribal health care as well as other supportive solutions like increased access to public and private insurance and increased emphasis on tribal self-determination to improve health outcomes for Native Americans.

This Note first describes the history of Native American health care and the current legal and statutory framework within which Native Americans receive health care. This Note then evaluates the shortcomings of the current system, including lack of funding, before suggesting use of Supreme Court's decision in *McGirt v. Oklahoma*[7] to reform and provide the health care funding promised to many tribes in their treaties with the federal government. This Note also suggests other supporting solutions, including increased access to public and private insurance, as well as greater emphasis on Native people taking control of their own health care.

II. THE LEGAL STATUS OF TRIBES AND TRIBAL HEALTH CARE

One common thread is interwoven throughout all of Native American law: tribal sovereignty. Tribal sovereignty is the right of all American indigenous people, including Alaska Natives, to govern themselves.[8] In Article 8, Section 1 of the U.S. Constitution, tribes are recognized as distinct governments with the same powers as federal and state governments to regulate internal affairs.[9] Tribal sovereignty includes "the right to establish their own form of government, determine membership requirements, enact legislation and establish law enforcement and court systems."[10] The concept of sovereignty includes the right to establish a health care system.[11]

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[4]25 U.S.C. § 1602 (2006); Snyder Act of 1921, ch. 115, 42 Stat. 208 (1921) (codified as amended at 25 U.S.C. § 13 [2004]); *see* NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY app. 509-10 (James N. Weinstein, Amy Geller, Yamrot Negussie, et. al. eds., 2017) (Native American Health: Historical and Legal Context), https://www.ncbi.nlm.nih.gov/books/NBK425854/ [https://perma.cc/C7TS-4H4A].

[5]Mark Walker, *Fed Up With Deaths, Native Americans Want to Run Their Own Health Care*, N.Y. TIMES (Jan. 3, 2021), https://www.nytimes.com/2019/10/15/us/politics/native-americans-health-care.html?smid=nytcore-ios-share [https://perma.cc/D86D-U5D9].

[6]25 U.S.C. § 5303 (2020); *see* Megan J. Renfrew, *The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives*, 40 COLUM. J.L. & SOC. PROBS. 173, 178–79 (2006).

[7]*McGirt v. Oklahoma*, 140 S. Ct. 2452 (2020).

[8]National Conference of State Legislatures, *An Issue of Sovereignty* (Jan. 2013) [hereinafter *An Issue of Sovereignty*], https://www.ncsl.org/research/state-tribal-institute/an-issue-of-sovereignty.aspx#:~:text=Tribal%20sovereignty%20refers%20to%20the,to%20regulate%20their%20internal%20affairs [https://perma.cc/9NX3-HQNB].

[9]U.S. CONST. art. I, § 8, cl. 3 (regulating commerce with Indians); U.S. CONST. art. II, § 2, cl. 2 (giving President and Senate power to make treaties).

[10]*An Issue of Sovereignty*, *supra* note 8.

[11]Snyder Act of 1921, Ch. 115, 42 Stat. 208 (1921) (codified as amended at 25 U.S.C. § 13 [2004]).

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Tribal sovereignty represents the evolution of tribal powers, with three major historical periods.[12] First, tribes possessed full and complete inherent authority over themselves pre-contact, or before Europeans arrived in the Americas, including "all the inherent powers of any sovereign state."[13] Second, this unconditional iteration of tribal sovereignty faded after years of genocide and land theft, beginning with European colonization.[14] Once tribes were designated as "domestic dependent nations,"[15] they could no longer exercise their right to make treaties with foreign nations, and their trust relationship with the U.S. government increasingly likened to one between a guardian and ward, rather than one between to two equal sovereign nations.[16] "This dependent status markedly figures in many recent U.S. Supreme Court decisions that further divest tribal powers."[17] Third, both legislation and treaties imposed more limits on tribal powers, including on tribes' hunting and fishing rights, as well as limiting their access to land ownership.[18]

Courts have used these treaties and legislation to create an "intricate web of judicially made Indian law."[19] Native American tribes, as independent political communities capable of exercising at least some powers of self-government, possess inherent rights over internal tribal affairs to make substantive laws governing their members and their territory.[20] "While the sphere of inherent tribal authority over external matters has been substantially modified, tribes retain limited civil jurisdiction over non-Indians on their reservations in two specific areas: 'consensual relationships with the tribe or its members [and] commercial dealings, contracts, leases, or other arrangements;' and conduct that 'threatens or has some direct effect on the political integrity, the economic security, or the health or welfare of the tribe.'"[21]

Over the past few decades, there has been a marked rise in Native Americans' desire to govern themselves.[22] This change has led to a reclaiming of culture, as well as a reclaiming of societal institutions, like courts, legislative bodies, and hospitals.

A. A History of Native Health Care

The erosion of tribal sovereignty eventually resulted in the promise of federal health care. Tribal numbers and resources became so decimated by the U.S. government—as well as state and local governments—that the federal government decided tribes were no longer able to care for themselves. The government's responsibilities for providing health care to Native Americans arise from treaties and settlements entered between the federal government and individual tribes, and also from Indian Commerce Clause in the Constitution, which provides that "The Congress shall have the power to … [r]egulate commerce

[12]Patrice H. Kunesh, *Tribal Self-Determination in the Age of Scarcity,* 54 S.D. L. Rev. 398, 401 (2009).

[13]*Id.* (citing Felix S. Cohen, *Handbook of Federal Indian Law* § 402 (Nell Jessup Newton et al. eds., LexisNexis 2005)).

[14]Kunesh, *supra* note 12, at 401 (citing *Cherokee Nation v. Georgia*, 30 U.S. 1, 13 (1831)).

[15]*Cherokee Nation v. Georgia*, 30 U.S. 1, 12-13 (1831).

[16]Kunesh, *supra* note 12, at 401.

[17]*Id.* (citing *United States v. Wheeler*, 435 U.S. 313, 326 (1978) ("[T]he dependent status of Indian tribes within our territorial jurisdiction is necessarily inconsistent with their freedom independently to determine their external relations.") (superseded by statute as stated in *United States. v. Lara*, 541 U.S. 193 (2004).

[18]*Id.* (citing Felix S. Cohen, *Handbook of Federal Indian Law* § 402, 123 (Nell Jessup Newton et al. eds., LexisNexis 2005)).

[19]*United States v. Lara*, 541 U.S. 193, 206 (2004).

[20]Kunesh, *supra* note 12, at 401.

[21]*Id.* at 401-2.

[22]Walker, *supra* note 5.

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with foreign nations, and among the several states, and with the Indian tribes."[23] Treaties signed by the U.S. government (and often misrepresented by it[24]) usually included provisions that would provide a basic level of health care to tribal communities, such as one or more physicians, housing for the physicians, and medical supplies.[25] The federal government also has a long-standing trust responsibility to aid and protect tribes.[26] The trust responsibility is a legal obligation under which the United States "has charged itself with moral obligations of the highest responsibility and trust" toward tribes; this is the major legal foundation for the argument that the federal government must provide health care to Native American people.[27]

In the early 1800s, the federal government began providing health care under the War Department, when the primary concern was containment for contagious diseases for tribes located near military outposts.[28] Infectious diseases such as smallpox were on the rise, and through the War Department, Congress had the means to authorize a large-scale smallpox vaccination in 1832.[29] In 1849, the Native American health program was transferred to the Department of the Interior, which currently houses the Bureau of Indian Affairs. Around the same time, the federal government began constructing hospitals and infirmaries for the use of Native American boarding school students.[30]

In 1908, Congress established the position of Chief Medical Supervisor, and for the first time, the Native American health program was supervised by medical professionals.[31] While appropriations for Native American health care appeared in the budget in 1911, "creation of the Health Division in 1924 raised the status of the program and allowed direct access to the Commissioner of Indian Affairs."[32] The Indian Health program became a primary responsibility of the Public Health Service in 1954.[33] This Act provides in part "that all functions, responsibilities, authorities, and duties … relating

[23]U.S. CONST. art I, § 8, cl. 3.

[24]Holly Miller & Michael Reese, *A History of Treaty Making and Reservations on the Olympic Peninsula*, CTR. FOR STUDY PAC. NW., https://depts.washington.edu/cspn/resources/curriculummaterials/treaties-reservations/#1510354839889-e3d2a8f4-0398 [https://perma.cc/QBX4-LLCA] ("In retrospect, these treaty negotiations seem highly suspect: They were carried out in a language that was understood by few of the participants and inadequate to convey the complexities of the treaties; they were held between two cultures that had conflicting ideas about land ownership, contractual obligations, and even basic social courtesies; and, ultimately, the terms were virtually dictated by Americans negotiators who had little inclination to bargain. In the end it is never clear whether the whites or the Indians ever understood the other during these negotiations.").

[25]Treaty with the Makah, 12 Stat. 939, art. 11 (Jan. 31, 1855) ("And the United States further agrees to employ a physician to reside at the said central agency, or as such other school should one be established, who shall furnish medicine and advice to the sick, and shall vaccinate them; the expenses of said school, shops, persons employed, and medical attendance to be defrayed by the United States and not deducted from the annuities."); Treaty with the Klamath, 16 Stat. 707, art. 5 (Oct. 14, 1864) ("The United States further engages to furnish and pay for the service and subsistence … for the term of twenty years of one physician … ."); Treaty with the Kiowa and Comanche, 15 Stat. 581, art. 14 (Oct. 21, 1867) ("The United States hereby agrees to furnish annually to the Indians the physician … and that such appropriations shall be made from time to time, on the estimates of the Secretary of the Interior, as will be sufficient to employ such [person].").

[26]The federal government's trust responsibility to tribes is discussed by Chief Justice John Marshall in the United States Supreme Court's decision in *Cherokee Nation v. Georgia*, 30 U.S. 1, 11-12 (1831).

[27]*Seminole Nation v. United States*, 316 U.S. 286 (1942).

[28]Everett Rhoades & Dorothy Rhoades, *The Public Health Foundation of Health Services for American Indians Alaska Natives*, 104 AM. J. OF PUB. HEALTH s3, s279 (Sep. 3, 2014).

[29]*Id.*

[30]*Id.* at s279-80.

[31]Brett Lee Shelton, *Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States,* KISER FAM. FOUND. 7 (Feb. 2014).

[32]*Timeline*, Native Voices, https://www.nlm.nih.gov/nativevoices/timeline/432.html [https://perma.cc/X5NW-F2X2].

[33]Pub. L. No. 568 (42 U.S.C. 2001) (Aug.5,1954).

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to the maintenance and operation of hospital and health facilities for Indians, and the conservation of Indian health… shall be administered by the Surgeon General of the United States Public Health Service."[34] Today, the IHS, established in 1955 within the Department of Health and Human Services, is the primary agency responsible for Native American health care.[35]

B. Public Health Implications of the History of Native Health Care

Despite this specific allocation of federal support, Native American health care is historically underfunded and has resulted in significant health disparities between indigenous populations and other Americans.[36] The life expectancy of Native Americans is five years shorter than that of the general U.S. population, and lower still for women who identify as indigenous.[37] Native Americans have low cancer survival rates, high rates of cardiovascular disease, and highest rate of Type 2 diabetes in the world.[38] This extreme disparity is due not only to a long history of negative health outcomes, but also to a lack of economic opportunities and a strict, narrow system that determines whether an individual is "Native enough" to qualify for a program under the IHS.[39] Native Americans also suffer from generational trauma due to the genocide of their people, which plays a huge role in health issues like alcoholism.[40]

Data collected by the Centers for Disease Control ("CDC") demonstrates that Native Americans also experience higher rates of COVID-19 as well as a greater risk for both hospitalization and death than other ethnic groups.[41] Other public health issues such as poor infrastructure, lack of nearby drinking water, and understaffed and underresourced health care facilities exacerbate the health problems described above.[42] Altogether, underfunded health care and significant health disparities are part of a negative feedback loop from which many Native Americans cannot escape.

C. The Current Legal Framework for Native Health

The IHS, the largest federally-funded program for Native American health care, has served as the primary health care provider for Native Americans for decades.[43] The department has a large pool of beneficiaries given the small size of the Native American population; over two million Native Americans receive some sort of basic health care from

[34] *Id.*

[35] *About IHS*, Indian Health Serv., https://www.ihs.gov/aboutihs/ [https://perma.cc/X4XQ-RG7D].

[36] U.S. Comm'n on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans 65 (2018).

[37] *Id.*

[38] *Id.* at 66.

[39] *Id.* at 65.

[40] *See* Cindy L. Ehlers et al., *Measuring Historical Trauma in an American Indian Community Sample: Contributions of Substance Dependence, Affective Disorder, Conduct Disorder and PTSD*, 133 Drug and Alcohol Dependence 1, 2 (2013).

[41] Risk for COVID-19 Infection, Hospitalization and Death by Race/Ethnicity, Ctrs for Disease Control and Prevention (June 17, 2021), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigationsdiscovery/hospitalization-death-by-race-ethnicity.html [https://perma.cc/W9A2-P5X7].

[42] Gloria Oladipo, *Native American communities lashed by Covid, worsening chronic inequities*, Guardian (Dec. 13, 2021), https://www.theguardian.com/us-news/2021/dec/13/pandemic-challenges-native-american-communities [https://perma.cc/Z6V4-DVUZ].

[43] *A Quick Look*, Indian Health Serv., https://www.ihs.gov/newsroom/factsheets/quicklook/ [https://perma.cc/AB7N-SNL4].

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the IHS.[44] The IHS provides many different services through a network of hospitals, clinics, and other health facilities located on or near reservations, from pharmacists to dentists.[45] The IHS also contracts with 41 nonprofit urban Native American organizations. [46] If the patient is on a reservation, health services are provided in IHS facilities for free to Native patients who qualify, though the IHS also has limited off-reservation services.[47] The IHS is funded through Congress' annual operating budget and is supplemented by billing both private and public insurance for services provided to insured Native Americans.[48]

The IHS provides strict eligibility requirements to access its services.[49] There are a number of criteria one must satisfy to qualify, including "the requirement that the individual be of Indian descent, regarded as a tribal member by his or her tribe, has some legal evidence of tribal enrollment or a Certificate of Indian Blood, resides on or near his or her federal reservation, and/or meets other local requirements."[50] As discussed earlier, these strict requirements can seriously impede access to these services; many tribes are still going through the expensive process of becoming federally recognized, and members of those tribes are not able to exercise the fundamental treaty right to the health care they are owed.[51]

There are also two important Acts of Congress to consider when discussing health care and how it is delivered to Indian Country,[52] both passed in the mid-1970s: the IHCIA and the ISDEAA.[53] The IHCIA, established in 1976, is the broader of the two acts.[54] Congress wished "to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[55] The IHCIA focused on promoting both the federal trust relationship and tribal self-determination.[56] However, one federal district court refused to give the IHCIA power through imposing obligations on the federal government, instead holding in 2020 that provisions of the IHCIA articulating

[44] *IHS Profile Fact Sheet*, Indian Health Serv. (Aug. 2020), https://www.ihs.gov/newsroom/factsheets/ihsprofile/ [https://perma.cc/X5W8-UC8F].

[45] *Id.*

[46] Indian Health Care Improvement Act, Pub. L. No. 94-437 § 3 ("It is the policy of the Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to ensure the highest possible health status for Indians and urban Indians."); *Urban Indian Health Program Fact Sheet*, Indian Health Serv. (Oct. 2018), https://www.ihs.gov/newsroom/factsheets/uihp/ [https://perma.cc/66XF-Y749].

[47] *IHS Profile*, Indian Health Serv. (Aug. 2020), https://www.ihs.gov/newsroom/factsheets/ihsprofile/ [https://perma.cc/SD2Y-63X9].

[48] Megan J. Renfrew, *The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives*, 40 Colum. J. L. & Soc. Probs. 173, 182 (2006).

[49] Jennie R. Joe, The Rationing of Healthcare and Health Disparity for the American Indians/Alaska Natives532 (2003), https://www.ncbi.nlm.nih.gov/books/NBK220367/ [https://perma.cc/VBU8-QQUW].

[50] *Id.*

[51] *See* Arica L. Coleman, *From the 'Pocahontas Exception' to a 'Historical Wrong': The Hidden Cost of Formal Recognition for American Indian Tribes*, Time (Feb. 9, 2018), https://time.com/5141434/virginia-indian-recognition-pocahontas-exception/ [https://perma.cc/V6A6-SH6Q].

[52] Indian country includes: 1) all land within the limits of an Indian reservation under the jurisdiction of the United States government; 2) all dependent Indian communities, such as the New Mexico Pueblos; and 3) all Indian allotments still in trust, whether they are located within reservations or not. It is generally within these areas that tribal sovereignty applies, and state power is limited.

[53] Starla Kay Roels & Liz Malerba, *New Opportunities for Innovative Healthcare Partnerships with Indian Tribes and Tribal Organizations*, 28 Health Lawyer 1, 25 (Oct. 2015).

[54] *See id.*

[55] 25 U.S.C. § 1602 (2006).

[56] *See id.*

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Congress's goal to "provide health services which will permit the health status of Indians to be raised to the highest possible level" and to "provide all resources necessary to effect that policy" to fulfill "its special trust responsibilities and legal obligations to Indians" did not impose any affirmative trust duties on the United States for Native American health care.[57] However, the IHCIA does cover many health care issues, including:

> programs designed to increase recruitment of healthcare professionals; scholarships for Native American students who choose to enter the health professions; health promotion and disease prevention, like diabetes treatment and prevention; reimbursements from third-party payors such as Medicare, Medicaid and private insurance; construction of healthcare facilities and sanitation facilities; licensure of health professionals providing care at tribally-operated healthcare facilities; health services to Indians living in urban areas; and behavioral health programs.[58]

Though the IHCIA does not contain an enforcement mechanism, it does embody an attitude held by many today: tribes should be encouraged to govern their own affairs.

The ISDEAA, established in 1975, "authorizes federally recognized tribes, including Alaska Native villages and tribal organizations sanctioned by tribes, to contract with the IHS to take over the management and operation of federal health programs for the benefit of eligible Indian people."[59] The purpose of the ISDEAA is to lower federal participation in the running of tribal programs while promoting both tribal self-determination and self-governance.[60] Tribes can either "administer programs and services the IHS would otherwise provide (referred to as Title I Self-Determination Contracting), or (2) assume control over health care programs and services that the IHS would otherwise provide (referred to as Title V Self-Governance Compacting or the TSGP)."[61] The ISDEAA thus allows tribes to take responsibility for providing health care—a responsibility previously held solely by the IHS—to their members.[62] Tribes do not all face the same barriers to health care access; the ISDEAA allows individual tribes to focus on those health issues that are most prevalent in their communities.[63] Tribes currently execute many different kinds of programs under the ISDEAA, "such as hospital and clinic services; licensed physician coverage; dental; pharmacy; substance abuse and mental health programs; maternal child health; traditional healing; vaccinations; preventative screening; and health/diabetes education."[64]

The ISDEAA promotes the drafting of a contractual agreement between the tribe wishing to take control of a program and the IHS, which is responsible for transferring its federal funding to the tribe so it can decide how best to satisfy its specific health care needs.[65] These contracts have a distinct statutory and regulatory structure; they are not considered federal procurement contracts nor are they subject to Federal Acquisition

[57] *Rosebud Sioux Tribe v. United States*, 450 F.Supp.3d 986, 996-97 (D.S.D. 2020).
[58] Roels & Malerba, *supra* note 53, at 26.
[59] Indian Self-Determination and Education Assistance Act, Pub. L. No. 93-638 (Jan. 4, 1975).
[60] *Cherokee Nation v. Leavitt*, 543 U.S. 631, 639 (2005).
[61] Office of Direct Service and Contracting Tribes, *Title I*, Indian Health Serv., https://www.ihs.gov/odsct/title1/ [https://perma.cc/RS7C-TKZN] (last visited Feb. 9, 2022).
[62] 25 U.S.C. §§ 450-458 (2020).
[63] Roels & Malerba, *supra* note 53, at 25.
[64] *Id.*
[65] *Id.*

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Regulations.[66] In 2015, the IHS received $4,642,381,000 from Congress; more than half of that funding was transferred to tribes under the ISDEAA.[67]

The ISDEAA deemphasized the role of IHS, allowing more tribes to assume the management and delivery of direct health care. Tribes currently manage "13 hospitals, 158 outpatient health centers, 158 village clinics in Alaska, 76 health stations, and 5 school health programs."[68] According to the National Indian Health Board, this redistribution of health care management led to "compacting," where tribes not only take over their health care systems but also spend time reprioritizing and changing care.[69] As of July 2016, the IHS and tribes have negotiated ninety compacts with sixty percent of the 567 federally recognized tribes through the ISDEAA.[70] The compacting program comprises approximately $1.8 billion, or forty percent, of the IHS budget.[71] Overall, the ISDEAA's response to problems exacerbated by the IHS has been admirable. However, this matters little in light of the prolific problems associated with Native American health care funding—or lack thereof.

D. The Funding Problem

Whether through public financing or personal insurance, a lack of funding prevents Native Americans from receiving adequate health care. Making matters worse, a large number of Native Americans go uninsured compared to the general population.[72] In 2019, only about fifty-two percent of Native Americans had private health insurance coverage, about forty-two percent relied on some sort of public health insurance coverage, and about fifteen percent had no health insurance at all.[73] Contrast these statistics with non-Hispanic whites' insurance coverage numbers: non-Hispanic whites are about seventy-five percent covered by private insurance, about thirty-four percent by public insurance, and only about six percent uninsured.[74]

One factor contributing to this disparity is that private insurance is often obtained through employment, and Native Americans have one of the highest rates of unemployment in the country.[75] Moreover, Native Americans have a long history of a lack of participation in public insurance programs. Non-participation stems from a lack of education about public insurance options and a lack of assistance with utilizing them.[76] Some Native Americans who rely on IHS "resist enrolling in Medicaid because they perceive IHS as an entitlement which should cover all of their needs, independent of their ability

[66] 25 U.S.C. §§ 450-458 (2020); 25 C.F.R. § 900; 25 C.F.R. § 1000; 42 C.F.R. § 137.

[67] *See, e.g.,* Dep't of Health & Hum. Servs., Fiscal Year (FY) 2015 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards (Includes Fiscal Year 2012 – 2015 Data), https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/CSC_Report.pdf [https://perma.cc/HSA2-4VBD]

[68] Joe, *supra* note 49, at 534.

[69] *Id.*

[70] *Tribal Self-Governance Fact Sheet*, Indian Health Serv., https://www.ihs.gov/newsroom/factsheets/tribalselfgovernance/ [https://perma.cc/HX9D-6ZRT] (last visited Feb. 10, 2022).

[71] *Id.*

[72] *See* Off. Minority Health, *Profile: American Indian/Alaska Native*, U.S. Dept. Health & Hum. Servs. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62 [https://perma.cc/MWR4-Y7NR] (last visited Feb. 10, 2022).

[73] *Id.*

[74] *Id.*

[75] Cara James, Karyn Schwartz & Julia Berndt, Race, Ethnicity, & Health Care Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage 6 (2009).

[76] H.R. Rep. No. 94-1026 at 107.

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to access payment through other sources."[77] There has, however, been a marked improvement in recent years: in 2004, twenty-nine percent of Native Americans were uninsured (an improvement from previous numbers) and as stated above, the percentage of uninsured individuals in 2019 was about fifteen percent.[78]

Evidence also suggests that the IHS is failing to provide health care for those it does manage to cover. For instance, by mid-year, the IHS has usually exhausted its annual budget for its Catastrophic Health Emergency Fund.[79] The IHS budget is not considered mandatory by Congress.[80] In 2010, the Affordable Care Act included the reauthorized IHCIA.[81] "Before it could really go into effect, however, the government shutdown in 2013 further crippled an already-deficient tribal health system."[82] After the shutdown, Congress cut the IHS budget by five percent.[83] "Three years later, that slash has had the cumulative effect of some 800,000 patient visits missed because of insufficient funds."[84]

Geography is another issue that contributes to the funding problem, given the diaspora of Native Americans beyond reservations. The IHS primarily operates in Indian Country, but life on reservations is not the norm for the majority of Native Americans.[85] Nearly eighty percent of Native Americans live in urban areas, but because the IHS operates primarily out of tribal reservations, the funding for urban patients makes up less than one percent of the IHS budget.[86] Many tribal members must travel long distances between population centers and tribal communities to access health care services.[87]

State and federal politics also complicate the funding problem. Due to the difficult process of becoming a federally recognized tribe, tribes are officially recognized in only thirty-five of the fifty states.[88] Also, thirty percent of senators do not have Native American constituents and therefore have no incentive to allocate additional federal dollars to the IHS.[89] Furthermore, because ISDEAA funding is linked to IHS funding through the contracting and compacting process, even the ISDEAA method of allowing tribes to become partially in control of their own health care does not relieve the funding issue.[90]

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[77]Megan J. Renfrew, *The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives*, 40 COLUM. J.L. & SOC. PROBS. 173, 178–79 (2006).

[78]*Id.*

[79]*Id.* at 819.

[80]*Id.* at 174.

[81]Ross Kenneth Urken, *Poor Cancer Care for Native Americans Might Be a Treaty Violation*, NEWSWEEK MAGAZINE (July 19, 2016, 9:10 AM), https://www.newsweek.com/2016/07/29/colorectal-cancer-indian-health-services-native-americans-481524.html [https://perma.cc/D6FZ-P6M4].

[82]*Id.*

[83]*Id.*

[84]*Id.*

[85]Urban Indian Health Program Fact Sheet, INDIAN HEALTH SERV. (Oct. 2018), https://www.ihs.gov/newsroom/factsheets/uihp/ [https://perma.cc/PPL2-6QL5].

[86]*FY 2021 Budget & Performance*, U.S. DEPT. OF HEALTH AND HUMAN SERVS., https://www.hhs.gov/about/budget/index.html [https://perma.cc/3Z4K-JGJZ]; Susannah Luthi, *Indian Health Service Urban Programs Threatened by Government Shutdown*, MODERN HEALTHCARE (Jan. 7, 2019), https://www.modernhealthcare.com/article/20190107/NEWS/190109933/indian-health-service-urban-programs-threatened-by-government-shutdown [https://perma.cc/M9SZ-MCSW].

[87]Dana Ferguson, *In Tense Meeting, Tribal Leaders, IHS Head Talk Solutions*, ARGUS LEADER (Apr. 5, 2016, 5:39 PM), https://www.argusleader.com/story/news/2016/04/05/tense-meeting-tribal-leaders-ihs-head-talk-solutions/82648032/ [https://perma.cc/S2FQ-6948].

[88]Martha Salazar, *State Recognition of American Indian Tribes*, NAT'L CONF. STATE LEGISLATURES (Oct. 2016), https://www.ncsl.org/research/state-tribal-institute/state-recognition-of-american-indian-tribes.aspx [https://perma.cc/6FQC-87M7].

[89]Urken, *supra* note 81.

[90]U.S. DEP'T HEALTH & HUM. SERVS., FY 2021 BUDGET IN BRIEF 41, https://www.hhs.gov/about/budget/fy2021/index.html [https://perma.cc/9K2D-GV77].

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The consequences of insufficient funding are very significant, including the inability to offer competitive salaries and benefits to health professionals. Also, "unlike other large federal health programs, health care rationing is necessary because the federal Indian health appropriation is not based on need."[91] The IHS also does not possess the legislative authority to negotiate good prices for pharmacy products or to battle with the private sector over medical services for Native patients.[92] This results in higher prices for Native Americans who seek health care. Overall, a lack of funding results in a web of public health issues beyond a quantitative lack of medical services. Nevertheless, there are both major reforms and supportive solutions that can ameliorate these problems.

III. *MCGIRT V. OKLAHOMA*: THE POTENTIAL TO REFORM NATIVE HEALTH CARE

While the IHS has been criticized as ineffective, decentralizing the IHS risks benefiting only those tribes with the resources to access federal funding, severely hurting those tribes who have smaller populations and little land in trust. One Native American physician noted "that unless there is continuing congressional and political support, the realization of self-determination by tribes may make it easy for the federal government to terminate its federal responsibility."[93] One tribal leader, in deciding whether to contract with the IHS, concluded that "until she gets further assurances, she is still skeptical about the federal push to encourage tribes to take over management of the federal program."[94] She is among the many that view self-determination as the beginning of the termination of the federal trust responsibility, which would destroy federal obligations to tribes and leave them to their own devices, the effects of which could be devastating if it were too abrupt.[95] Though the quality of health care is improving under local control, financial shortfalls could worsen without federal support, forcing tribes back to square one of rationing care.[96]

One potential solution is to judicially mandate Congress to fund all health care promised to individual tribes in treaties because federal treaty obligations have not been met. For example, the treaty between the federal government and the Makah promised a physician for the tribe that would "reside at the said central agency … who shall furnish medicine and advice to the sick, and shall vaccinate them; the expenses of [a] school, shops, persons employed, and medical attendance to be defrayed by the United States and not deducted from the annuities."[97] In a treaty with the Kiowa and Comanche, the federal government agreed to appropriate funds for a tribal physician.[98] In the Fort Laramie Treaty, which was signed by multiple bands of the Sioux tribe, the United States also promised a physician and appropriations to that effect.[99]

In a recent 2020 case, *McGirt v. Oklahoma*,[100] the U.S. Supreme Court held that unless Congress has explicitly said otherwise, both the federal government and individual

[91] Joe, *supra* note 49, at 541.
[92] *Id.*
[93] *Id.* at 535 (citing A.B. Bergman et al, *A Political History of the Indian Health Service*, 77 THE MILBANK QUARTERLY 571, 601 (1999)).
[94] *Id.* at 544.
[95] *See id.*
[96] *Id.*
[97] Treaty with the Makah, Makah-U.S., art. 11, Jan. 31, 1855, 12 Stat. 939.
[98] Kiowas: Treaty between the United States of America and the Kiowa and Comanche Tribes of Indians art. 14, 15 Stat. 581 (Oct. 21, 1867).
[99] Treaty between the United States of America and different tribes of Sioux Indians art. 13, 15 Stat. 635 (May 25, 1868).
[100] *McGirt*, 140 S. Ct. 2452, 2453 (2020).

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states must follow the terms of a treaty made with a Native American tribe.[101] The opinion highlights how state interests have often differed from tribal interests, drawing a picture of the long history of how the state of Oklahoma has undermined tribal sovereignty. The opinion then recognized that treaties are still enforceable. Under the terms of the 1833 treaty between the federal government and the Muscogee Creek Nation, a significant piece of Oklahoma land remains Native American territory, and therefore, state authorities cannot prosecute crimes committed by or against Native Americans there. Instead, jurisdiction of those cases falls to either federal or tribal law.[102] The Court also noted that treaty rights should be construed in favor of tribal rights.[103] If treaty language is ambiguous, courts may reference contemporaneous usages to determine Congress' original intention, as well as the tribe's understanding of that intention.[104]

As of April 2022, Oklahoma continues to protest *McGirt*, arguing that the state has been robbed of its authority to prosecute crimes involving both non-Native Americans and Native Americans.[105] Pushing back against the state of Oklahoma, Justice Neil Gorsuch said the following: "We have the treaties … which have been in existence and promising this tribe since before the Trail of Tears that they would not be subject to state jurisdiction precisely because the states were known to be their enemies."[106] He goes on to remind the Court of the federal government's promises several times, highlighting the above reasons why *McGirt* was decided in the first place. While *McGirt* could be adjusted by this case, the Supreme Court has already refused to revisit its holding in *McGirt*, encouraging the idea that the decision will persist despite pushback.

Though *McGirt*'s facts are only about treaty terms regarding land and territory lines, the broader implication is a protection of all treaty terms. Given that many treaties discuss health care access, the Court could soon see cases where that promise is put to the test. Congress has the ability to state that it will not provide health care to Native Americans, but it has never done so. To the contrary, Congress has put legislation in place supporting its duty to provide health care.[107] Though most treaties only promise funds for one physician, one physician would have likely satisfied an entire community's health care needs in the 1800s. Now, this term could be understood to mean all health care needs, which cannot be provided by only one physician. Instead, tribes require more facilities and providers. Where Congress has not expressly denied this treaty right to a tribe, the Supreme Court's conclusion in *McGirt* could lead to the Court requiring the federal government to fund Native American health care wholly and directly.[108]

IV. ALTERNATIVE SUPPORTIVE STRUCTURES

Though major reform is the most ideal method by which to improve Native American health care, there are several supportive measures which could be taken to improve health care within the current system.

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[101] *Id.* at 2462 ("So it's no matter how many other promises to a tribe the federal government has already broken. If Congress wishes to break the promise of a reservation, it must say so.").

[102] *Id.*

[103] Solem v. Bartlett, 465 U.S. 463, 470 (1984).

[104] *McGirt*, 140 S. Ct. 2468; Montana v. U.S., 450 U.S. 544, 545 (1981).

[105] Transcript of Oral Argument at 19, Oklahoma v. Castro-Huerta, No. 21-429 (U.S. argued Apr. 27, 2022).

[106] *Id.* at 17.

[107] The Snyder Act of 1921, ch. 115, 42 Stat. 208 (1921) (codified as amended at 25 U.S.C. § 13 (2018)).

[108] *McGirt*, 140 S. Ct. at 2452.

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A. Increased Use of Medicaid

One solution to facilitate a transition away from IHS is to encourage more Native American use of Medicaid because Medicaid provides access to affordable insurance coverage outside the IHS. Native Americans are among the least likely of all ethnic groups to access Medicaid; "nonelderly [Native Americans] remain significantly more likely to be uninsured [through Medicaid] than the rest of the nonelderly population (17 percent vs. 11 percent)."[109]

Many Native Americans who were not historically eligible for Medicaid now are due to the Affordable Care Act.[110] Since 2013, Medicaid expansion has caused a reduction in the number of overall uninsured population.[111] Native Americans specifically are benefiting from Medicaid expansion; "in the states that adopted it, the Medicaid expansion has provided a 'much-needed boost' to the IHS by increasing Native American eligibility for Medicaid and providing direct compensation to IHS care."[112] One study shows that the national uninsured rate for Native Americans dropped from about twenty-five percent in 2013 to about twenty-one percent in 2014, which was the year after the ACA was adopted.[113] The largest gains occurred in states that expanded Medicaid and must also be put into the context of IHS coverage.[114] IHS facilities can now reimburse their costs through Medicaid, as evidenced by the lack of change in IHS rates.[115] Therefore, the Medicaid expansion supplements IHS's struggling budget.[116]

A recent example of Medicaid expansion helping Native Americans might soon be found in Oklahoma.[117] Prior to the expansion, Oklahoma had the largest population of uninsured Native Americans in the country.[118] Though coverage did not become effective until July 1, 2021—and, therefore, little information about the effect of expansion presently exists—the experiences of prior states indicate that Oklahoma will likely see a drop in its uninsured Native population.[119] Aside from encouraging Medicaid expansion, tribal hospitals and clinics could begin a public health insurance literacy program. Physicians

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[109]Samantha Artiga et al., *Medicaid and American Indians and Alaska Natives,* Kaiser Fam. Found. (Sep. 2017), https://www.kff.org/medicaid/issue-brief/medicaid-and-american-indians-and-alaska-natives/ [https://perma.cc/CHV9-YCL3].

[110]Eric Whitney, *Native Americans Feel Invisible in U.S. Health Care System*, NPR (Dec. 12, 2017, 5:00 AM), https://www.npr.org/sections/health-shots/2017/12/12/569910574/native-americans-feel-invisible-in-u-s-health-care-system [https://perma.cc/DYS9-755G].

[111]Larisa Antonisse, Rachel Garfield, Robin Rudowitz & Samantha Artiga, *The Effects of Medicaid Expansion under the ACA: Updated Findings from Literature Review—Issue Brief*, Kaiser Fam. Found., (Mar. 2018), https://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review [https://perma.cc/FYM4-4T4Q].

[112]U.S. Comm'n on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans, 91 (2018), https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf [https://perma.cc/9LXK-5X9N].

[113]Molly Frean et al., *Health Reform and Coverage Changes Among Native Americans*, 176 JAMA Internal Med. 858, 859 (2016).

[114]*See id.*

[115]*Id.*

[116]*Id.*

[117]Press Release, U.S. Dep't. of Health & Hum. Servs., Oklahoma's Medicaid Expansion Will Provide Access to Coverage for 190,000 Oklahomans (July 1, 2021), https://www.hhs.gov/about/news/2021/07/01/oklahomasmedicaid-expansion-will-provide-access-to-coverage-for-190000-oklahomans.html [https://perma.cc/D7S2-QGQD].

[118]Press Release, U.S. Dep't. of Health & Hum. Servs., Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges (July 22, 2021), https://aspe.hhs.gov/sites/default/files/2021-07/aspe-aian-health-insurance-coverage-ib.pdf [https://perma.cc/ZN85-4KGH].

[119]*See* Press Release, U.S. Dep't of Health & Hum. Servs., *supra* note 117.

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could also emphasize discussions of public insurance in their daily practice, as well as include descriptions of their patients' options both orally and in writing.

B. Increased Self-Determination in Native Health Care

As compacting through the ISDEAA has become more popular among Native Americans, individual tribes are now able to focus more attention on the specific issues facing their communities. Increased self-determination is an end in and of itself. It gives dignity and decisionmaking capabilities back to a group that has long been without them. Although self-determination in tribal health care does not directly relieve the funding problem, it can help tribes better direct resources to the issues in most need of their attention.[120] If Native Americans can direct resources provided by the federal government in their own optimized ways, funds will not be misused or spent needlessly in ways that are not helping the community. In enacting the ISDEAA, Congress found that "true self-determination in any society of people is dependent upon an educational process which will ensure the development of qualified people to fulfill meaningful leadership roles … [and] parental and community control of the educational process is of crucial importance to the Indian people."[121]

The following two entities illustrate health care decisionmaking and policies that centralize Native American leadership and caregivers. Both are examples of successful partnerships between the federal government and tribes and represent effective secession of control to tribes.

1. The Alaska Native Tribal Health Consortium

The Alaska Native Tribal Health Consortium ("ANTHC"), which began contracting its own health care through the ISDEAA in 1998, is designed to meet all health care needs of Alaska Natives.[122] The ANTHC provides many diverse health services, which include "comprehensive medical services at the Alaska Native Medical Center, wellness programs, disease research and prevention, rural provider training and rural water and sanitation systems construction."[123] The ANTHC is also considered a Magnet Center, or a facility that has been singled out for nursing excellence.[124] One IHS provider noted:

> My sense is that on balance, contracting and compacting has improved healthcare services. In Alaska, where healthcare has been compacted for the last 4-5 years, there are improvements in clinical care. If you walk into the Alaska Native Medical Center today, you get treated today, whereas under the old system, sometimes it was a couple of weeks before you could get an appointment.[125]

To grasp the scope of the ANTHC's success, one needs to look no further than its dental program. Alaska Natives have had a long history of dental caries, and the historical lack of health care exacerbated this issue. For example, "American Indian and

[120] U.S. Dep't Health & Hum. Servs., FY 2021 Budget in Brief, *supra* note 90.
[121] 25 U.S.C.A. §5301 (West).
[122] *Overview*, Alaska Native Tribal Health Consortium, https://anthc.org/who-we-are/overview/ [https://perma.cc/F35E-PNGW] (last visited Feb. 10, 2022).
[123] *Id.*
[124] *Magnet Recognition Program*, American Nurses Credentialing Ctr., https://www.nursingworld.org/organizational-programs/magnet/ [https://perma.cc/9XM6-J2PR] (last visited Feb. 10, 2022).
[125] Joe, *supra* note 49, at 543-44.

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Alaska Native children between the ages of 2 and 4 have the highest rate of decay in the United States—five times the national average."[126] This adverse health outcome also has wide-reaching social implications. "One-third of school-age children in rural Alaska miss school because of dental pain, and one-fourth report avoiding laughing or smiling because of the appearance of their teeth."[127] By the time they reach adulthood, many have already experienced devastating consequences due to lack of dental care.[128] Additionally, if these children are unable to eat healthy foods because they often require vigorous chewing, it leads to other health issues, such as malnutrition and obesity in both childhood and adulthood.[129]

When the ANTHC took over health care services from the IHS, it addressed this specific need. The Alaska Dental Health Aide Program, which was introduced by the ANTHC, was intended to increase access to oral health care by "training new types of dental providers to provide culturally appropriate education and routine dental services under the supervision of a dentist to high-risk residents of rural villages."[130] Since 2004, the program has facilitated the training of twenty-eight dental therapists, who were trained through the program and can now provide care in communities which "typically had no dedicated oral health care provider or programs to encourage engagement in oral health care, prevention, and literacy."[131] Key components include recruitment and training for dental aides in remote communities and a federal agreement allowing dental therapists to bill the Medicaid program directly for the services they provide to receive reimbursement.[132] These therapists commit to providing care in regions where accessing care is difficult, an effective strategy because these therapists already have the cultural and language skills to work with these communities, offering treatments that were previously unavailable in remote areas of Alaska.[133] "Post-implementation usage data suggests that the program has enhanced access to quality oral health services for individuals living in rural Alaska villages who previously had limited or no access to such services."[134] Care is improving and patients themselves report positive social and emotional outcomes; one patient even referred to the care as a return to dignity.[135]

The ANTHC still works with the IHS. In 2013, Congress passed the Alaska Native Tribal Health Consortium Land Transfer Act, which allowed the ANTHC to build a patient housing facility on the parcel of federal land; therefore, those living in remote towns and traveling long distances to receive medical care in Anchorage were able to house themselves.[136] This was set forth by the ANTHC because they knew what was needed in their particular community, and the program cut costs related to transportation and housing.[137] The ANTHC is fulfilling the federal trust responsibility of the IHS and is doing so more effectively and economically.

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[126]David A. Nash and Ron J. Nagel, *Confronting Oral Health Disparities Among American Indian/Alaska Native Children: The Pediatric Oral Health Therapist*, 95 Am. J. Pub. Health 1325, 1325 (2005).

[127]*Id.*

[128]*Id.*

[129]Connie Mobley et al., *The Contribution of Dietary Factors to Dental Caries and Disparities in Caries*, 9 Acad. Pediatrics 410, 410 (2009).

[130]Agency for Healthcare Research and Quality, *supra* note 120.

[131]*Id.*

[132]*Id.*

[133]*Id.*

[134]*Id.*

[135]*Id.*

[136]H.R. Rep. No. 113-248 at 2 (2013).

[137]Press Release, Senator Lisa Murkowski, Delegation Land Transfer Passes Congress, Benefitting Native Health Effort (Dec. 20, 2013).

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Though the Alaska Native Tribal Health Consortium Land Transfer Act is an example of the IHS fulfilling a contractual duty under ISDEAA, Alaska officials must continue to aggressively seek grants, bill Medicaid and Medicare, and use revenue from their investments to fund their projects.[138] The ANTHC works for Alaska Natives in part because Alaska Native tribes operate differently than most; they are set up as corporations with gross revenue in the billions, and are often self-funded due to lucrative oil deals, energy support services, and tourism.[139] However, this model of socially and culturally conscious treatment provided by Native Americans to Native Americans is still one that other tribes should emulate regardless of their operative structures, especially given that the increase in good public health outcomes would likely become cost-saving in the long run.

2. COVID-19 Vaccination Rollout for Native American Communities

Interestingly, Native American communities have a higher COVID-19 vaccination rate than other groups despite widespread vaccine hesitancy among minority groups.[140] As of January 13, 2022, sixty-seven percent of Native Americans have received at least one dose of COVID-19 vaccine, compared to about fifty-two percent for non-Hispanic whites.[141] Multiple factors likely contribute to this high vaccination rate, including but not limited to "distinct features of vaccine-distribution networks in [Native American] communities, innovative approaches to encouraging vaccination, and culturally attuned messaging strategies for confronting vaccine hesitancy."[142] High rates of COVID-19-related hospitalizations and deaths among Native American populations may have also created a more urgent demand for vaccines.[143]

Regardless, community leaders maintain that the vaccination effort has been successful for two reasons: "first, the US government's decision to allow Native American communities to control vaccine distribution; and second, traditional ethnic values including respect for elders, 'community first' philosophies, and a willingness to trust science—so long as it's presented by community members themselves."[144]

One example of this methodology was one tribe's decision to initially allow vaccination for those fifty and older instead of the more common guideline of sixty and older.[145] The tribe's reasoning was twofold: first, chronic health disparities resulting in higher mortality rates means that elders in Native American communities are younger than in other ethnic groups. Second, younger individuals were more likely to get vaccinated when elders recommended it due to the cultural traditions of respect and trust in elders.[146] Because Native leaders were involved in the vaccine rollout decisionmaking, they could

[138]Alaska Native Tribal Health Consortium, *Health Within Reach Alaska Native Tribal Health Consortium 2019 Annual Report*, (2019), https://anthc.org/wp-content/uploads/2019/12/2019-ANTHC-Annual-Report-web-1.pdf [https://perma.cc/A7PS-6DZT].

[139]Joaqlin Estus, *Alaska Native Corporations Dominate List of State's Top Businesses*, Indian Country Today (Oct. 5, 2020), https://www.indianz.com/News/2020/10/05/indian-country-today-alaska-native-corporations-mean-business/ [https://perma.cc/SC7P-D5TA].

[140]Joanne Silberner, *Covid-19: How Native Americans Led the Way in the US Vaccination Effort*, 374 BMJ (2021).

[141]COVID data tracker, Ctrs for Disease Control & Prev., https://covid.cdc.gov/covid-data-tracker/#vaccination-demographics-trends [https://perma.cc/K6AE-2SS2] (last visited Feb. 10, 2022).

[142]Raymond Foxworth et al., *Covid-19 Vaccination in American Indians and Alaska Natives — Lessons from Effective Community Responses*, 385 New Eng. J. Med. 2403, 2405 (2021).

[143]*Id.*

[144]Silberner, *supra* note 140, at 1.

[145]*Id.* at 2.

[146]*Id.* at 1.

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formulate tactics focused on cultural and community needs. Due to the historical distrust between Native Americans and the federal government, similar efforts made by the federal government would likely have been unsuccessful.

Other tribal efforts to vaccinate their populations included the use social media to hold otherwise in-person talking circles and storytelling, the requirement proof of vaccination to attend sacred ceremonies, and the use of community venues such as urban Native centers to have drive-through vaccination events.[147] These practices show that allowing Native Americans to create their own public health guidelines and increasing collaboration among the IHS, the federal government, and individual tribal leaders results in creative solutions that can improve overall health for Native Americans.

3. A Framework for Self-Determination

The above examples demonstrate the increase in the efficacy of health care when it is socially and culturally conscious and directed at needs identified by the local community. Though the federal government has made an effort to increase Native Americans' opportunities to determine their own health care through the above examples and the ISDEAA process, there remains a distinct need to develop a framework to encourage Native Americans' continued self-determination going forward.

Intentional induction of guidelines might be one way to meet this need. The federal government funds Native American health care, and even if those funds increase, guidelines on how and by when to use the funds will still attach. The Departments of the Treasury and the Interior often hold tribal consultations to determine the amount of funding when funding is flowing to tribes, but this is not self-determination.[148] The specific programs to be funded must be entirely determined by tribal leaders, and these programs should not be uniform across all tribes. There should also be more representation for urban Natives, whose concerns are frequently under-addressed.

Native Americans should be allowed to amend the guidelines given to them by the federal government, or to suggest new guidelines depending on each individual tribe. Redefining who was elderly in the context of vaccinations was a successful demonstration of how to improve upon set guidelines. This redefinition was not an attack on the federal government's guidelines; instead, it identified a community-specific need.

In the future, the federal government should create a mechanism by which tribes can provide input on guidelines and make changes where necessary. Setting up a system through which tribes can decide how care is provided—and how information about that care is provided—would go a long way to encouraging self-determination.

V. CONCLUSION

Native Americans have a long history of negative health outcomes, but they are also working steadfastly to protect the health of their own communities. For example, in light of the IHS's refusal to provide preventative care, Joy Rivera, who is a Haudenosaunee Native and a former math teacher, drives to reservations to give eight-hour workshops on the anatomy of the digestive system and colorectal cancer risk factors.[149] However, Native Americans do not have all the resources to take care of themselves. Native Americans are

[147]Foxworth, *supra* note 142, at 2405-06.

[148]*See* 2020 CARES Act, U.S. Dep't of the Interior, https://www.bia.gov/covid-19/cares-act [https://perma.cc/F3KT-SRDU] (last visited Feb. 10, 2022).

[149]Urken, *supra* note 81.

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owed constitutionally guaranteed funding and rights, which are also guaranteed by the treaties shared by federal and Native governments. Ultimately, this funding should come directly from the treaties, but supportive structures like encouraging Medicaid expansion and increased self-determination in tribal health care facilities are also effective. Other solutions must be workshopped for urban Natives and federally unrecognized tribes. Native self-determination does not and should not mean termination from the U.S. government. Instead, the government needs to work directly with tribes to uncover local needs and find innovative ways to fund caregivers and those receiving care.

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