TRIBAL HEALTH SELF-DETERMINATION: THE ROLE OF TRIBAL HEALTH SYSTEMS IN ACTUALIZING THE HIGHEST ATTAINABLE STANDARD OF HEALTH FOR AMERICAN INDIANS AND ALASKA NATIVES

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ABSTRACT

In this Article, I explore the concept of Tribal self-determination in the context of systems that serve American Indian and Alaska Native communities. I investigate the vast health disparities that exist in Tribal communities, as well as the history and current legal framework for the provision of health care in Indian Country. Part of this discussion also provides information on the federal laws and policies that have fractured the traditional lifeways of Native communities and contributed to the disparate health outcomes that now exist. I also provide background on the fundamental federal laws and policies, particularly the Indian Self-Determination and Education Assistance Act of 1975, that have facilitated greater Tribal control over programs and services for Tribal communities, including health systems. Tribally managed health systems can, and are, playing a crucial role in closing this health gap.

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This Article also positions the status of Native communities in the United States within the global dialogue on the right to health, as Indigenous Peoples in settler colonial states are demonstrably experiencing similar disparate outcomes. This discussion includes background on the international legal framework for the right to the highest attainable standard of health, the rights of Indigenous Peoples, and the social determinants of health, some of which are arguably unique to Indigenous communities. The Article explores these concepts for the lessons that may be garnered for the benefit of Tribal health systems. It also argues that Tribes that are successfully operating healthcare systems have their own lessons to offer the global community in providing quality care and bringing American Indian and Alaska Native communities closer to actualizing the highest attainable standard of health.

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INTRODUCTION

There is a well-known saying in Indian Country: "Don't get sick after June." The expression references how, by June—only midway through the federal fiscal year—funding allocated for Indian health services is typically depleted. The saying poignantly underscores the systematic underfunding of the healthcare system for American Indians and Alaska Natives (AI/AN), as Native communities[1] are often left to grapple with inadequate federal healthcare systems and well-documented health disparities.[2]

Prior to colonization, many Native communities could sustain general health and wellness through culturally-based practices and traditional lifeways conducive to good health.[3] However, early contact with European nations introduced a series of deadly infectious diseases, leading to the decimation of many Native American communities and forcing them to fight for their continued existence.[4]

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1. This Article uses the terms "Native American," "Native communities," "Tribes," and "Indian" interchangeably to describe American Indians and Alaska Natives. The Author's intent is to use these terms with the utmost respect while being cognizant of the varying personal preferences of Indigenous Peoples in the United States. The Author also acknowledges that "Indian" is both a legal term of art, used frequently in Acts of Congress and judicial opinions, and a "misnomer" often used in offensive contexts. *See* 25 U.S.C. (devoted to "Indians"); Johnson v. M'Intosh, 21 U.S. 543, 586, 590 (1823) (utilizing phrases such as "warlike tribes of Indians"); Angelique EagleWoman, *The Capitalization of "Tribal Nations" and the Decolonization of Citation, Nomenclature, and Terminology in the United States*, 49 MITCH. HAMLINE L. REV. 624, 638–39 (2023) (describing phrases applying racist characteristics to Native Americans). This Article does not go so far as to explore the important experiences of Native Hawaiians and other Pacific Islanders, as American Indians and Alaska Natives are subject to a separate and unique legal framework that determines their healthcare systems.

2. *See generally infra* Part II (discussing funding shortfalls for healthcare systems in Indian Country and the historically disparate health outcomes for AI/AN populations).

3. *See* Mary Koithan & Cynthia Farrell, *Indigenous Native American Healing Traditions*, 6 J. NURSE PRAC. 477, 477 (2010) ("For thousands of years, traditional indigenous medicine ha[s] been used to promote health and wellbeing for millions of Native people who once inhabited this continent. Native diets . . . and the use of native plants for healing purposes have been used . . . to promote health by living in harmony with the earth."). *But see* David S. Jones, *The Persistence of American Indian Health Disparities*, 96 AM. J. PUB. HEALTH 2122, 2122 (2006) (arguing that "American Indians struggled with ill health even before Europeans arrived" but acknowledging that "[c]olonization made matters worse").

4. *See, e.g.*, DAVID H. GETCHES ET AL., CASES AND MATERIALS ON FEDERAL INDIAN LAW 431 (7th ed. 2017) ("First contact with colonizers from the West immediately created cataclysmic health consequences for Indian people, with

The genesis of the United States government also brought centuries of federal Indian laws and policies that actively sought to eradicate Tribal Nations[5] and assimilate Native people into the larger American society.[6] These laws and policies often introduced fundamental changes to Native peoples' traditional lifestyles, and these changes have contributed to severe modern-day health issues.[7] More recently, the COVID-19 pandemic highlighted the inequities Tribal Nations face. Native populations disproportionately suffered during the pandemic for reasons attributed to a wide variety of social determinants,[8] including housing shortages and a lack of running

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many effects continuing today. Epidemics of infectious diseases such as smallpox and influenza killed more than 90% of all Indian people on the continent by 1900.").

5. In this Article, the author elects to capitalize "Tribal Nation," "Tribe," "Indigenous," and other references to Indigenous Peoples. *See* EagleWoman, *supra* note 1, at 627 ("Capitalization signals dignity and importance in the English language . . . . Tribal Nations are nationalities and, therefore, should be capitalized."); *see also* GREGORY YOUNGING, ELEMENTS OF INDIGENOUS STYLE: A GUIDE FOR WRITING BY AND ABOUT INDIGENOUS PEOPLES 77 (2018) (explaining that "Indigenous style uses capitals where conventional style does not" because "[i]t is a deliberate decision that redresses mainstream society's history of regarding Indigenous Peoples as having no legitimate national identities; governmental, social, spiritual, or religious institutions; or collective rights").

6. *See, e.g.*, Indian Removal Act, Act of May 28, 1830, ch. 148, 4 Stat. 411 (authorizing the President of the United States to exchange land west of the Mississippi River for Tribal land to facilitate the federal government's removal of Tribes to the west); General Allotment (Dawes) Act of 1887, ch. 119, 24 Stat. 388 (codified as amended at 25 U.S.C. §§ 331–358 (2012)) (allotting Tribal land into individual parcels, with the ultimate aim of assimilating Native Americans into American society); *see also* Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance Under the Indian Self-Determination and Education Assistance Act*, 39 AM. INDIAN L. REV. 1, 1–15 (2015) (discussing the federal laws and policies of the removal, allotment, assimilation, and termination eras); *infra* Part I (describing the historical relationship between the federal government and Tribal nations in the United States).

7. GETCHES ET AL., *supra* note 4, at 431 (describing how social determinants "combined with assimilationist practices and historical trauma, led to poor health conditions and created barriers to improvement").

8. "Many factors affect health, including income, social support, education, and social and physical environments . . . . [S]uch factors are often referred to as the social determinants of health, but [i]n indigenous communities, the broader determinants of health include cultural continuity, responses to colonialism, and responses to the 'new colonialism'—globalization . . . ." KAREN M. ANDERSON & STEVE OLSON, INST. MED. NAT'L ACADS., LEVERAGING CULTURE TO ADDRESS HEALTH INEQUALITIES: EXAMPLES FROM NATIVE COMMUNITIES: WORKSHOP SUMMARY 5–6 (2013),

water on some reservations, high rates of underlying conditions, and limited access to healthcare facilities in rural areas.[9] In August 2022, the Centers for Disease Control and Prevention produced a report demonstrating a shocking discrepancy in the life expectancy for AI/AN: the provisional life expectancy for AI/AN in 2021 was nearly eleven years less than the average life expectancy for all races and origins in the United States.[10]

The federal government has significant responsibility for the provision of health care in Indian Country and currently provides health care to AI/AN through the Indian Health Service (IHS).[11] To be sure, the provision of federal Indian health services has, in many ways, improved the overall health status of Native peoples.[12] However, the unmet needs remain "severe," and "the health status of the Indians [remains] far below that of the general population in the United States."[13] The inadequacy of health care provided to Native Americans is a public health crisis that punctuates societal inequities that exist along political, racial, gender, and socioeconomic divides. While an increasing body of research has shown that Native

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https://www.ncbi.nlm.nih.gov/books/NBK201294/pdf/Bookshelf_NBK201294.pdf [https://perma.cc/2U6H-5QJB].

9. *See* Katherine Florey, *Toward Tribal Regulatory Sovereignty in the Wake of the COVID-19 Pandemic*, 63 ARIZ. L. REV. 399, 403 (2021) ("Many of the challenges tribes face—fragile tribal finances, a high chronic-disease burden, locations far from medical facilities—make COVID-19 particularly dangerous for Native people.") (citing Thomas D. Sequist, *The Disproportionate Impact of Covid-19 on Communities of Color*, NEW ENG. J. MED. (July 6, 2020); Sunnie R. Clahchischiligi, *Navajo Elders: Alone, Without Food, in Despair*, GUARDIAN (Aug. 6, 2020), https://www.theguardian.com/us-news/2020/aug/06/navajo-nation-reservation-elderly-people-covid-19 [https://perma.cc/4DNL-MYDW]).

10. ELIZABETH ARIAS ET AL., NAT'L CTR. FOR HEALTH STATS., VITAL STATISTICS RAPID RELEASE: PROVISIONAL LIFE EXPECTANCY ESTIMATES FOR 2021, at 3 (Aug. 31, 2022), https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf [https://perma.cc/2BYM-MK4S] (describing how the provisional life expectancy for AI/AN in 2021 was an average of 65.2 years).

11. *About IHS*, INDIAN HEALTH SERV., https://www.ihs.gov/aboutihs [https://perma.cc/W5SY-DGXT]; *see also infra* notes 105–113 and accompanying text (discussing the historical role of IHS in providing healthcare to AI/AN communities).

12. *See infra* notes 110–112 and accompanying text (describing the impact of federal health care services on health outcomes for AI/AN).

13. 25 U.S.C. § 1601(d); *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-05-789, INDIAN HEALTH SERVICE: HEALTH CARE SERVICES ARE NOT ALWAYS AVAILABLE TO NATIVE AMERICANS (2005) [hereinafter GAO, HEALTH CARE SERVICES], https://www.gao.gov/assets/gao-05-789.pdf [https://perma.cc/546Y-KYPP] (reporting gaps in health care services available to Native Americans).

Americans suffer from disturbingly high mortality rates and disproportionately low health outcomes in comparison with all other populations within the United States,[14] the federal government has yet to come remotely close to adequately funding the Indian health services needed to close these gaps. This dilemma is all the more egregious when understood as the federal government's failure to uphold its trust obligations and treaty promises[15] to Tribal Nations. Yet, federal courts remain divided on whether the federal government has a judicially enforceable trust obligation to provide adequate health care to Native peoples.[16] There are well-founded arguments that the federal government has both a legal and moral obligation to provide adequate health care to Tribal communities,[17] but many Tribal Nations are exploring additional options beyond litigation to procure better healthcare systems for their communities.[18] This Article adds to the discourse by examining how Tribally operated health systems, when adequately supported, can play a valuable role in closing the health gap.

Part I of this Article provides a history of the legal framework for the federal government's provision of health care in Indian Country. In particular, Part I provides background on the federal government's responsibility to provide health care to Native Americans and how that responsibility, in part, arises from the federal trust obligation and treaty promises made to Tribes. Part I places this foundation within the context of federal laws and policies that have negatively impacted the health status of Native Americans.

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14. MARY BERRY ET AL., U.S. COMM'N ON CIV. RTS., BROKEN PROMISES: EVALUATING NATIVE AMERICAN HEALTH CARE iii (2004) [hereinafter BROKEN PROMISES].

15. The federal government maintains a trust relationship with federally recognized Tribal nations, and the characteristics of this relationship have developed primarily through Supreme Court opinions and Acts of Congress that acknowledge the existence of this relationship between Tribes and the federal government. *See* COHEN'S HANDBOOK OF FEDERAL INDIAN LAW § 5.04(3)(a), LexisNexis (Nell Jessup Newton ed., updated July 2023) [hereinafter COHEN'S HANDBOOK]. The federal government has also entered into approximately 370 Senate-ratified treaties with Tribal nations, in which the United States has made numerous promises in exchange for the cession of Indian land. *See infra* notes 31–36 and accompanying text (describing the treaty-making era).

16. *See infra* Section II.B (discussing litigation in federal courts related to the federal government's trust obligation to provide adequate health care).

17. *See infra* Sections II.B–III.A (discussing legal and moral arguments for a right to adequate health care).

18. *See infra* Section III.C (describing Tribally operated health systems as one alternative to federally administered health care).

Then, Part II provides an overview of the current healthcare system and health disparities that exist for Native Americans. Part II pays particular attention to the ways individual community members' health impacts other social outcomes across the entire community, including economic development and educational achievement. Part II also analyzes the legal framework surrounding the judicially enforceable trust obligation and the challenges associated with using judicial recourse to secure adequate health care in Indian Country.

Although the basis for the provision of health care in Indian Country is rooted in domestic federal law, Part III discusses the treatment of the right to health under international law and suggests ways the global discourse around the right to health can serve as a model for the progressive improvement of the healthcare system that serves Native Americans. Additionally, it examines how Tribally managed health services impart their own lessons and models that can both inform the global discourse on health as a human right and shed light on the important role Indigenous-led systems can play in undoing health inequities stemming from settler colonialism. Part III of this Article further explores how Tribal sovereign authority can be, and has been, utilized to create health systems under Tribal law, self-determination contracts, and self-governance compacts, and how these Tribal health systems may be better positioned than the federal government to actualize the highest attainable standard of health for the communities they serve.

I. THE HISTORICAL AND LEGAL CONTEXT FOR HEALTH CARE IN INDIAN COUNTRY

Before the arrival of European nations, Native peoples maintained their health through traditional and culturally centered practices.[19] During the European colonization of North America through the 17th and 18th centuries, European immigrants brought a range of infectious diseases—including smallpox, the plague, and tuberculosis—that burned through and rapidly decimated many Tribal groups.[20] The loss of a substantial majority of the Native

19. *See supra* note 3 and accompanying text.

20. *See* ROBERT J. MILLER, RESERVATION "CAPITALISM": ECONOMIC DEVELOPMENT IN INDIAN COUNTRY 29–30 (2012) ("European diseases destroyed Indian life and prosperity . . . . Many tribal communities were hit by wave after wave of epidemics . . . [and m]any tribal populations were reduced up to 80 to 90 percent in just a few decades . . . ."); *see also* Jones, *supra* note 3, at 2123 (outlining the devastation to Native Americans caused by diseases brought by European colonists).

American population altered the structure and well-being of Tribal communities and culture in fundamental ways.[21] Then, from the early formation of the United States, the federal government enacted a series of policies with the intent of annihilating Native Americans and then assimilating them into Western society.[22] These policies often required Native communities to change their fundamental lifestyles in ways that have dramatically impacted their health,[23] including by cutting off access to healthier traditional foods[24] and forcing a less nomadic lifestyle[25] on reservations that are often a fraction of Tribes' aboriginal territory.[26] At multiple junctures, federal government officials tried to implement paternalistic policies, believing that civilizing and assimilating Native people would be in

21. *See* GETCHES ET AL., *supra* note 4, at 431 (explaining how, in addition to the destructive impact of these epidemics, "the new foods, economics, and stresses of the new arrivals bred a long-term health crisis in Indian country").

22. *See* FRANCIS PAUL PRUCHA, AMERICAN INDIAN POLICY IN THE FORMATIVE YEARS: THE INDIAN TRADE AND INTERCOURSE ACTS, 1790–1834, at 224 (1962), *in* GETCHES ET AL., *supra* note 4, at 121–22 (describing "the desire of eastern whites for Indian lands" and to be "disencumbered" of Indians).

23. ANDERSON & OLSON, *supra* note 8, at 7 ("The dispossession of land . . . destroyed traditional economies and undermined identity . . . and culture. The loss of land and self-determination through missionization, residential and industrial schools, and the destruction of indigenous forms of governance also resulted in the breakdown of traditional and healthy patterns of individual, family, and community life.").

24. *See, e.g.*, Carol Clark, *Buffalo Slaughter Left Lasting Impact on Indigenous Peoples*, EMORY NEWS CTR. (Aug. 23, 2023), https://news.emory.edu/stories/2023/08/esc_bison_impact_24-08-2023/story.html [https://perma.cc/EH33-6EH7] (describing how the mass slaughter of North American bison by white settlers had a devastating impact on "bison-reliant" Tribal nations).

25. It bears noting that not all Tribes were nomadic. For instance, the Pueblo people in the Four Corners region transitioned from a nomadic lifestyle into a more settled and agriculture-based lifestyle even prior to colonial contact. *See* Winston Hurst & Jonathan Till, *The Ancestral Puebloan Period*, UTAH: HISTORY TO GO, https://historytogo.utah.gov/anasazi [https://perma.cc/HCF4-MSW8] (describing Ancestral Pueblo people's agricultural practices dating back to approximately 300 B.C.E.).

26. *See, e.g.*, Indian Removal Act, Act of May 28, 1830, ch. 148, 4 Stat. 411 (authorizing the removal of eastern Tribes to western territory); General Allotment (Dawes) Act of 1887, ch. 119, 24 Stat. 388 (codified as amended at 25 U.S.C. §§ 331–358 (2012)) (authorizing the breakup of reservation land into individual allotments, leading to the loss of the majority of remaining Indian land).

their best interests.[27] However, these policies "rarely led to improvement and often made matters worse."[28]

A. Treaty Making with Tribal Nations

Tribal Nations are unique within the United States because of their status as "domestic dependent nations"[29] and their complex government-to-government relationship with the United States.[30] Over the course of a century, Native Americans entered into hundreds of treaties with the United States, in which they ceded hundreds of millions of acres of their aboriginal homelands in exchange for promises the United States government made, including, in select treaties, the provision of federal healthcare services.[31] The first treaty to address the provision of medical services was between the United States and the Winnebago Indians in 1832.[32]

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27. *See supra* notes 6–7 and accompanying text (describing the key federal policies that sought to "civilize" Native peoples, which often proved deeply harmful).

28. Jones, *supra* note 3, at 2128.

29. Cherokee Nation v. Georgia, 30 U.S. 1, 13 (1831).

30. *See, e.g.*, U.S. CONST. art. I, § 8, cl. 3 ("The Congress shall have power . . . to regulate Commerce with foreign Nations, and among the several States, and with the Indian tribes"); Lone Wolf v. Hitchcock, 187 U.S. 553, 565 (1903) ("Plenary authority over the tribal relations of the Indians has been exercised by Congress from the beginning, and the power has always been deemed a political one, not subject to be controlled by the judicial department of the government.").

31. BROKEN PROMISES, *supra* note 14, at 21; *see also* DAVID H. DEJONG, IF YOU KNEW THE CONDITIONS: A CHRONICLE OF THE INDIAN MEDICAL SERVICE AND AMERICAN INDIAN HEALTH CARE 5 (2008) (noting how "[i]n exchange for hundreds of millions of acres of land, the United States took upon itself the provision of a variety of goods and services to the Indians"); Emery A. Johnson & Everett R. Rhoades, *The History and Organization of Indian Health Services and Systems*, *in* AMERICAN INDIAN HEALTH: INNOVATIONS IN HEALTH CARE, PROMOTION, AND POLICY 74–75 (Everett R. Rhoades ed., 2000) ("The cession of most of the lands of the United States by the Indians, codified in hundreds of treaties, forms the basis for the federal government's provision of health care to Indians and for the intensely held belief that these services are not provided free."); President Richard Nixon, Special Message on Indian Affairs, H.R. Doc. No. 91-363, at 9–10 (2d Sess. 1970), *reprinted in* 116 Cong. Rec. 23131, at 23132 (1970) ("Indians have often surrendered claims to vast tracts of land and . . . [i]n exchange, the government has agreed to provide community services such as health, education and public safety, services which would presumably allow Indian communities to enjoy a standard of living comparable to that of other Americans.").

32. *See* Treaty with the Winnebago, art. 5, Sept. 15, 1832, 7 Stat. 370 (providing "for the services and attendance of a physician at Prairie du Chien, and of one at Fort Winnebago, each, two hundred dollars, per annum").

That same year, Congress provided $12,000[33] to fund Indian health care, specifically for the provision of smallpox vaccines.[34] Ultimately, by the time treaty-making ended in 1871, thirty-one of the approximately 370 Senate-ratified treaties[35] "contain[ed] provisions . . . related to Indian health care: 28 providing for . . . physician[s] and 9 providing for a hospital."[36] Yet, by 1880, the federal government had only constructed four hospitals and provided seventy-seven physicians for the provision of Indian health services,[37] falling short of the assurances made in the majority of these treaties.[38] Even

33. For the purpose of comparison, $12,000 in the 1830s is equivalent in purchasing power to approximately $410,000 in 2024. *U.S. Inflation Calculator*, CPI INFLATION CALCULATOR, https://www.officialdata.org/us/inflation/1830?amount=12000 [https://perma.cc/H5YW-9LXV].

34. Act of May 5, 1832, ch. 75, 4 Stat. 514, 515; *see also* Johnson & Rhoades, *supra* note 31, at 74 (noting the congressional appropriation of $12,000 for smallpox immunizations); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 401 (2000) (noting the congressional appropriation of $12,000 for smallpox immunizations).

35. Scholars disagree on the exact number of treaties between the United States and Tribal nations that were ratified by the Senate. *See, e.g.*, VINE DELORIA, JR. & RAYMOND J. DEMALLIE, DOCUMENTS OF AMERICAN INDIAN DIPLOMACY: TREATIES, AGREEMENTS, AND CONVENTIONS, 1775–1979, at 181–82 (1999) ("[S]cholars . . . have a difficult time locating an accurate or official list of Indian treaties. Different sources provide different lists, and no single source has a complete list of documents or an accurate count . . . . The figure of 369 ratified treaties is generally accepted by most people . . . in the field . . . ."); David H. Moore & Michalyn Steele, *Revitalizing Tribal Sovereignty in Treatymaking*, N.Y.U. L. REV. 137, 146–47 (2022) ("During almost 100 years of tribal treatymaking, the United States entered into roughly 370 treaties, and negotiated many more that were never ratified.").

36. DEJONG, *supra* note 31, at 5; *see also* Treaty with the Winnebago, *supra* note 31, art. 5 (providing for medical care); Treaty with the Rogue River, Nov. 15, 1854, art. 2, 10 Stat. 1119 (agreeing "that provision shall be made . . . for a hospital, medicines, and a physician . . . ."); Treaty with the Ottawas and Chippewas, art. 4, Mar. 28, 1836, 7 Stat. 491, 491–92 (promising "[t]hree hundred dollars per annum for vaccine matter, medicines, and the services of physicians, to be continued while the Indians remain on their reservations").

37. COHEN'S HANDBOOK, *supra* note 15, § 22.04 ("Despite numerous treaty promises of hospitals, there were only 4 hospitals and 77 physicians in the entire Indian Service by 1880.") (citing LAURENCE F. SCHMECKEBIER, INST. FOR GOV'T RSCH., THE OFFICE OF INDIAN AFFAIRS: ITS HISTORY, ACTIVITIES AND ORGANIZATION 228 (1927) (reprinted 1972)); Johnson & Rhoades, *supra* note 31, at 74 ("By 1880, the federal government operated four hospitals and employed 77 physicians for the care of Indians.").

38. *See, e.g.*, Treaty with the Nez Perces, art. 5, 14 Stat. 647 (1863) (pledging to build a hospital, among other resources, that had been promised in an 1855 treaty but not provided).

though most of the treaties with terms related to the provision of health care included "time limits of 5 to 20 years on the provision of care, the Federal Government adopted a policy of continuing services under so-called 'gratuity appropriations' after the original benefit period expired."[39]

Additionally, although not every treaty has explicit language guaranteeing the provision of a physician or a hospital, the vast majority of treaties contain language that makes assurances that the United States would provide protection to the signatory Tribes,[40] which the federal government and Tribes have often interpreted to mean that the United States would provide for Indian health care.[41] These promises to "protect" Tribes have also been generally thought to serve as the foundation for the trust relationship between the United States and Tribal Nations.[42]

The form and scope of the federal provision of health care in Indian Country has greatly evolved over the past two centuries. In the early 1800s, the Office of Indian Affairs within the War Department initially oversaw healthcare services provided to Native Americans.[43] In the 1850s, the Department of the Interior (DOI)

39. U.S. PUB. HEALTH SERV., HEALTH SERVICES FOR AMERICAN INDIANS 86–87 (1957).

40. Worcester v. Georgia, 31 U.S. 515, 551–52, 556 (1832) (recognizing that treaties with Tribes generally contained language placing them under the protection of the United States federal government).

41. *See Basis for Health Services*, INDIAN HEALTH SERV. (Jan. 2015), https://www.ihs.gov/newsroom/factsheets/basisforhealthservices [https://perma.cc/7UBH-RMNV]; NAT'L TRIBAL BUDGET FORMULATION WORKGROUP, HONOR TRUST AND TREATY OBLIGATIONS: A TRIBAL BUDGET REQUEST TO ADDRESS THE TRIBAL HEALTH INEQUITY CRISIS 6 (2023) [hereinafter HONOR TRUST AND TREATY OBLIGATIONS] (describing the United States' "long-standing and repetitive use of language regarding trust relationships and legal obligations").

42. *See* COHEN'S HANDBOOK, *supra* note 15, §§ 5.04, 5.05 (describing the Tribal-federal relationship); Cherokee Nation v. Georgia, 30 U.S. 1, 17–18 (1831) (providing the original enumeration of the guardian-ward relationship between Tribes and the United States); United States v. Douglas, 190 F. 482, 485–86, 490 (8th Cir. 1911) (describing the United States federal government as a quasi-guardian for Tribes).

43. Johnson & Rhoades, *supra* note 31, at 74; U.S. PUB. HEALTH SERV., HEALTH SERVICES FOR AMERICAN INDIANS 86 (1957) ("As early as 1802 or 1803, Army physicians took emergency measures to curb smallpox and other contagious diseases among Indian tribes in the vicinity of military posts. Without doubt, these measures were intended primarily to protect soldiers at the forts from infection, but Indians benefitted."); Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and*

assumed responsibility for providing health care to Native Americans.[44] By the 1880s, the federal government had started operating a handful of hospitals to provide Indian health care.[45] Frequently, funding for these medical services was tied to other purposes, such as education.[46] Congress first appropriated funding specifically for Indian health in 1911.[47] In 1955, Congress transferred responsibility for Indian health care from the DOI to the United States Public Health Service (USPHS),[48] a division of the former Department of Health, Education, and Welfare, now known as the Department of Health and Human Services (HHS).[49] The USPHS formed the Division of Indian Health, later renamed the Indian Health Service (IHS).[50]

From its inception, IHS was plagued by barriers to providing adequate health care, including a shortage of skilled doctors and a high volume of patients.[51] Although IHS delivers care to over 2.5

Practices, 21 AM. INDIAN L. REV. 211, 214–15 (1997); *see also* DEJONG, *supra* note 31, at 2 (describing how "minimal" medical services were provided "to small numbers of Indians living near military posts" when the Office of Indian Affairs remained under the War Department from 1824 to 1849).

44. Holly T. Kuschell-Haworth, *Jumping Through Hoops: Traditional Healers and the Indian Health Care Improvement Act*, 2 DEPAUL J. HEALTH CARE L. 843, 845 (1999); Lawrence, *supra* note 34, at 401 ("In 1849 Congress transferred the Bureau of Indian Affairs (BIA) from the War Department to the Department of the Interior, including all health care responsibilities for American Indians.").

45. *See supra* note 37 and accompanying text.

46. Johnson & Rhoades, *supra* note 31, at 74.

47. Johnson & Rhoades, *supra* note 31, at 74.

48. Transfer Act, Pub. L. No. 83-568, § 1, 68 Stat. 674 (1954) (codified as amended at 42 U.S.C. § 2001) (transferring jurisdiction of facilities and matters relating to the "conservation of the health of Indians" from the DOI to the Public Health Service, effective July 1, 1955); Johnson & Rhoades, *supra* note 31, at 75–76 (describing the transfer of responsibility for the "Indian health program" to the USPHS); Lawrence, *supra* note 34, at 401.

49. The Department of Health, Education, and Welfare became the Department of Health and Human Services in 1980 after the Department of Education Organization Act was signed into law. *HHS Historical Highlights*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/about/historical-highlights/index.html [https://perma.cc/7TXW-DBP2].

50. Lawrence, *supra* note 34, at 401.

51. DEJONG, *supra* note 31, at 7–8 (describing how in the late 1800s "the Indian Service was chronically short of doctors" due to low pay—earning less than half of physicians serving in the Army and Navy—and high patient volume, with an average of 1,142 cases per physician in the year 1879).

million American Indians and Alaska Natives across the country,[52] the "federal legal and treaty obligation to provide health care has never been adequately fulfilled, and these problems have continued over time."[53]

B. The Snyder Act and Its Impact

The federal government first codified its obligation to provide health care to Native Americans in the Snyder Act of 1921.[54] In the Act, Congress mandated that the "Bureau of Indian Affairs . . . direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians . . . [f]or relief of distress and conservation of health."[55] The Act did not explicitly create any healthcare programs, but it did declare a clear nationwide healthcare policy and institutionalize the federal government's trust obligation to supply health care to Indians.[56] Although the Snyder Act recognized the federal government's role in providing healthcare services to Native Americans, it did not allocate sufficient federal funds to fulfill this obligation[57]—a continuing trend in the federal government's approach to Indian health care. Seven years after the enactment of the Snyder Act, the Meriam Report, a comprehensive survey of the status of American Indians, described shocking conditions on the reservations, including extremely poor

52. *IHS Profile*, INDIAN HEALTH SERV. (Aug. 2020), https://www.ihs.gov/newsroom/factsheets/ihsprofile [https://perma.cc/6V59-R7FQ] (noting approximately 2.56 million American Indians and Alaska Natives are served by IHS, based on data from 2015 to 2020).

53. Joe Davidson, *Staffing, Budget Shortages Put Indian Health Service at 'High Risk'*, WASH. POST (Feb. 20, 2017), https://www.washingtonpost.com/news/powerpost/wp/2017/02/20/staffing-budget-shortages-put-indian-health-service-at-high-risk (on file with the *Columbia Human Rights Law Review*) (quoting Brian Cladoosby, then-President of the National Congress of American Indians).

54. Snyder Act of 1921, Pub. L. No. 67-85, 42 Stat. 208 (codified as amended at 25 U.S.C. § 13).

55. *Id.*

56. Pfefferbaum et al., *supra* note 43, at 215.

57. Congress instead later "curbed the use of appropriated funds for general assistance where equivalent state programs are available." Robert McCarthy, *The Bureau of Indian Affairs and the Federal Trust Obligation to American Indians*, 19 BYU J. PUB. L. 1, 118 (2004) ("Such programs are secondary to other sources of Federal, state or local assistance, and are subject to annual Congressional appropriations. Tribes operating assistance programs under BIA contracts may establish different eligibility criteria or benefit levels.").

health conditions of Native peoples.[58] In particular, the Meriam Report produced documentation of gross malnutrition, lack of treatment, and high infant mortality rates.[59] The report pointed to insufficient funding as one key factor underpinning the inadequacy of Indian health care.[60] The specialists working on the Meriam Report also "found inadequate health facilities and equipment, unqualified and/or a shortage of health personnel, inadequate salaries and housing for health professionals, and a system of purchasing obsolete and outdated medical supplies and medicines from excess army and navy supplies."[61]

In 1957, the Surgeon General of the USPHS submitted another comprehensive report on the health conditions of Native peoples. Now known as the "1957 IHS Gold Book,"[62] the report is a "founding historical marker"[63] that outlines the challenges the newly formed IHS faced in addressing the disparate health conditions of Indian people. Congressional appropriations for Indian health had increased dramatically by 1955—reaching nearly $18 million[64]—but

58. LEWIS MERIAM ET AL., INST. FOR GOV'T RSCH., THE PROBLEM OF INDIAN ADMINISTRATION 189 (1928) [hereinafter MERIAM REPORT].

59. *Id.*

60. *Id.* at 189, 192, 194, 206.

61. DEJONG, *supra* note 31, at 59; *see also* MERIAM REPORT, *supra* note 57, at 189–345 (describing the findings of a study by the Institute for Government Research, including detailed explanations of how supplies and practices at each type of health care institution serving Native peoples fall short of accepted medical standards); Jones, *supra* note 3, at 2128 ("Commissioner of Indian Affairs T.J. Morgan compared the salaries paid to government physicians in the Army, Navy, and IHS and divided these sums by the populations served. He then calculated a crude estimate of how the government valued people: $21.91 per soldier, $48.10 per sailor, and $1.25 per Indian.") (citation omitted).

62. U.S. PUB. HEALTH SERV., *supra* note 39; *see also* INDIAN HEALTH SERV., THE FIRST 50 YEARS OF THE INDIAN HEALTH SERVICE: CARING & CURING 3 (2017) [hereinafter FIRST 50 YEARS], https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/GOLD_BOOK_part1.pdf [https://perma.cc/4XVZ-YPAZ] (terming the report the "1957 IHS Gold Book").

63. FIRST 50 YEARS, *supra* note 62, at 3.

64. $18 million still would have been a minute fraction of national health care spending. Although the National Health Expenditure Accounts—the official estimates of total healthcare spending in the United States—do not date back to 1955, just five years later, in 1960, total national health expenditures were estimated to have been 27.1 billion dollars, which includes expenditures from both public and private funds. *See* NATIONAL HEALTH EXPENDITURE SUMMARY, INCLUDING SHARE OF GDP, CY 1960–2022, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/data-research/statistics-trends-and-reports/national-

the Division of Indian Health reported to Congress that even this amount was not enough to meet the needs of the populations it served.[65]

Around the same time, the Division of Indian Health began to engage in one of its most destructive policies towards Native women: forced sterilization. In 1965, the Division, soon renamed IHS, started to provide family planning services that gave women information "on the different methods of birth control, how the methods work, and how to use them."[66] But by the 1970s, the sterilization of Native American women became a common practice.[67] In the six years following the passage of the Family Planning Services and Population Research Act of 1970, physicians sterilized between 25–50% of Native American women of childbearing age.[68] These procedures occurred both in hospitals operated by the federal government and facilities that contracted with the federal government to provide health care to Native Americans.[69] Common tactics to coerce Native women into agreeing to sterilization included: threatening them with the loss of their children and/or welfare benefits, obtaining their consent while they were heavily sedated, or providing them with consent forms that they could not understand.[70] The law provided subsidies for the sterilization of patients receiving health care at IHS or through Medicaid, targeting not only Native women but also Black and Latina

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health-expenditure-data/historical (on file with the *Columbia Human Rights Law Review*).

65. U.S. PUB. HEALTH SERV., *supra* note 39, at 88–89 ("Even in the mid-[1950s], despite the substantial improvements of facilities and staffing, only 16 Indian hospitals and sanatoria met the requirements of the Joint Commission on Accreditation of hospitals for full or provisional accreditation.").

66. Lawrence, *supra* note 34, at 402.

67. Lawrence, *supra* note 34, at 407 (describing a 1976 report from the Government Accounting Office confirming that IHS performed 3,406 sterilizations from 1973 to 1976).

68. BRIANNA THEOBALD, REPRODUCTION ON THE RESERVATION: PREGNANCY, CHILDBIRTH, AND COLONIALISM IN THE LONG TWENTIETH CENTURY 1 (2019) [hereinafter THEOBALD, REPRODUCTION ON THE RESERVATION] ("Scholars estimate that beginning in 1970, physicians sterilized between 25 and 42 percent of Native women of childbearing age over a six-year period."); Lawrence, *supra* note 34, at 410 ("Various studies revealed that the Indian Health Service sterilized between 25 and 50 percent of Native American women between 1970 and 1976."); Brianna Theobald, *A 1970 Law Led to the Mass Sterilization of Native American Women. That History Still Matters*, TIME (Nov. 28, 2019) [hereinafter Theobald, *A 1970 Law*], https://time.com/5737080/native-american-sterilization-history [https://perma.cc/X4SA-ADLL].

69. THEOBALD, REPRODUCTION ON THE RESERVATION, *supra* note 68, at 1.

70. Lawrence, *supra* note 34, at 411–12.

women.[71] This scheme was further complicated for Native American women with the passage of the Hyde Amendment in the 1970s,[72] which has contributed to a reproductive health desert for Native American women who rely on IHS for health care.[73] This dark history taints the complicated legacy of federally provided health services in Indian Country—a legacy that continues to create, in some instances, deeply embedded barriers to adequate care.

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71. Lawrence, *supra* note 34, at 409; Theobald, *A 1970 Law*, *supra* note 68.

72. Shortly after the 1973 Supreme Court decision in *Roe v. Wade*, 410 U.S. 113 (1973), Congress passed the first "Hyde Amendment" to the fiscal 1977 Medicaid appropriation. Before the Hyde Amendment went into effect, Medicaid funded nearly 25% of abortions in the United States. Cynthia Soohoo, *Hyde-Care for All: The Expansion of Abortion-Funding Restrictions Under Health Care Reform*, 15 CUNY L. REV. 391, 401–02 (2012). The Hyde Amendment prohibits the use of federal Medicaid funds for abortion except when the life of the woman would be endangered by carrying the pregnancy to term. The most recently enacted version of the Hyde Amendment also includes an exception for pregnancies resulting from rape or incest. Pub. L. No. 117-328. Div. H, §§ 506–507, 136 Stat. 4459, 4908 (2022). Outside of these few exceptions, the Hyde Amendment functions as a far-reaching limitation on abortions funded under major federal health care programs that provide medical benefits assistance to low-income individuals, thus primarily impacting indigent individuals who receive health care through these programs. Richard Vuernick, Comment, *State Constitutions as a Source of Individual Liberties: Expanding Protection for Abortion Funding Under Medicaid*, 19 J. CONTEMP. L. 185, 195–96 (1993) ("According to the Centers for Disease Control, approximately 295,000 low-income women obtained abortions financed by combined federal-state Medicaid funds in fiscal year 1977 . . . . By contrast, the federal government funded 2,400 abortions in 1979."); CONG. RSCH. SERV., IN FOCUS: THE HYDE AMENDMENT: AN OVERVIEW 1 (July 20, 2022), https://crsreports.congress.gov/product/pdf/IF/IF12167 (on file with the *Columbia Human Rights Law Review*). The Hyde Amendment has also been incorporated by statutory cross-reference to apply to IHS. *Id.* at 1.

73. *See* Lauren van Schilfgaarde et al., *The Indian Country Safe Harbor Fallacy*, LPE PROJECT (June 6, 2022), https://lpeproject.org/blog/the-indian-country-abortion-safe-harbor-fallacy [https://perma.cc/DMB6-LGXT] (discussing the impact of the Hyde Amendment and the "devastating historical deprivation of reproductive healthcare to Native women"); KATI SCHINDLER ET AL., NATIVE AM. WOMEN'S HEALTH EDUC. RES. CTR., INDIGENOUS WOMEN'S REPRODUCTIVE RIGHTS: THE INDIAN HEALTH SERVICE AND ITS INCONSISTENT APPLICATION OF THE HYDE AMENDMENT 3–6 (Oct. 2002), https://www.prochoice.org/pubs_research/publications/downloads/about_abortion/indigenous_women.pdf [https://perma.cc/J5V2-SKZL] (assessing inconsistencies across IHS Service Units in the provision of services to women and discussing how the Hyde Amendment restricts Native American women's reproductive rights).

C. The Indian Health Care Improvement Act

In 1976, Congress shifted its attention back to the waning Indian healthcare system and enacted the Indian Health Care Improvement Act (IHCIA), providing that the "most basic human right must be the right to enjoy decent health."[74] The IHCIA acknowledged the federal government's unique obligations to Native Americans, stating that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[75] Of note, the IHCIA appropriated federal funds for healthcare services to Native Americans, the construction of hospitals and medical service facilities, and the hiring of trained medical providers.[76] Rather than specifying how funds should be allotted, the Act allows congressional appropriations to be wholly discretionary.[77] The lack of both specificity and bright-line rules is a practical barrier to equitable access to comprehensive and adequate healthcare services. Notwithstanding these challenges, the IHCIA served several other significant purposes. For instance, the IHCIA established Urban Indian Health Programs[78] and addressed the distinct needs of Native women by establishing the Office of Indian Women's Health Care to oversee IHS' efforts to provide healthcare services to Native women.[79] The IHCIA also provided Tribal health organizations with the ability

74. H.R. REP. NO. 94-1026(l), at 13 (1976).

75. Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, § 2, 90 Stat. 1400 (1976) (codified as amended in scattered sections of 25, 40, and 42 U.S.C.). The IHCIA also set two major national goals: (1) "to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States" and (2) "to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services." 25 U.S.C. § 1601(2)–(3).

76. Indian Health Care Amendments of 1980, Pub. L. No. 96-537, 94 Stat. 3173.

77. *See* 25 U.S.C. § 1602 (failing to denote a specific amount or source of funding and setting only the limitation that funding amounts "are not less than the amounts provided to programs and facilities operated directly by the [Indian Health] Service").

78. 25 U.S.C. §§ 1601, 1651–58.

79. Indian Health Care Amendments of 1992, Pub. L. No. 102-573, § 223, 106 Stat. 4526, 4559.

to bill Medicare and Medicaid for eligible patients.[80] Given the ongoing funding shortfalls, Tribes' ability to bill third-party payers, specifically Medicare, Medicaid, and private insurers, is necessary to meet the needs of Indian health care programs.[81]

The IHCIA was a clear manifestation of Congress' policy and intent to provide adequate healthcare programs and services to American Indians. Further, the IHCIA remains in full force and effect, as Congress permanently reauthorized the IHCIA when it passed the Patient Protection and Affordable Care Act (ACA) in 2010.[82] Specifically, by including the IHCIA in the ACA, Congress reaffirmed that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to *ensure the highest possible health status for Indians* . . . and to provide all resources necessary to effect that policy."[83] Despite these promises, the IHCIA has not fully realized its goals, and there remain

80. 25 U.S.C. § 1641(d)(1) ("Subject to complying with the requirements of paragraph (2), a tribal health program may elect to directly bill for, and receive payment for, health care items and services provided by such program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act . . . ."). In 1976, as part of the Indian Health Care Improvement Act, Congress provided for Medicare and Medicaid reimbursement for IHS and Tribally operated facilities. 42 U.S.C. §§ 1395qq, 1396j. Congress later made IHS and Tribes eligible for reimbursement of services under Medicare Part B. 42 U.S.C. § 1395qq(e)(1)(A).

81. *See* Brief in Response at 1, Becerra v. San Carlos Apache Tribe, 602 U.S. 222 (2024) (No. 23-250) (explaining that because "funding is woefully insufficient to support the unmet needs within Indian healthcare programs . . . both IHS . . . and Tribes . . . bill and collect from third-party payors, such as Medicare, Medicaid, and private insurers, for services provided by the Indian healthcare program").

82. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221(a), 124 Stat. 119, 935–36 (2010) (codified as amended in scattered sections of 25 and 42 U.S.C.); *see also* NAT'L INDIAN HEALTH BD., THE LEGAL FOUNDATIONS FOR DELIVERY OF HEALTH CARE TO AMERICAN INDIANS AND ALASKA NATIVES 2 (2015), https://www.nihb.org/docs/05202015/Foundations%20of%20Indian%20Health%20Care%20(March%202015).pdf (on file with the *Columbia Human Rights Law Review*) ("In passing the Affordable Care Act, Congress also reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA).").

83. Affordable Care Act § 10221(a) (codified as amended at 26 U.S.C. 1602) (emphasis added) (reaffirming, with moderate amendments, the original text of section 3 of the Indian Health Care Improvement Act, codified as 25 U.S.C. § 1602 (1976)). Additionally, the Act spelled out its specific health care goals of "rais[ing] the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives . . . ." 25 U.S.C. § 1602.

inadequate resources to procure "the highest possible health status" for Native Americans.

D. The Indian Self-Determination and Education Assistance Act of 1975

Federal Indian policy shifted dramatically from the failed assimilationist policies of the termination era[84] to policies promoting Tribal self-determination in the 1970s.[85] In one of the landmark acts of the self-determination era, the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), Congress gave Tribes the option of receiving health care through IHS or "assuming from the IHS the administration and operation of health services and programs in their communities"[86] through what are commonly referred to as "638 contracts" or "self-determination contracts."[87] Under these contracts, Tribes essentially "step into the shoes of the federal government"[88] and "administer programs or services traditionally administered by the federal government while using federal funding and tribal employees."[89] Initially, the movement towards entering into 638 contracts was slow, with many Tribes

84. The termination era ran from approximately 1943 through 1961 and consisted of a number of federal laws that sought to terminate the federal-Tribal relationship. *See* COHEN'S HANDBOOK, *supra* note 15, § 1.06 (providing background information on the termination era).

85. Nixon, Cong. Rec., *supra* note 31, at 23131 (explaining President Nixon's self-determination policy and noting that "[o]n virtually every scale of measurement—employment, income, education, health—the condition of the Indian people ranks at the bottom").

86. U.S. DEP'T HEALTH & HUM. SERVS., INDIAN HEALTH SERV., INDIAN HEALTH SERVICE: A QUICK LOOK 1 (2017), https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/ factsheets/QuickLook.pdf [https://perma.cc/4PJA-TMGN]; *see also* Indian Self-Determination and Education Assistance Act of 1975 § 103(A), Pub. L. No. 93-638, 88 Stat. 2203 (codified as amended at 25 U.S.C. §§ 5301–423).

87. OFF. OF INSPECTOR GEN., U.S. DEP'T HEALTH & HUM. SERVS., OEI-09-93-00350, TRIBAL CONTRACTING FOR INDIAN HEALTH SERVICES i (1996), https://oig.hhs.gov/oei/reports/oei-09-93-00350.pdf [https://perma.cc/NZH3-Q2ZL] ("Through a contract, tribes can receive the money that IHS would have used to provide . . . directly, or through another entity, a broad range of health services. This option . . . is commonly known as '638 contracting.'"); *see generally* Indian Self-Determination and Education Assistance Act of 1975, *supra* note 86 (referencing "self-determination contracts" throughout its text).

88. Kevin K. Washburn, *What the Future Holds: The Changing Landscape of Federal Indian Policy*, 130 HARV. L. REV. F. 200, 204 (2017).

89. DAVID S. CASE & DAVID A. VOLUCK, ALASKA NATIVES AND AMERICAN LAWS 232 (3rd ed. 2012) (citing 25 U.S.C. § 450f).

finding IHS contracting requirements unnecessarily cumbersome and bureaucratic.[90]

Congress has amended the ISDEAA numerous times to facilitate greater self-determination of Tribes and reduce cumbersome contracting provisions.[91] In 1992, Congress amended the ISDEAA to authorize a Tribal Self-Governance Demonstration Project within IHS, providing Tribes with the option of entering into self-governance compacts to enhance control over their healthcare programs.[92] By 1996, Tribes were "operating 12 of 49 hospitals and 379 of 492 ambulatory facilities, including 134 health centers, 4 school health centers, 73 health stations, and 168 Alaska Village clinics."[93] By 2009, Tribes were running "15 hospitals, 254 health centers, 18 school health centers, 112 health stations, and 166 Alaska Native village clinics."[94] By 2016, IHS had negotiated ninety self-governance compacts with over 350 Tribes, roughly 60% of all Tribes.[95] And currently, "more than half of IHS funds are administered by tribes themselves."[96] Although many Tribes have indicated an interest in assuming control over healthcare programs, with a growing number successfully doing so, some still lack enough capital—both financial and personnel—to completely assume control over their health services.

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90. *See id.* at 233 ("[B]y the late 1980s the nation's Native American communities were experiencing frustrations with the bureaucratic requirements of contracting as well as the uneven implementation of the act.") (citing 2 ALASKA NATIVES COMM'N, FINAL REPORT 188 (1994), http://www.alaskool.org/resources/anc2/anc2_toc.html [https://perma.cc/T64Y-EB74]); Washburn, *supra* note 88, at 204 ("The IHS seems to remain somewhat resistant [to contracting federal functions], perhaps because the culture in which doctors and healthcare professionals live inculcates a deep personal responsibility for saving the world one human being at a time and resists contracting out that very important mission."); ALASKA NATIVE TRIBAL HEALTH CONSORTIUM, OUR HEALTH IN OUR HANDS 7 (2019), https://www.anthc.org/wp-content/uploads/2021/01/Our-health-in-our-hands.pdf [https://perma.cc/6NMS-CRGC] ("Tribal organizations sometimes felt as though IHS contracting requirements were unduly burdensome, from highly detailed budgets to rules around who could approve certain hires.").

91. CASE & VOLUCK, *supra* note 89, at 233.

92. INDIAN HEALTH SERV., U.S. DEP'T HEALTH & HUM. SERVS., TRIBAL SELF-GOVERNANCE (2016), https://www.ihs.gov/newsroom/factsheets/tribalselfgovernance [https://perma.cc/NT5L-SQVF]; 25 U.S.C. §§ 5301–5423; 42 C.F.R. § 137 (2024).

93. Johnson & Rhoades, *supra* note 31, at 79.

94. COHEN'S HANDBOOK, *supra* note 15, § 22.04 (citation omitted).

95. TRIBAL SELF-GOVERNANCE, *supra* note 92.

96. COHEN'S HANDBOOK, *supra* note 15, § 22.04 (citation omitted).

One notable example of the financial hurdles that Tribes have had to overcome, and ultimately litigate, is reimbursement of "contract support costs"[97] accrued when operating programs, services, functions, and activities pursuant to a self-determination contract. Although the ISDEAA provides that IHS must reimburse Tribal contractors for these contract support costs,[98] Tribes have had to file several major lawsuits to recoup such costs.[99] Most recently, in *Becerra v. San Carlos Apache Tribe*,[100] the Supreme Court held that IHS must reimburse Tribal contractors for contract support costs for healthcare services funded by income from third-party payers.[101] Much of the tension arises from insufficient congressional funding, but the outcome of this litigation provides a legal framework that can facilitate financial parity between IHS and Tribal health services.

Despite these challenges, when Tribes do elect to assume control over health services, Tribal governments have often demonstrated a higher degree of competency than the federal government in serving their communities.[102] Studies have indicated that when Tribes assume control, they often expand healthcare services and programming.[103] The success of 638 contracts and self-

97. "Contract support costs" are "the reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract." 25 U.S.C. § 5325(a)(2). The terms of each self-determination contract will generally determine which activities will receive contract support costs. Becerra v. San Carlos Apache Tribe, 602 U.S. 222, 233–34 (2024) ("The touchstone for determining which 'activities' must receive contract support costs is . . . 'the terms of the contract.'") (quoting 25 U.S.C. § 5325(a)(2)).

98. 25 U.S.C. § 5325(a)(2)–(3).

99. *See, e.g.*, Cherokee Nation of Okla. v. Leavitt, 543 U.S. 631 (2005) (holding that the federal government was required by ISDEAA to pay full contract support costs incurred by Tribes); Salazar v. Ramah Navajo Chapter, 567 U.S. 182 (2012) (holding the same).

100. Becerra v. San Carlos Apache Tribe, 602 U.S. 222 (2024).

101. *Id.* at 1445.

102. *See, e.g.*, Rebecca Ruiz-McGill, *Research Finds Tribal Management Key to Improved Health Services*, UNIV. OF ARIZ. (July 24, 2009), https://news.arizona.edu/story/research-finds-tribal-management-key-to-improved-health-services [https://perma.cc/8V7B-4H45] (discussing the results of a survey of eighteen Tribal leaders, health professionals, and providers and finding that "tribal management can significantly improve tribal citizens' access to health services"); Washburn, *supra* note 88, at 201 ("As tribal governmental powers have increased and tribes have entered contracts to perform more federal functions, tribal governments have proven more institutionally competent than the federal government in serving Indian people.") (citation omitted).

103. *See* B.L. SHELTON ET AL., NAT'L INDIAN HEALTH BD., TRIBAL PERSPECTIVES ON INDIAN SELF-DETERMINATION AND SELF-GOVERNANCE IN

governance compacts in improving the quality of health care provided to Native populations is perhaps one of the strongest indicators that Tribally owned and operated health services are a key component in delivering a high standard of care to Tribal communities. The "profound"[104] impact ISDEAA has had on the provision of healthcare services to Native Americans cannot be overstated.

II. INDIAN HEALTH CARE AND HEALTH DISPARITIES

A. General Funding and Health Disparities

As described in Part I, the federal government provides health care to AI/AN through IHS, an agency within the HHS.[105] IHS is one of three major components of the complex, federally funded healthcare system provided to Native people, commonly referred to as the "I/T/U" system:[106] IHS, Tribal Health Services, and Urban Indian Health Programs.[107] While AI/AN may access health care through state programs and private healthcare providers, health services offered through the I/T/U system are often all that is available to AI/AN patients, particularly in rural areas.[108] In 2022, approximately 19.9% of AI/AN were uninsured, making them the population with

HEALTH CARE MANAGEMENT 4–6 (1998) (concluding, based on a review of previous studies, financial analysis of federal funding, and surveys of tribes, that "[i]n the past three years there have been more gains than losses in programs in every type of service and in every type of tribe"); Ruiz-McGill, *supra* note 102 (describing research on the impacts of Tribal management of health services).

104. Geoffrey D. Strommer et al., *Tribal Sovereign Authority and Self-Regulation of Health Care Services: The Legal Framework and the Swinomish Tribe's Dental Health Program*, 21 J. HEALTH CARE L. & POL'Y 115, 127 (2019).

105. *About IHS*, *supra* note 11.

106. Aila Hoss, *Toward Tribal Health Sovereignty*, 2022 WIS. L. REV. 413, 422 (citing Aila Hoss & Michelle Castagne, *Public Health Law and American Indians and Alaska Natives*, *in* PUBLIC HEALTH LAW: CONCEPTS AND CASE STUDIES 209, 216–17 (Montrece McNeill Ransom & Laura Magaña Valladares eds., 2022)).

107. There are currently forty-one nonprofit Urban Indian Organizations (UIOs), with over eighty sites that provide health care to Native people who reside in urban areas. *See About Urban Indian Organizations*, INDIAN HEALTH SERV., https://www.ihs.gov/Urban/aboutus/about-urban-indian-organizations [https://perma.cc/R4Q7-2SNK]. UIOs provide services to "urban Indians residing in the urban centers in which such organizations are situated." 25 U.S.C. § 1653(a).

108. ASSISTANT SEC'Y FOR PLAN. & EVAL., REPORT NO. HP-2024-15, HEALTH INSURANCE COVERAGE AND ACCESS TO CARE AMONG AMERICAN INDIANS AND ALASKA NATIVES: RECENT TRENDS AND KEY CHALLENGES 10–11 (2024) (discussing the challenges AI/ANs face in accessing health care).

the highest uninsured rate compared to other racial and ethnic populations.[109]

IHS has made significant strides in improving the health of Indian people,[110] including by increasing the amount of available preventative care and public health services[111] and lowering infant and maternal mortality rates.[112] However, Congress has recognized that "the unmet health needs of American Indian people are severe, and the health and status of the Indians is far below that of the general population in the United States."[113]

The provision of health care arises from treaty, trust, and statutory obligations[114] and, in part, is the result of a price already paid by Native people through the cession of their land.[115] Yet, per capita spending allotted to IHS remains far lower than any other federal healthcare agency, including Medicare, Medicaid, the

109. *Id.* at 1, 3–4. "Individuals were . . . defined as uninsured if they reported having only Indian Health Service or had only a private plan that paid for one type of service, such as care for accidents or dental care." *Id.* at 4.

110. 25 U.S.C. § 1601(2)(4) ("Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians."); Jones, *supra* note 3, at 2130 ("[B]y 1989, [IHS] claimed great success, arguing that its efforts since 1955 had reduced tuberculosis by 96%, infant mortality by 92%, pulmonary infections by 92%, and gastrointestinal infections by 93%.") (citing U.S. PUB. HEALTH SERV., INDIAN HEALTH SERVICE: A COMPREHENSIVE HEALTH CARE PROGRAM FOR AMERICAN INDIANS AND ALASKA NATIVES (1989)); Pfefferbaum et al., *supra* note 43, at 217 ("There is general agreement that Indian people have experienced substantial improvement in health status since transfer of Indian health services from the BIA to the PHS in 1955."); Stephen J. Kunitz, *The History and Politics of US Health Care Policy for American Indians and Alaskan Natives,* 86 AM. J. PUB. HEALTH 1468, 1471 (1996) (demonstrating that, in the forty years after the formation of IHS, AI/AN life expectancy increased by nearly fifteen years).

111. COHEN'S HANDBOOK, *supra* note 15, § 22.04 (citing U.S. DEP'T HEALTH & HUM. SERVS., TRENDS IN INDIAN HEALTH 1998-1999, at 7–8 (2000)).

112. COHEN'S HANDBOOK, *supra* note 15, § 22.04 (citing U.S. DEP'T HEALTH & HUM. SERVS., TRENDS IN INDIAN HEALTH: 2002-2003, at 4, tbl. 3.8 (2009)).

113. 25 U.S.C. § 1601(5); *see also* GAO, HEALTH CARE SERVICES, *supra* note 13 (reporting shortcomings in health care services available to Native Americans).

114. 25 U.S.C. § 1601.

115. *See* Pfefferbaum et al., *supra* note 43, at 219 ("To the extent that the government has provided health services for Indians in conjunction with treaties in which land was ceded, Indian health care represents a prepaid health plan."); *supra* notes 15–18 and accompanying text (describing the federal government's trust obligation).

Veterans Health Administration, and the Bureau of Prisons.[116] For example, in 2016, Congress invested $3,337 per capita on health care for Native Americans, compared to $5,000 per capita on state prisoners and $12,744 per capita on Medicare beneficiaries.[117] Further, the United States Commission on Civil Rights has previously found that IHS operates with approximately 59% of the funding required to provide adequate health care.[118] Other sources estimate that IHS is funded at anywhere from approximately 15%[119] to 50%[120] of what is necessary to meet the healthcare needs of the

116. JORDAN K. LOFTHOUSE, GEORGE MASON UNIV. MERCATUS CTR., INCREASING FUNDING FOR THE INDIAN HEALTH SERVICE TO IMPROVE NATIVE AMERICAN HEALTH OUTCOMES 2 (2022) ("Since the federal government became involved in Native American healthcare, it has allocated smaller proportions of money per capita to the IHS than any other federally funded healthcare program. Medicare, Medicaid, the Veterans Health Administration . . . , and federal prisons receive two to three times as much federal funding per person."); Phuoc Le & Sam Aptekar, *For American Indians, Health is a Human and Legal Right*, HEALTH CARE BLOG (Mar. 29, 2019), https://thehealthcareblog.com/blog/2019/03/29/for-american-indians-health-is-a-human-and-legal-right [https://perma.cc/D3NA-M5NL] ("[P]er capita spending on Indian Health Services is far lower than any other federal health care agency, including Medicare, Medicaid, and the Bureau of Prisons. In 2016, Congress invested $3,337 per capita on Indian health care, compared to $5,000 on prisoners and $12,744 on Medicare beneficiaries.").

117. Davidson, *supra* note 53; *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-74R, INDIAN HEALTH SERVICE: SPENDING LEVELS AND CHARACTERISTICS OF IHS AND THREE OTHER FEDERAL HEALTH CARE PROGRAMS (2018), https://www.gao.gov/assets/gao-19-74r.pdf [https://perma.cc/F79C-Y6Y4] (finding that in 2017, IHS per capita spending was $4,078, whereas Medicaid spent $8,109, VHA spent $10,692, and Medicare spent $13,185).

118. U.S. COMM'N ON CIVIL RIGHTS, A QUIET CRISIS: FEDERAL FUNDING AND UNMET NEEDS IN INDIAN COUNTRY 42, 65–66, 209 (2003).

119. HONOR TRUST AND TREATY OBLIGATIONS, *supra* note 41, at 1, 3–4, 10–11 (finding that appropriations for IHS are "roughly 7 times less than the need-based estimate from the Workgroup" in FY 2023 and that it would take $53.9 billion to fully fund IHS for FY 2025, rather than the $7.1 billion appropriated for FY 2023).

120. ASSISTANT SEC'Y FOR PLAN. & EVAL., REPORT NO. HP-2022-21, HOW INCREASED FUNDING CAN ADVANCE THE MISSION OF THE INDIAN HEALTH SERVICE TO IMPROVE HEALTH OUTCOMES FOR AMERICAN INDIANS AND ALASKA NATIVES 1 (2022), https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf [https://perma.cc/MR8V-WFJ2] ("Funding for the [IHS] addresses only an estimated 48.6% of the health care needs for AI/ANs and has historically been subject to year-by-year discretionary allocations from Congress, which creates substantial long-term uncertainty in funding levels and makes it challenging to maintain and modernize needed health care infrastructure.").

AI/AN population. The strain on this limited funding is exacerbated by multiple Tribes often competing for the same pool of grant and cooperative agreement funding.

In addition to inadequate funding, IHS has long been plagued by a never-ending list of complex challenges that impact the accessibility and quality of healthcare services, including a lack of long-standing leadership,[121] outdated equipment, long patient wait times, and a lack of clear accountability measures for provider misconduct and substandard performance.[122] Mismanagement of IHS has been so dire that it has earned a spot on the U.S. Government Accountability Office's (GAO) High Risk List,[123] which is the GAO's list of "government operations with greater vulnerabilities to fraud, waste, abuse, and mismanagement, or that are in need of transformation."[124]

These defects result in health services that are often inadequate and contribute to the significant inequity in health status for Native peoples. As noted in Part I, Native Americans have a life expectancy that is almost eleven years less than the average for all

121. U.S. GOV'T ACCOUNTABILITY OFF., GAO-17-181, INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE OVERSIGHT OF QUALITY OF CARE 12 (2017), https://www.gao.gov/assets/gao-17-181.pdf [https://perma.cc/KJ7M-624G] (finding that there is "significant turnover in area leadership," as evidenced by the fact that four of the nine area offices had each had at least three area directors within the previous five years).

122. *See* Chairman Byron L. Dorgan, Senate Comm. on Indian Affairs, 111th Cong., In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area 4–7 (Comm. Print 2010) (investigating complaints about Aberdeen Area IHS-run facilities that "identified mismanagement, lack of employee accountability and financial integrity, as well as insufficient oversight of IHS' Aberdeen Area facilities"); U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-97, INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE OVERSIGHT OF PROVIDER MISCONDUCT AND SUBSTANDARD PERFORMANCE 26 (2020), https://www.gao.gov/assets/d2197.pdf [https://perma.cc/JW8R-9PHD] ("[I]nconsistencies in IHS's oversight activities could limit IHS's efforts to oversee provider misconduct and substandard performance."); Davidson, *supra* note 53 (detailing long patient wait times and the outdated equipment crisis).

123. U.S. GOV'T ACCOUNTABILITY OFF., GAO-23-106203, HIGH-RISK SERIES: EFFORTS MADE TO ACHIEVE PROGRESS NEED TO BE MAINTAINED AND EXPANDED TO FULLY ADDRESS ALL AREAS 100 (2023) [hereinafter HIGH-RISK SERIES], https://www.gao.gov/assets/gao-23-106203.pdf [https://perma.cc/QLV9-4U3H]; *see also* U.S. Gov't Accountability Off., *High Risk List*, U.S. GAO, https://www.gao.gov/high-risk-list [https://perma.cc/HH64-MUXQ] (designating IHS as part of "improving federal management of programs that serve Tribes and their members").

124. HIGH-RISK SERIES, *supra* note 123, at 1.

race populations in the United States.[125] In some states, the life expectancy for Native Americans is over twenty years less than that of non-Native populations.[126]

Moreover, Native Americans "continue to die at higher rates than other Americans in many categories of preventable illness";[127] they are 4.6 times more likely to die from chronic liver disease and cirrhosis, 3.2 times more likely to die of diabetes, and 1.8 times more likely to die of preventable lower respiratory diseases like pneumonia and influenza.[128] The COVID-19 pandemic exacerbated these disparate health outcomes. During the first year of the pandemic, Native Americans experienced the highest rates of COVID-19 infection, hospitalization, and mortality.[129] Additionally, mental health issues, including anxiety, depression, suicidal ideation, and substance abuse, disproportionately increased amongst Native American populations during the pandemic.[130] Even before the

125. *See* ARIAS ET AL., *supra* note 10, at 2 (providing a provisional life expectancy for non-Hispanic American Indian or Alaska Natives that averaged 65.2 years in comparison to 76.1 years for all races and origins combined).

126. NAT'L TRIBAL BUDGET FORMULATION WORKGROUP, RECLAIMING TRIBAL HEALTH: A NATIONAL BUDGET PLAN TO RISE ABOVE FAILED POLICIES AND FULFILL TRUST OBLIGATIONS TO TRIBAL NATIONS 2 (2020) ("[I]n South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians."); 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/MN28-HZM5] (stating that the life expectancy for Native women in some states, like Montana, is twenty years less than that of the state's population of non-Native women).

127. Mary Smith, *Native Americans: A Crisis in Health Equity*, ABA, 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 (on file with the *Columbia Human Rights Law Review*); *see also* BROKEN PROMISES, *supra* note 14, at 7.

128. INDIAN HEALTH SERV., INDIAN HEALTH DISPARITIES 2 (2019), https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf [https://perma.cc/B2LZ-RJDY] (reporting data from 2009 to 2011).

129. LOFTHOUSE, *supra* note 116; *see also* Sarah M. Hatcher et al., *COVID-19 Among American Indian and Alaska Native Persons—23 States, January 31–July 3, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1166, 1167 (2020) (finding that "in 23 states with sufficient COVID-19 patient race/ethnicity data, the overall COVID-19 incidence among AI/AN persons was 3.5 times that among white persons").

130. HARV. T.H. CHAN SCH. PUB. HEALTH, HOUSEHOLD EXPERIENCES IN AMERICA DURING THE DELTA VARIANT OUTBREAK, BY RACE/ETHNICITY 27 (2021), https://www.rwjf.org/en/insights/our-research/2021/10/household-experiences-in-

pandemic, Native populations faced complex mental health challenges, including "depression, substance abuse, collective trauma exposure, interpersonal losses and unresolved grief."[131]

These disparate health issues impact urban[132] and reservation Indians[133] alike. Although the lifestyles and access to resources may differ between urban and reservation Indians, urban Indians still struggle with high rates of physical and mental illnesses and substance abuse issues.[134] The health status of Native peoples should thus "be viewed within the dynamics of various sociocultural, political and economic interactions."[135] The long-standing relationship between the federal government and Tribal Nations, which has included actively destructive assimilationist policies, is an important part of the story when discussing the current structure of federally provided Indian health services.

A substantial mission of federal Indian policy prior to the 1960s was to separate Indians from mainstream American society, often treating them as "a subordinate group."[136] This isolation of reservation Indians has had long-term impacts on their access to

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america-during-the-delta-variant-outbreak.html [https://perma.cc/EU78-5WCN] (sharing data from a 2021 survey where 74% of Native American respondents indicated they, or someone living in their household, had "been having serious problems with depression, anxiety, or stress, or serious problems sleeping").

131. Maria Yellow Horse Brave Heart et al., *Historical Trauma Among Indigenous Peoples of the Americas: Concepts, Research, and Clinical Considerations*, 43 J. PSYCHOACTIVE DRUGS 282, 282 (2011).

132. Under the IHCIA, "Urban Indians" are defined as any individual who "[r]esides in an urban center, which is any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under the IHCIA, as determined by the Secretary of the Department of Health and Human Services." *About Urban Indian Organizations*, *supra* note 107 (citing 25 U.S.C. § 1603(13), (27), (28)).

133. Approximately 87% of the AI/AN population live in urban areas, and 13% live in legal and statistical areas such as reservations, off-reservation trust lands, Oklahoma Tribal statistical areas, and Tribal designated statistical areas. *See About Urban Indian Organizations*, *supra* note 107 (citing U.S. Census Bureau 2020).

134. URBAN INDIAN HEALTH COMM'N, INVISIBLE TRIBES: URBAN INDIANS AND THEIR HEALTH IN A CHANGING WORLD 5 (2007); H.R. Rep. No. 94-1026(l), at 109–14 (1976).

135. Jennie Joe, *The Delivery of Health Care to American Indians: History, Policies and Prospects*, *in* AMERICAN INDIANS: SOCIAL JUSTICE AND PUBLIC POLICY 151 (Donald E. Green & Thomas V. Tonnesen eds., 1991).

136. Reid Peyton Chambers, *Reflections on the Changes in Indian Law, Federal Indian Policies and Conditions on Indian Reservations since the Late 1960s*, 46 ARIZ. ST. L.J. 729, 734, 740 (2014).

drivers of health, such as fresh food and preventative care. When the federal government removed many Tribes to the western portion of the United States and ushered them onto small reservations, it resulted in "a complete reversal in food security" and shifted many Native communities into a pattern of inadequate diets and sedentary lifestyles.[137] The federal government would often provide those Tribes with food that contained high fat and "low nutritional value, such as lard and flour,"[138] which consequently became a staple of the diet of many Native peoples. This federal provision of food commodities had a tremendous impact on the health of Native peoples that continues today.[139] Other factors that can impact—and for many Native peoples, have impacted—the health of communities include access to safe drinking water, access to healthy foods, and resiliency to climate change.[140]

Poor health outcomes are often cyclical in nature, as they "propagate[] social inequality by reducing economic security, mobility, and access to social supports."[141] Naturally, an individual struggling with significant health issues may face greater hurdles in engaging with their community, pursuing educational opportunities, and maintaining steady employment—all markers for social mobility that require some degree of health to pursue. In discussing the intertwined nature of these social issues, Professor Robert J. Miller states:

> [A]ll of Indian Country is injured when Indians live in poverty and substandard housing, and lack adequate education and health care. These issues keep Indian peoples from having the time, health, and resources to sustain and expand their communities and from

137. Michelle Chino et al., *Patterns of Commodity Food Use Among American Indians*, 7 PIMATISIWIN: J. ABORIG. & INDIG. CMTY. HEALTH 279, 280 (2009).

138. Aila Hoss, *A Framework for Tribal Public Health Law*, 20 NEV. L.J. 113, 122 (2019).

139. *Id.* (citing Dana Vantrease, *Commod Bods and Frybread Power: Government Food Aid in American Indian Culture*, 126 J. AM. FOLKLORE 55, 57 (2013); Mary Story et al., *The Epidemic of Obesity in American Indian Communities and the Need for Childhood Obesity-Prevention Programs*, 69 AM. J. CLINICAL NUTRITION 747S, 751S–52S (1999)).

140. Heather Tanana, *Protecting Tribal Public Health from Climate Change Impacts*, 15 NE. U. L. REV. 89, 119–22 (2023) (describing the link between climate change, availability of water resources, and Tribal public health).

141. Lucas Trout et al., *Social Medicine in Practice: Realizing the American Indian and Alaska Native Right to Health*, 20 HEALTH & HUM. RTS. J. 19, 26 (2018).

> studying and practicing their traditions, cultures, religions, and languages. In fact, studies and experience have shown that actual health and community benefits follow from even small improvements in tribal and Indian financial conditions. These concrete results include tribal families being able to live and work on their reservations, improved child mental health, longer life expectancy rates, lower infant mortality rates, and higher educational attainment rates.[142]

These disparate social outcomes also appear to have a particularly acute impact on Native American women. Specifically, many Native American women generally have insufficient access to routine and preventative healthcare services,[143] are at a higher risk of cardiovascular disease when compared to the general population,[144] suffer from an increased risk of death from cancer,[145] and are the least likely population to receive adequate prenatal care.[146] Native women also generally receive lower-quality maternity care than white women, and the care they receive often does not include traditional cultural birth practices that may be found in their respective Tribal communities.[147] At the moment, there are only nine IHS-operated

142. MILLER, *supra* note 20, at 7.

143. Nada Hassanein, *Native Americans Given Promise of Health Care. For Rural Moms, It's an Empty One.*, USA TODAY (Dec. 16, 2022), https://www.usatoday.com/in-depth/news/health/2022/08/11/rural-native-americans-suffer-lack-maternal-health-care-access/10084897002 [https://perma.cc/62DA-LQTB]; JESSICA HUGHES, WORLD HEALTH ORG., GENDER, EQUITY, AND INDIGENOUS WOMEN'S HEALTH IN THE AMERICAS 12 (2004).

144. BROKEN PROMISES, *supra* note 14, at 7.

145. *See, e.g.*, Amanda S. Bruegl et al., *Gynecologic Cancer Incidence and Mortality among American Indian/Alaska Native Women in the Pacific Northwest, 1996–2016*, 157 GYNECOLOGIC ONCOLOGY 686, 686 (2020) (finding AI/AN women have a higher rate of mortality from uterine and cervical cancer than white women).

146. BROKEN PROMISES, *supra* note 14, at 19; *accord* Rebecca A. Hart, *No Exceptions Made: Sexual Assault Against Native American Women and the Denial of Reproductive Healthcare Services*, 25 WIS. J. L. GENDER & SOC'Y 209, 222 (2010); BARBARA GURR, REPRODUCTIVE JUSTICE: THE POLITICS OF HEALTH CARE FOR NATIVE AMERICAN WOMEN 45 (2014); George R. Brenneman, *Maternal, Child, and Youth Health*, *in* AMERICAN INDIAN HEALTH: INNOVATIONS IN HEALTH CARE, PROMOTION, AND POLICY, *supra* note 31, at 140 ("Prenatal care is not consistently available for nor accepted equally by all Indian women.").

147. NAT'L P'SHIP FOR WOMEN & FAMS., AMERICAN INDIAN AND ALASKA NATIVE WOMEN'S MATERNAL HEALTH: ADDRESSING THE CRISIS 2 (2019), https://www.nationalpartnership.org/our-work/resources/health-care/maternity/american-indian-and-alaska.pdf [https://perma.cc/SXQ3-QRHS].

facilities that have a labor and delivery program; however, some Tribes do offer a few of their own labor and delivery units.[148] Altogether, approximately 75% of AI/AN women give birth in "non-Indigenous health care centers."[149]

Native women residing in rural areas trek some of the longest distances in the country for obstetric care, sometimes driving more than one hundred miles in one direction.[150] The growth in these so-called "maternity care deserts"[151] has been partly fueled by "financial and logistical challenges" associated with the COVID-19 pandemic, resulting in the loss of obstetric providers and hospital services.[152] In 2020, one in four Native babies were "born in areas of limited or no access to maternity care services."[153] Additionally, "[m]any reservations also lack regular prenatal care, which contributes to high maternal death and morbidity rates that experts say underscore a systemic failure to uphold the nation's promise of health care for Indigenous people."[154]

Further, the especially high rate of violence[155] towards Native American women creates unique healthcare needs for victims and survivors, including treatment for "physical injuries, psychological trauma, exposure to sexually transmitted infections, and unwanted pregnancy."[156] This complex epidemic facing Native American women should be factored into creating an effective health care strategy that includes adequate resources and comprehensive reproductive healthcare services tailored to the unique needs of Native women.

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148. Hassanein, *supra* note 143.

149. *Id.*

150. *Id.*

151. "Maternity care deserts" refers to areas without obstetric providers, hospitals providing obstetric care, birth centers, or certified nurse midwives. MARCH OF DIMES, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S. 2 (2022); Rachel Tresiman, *Millions of Americans Are Losing Access to Maternal Care. Here's What Can Be Done*, NPR (Oct. 12, 2022), https://www.npr.org/2022/10/12/1128335563/maternity-care-deserts-march-of-dimes-report [https://perma.cc/2ZU4-7LPT].

152. Tresiman, *supra* note 151.

153. MARCH OF DIMES, *supra* note 151, at 6.

154. Hassanein, *supra* note 143.

155. It is estimated that approximately ninety-eight out of one thousand AI/AN females will experience violence in their lifetime, a rate that is significantly higher than all other women. HUGHES, *supra* note 143, at 7–8.

156. Lauren van Schilfgaarde, *Native Reproductive Justice: Practices and Policies from Relinquishment to Family Preservation*, BILL OF HEALTH, https://blog.petrieflom.law.harvard.edu/2022/05/12/native-reproductive-justice-adoption-relinquishment-family-preservation [https://perma.cc/N9K9-GTNL].

Additionally, the health conditions of Native Americans are often exacerbated by the realities of colonization[157] and historical trauma.[158] Well-established health disparities exist in Indigenous populations across a number of settler colonial states,[159] and a growing body of research seeks to demonstrate the link between settler colonialism and health outcomes globally.[160] In the United States, many Native people "still experience historical trauma associated with colonization, removal from their homelands, and loss of their traditional ways of life, and this has been identified as a contributor to contemporary physical and mental health impacts."[161]

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157. *See* Bram Wispelwey et al., *Because Its Power Remains Naturalized: Introducing the Settler Colonial Determinants of Health*, FRONTIERS PUB. HEALTH, at 1–2 (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10393129/pdf/fpubh-11-1137428.pdf [https://perma.cc/FYJ5-WA23] ("Settler colonialism's relationship to health inequity is at once obvious and incompletely described . . . . [It] is a form of exogenous domination in which the primary goal . . . is to obtain and stay on the land, seeking the elimination of Indigenous communities—as individuals but especially as peoples with sovereign status and claims.").

158. Historical trauma can be defined as "the collective emotional and psychological injury both over the life span and across generations resulting from the history of difficulties that Native Americans as a group have experienced in America." PEGGY HALPERN, U.S. DEP'T OF HEALTH & HUM. SERVS., OBESITY AND AMERICAN INDIANS/ALASKA NATIVES, xi, 31 (2007).

159. *See* Wispelwey et al., *supra* note 157, at 4 ("The consistency of health inequities . . . across settler colonial contexts should lead us instead to a radically different explanatory model, shifting the focus – and the culpability – from Native biology and culture to settler sociopolitical formations and their attendant violence."); Patrick Wolfe, *Settler Colonialism and the Elimination of the Native*, 8 J. GENOCIDE RSCH. 387, 399 (2006) (providing an example of health inequity in a non-American context: "Even in contemporary, post-Native Title Australia, Aboriginal life expectancy clings to a level some 25% below that enjoyed by mainstream society, with infant mortality rates that are even worse").

160. *See generally* Wispelwey et al., *supra* note 157 (elucidating the relationship between settler colonialism and health inequity); Sarah Hyett et al., *Deficit-Based Indigenous Health Research and the Stereotyping of Indigenous Peoples*, 2 CAN. J. BIOETHICS 102, 104 (2019) (arguing for "researchers [to] engage in a discussion of the influence of colonization and Westernization [on health], thereby reframing the issue and reassigning the shame to such influences rather than to Indigenous Peoples"); Trout et al., *supra* note 141, at 23 (pointing out that "colonialism itself is often and rightly indexed as a social force shaping the inequitable burden of disease in Indigenous communities"); Yin Paradies, *Colonisation, Racism and Indigenous Health*, 33 J. POPULATION RSCH. 83, 89 (2016) (observing epidemiology's limitations in measuring the impact of colonization on health outcomes).

161. Lesley Jantarasami et al., *Tribes and Indigenous Peoples*, *in* RACHAEL NOVAK, 2 U.S. GLOB. CHANGE RSCH. PROGRAM, IMPACTS, RISKS, AND ADAPTATION

Tribal communities are still, in many ways, healing from the historical and ongoing impact of mass genocide and federal assimilationist policies that sought to destroy Native identity, and this historical context is an important contributor to the disparate physical and mental health conditions of Native peoples.

Understanding this unique history and the resulting contemporary challenges for AI/AN populations should be a necessary component of developing health systems that can adequately meet the needs of Native populations. In many ways, Tribal health systems, driven by the knowledge of the Tribal communities they serve, are best positioned to offer such context-specific care. But when a Tribe may not yet have the financial resources to develop its own health infrastructure, at a minimum IHS and other U.S. governmental agencies should engage in meaningful Tribal consultation when developing health systems that serve Tribal communities.

B. Litigating for Adequate Health Care

The disparate health outcomes of Native populations and the frequent shortfalls within the IHS system have created a situation so dire for Tribal Nations that some have shouldered the burden and costs of filing suit, arguing that the federal government has a fiduciary duty to provide adequate health care to Native Americans.

1. Litigation over a Judicially Enforceable Trust

The federal government's trust responsibility owed to Tribal Nations traces back to the formation of the United States government.[162] Treaties, federal statutes,[163] policies, and statements

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IN THE UNITED STATES: FOURTH NATIONAL CLIMATE ASSESSMENT 582 (2018). *See also* Trout et al., *supra* note 141, at 25 ("[C]olonialism in this context must be understood as a contemporary social force continuing to play out in the day-to-day existence of Alaska Natives and the social, political, and health care systems that shape their worlds."); Wispelwey et al., *supra* note 157, at 2 (arguing that "settler colonialism shapes health in ways that are both fundamental and distinct from other determinants").

162. In what is commonly referred to as the "Indian Commerce Clause," the United States Constitution recognized Indian Tribes as distinct governments, separate from states and foreign nations. U.S. CONST. art. I, § 8, cl. 3 ("The Congress shall have Power . . . [t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes . . . .").

163. Such acknowledgements occur, for example, in the Indian Self-Determination and Education Assistance Act of 1975, *supra* note 86, § 106(f), the

by former Presidents[164] and Secretaries of the Interior consistently acknowledge this responsibility.[165] The trust doctrine has evolved

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Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, § 3, 114 Stat. 711, 712 (2000), the American Indian Trust Fund Management Reform Act of 1994, Pub. L. No. 103-412, § 101, 108 Stat. 4239, 4240 (1994), the Federally Recognized Indian Tribe List Act of 1994, Pub. L. No. 103-454, § 102, 108 Stat. 4791, 4791 (1994), the Indian Mineral Development Act of 1982, Pub. L. No. 97-382, § 4(e), 96 Stat. 1938, 1939 (1982), and the Indian Child Welfare Act of 1978, 25 U.S.C. § 1901(2) (recognizing a "special relationship between the United States and the Indian tribes and their members and the Federal responsibility to Indian people" and determining "that Congress, through statutes, treaties, and the general course of dealing with Indian tribes, has assumed the responsibility for the protection and preservation of Indian tribes and their resources . . . .").

164. On July 8, 1970, former President Nixon delivered a historic Special Message on Indian Affairs to Congress, where he stated that "[t]he United States Government acts as a legal trustee for the land and water rights of American Indians," and "[e]very trustee has a legal obligation to advance the interests of the beneficiaries of the trust without reservation and with the highest degree of diligence and skill." Nixon, Cong. Rec., *supra* note 31, at 23135; *see also* President Joseph R. Biden, Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships, 86 Fed. Reg. 7491 (Jan. 26, 2021) (noting it is a priority of the Administration to "commit[] to fulfilling Federal trust and treaty responsibilities to Tribal Nations"); President William J. Clinton, Remarks to Indian and Alaska Native Tribal Leaders, 1994 PUB. PAPERS 800, 801 (Apr. 29, 1994) ("I pledge to fulfill the trust obligations of the Federal Government."); President George H.W. Bush, Statement Reaffirming the Government-to-Government Relationship Between the Federal Government and Indian Tribal Governments, 1991 PUB. PAPERS 662, 662 (June 14, 1991) (establishing an Office of American Indian Trust to oversee the trust responsibility); President Ronald Reagan, American Indian Policy Statement, 19 WEEKLY COMP. PRES. DOC. 98, 99 (Jan. 24, 1983) ("[W]e shall continue to fulfill the Federal trust responsibility."); President Gerald L. Ford, Remarks at a Meeting with American Indian Leaders, 1976 PUB. PAPERS 2020, 2021 (July 16, 1976) ("The Federal Government has a very unique relationship with you and your people. It is a relationship of a legal trust and a high moral responsibility."); President Barack Obama, Memorandum on Tribal Consultation, 74 Fed. Reg. 57881 (Nov. 5, 2009) (acknowledging "a unique legal and political relationship . . . established through and confirmed by the Constitution of the United States, treaties, statutes, executive orders, and judicial decisions"); President Lyndon B. Johnson, Special Message to the Congress on the Problems of the American Indian: "The Forgotten American", 1963 PUB. PAPERS 335, 343 (Mar. 6, 1968) (acknowledging a "special relationship between the Indian and his government"); President George W. Bush, American Indian and Alaska Native Education, Exec. Ord. No. 13,336, 69 Fed. Reg. 25295, pmbl., § 9(a) (Apr. 30, 2004) (acknowledging a "unique political and legal relationship").

165. *See* Press Release, U.S. Dep't of the Interior, Reaffirmation of the Federal Trust Responsibility to Federally Recognized Indian Tribes and Individual Indian Beneficiaries (Aug. 20, 2014), https://www.doi.gov/sites/doi.gov/files/migrated/news/pressreleases/upload/Signed-

most notably through case law.[166] The Supreme Court first articulated the existence of a guardianship responsibility in *Cherokee Nation v. Georgia*,[167] but it is unclear "whether the trust relationship exists independently as a legal doctrine or is only a consequence of specific federal treaties and statutes."[168] However, particularly in the past fifty years, the Supreme Court has grappled with this question and enumerated parameters for the establishment of a judicially enforceable trust duty. Many of the Court's decisions make clear that Congress has the power to change the terms of the trust relationship through new treaties and statutes.[169]

In *United States v. Mitchell* (*Mitchell I*),[170] the Supreme Court reviewed "the extent to which the Secretary of the Interior could be held accountable for breach of trust for mismanagement of [Tribal] timber resources and the funds derived" from their sale.[171] The Court found that the Indian General Allotment Act of 1887[172] had only created a "limited trust relationship" because it did not give the federal government "full fiduciary responsibility" over the Tribes' timber resources.[173] In a different opinion in the same case, *Mitchell II*, the Court reviewed a number of federal timber management statutes and found that the federal government exercised "elaborate control" over Tribal money and property, which "necessarily" created a fiduciary relationship.[174] The Court, in turn, found that "[a]ll of the

SO-3335.pdf [https://perma.cc/FR9G-PDNM] ("Presidents, Congress, and past Secretaries of the Interior have recognized the trust responsibility repeatedly, and have strongly emphasized the importance of honoring the United States' trust responsibility to federally recognized tribes and individual Indian beneficiaries.").

166. *See* COHEN'S HANDBOOK, *supra* note 15, § 5.05(1)(a) ("The trust relationship is a doctrine originating in common law, and also expressed in numerous treaties and statutes.").

167. Cherokee Nation v. Georgia, 30 U.S. 1, 17 (1831) (depicting Native Americans as "domestic dependent nations" and likening "[t]heir relations to the United States [as] that of a ward to his guardian").

168. Reid Peyton Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213, 1220 (1975).

169. *See, e.g.*, *id.* at 1221, 1224–26 (discussing *United States v. Kagama*, 118 U.S. 375 (1886), which outlined congressional power to legislate in Indian affairs, and *Lone Wolf v. Hitchcock*, 187 U.S. 553 (1903), which found that the terms of a treaty, or the trust relationship, can be unilaterally modified by Congress without Tribal consent).

170. United States v. Mitchell (*Mitchell I*), 445 U.S. 535 (1980).

171. COHEN'S HANDBOOK, *supra* note 15, § 5.05(1)(b).

172. 25 U.S.C. § 348 (providing that the United States would hold allotted land "in trust").

173. *Mitchell I*, 445 U.S. at 542–43.

174. United States v. Mitchell (*Mitchell II*), 463 U.S. 206, 225 (1983).

necessary elements of a common-law trust are present: a trustee (the United States), a beneficiary (the Indian allottees), and a trust corpus (Indian timber, lands, and funds)."[175] The *Mitchell* cases established that neither the general historic trust relationship nor a general reference to a "trust" within a statute create a judicially enforceable trust obligation. But statutes that provide the federal government with "pervasive and comprehensive control of tribal resources" could give rise to an enforceable trust claim.[176]

The elements of the trust relationship are further defined in *Navajo I*[177] and *Navajo II*.[178] In *Navajo I*, the Court found that despite the "undisputed existence of a general trust relationship" between the federal government and Tribes, "that relationship alone is insufficient" to support a claim of money damages under the Indian Tucker Act.[179] The Court also noted that the relevant statute aimed to "enhance tribal self-determination by giving Tribes" the "lead role in negotiating mining leases."[180] This act of promoting Tribal self-determination, the Court believed, was incongruent with Secretarial control and Secretarial liability.[181] In *United States v. Jicarilla Apache Nation*, the Supreme Court recognized the existence of the trust relationship and stated that the "Government, following 'a humane and self-imposed policy . . . has charged itself with moral obligations of the highest responsibility and trust,' obligations 'to the fulfillment of which the national honor has been committed.'"[182] More recently, the Supreme Court reiterated that to successfully bring a breach-of-trust claim, a Tribe "must establish, among other things, that the text of a treaty, statute, or regulation imposed certain duties

175. *Id.*

176. Washburn, *supra* note 88, at 210.

177. United States v. Navajo Nation (*Navajo I*), 537 U.S. 488 (2003).

178. United States v. Navajo Nation (*Navajo II*), 556 U.S. 287 (2009).

179. *Navajo I*, 537 U.S. at 506. Under the Tucker Act, codified as amended at 28 U.S.C. § 1491, the Court of Federal Claims has exclusive jurisdiction over claims for money damages "founded . . . upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States." COHEN'S HANDBOOK, *supra* note 15, § 5.05(1)(b).

180. *Navajo I*, 537 U.S. at 508.

181. Washburn, *supra* note 88, at 211 ("It appeared to the Court that the freight train of tribal self-determination had rolled over and killed the federal trust responsibility.").

182. United States v. Jicarilla Apache Nation, 564 U.S. 162, 175–78 (2011) (citations omitted).

on the United States."[183] Professor Kevin Washburn has interpreted the line of cases construing the parameters of the judicially enforceable trust obligation as:

> [S]uggest[ing] that the federal government will continue to be accountable to tribes if it has retained wholesale control over Indian resources, but is much less accountable if it has surrendered a measure of power. In other words, it seems that the trust responsibility exists, but only in situations in which tribal self-determination does not.[184]

As described in Part I, there is a general recognition that the federal government has a trust responsibility to provide health services to Indians, but "that obligation is ill-defined with respect to specific rights and responsibilities."[185] For example, in *Gila River Pima-Maricopa Indian Community v. United States*, the Tribes sued, alleging, in part, damages from the U.S. government's failure to provide adequate medical facilities and personnel for their health and safety. However, the U.S. Court of Claims found that the government's trust responsibility by itself cannot support a claim or create a legal entitlement to benefits.[186] Nevertheless, an analysis focused on the trust responsibility must recognize not only the purpose and intent of laws such as the IHCIA and the Snyder Act, but the explicit text within the laws as well.

In recent years, a growing body of litigation against IHS has argued, among other claims, that shortcomings in the healthcare system violate the federal trust relationship.[187] The Eighth and Ninth Circuits are currently divided on whether the federal government has a fiduciary duty to provide health care to Native Americans. The Eighth Circuit, in *Rosebud Sioux Tribe v. United States*, held that

183. Arizona v. Navajo Nation, 599 U.S. 555, 563–64 (2023) (citations omitted).

184. Washburn, *supra* note 88, at 212.

185. Pfefferbaum et al., *supra* note 43, at 219.

186. Gila River Pima-Maricopa Indian Cmty. v. United States, 427 F.2d 1194, 1198 (Ct. Cl. 1970), *cert. denied*, 400 U.S. 819 (1970).

187. For example, in *Yankton Sioux Tribe v. U.S. Dep't of Health & Hum. Servs.* (*Yankton II*), the Yankton Sioux Tribe challenged the decision of IHS to close the emergency room at the Wagner IHS Health Care Facility. *Yankton II*, 496 F. Supp. 2d 1044, 1048 (D.S.D. 2007), *aff'd*, 533 F.3d 634 (8th Cir. 2008). This litigation traces back to 1994, when the Tribe brought an action to challenge IHS' decision to discontinue inpatient and emergency medical services for members of the Tribe. Yankton Sioux Tribe v. U.S. Dep't of Health & Hum. Servs. (*Yankton I*), 869 F. Supp. 760, 761 (D.S.D. 1994); *see also Yankton II*, 496 F. Supp. 2d at 1048 (discussing *Yankton I*).

such a duty exists under certain treaties and the IHCIA.[188] Yet, the Ninth Circuit, in *Quechan Tribe v. United States*, found that "the federal-tribal trust relationship does not, in itself, create a judicially enforceable duty."[189] Some could argue that the Ninth Circuit failed to properly apply the Indian canons of construction when interpreting the statutory language of the IHCIA.[190] In contrast, the Eighth Circuit correctly found the existence of a judicially enforceable trust obligation to provide adequate health care to Native Americans. The divergent analysis amongst the federal circuits demonstrates how seeking judicial enforcement of the trust obligation in order to secure adequate health care in Indian Country has its own significant challenges and can sometimes be an imperfect means to closing the health gap.

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188. Rosebud Sioux Tribe v. United States, 9 F.4th 1018, 1026 (8th Cir. 2021); *see also* White v. Califano, 581 F.2d 697, 698 (8th Cir. 1978), *aff'g* 437 F. Supp. 543, 555 (D.S.D. 1977) (quoting the District Court: "We think that Congress has unambiguously declared that the federal government has a legal responsibility to provide health care to Indians. This stems from the 'unique relationship' between Indians and the federal government . . . .").

189. Quechan Tribe v. United States, 599 F. App'x 698, 699 (9th Cir. 2015).

190. *See, e.g.*, COHEN'S HANDBOOK, *supra* note 15, § 2.02(1) ("The basic Indian law canons of construction require that treaties, agreements, statutes, and executive orders be liberally construed in favor of the Indians and that all ambiguities are to be resolved in their favor.") (citations omitted); Philip Frickey, *Congressional Intent, Practical Reasoning, and the Dynamic Nature of Federal Indian Law*, 78 CAL. L. REV. 1137, 1141 (1990) (noting that the canons of construction "originated in a Marshall Court decision interpreting an Indian treaty, but are sometimes applied in modern statutory interpretation cases as well" and that their "essential point . . . is to encourage narrow construction against invasions of Indian interests and broad construction favoring Indian rights"); Alex Tallchief Skibine, *Textualism and the Indian Canons of Statutory Construction*, 55 U. MICH. J. L. REFORM 267, 275 (2022) (quoting County of Yakima v. Confederated Tribes & Bands of the Yakima Indian Nation, 502 U.S. 251, 269 (1992) (stating that "[w]hen we are faced with these two possible constructions, our choice between them must be dictated by a principle deeply rooted in this Court's Indian jurisprudence: '[S]tatutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit'") (internal citations omitted)). For an analysis of how inconsistent application of these canons to federal statutes undermines Native peoples' interests and the principles of the trust relationship, see generally Jill De La Hunt, Note, *The Canons of Indian Treaty and Statutory Construction: A Proposal for Codification*, 17 U. MICH. J. L. REFORM 681 (1984). *See also id.* at 689 n.60 (citing Jones v. Meehan, 175 U.S. 1, 11 (1989) (adopting the approach of Justice McLean's concurrence to *Worcester v. Georgia*, concluding that "the treaty must therefore be construed, not according to the technical meaning of its words to learned lawyers, but in the sense in which they [sic] would naturally be understood by the Indians")).

2. Ninth Circuit: Quechan Tribe of the Fort Yuma Indian Reservation v. United States

In *Quechan Tribe of the Fort Yuma Indian Reservation v. United States*, the Quechan Tribe alleged that the federal government "violated statutory, common law, and constitutional duties that it owes the Tribe when it provided inadequate medical care at the Fort Yuma Service Unit of the Indian Health Service."[191] In affirming the District Court's grant of the federal government's motion to dismiss, the Ninth Circuit found that, while the federal-Tribal trust relationship exists in general terms, the IHCIA did not create a judicially enforceable trust obligation.[192] The court reasoned that neither the Snyder Act nor the IHCIA could create an enforceable duty because the Acts only spoke of Native American health generally and did not set specific standards.[193] The analysis focused on the court's belief that the statutes contained ambiguous language and unequivocal requirements, so the court could not judicially enforce a trust duty.[194] This decision left the Quechan Tribe with no recourse to obtain sufficient health care for their people besides advocating to Congress to enact statutory changes or turning to the Executive Branch to implement changes.[195]

3. Eighth Circuit: Rosebud Sioux Tribe v. United States

In *Rosebud Sioux Tribe v. United States*, the Eighth Circuit addressed whether "the United States has a duty to provide 'competent physician-led healthcare' to the Rosebud Sioux Tribe . . . and its members."[196] In April 1868, the Rosebud Sioux Tribe and a number of "different bands of the Sioux Nation of Indians" signed the Treaty of Fort Laramie of 1868,[197] which "temporarily put an end to fighting between the United States" and the respective Tribes.[198]

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191. Quechan Tribe of the Fort Yuma Indian Reservation v. United States, 599 F. App'x 698, 699 (9th Cir. 2015).

192. *Id.*

193. *Id.*

194. *Id.*

195. *See id.* at 699–700 (emphasizing that while the Court "appreciate[s] the Tribe's commitment to ensuring adequate healthcare for its members, and [the Court] acknowledge[s] the challenges faced by the Tribe in ensuring such care . . . . , the solution lies in Congress and the executive branch, not the courts").

196. Rosebud Sioux Tribe v. United States, 9 F.4th 1018, 1020 (8th Cir. 2021).

197. Treaty of Fort Laramie of 1868, Apr. 29, 1868, 15 Stat. 635.

198. *Rosebud Sioux Tribe*, 9 F.4th at 1020.

Under various articles of the treaty, the United States acquired significant acreage of land in exchange for several promises to the Tribes, including that it would "furnish annually to the Indians [a] physician," any appropriations sufficient to employ this and other workers, and a residence for the physician.[199] In exchange, the Tribes agreed to stop attacking the settlers and to relinquish "vast acreage" of their ancestral land.[200] In the years after the treaty, the federal government built the Rosebud Hospital in Rosebud, South Dakota and brought in physicians to provide health care to members of the Rosebud Sioux Tribe, with IHS ultimately operating the hospital.[201]

In 2015, the Centers for Medicare and Medicaid Services (CMS) discovered such significant deficiencies in the Rosebud Hospital's emergency care department that there was "an immediate and serious threat to the health and safety of patients."[202] Because of these defects, in December 2015, IHS placed the Emergency Department on "'divert' status, which meant emergency patients were diverted [to hospitals] approximately 50 miles away."[203] But even those "receiving hospitals were overwhelmed by the volume and complexity of patients."[204] Additionally, as a result of staffing shortages, IHS reduced the hospital's operating hours and, in June 2016, diverted surgical and obstetrics services.[205] Due to these continuous health care deficiencies, the Rosebud Sioux Tribe brought a claim against the federal government, arguing that the United States has a "specific, special trust duty" to provide it with adequate health care services "pursuant to the Snyder Act, the IHCIA, [the Treaty], and federal common law."[206]

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199. *Id.* at 1020, 1024 (citing Treaty of Fort Laramie of 1868, 15 Stat. 635, at art. XIII (providing that the United States would "furnish annually to the Indians [a] physician," and that "appropriations shall be made from time to time . . . as will be sufficient to employ" the physician); *id.* at art. IV (providing that the United States would provide a residence for the physician)).

200. *Id.* at 1020.

201. *Id.* at 1021 ("Rosebud Hospital is the primary source of healthcare services to approximately 28,000 Native Americans in the south-central region of South Dakota.").

202. *Id.*

203. *Id.* at 1021.

204. OFF. OF INSPECTOR GEN., U.S. DEP'T HEALTH & HUMAN SERVS., ROSEBUD HOSPITAL: INDIAN HEALTH SERVICE MANAGEMENT OF EMERGENCY DEPARTMENT CLOSURE AND REOPENING i (2019) ("The receiving hospitals were overwhelmed by the volume and complexity of patients, and EMS struggled to meet demands with its limited staff and longer patient transports.").

205. *Rosebud Sioux Tribe*, 9 F.4th at 1021.

206. *Id.* (quoting Complaint at ¶ 61).

Importantly, the court noted that "[t]he canons of construction applicable in Indian law are rooted in the unique trust relationship between the United States and the Indians. Thus, it is well established that treaties should be construed liberally in favor of the Indians."[207] The court went on to explain that the treaty at issue promised that the federal government would annually furnish a physician and that appropriations would be made for their salary and housing.[208] Additionally, in the years following the treaty, the government reinforced its promises by consistently providing health care and encouraging Tribal members to forego cultural remedies for formal health care.[209] Thus, both the treaty language and the government's conduct reflected the expectation that the government had a persisting duty to supply the Tribe with healthcare services.

The court then turned to the Snyder Act and the IHCIA to demonstrate how these statutes further reinforced the government's obligations.[210] It explained that the Snyder Act "marked the beginning of Congressional funding for health care to all federally-recognized tribes, and the IHCIA established the structure to deliver services throughout Indian country."[211] Thus, the court reasoned that those statutes created an avenue for courts to judicially enforce the government's health care trust to the Tribes.[212]

Finally, the court ended the opinion by distinguishing the case from *Quechan Tribe*. The court reasoned the duty was judicially enforceable under the *Rosebud Sioux Tribe* facts because the Rosebud Sioux Tribe, unlike the Quechan Tribe, had a treaty that first created

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207. *Id.*; *see also supra* note 190 (containing sources discussing the applicable canons of construction in depth).

208. *Rosebud Sioux Tribe*, 9 F.4th at 1025; *see also* Pfefferbaum et al., *supra* note 42, at 221 ("As a result of treaty provisions and a long legislative history, many Indians are also entitled to certain additional health services provided by the federal government.").

209. *Rosebud Sioux Tribe*, 9 F.4th at 1024.

210. *Id.*

211. *Id.* at 1021; Snyder Act, 42 Stat. 208 (1908) (codified as amended at 25 U.S.C. § 13); Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, 90 Stat. 1400 (1976) (codified as amended in scattered sections of 25, 40, and 42 U.S.C.).

212. *Rosebud Sioux Tribe*, 9 F.4th at 1024 (citing White v. Califano, 581 F.2d 697, 698 (8th Cir. 1978) (affirming the District Court, which wrote that "[w]e think that Congress has unambiguously declared that the federal government has a legal responsibility to provide health care to Indians. This stems from the 'unique relationship' between Indians and the federal government . . . ."); *see also* Quick Bear v. Leupp, 210 U.S. 50 (1908) (detailing similar reasoning).

this healthcare duty.[213] Consequently, the treaty-created duty was merely reinforced by the government's actions and statutes.[214] Thus, the court relied on the "interpretation and construction of the Treaty, the trust relationship between the Government and the Tribe, and the statutory scheme underlying the alleged duty" to rightfully find that the government had an obligation to provide healthcare services.[215]

The divergent outcomes between *Quechan Tribe* and *Rosebud Sioux Tribe* are indicative the ever-shifting judicial approach towards the federal trust doctrine and its enforceability.[216] In theory, judicial enforcement could assist in holding the federal government accountable for providing adequate health care pursuant to both the federal trust responsibility and the actual terms of the IHCIA and the Snyder Act. However, the Ninth Circuit's opinion in *Quechan Tribe* appears to leave some Tribes without a judicial remedy if they did not enter into treaties that explicitly created a healthcare duty. Additionally, Tribal and federal resources applied toward this litigation are resources that could be directed toward the actual health systems. Accordingly, a comprehensive approach to addressing this issue should incorporate elements of Tribal self-determination and control over their own health systems to the extent feasible.

III. ACTUALIZING THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

A. The Right to the Highest Attainable Standard of Health Under International Law

In addition to diligent advocacy at the domestic level, Tribal Nations have also turned to the international community to advocate for their rights and interests.[217] Many human rights developments in the international system over the past twenty years have seen

213. *Rosebud Sioux Tribe*, 9 F.4th at 1025.

214. While the Rosebud Sioux Tribe had a treaty that explicitly promised healthcare services, the Quechan Tribe's treaty contained no such promise. *Id.*

215. *Id.* at 1023.

216. Lauren E. Schneider, *Trust Betrayed: The Reluctance to Recognize Judicially Enforceable Trust Obligations Under the Indian Health Care Improvement Act (IHCIA)*, 52 LOY. U. CHI. L.J. 1099, 1149 (2021) (discussing the trust doctrine's narrowing enforceability, including in the context of a circuit split between the Eighth Circuit in *Califano* and the Ninth Circuit in *Quechan Tribe*).

217. S. James Anaya, *The Human Rights of Indigenous Peoples: United Nations Developments*, 35 U. HAW. L. REV. 983, 983 (2013).

considerable advancements in not only the right to the highest attainable standard of health but also the applicability of universal human rights to Indigenous Peoples. While some remain doubtful over the impact of non-binding international legal instruments,[218] other legal experts have argued that such legal instruments "are growing in importance."[219] For instance, the United Nations Declaration on the Rights of Indigenous Peoples (the Declaration), may be viewed as "a highly influential legal instrument that can both generate realistic expectations of complying behavior and produce legal effects."[220] Although the right to the highest attainable standard of health is not recognized as an affirmative right under the domestic laws of the United States, it is recognized in many international human rights instruments,[221] and the analytical and political discourse around the right to the highest attainable standard of health contains models and suggestions that can inform the improvement of the health policies and programs that impact Indian Country.

International human rights instruments that reference the right to health include the Constitution of the World Health Organization (WHO), which recognizes that "[h]ealth is a state of complete physical, mental and social well-being," not simply the

218. *See, e.g.*, David H. Moore et al., *International Human Rights as a Vehicle for Achieving Rural Health*, 124 W. VA. L. REV. 773, 773–74 (2022) ("The gap between rights on paper and rights in practice can be so vast as to undermine confidence in human rights as a vehicle for achieving human dignity."); Anthony D'Amato, *Is International Law Really "Law"?*, 79 NW. U. L. REV. 1293, 1293–95 (1984) (introducing the question of whether enforcement is required to make international law "law").

219. Kristen A. Carpenter, *"Aspirations": The United States and Indigenous Peoples' Human Rights*, 36 HARV. HUM. RTS. J. 41, 48 (2023).

220. *Id.* (quoting MAURO BARELLI, SEEKING JUSTICE IN INTERNATIONAL LAW: THE SIGNIFICANCE AND IMPLICATIONS OF THE UN DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES 25 (2015)); *see also* Odette Mazel, *Indigenous Health and Human Rights: A Reflection on Law and Culture*, 15 INT'L J. ENVIRO. RSCH. PUB. HEALTH, at 6 (2018) ("While the [Declaration] is aspirational in nature and creates no enforceable rights in international law, it provides a framework for political advocacy and an authoritative statement on potentially emerging law concerning Indigenous people."); Rebecca Tsosie, *Indigenous People and Environmental Justice: The Impact of Climate Change*, 78 UNIV. COLO. L. REV. 1625, 1652 (2007) (noting "the concept of international human rights is interesting at the normative level, and it is worth contemplating the possibility of constructing a more just system of domestic law by investigating principles that are emerging through international consensus").

221. *See infra* notes 222–244 and accompanying text (examining different international human rights instruments containing the right to health).

absence of illness. [222] In 1948, the United Nations (U.N.) General Assembly adopted the Universal Declaration of Human Rights,[223] the first international declaration to acknowledge a universal set of rights, including the right to health. Almost twenty years later, the International Covenant on Economic, Social and Cultural Rights (ICESCR) codified the right to health,[224] although the United States is not a party to the ICESCR.[225] Both the ICESCR[226] and the Convention on the Rights of the Child (CRC)[227] provide that the right to the highest attainable standard of health is not only about access to medical care but also includes factors related to social determinants of health and preventative care, such as access to, and education about, nutritious foods. Several other international

222. Constitution of the World Health Organization, pmbl., July 22, 1946, 14 U.N.T.S. 185, 186. Adopted in 1946, this constitution also provides in its preamble that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." *Id.*

223. G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 25, ¶ 1 (Dec. 10, 1948).

224. International Covenant on Economic, Social and Cultural Rights art. 12, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR].

225. *Status of Ratification Interactive Dashboard*, U.N. OFF. HIGH COMM'R FOR HUM. RTS., https://indicators.ohchr.org (on file with the *Columbia Human Rights Law Review*).

226. Article 12 of the ICESCR recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and identifies concrete steps to "achieve the full realization of this right": (1) measures to reduce infant mortality and improve child health; (2) improvement of "environmental and industrial hygiene"; (3) measures to prevent, treat and control infectious diseases; and (4) access to medical care. ICESCR, *supra* note 224, at art. 12.

227. Article 24 of the CRC provides for a "right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" and includes access to "adequate nutritious foods and clean drinking-water," pre-natal and post-natal health care for mothers, and education on child health and nutrition. United Nations Convention on the Rights of the Child, art. 24, *opened for signature* Nov. 20, 1989, 44 U.N.T.S. 25 (entered into force Sept. 2, 1990). The United States has signed, but not ratified, the CRC, making it the only U.N. member nation to not do so. *See* Hannah Lichtsinn & Jeffrey Goldhagen, *Why the USA Should Ratify the UN Convention on the Rights of the Child*, 7 BMJ PAEDIATRICS OPEN, at 1 (2023), https://bmjpaedsopen.bmj.com/content/bmjpo/7/1/e001355.full.pdf [https://perma.cc/8SMQ-4XM4].

treaties, regional agreements, and international instruments also acknowledge the right to health.[228]

However, Article 12 of the ICESCR remains the "core source" of this right, which the U.N. Committee on Economic, Social and Cultural Rights expanded upon in General Comment No. 14, adopted in 2000.[229] The promulgation of General Comment No. 14 on the right to the highest attainable standard of health helped facilitate "wider agreement on the major elements of the right to health" by providing international standards.[230] General Comment No. 14 imposes a duty on each state "to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health." Further, "health facilities, goods and services must be . . . respectful of the culture of individuals, minorities, peoples and communities, [and] sensitive to gender and

228. *See, e.g.*, International Convention on the Elimination of All Forms of Racial Discrimination, art. 5(e)(iv), *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195, 222 (recognizing "[t]he right to public health, medical care, social security and social services"); Convention on the Elimination of All Forms of Discrimination Against Women, arts. 11(1)(f), 12, 14(2)(b), 1249 U.N.T.S. 13, 18–19 (recognizing "[t]he right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction" and directing Parties to take "all appropriate measures to eliminate discrimination against women in the field of health care" and "[t]o have access to adequate health care facilities"); Convention on the Rights of Persons with Disabilities, art. 25, *opened for signature* Mar. 30, 2007, 2515 U.N.T.S. 3, 84 (recognizing "the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability"); Organization of American States, American Declaration on the Rights of Indigenous Peoples, art. XVIII, June 15, 2016, AG/RES. 2888 (XLVI-O/16) ("Indigenous peoples have the collective and individual right to the enjoyment of the highest attainable standard of physical mental, and spiritual health . . . [and] the right to their own health systems and practices."); Int'l Labour Org., Indigenous and Tribal Peoples Convention, art. 25, June 27, 1989, C169 ("Governments shall ensure that adequate health services are made available . . . ."); International Covenant on Civil and Political Rights, art. 11(3), 18(3), 19(3)(b), 21, 22, *opened for signature* Dec. 16, 1966, 999 U.N.T.S. 171, 176, 178 (entered into force Mar. 23, 1976) (recognizing multiple instances where certain civil and political rights may be restricted as necessary for the protection of the public health). The United States has signed and ratified the International Convention on the Elimination of All Forms of Racial Discrimination and the International Covenant on Civil and Political Rights. *Status of Ratification Interactive Dashboard*, *supra* note 225.

229. Moore et al., *supra* note 218, at 777.

230. Gabriela Belova & Stanislov Pavlov, *Some Comments on the Highest Attainable Standard of Health*, 26(2) INT'L CONF.: KNOWLEDGE-BASED ORG. 134, 134 (2000).

life-cycle requirements."[231] In doing so, General Comment No. 14 provided that "the highest attainable standard of physical and mental health is not confined to the right to health care" but includes a myriad of social determinants of health, including "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."[232] An exhaustive exploration of each of these facets of the right to health in the context of Tribal Nations is beyond the scope of this Article, but Section IV.C herein will further discuss how Tribal Nations can be best positioned to fulfill some of these elements through exercises of Tribal self-determination when they have the adequate resources to do so.

The Study of the Problem of Discrimination Against Indigenous Populations[233]—prepared by former U.N. Special Rapporteur José R. Martínez Cobo of Ecuador—was a significant contribution to the U.N.'s focus on Indigenous Peoples as a pressing matter. In 2007, the U.N. General Assembly adopted the Declaration.[234] The Declaration serves to "contextualize universal human rights" as they apply to Indigenous Peoples.[235] Specific to Indigenous Peoples' health, Article 24(1) of the Declaration provides that Indigenous Peoples, including American Indians, have "the right to their traditional medicines and to maintain their health practices," as well as "the right to access, without any discrimination, to all social and health services."[236] Article 24(2) further provides that "Indigenous individuals have an equal right to the enjoyment of *the highest attainable standard of physical and mental health*."[237] The

231. Comm. on Econ., Soc., & Cultural Rts., General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), ¶ 12(c), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

232. *Id.* ¶ 4 (internal quotations omitted).

233. *See generally Preliminary Report of the Special Rapporteur on the Study of the Problem of Discrimination Against Indigenous Populations*, ¶ 12, U.N. Doc. E/CN.4/Sub.2/L.566 (June 29, 1972) (setting forth the scope of a study of discrimination against Indigenous populations, to include both a study of the problem and recommendations for national and international measures to eliminate discrimination).

234. G.A. Res. 61/295, United Nations Declaration on the Rights of Indigenous Peoples (Oct. 2, 2007).

235. Carpenter, *supra* note 219, at 46 (citing S. James Anaya, *International Human Rights and Indigenous Peoples*, 21 ARIZ. J. INT'L & COMPAR. L. 13, 59 (2009)).

236. G.A. Res. 61/295, annex, United Nations Declaration on the Rights of Indigenous Peoples, art. 24(1) (Oct. 2, 2007).

237. *Id.* at art. 24(2) (emphasis added).

Declaration also provides for other rights that factor into health outcomes, including Indigenous Peoples' right to improve their economic and social conditions[238] and the right to determine and develop priorities and strategies for exercising their right to development.[239] Together, these articles provide a "framework for protecting and promoting indigenous peoples' health."[240]

To date, numerous Tribes have adopted resolutions affirming support for the implementation of the Declaration, and two federally recognized Tribes, the Muscogee (Creek) Nation and the Pawnee Nation, have gone so far as to adopt the Declaration as part of their own Tribal law.[241]

On May 29, 2023, the WHO also adopted a resolution specific to the health of Indigenous Peoples, calling on Member States "to develop, fund, and implement national plans for Indigenous health."[242] The resolution requests that the WHO Director-General develop a global action plan for the health of Indigenous Peoples that will be presented to the World Health Assembly in 2026.[243] As Stacy Bohlen, Chief Executive Officer of the National Indian Health Board and citizen of the Sault Ste. Marie Tribe of Chippewa Indians stated: "This action is just the beginning. Now the work begins to reclaim

238. *Id.* at art. 21.

239. *Id.* at art. 23.

240. James Anaya, U.N. Special Rapporteur on the Rights of Indigenous Peoples, 2008–14, *Statement to the International Expert Group Meeting on the Theme: Sexual Health and Reproductive Rights* (Jan. 15, 2014), http://unsr.jamesanaya.org/?p=1083 [https://perma.cc/5HGA-RQVT].

241. *See* Carpenter, *supra* note 219, at 70–71 (2023) (discussing Tribes' recognition and implementation of the Declaration); *see also* NATIVE AM. RTS. FUND ET AL., TRIBAL IMPLEMENTATION TOOLKIT 11 (2021), https://un-declaration.narf.org/wp-content/uploads/Tribal-Implementation-Toolkit-Digital-Edition.pdf [https://perma.cc/ND6L-HY38] (citing Pit River Tribe and Seminole Nation resolutions); Pit River Tribe, *A Tribal Resol. Affirming the U.N. Declaration on the Rts. of Indigenous Peoples*, Res. No. 12-03-05 (2012) (recognizing the Declaration "as a minimum expression of the Indigenous rights of the Pit River Tribe of California"); Seminole Nation of Oklahoma, *A Tribal Resol. Affirming the U.N. Declaration on the Rts. of Indigenous Peoples*, Res. TR 2010-26 (2010) (recognizing the Declaration "as a minimum expression of the Indigenous rights of the members of the Seminole Nation of Oklahoma").

242. *NIHB Advocates Internationally, WHO Adopts Indigenous Peoples Health Resolution*, SPECIAL NEWS FOR INDIAN COUNTRY (Nat'l Indian Health Bd., Washington, D.C.), June 1, 2023 (on file with the *Columbia Human Rights Law Review*) [hereinafter *NIHB Advocates Internationally*].

243. World Health Org. Res., The Health of Indigenous Peoples, U.N. Doc. A76/A/CONF./1, at 4 (May 23, 2023).

and re-cut the trail of Indigenous health and wholeness deliberately over-planted with colonization's bitter, thorny brambles."[244]

B. Indigenous Social Determinants of Health and Effective Health Approaches

A growing body of research has demonstrated how economic, social, and environmental forces influence the health of individuals and communities.[245] These factors are widely referred to as the social determinants of health, which are defined as the "conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[246] The WHO has also produced numerous reports examining the social determinants of health and has asserted that the social conditions an individual experiences throughout their lifetime can often have a greater impact on health status than biological factors—like genetics—or health care.[247] These impacts include social conditions such as social inequities and exclusion, access to healthy food and clean water, and the capacity to secure and maintain steady employment.[248] The Commission on Social Determinants of Health, instituted by the WHO, has also established

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244. *NIHB Advocates Internationally*, *supra* note 242.

245. *See* Faith Khalik & Alisa Lincoln, *Salus Populi: Educating Judges on the Social Determinants of Health*, 71 J. LEGAL EDUC. 260, 261 (2023) (citing William C. Cockerham et al., *The Social Determinants of Chronic Disease*, 52 AM. J. PREVENTIVE MED. S5, S10 (2017) (stating that the "debate over whether or not social factors are fundamental causes of health and disease is essentially over")); *see also* NAT'L ACADS. SCIS., ENG'G, & MED., INTEGRATING SOCIAL CARE INTO THE DELIVERY OF HEALTH CARE: MOVING UPSTREAM TO IMPROVE THE NATION'S HEALTH 27 (2019) (stating that "[t]he consistent and compelling evidence on how social determinants shape health has led to a growing recognition throughout the health care sector that improving health and reducing health disparities is likely to depend—at least in part—on improving social conditions and decreasing social vulnerability").

246. Healthy People 2030, *Social Determinants of Health*, OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, https://health.gov/healthypeople/priority-areas/social-determinants-health [https://perma.cc/678C-6XGH].

247. COMM'N ON SOC. DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 43 (2008).

248. Stephanie Russo Carroll et al., *Reclaiming Indigenous Health in the US: Moving Beyond the Social Determinants of Health*, 19 INT'L J. ENVIRO. RSCH. & PUB. HEALTH, at 2 (2022) (citations omitted), https://pmc.ncbi.nlm.nih.gov/articles/PMC9223447/pdf/ijerph-19-07495.pdf [https://perma.cc/VDG6-MT7B].

a conceptual framework for action on the social determinants of health.[249]

However, WHO's framework may not "adequately capture[] Indigenous Peoples' lifeways."[250] Particularly relevant to Indigenous communities, but not fully accounted for in the WHO framework, are often-shared traumatic experiences originally perpetuated by the settler colonial state, including experiences such as the active dismantling of traditions and culture, removal from aboriginal homelands, active violence, and racism, which can result in intergenerational trauma.[251]

In April 2023, Indigenous representatives presented a report on Indigenous determinants of health to the U.N. Permanent Forum on Indigenous Issues.[252] The study both recognizes Indigeneity as "an overarching determinant of health" and identifies thirty-three interrelated Indigenous determinants of health that are divided into three categories: (1) intergenerational holistic healing, (2) the "Health of Mother Earth," and (3) decolonizing and re-Indigenizing culture.[253] The study also provides a series of recommendations pertaining to each category, intending to serve as a "foundational guide" for global and local leaders.[254] Overall, dialogue with and input from Indigenous Peoples are underlying values that drive the legitimacy of the report.

1. Accountability and Tribal Consultation

Reform of health systems serving Indigenous populations would be most effectively developed in consultation with, or led by, the communities they serve, because the community itself is the greatest source of Indigenous knowledge systems. Indigenous knowledge systems are inherently supportive of health and well-being, as they favor community-based approaches to health.[255] As

249. COMM'N ON SOC. DETERMINANTS OF HEALTH, A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 6 (2010).

250. Carroll et al., *supra* note 248, at 3.

251. *Id.*; *see supra* Part II (describing the history of traumatic experiences of Indigenous Peoples in the United States).

252. U.N. Econ. & Soc. Council, *Indigenous Determinants of Health in the 2030 Agenda for Sustainable Development*, U.N. Doc. E/C.19/2023/5 (Jan. 31, 2023).

253. *Id.* at 4.

254. *Id.* at 15–20.

255. *See, e.g.*, *Our Mission, Vision, and Values*, CHEROKEE INDIAN HOSP. AUTH., https://cherokeehospital.org/about/mission-vision-values/ [https://perma.cc/RLR6-X2BS] (listing guiding principles in the Cherokee language that emphasize balance, family, and community interests).

Professor Aila Hoss has stated, "Tribal consultation is essential for effective Indian health policy."[256] Meaningful Tribal consultation should be a cornerstone of the development of high-quality healthcare delivery systems. The needs and priorities of each Tribal Nation may be unique, and Tribes are the most well-positioned to speak to their community's priorities.

Additionally, accountability to the community should be a touchstone for effective Indian health policy and the development of health systems. Accountability is one of the most critical components in the realization of human rights,[257] but the specifics of what it looks like in practice are varied and dependent on specific circumstances.

2. Culturally Competent Care

A significant barrier to care that Indigenous Peoples face is racism.[258] A survey conducted by the Harvard School of Public Health found that 23% of AI/AN survey respondents experienced discrimination when seeking health care and 15% avoided seeking health care altogether for themselves or their families because of concern that they would face discrimination.[259] A commitment to providing culturally competent care must be part of an effective Tribal health system; this commitment includes service providers recognizing how culture matters and affects health, providing care in

256. Aila Hoss, *Securing Tribal Consultation to Support Tribal Health Sovereignty*, NE. UNIV. L. REV. 1, 2 (2022).

257. Paul Hunt & Gunilla Backman, *Health Systems and the Right to the Highest Attainable Standard of Health*, 10 HEALTH & HUM. RTS. 81, 87 (2008).

258. *See, e.g.*, BILLIE ALLAN & JANET SMYLIE, WELLESLEY INST., FIRST PEOPLES, SECOND CLASS TREATMENT: THE ROLE OF RACISM IN THE HEALTH AND WELL-BEING OF INDIGENOUS PEOPLES IN CANADA 2 (2015) ("Racist ideologies continue to significantly affect the health and well-being of Indigenous peoples . . . ."). Racism can result in death in some circumstances. For example, in the case of Brian Sinclair, healthcare workers in an emergency room in Canada assumed an Indigenous man was intoxicated and ignored him for over thirty hours while he remained in medical distress until his death. Aidan Geary, *Ignored to Death: Brian Sinclair's Death Caused by Racism, Inquest Inadequate, Group Say*s, CBC NEWS (Sept. 18, 2017), https://www.cbc.ca/news/canada/manitoba/winnipeg-brian-sinclair-report-1.4295996 [https://perma.cc/A4S9-QMSU]; BRIAN SINCLAIR WORKING GRP., OUT OF SIGHT (2017), https://professionals.wrha.mb.ca/old/professionals/files/OutOfSight.pdf [https://perma.cc/4L6N-FPVG].

259. ROBERT WOOD JOHNSON FOUND. ET AL., DISCRIMINATION IN AMERICA: EXPERIENCES AND VIEWS OF NATIVE AMERICANS 8, 12 (2017).

a patient's language, and delivering services in a manner that respects a patient's traditional practices.[260]

Native women often face discriminatory treatment when they seek care at facilities both on and off the reservation. [261] For example, during the early days of the COVID-19 pandemic in 2020, Lovelace Women's Hospital in Albuquerque, New Mexico reportedly had an informal policy of screening Native American women for COVID-19, targeting them by zip codes for Tribal areas, and then separating them from their newborns while test results were pending.[262] More generally, according to a poll by NPR, the Robert Wood Johnson Foundation, and the Harvard School of Public Health, "about a quarter of Native Americans reported experiencing discrimination when going to a doctor or health clinic."[263] These incidents occur both

260. ANDERSON & OLSON, *supra* note 8, at 8.

261. It is important to note that Indigenous women in other countries also face discriminatory treatment, which may be a marker of healthcare systems rooted in colonization. *See, e.g.*, Melissa Godin, *She Was Racially Abused by Hospital Staff as She Lay Dying. Now a Canadian Indigenous Woman's Death Is Forcing a Reckoning on Racism*, TIME (Oct. 9, 2020), https://time.com/5898422/joyce-echaquan-indigenous-protests-canada [https://perma.cc/6L37-5GQ9] (describing the case of Joyce Echaquan, an Indigenous Canadian woman who recorded the racist taunting of hospital staff as she was dying, sparking national outrage over racism in Canada's healthcare system). Additionally, Black and Latina women have also historically faced discriminatory treatment and considerable barriers when seeking medical treatment. *See, e.g.*, KAISER FAMILY FOUND., ISSUE BRIEF: AN UPDATE ON WOMEN'S HEALTH POLICY (2004), https://www.kff.org/wp-content/uploads/2013/01/racial-and-ethnic-disparities-in-women-s-health-coverage-and-access-to-care.pdf [https://perma.cc/UJU4-AFV7] (exploring "racial and ethnic disparities in health care among women").

262. Bryant Furlow, *Federal Investigation Finds Hospital Violated Patients' Rights by Profiling, Separating Native Mothers and Newborns*, PROPUBLICA (Aug. 22, 2020), https://www.propublica.org/article/federal-investigation-finds-hospital-violated-patients-rights-by-profiling-separating-native-mothers-and-newborns (on file with the *Columbia Human Rights Law Review*); *ACLU Responds to Reports That Lovelace Hospital Profiled Pregnant Native American Mothers, Separated Them from Their Newborns*, ACLU N.M. (June 15, 2020), https://www.aclu-nm.org/en/press-releases/aclu-responds-reports-lovelace-hospital-profiled-pregnant-native-american-mothers [https://perma.cc/MP6F-E8WC]; Bryant Furlow, *New Mexico In Depth, A Hospital Was Accused of Racially Profiling Native American Women. Staff Said Administrators Hid the Evidence*, N.M. IN DEPTH (June 22, 2020), https://nmindepth.com/2020/a-hospital-was-accused-of-racially-profiling-native-american-women-staff-said-administrators-hid-the-evidence (on file with the *Columbia Human Rights Law Review*).

263. Eric Whitney, *Native Americans Feel Invisible in U.S. Health Care System*, NPR (Dec. 12, 2017), https://www.npr.org/sections/health-

within and outside of federally managed Indian health systems and indicate a need for Tribally managed health systems, doctors trained in cultural competence, and Native doctors[264] who could treat Native patients with markedly less bias.[265]

Crafting healthcare systems with Native culture in mind could be lifesaving. In 2018, Larry Williams—a Navajo man who was sixty-seven years old—sought medical care at the corporate-owned San Juan Regional Medical Center in Farmington.[266] Mr. Williams

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shots/2017/12/12/569910574/native-americans-feel-invisible-in-u-s-health-care-system [https://perma.cc/H4JH-PBHM] (citing ROBERT WOOD JOHNSON FOUND., *supra* note 259); Joe Neel, *Poll: Native Americans See Far More Discrimination in Areas Where They Are a Majority*, NPR (Nov. 14, 2017), https://www.npr.org/2017/11/14/563306555/poll-native-americans-see-far-more-discrimination-in-areas-where-they-are-a-majo [https://perma.cc/E6FA-KP32] (citing ROBERT WOOD JOHNSON FOUND., *supra* note 259).

264. *See* LYNNE KIRK, AM. MED. ASSOC., STUDY OF DECLINING NATIVE AMERICAN MEDICAL STUDENT ENROLLMENT, CME REPORT 5-A-18, at 2 (2018), https://www.ama-assn.org/system/files/2021-05/a18-cme-05.pdf [https://perma.cc/W4FQ-FES7] ("Out of the total active MD workforce (approximately 850,000) in the U.S., 0.4% (3,400) are self-identified as AI/AN."); Tom Marcinko, *More Native American Doctors Needed to Reduce Health Disparities in Their Communities*, AAMC NEWS (Nov. 13, 2016), https://www.aamc.org/news/more-native-american-doctors-needed-reduce-health-disparities-their-communities (on file with the *Columbia Human Rights Law Review*) (discussing how "familiarity with the cultural values, lifestyles, and spiritual beliefs of a patient can enhance the doctor-patient relationship").

265. A growing body of research is demonstrating the bias that can exist when physicians and patients do not share the same race or ethnicity. *See, e.g.*, Colin A. Zestcott et al., *Health Care Providers' Negative Implicit Attitudes and Stereotypes of American Indians*, 8 J. RACIAL ETHNIC HEALTH DISPARITIES 230, 230 (2020) (finding evidence of negative implicit attitudes among health care providers toward American Indians based on an implicit bias test administered to 111 providers); Melissa L. Walls et al., *Unconscious Biases: Racial Microaggressions in American Indian Health Care*, 28 J. AM. BD. FAM. MED. 231, 231 (2015) (finding, based on a survey of 218 individuals in two AI/AN reservation communities, that over one third reported experiencing a racial microaggression in interactions with healthcare providers); Ryan Huerto, *Minority Patients Benefit from Having Minority Doctors, but That's a Hard Match to Make*, MICH. MED. (Mar. 31, 2020), https://www.michiganmedicine.org/health-lab/minority-patients-benefit-having-minority-doctors-thats-hard-match-make [https://perma.cc/J9WK-NA7N] (arguing that "increas[ing] the probability that minorities see doctors of their race or ethnicity" can improve health outcomes for minorities).

266. Jeanette DeDois, *Larry Williams Wasn't Given a Navajo Translator to Speak to His Doctor; He Died After His Visit*, SOURCE NM (Mar. 6, 2023), https://sourcenm.com/2023/03/03/larry-williams-suffered-a-serious-medical-episode-and-needed-a-navajo-interpreter-to-speak-to-his-doctor-that-didnt-happen-and-he-died-after-his-visit [https://perma.cc/6YCY-DTPQ].

primarily spoke Navajo, and, when the hospital did not provide a Navajo interpreter, medical personnel missed key symptoms during the examination.[267] The incomplete information led to the insufficient provision of care, and Williams went into severe septic shock that evening and passed the following day from respiratory failure.[268] His preventable death is but one instance in a larger pattern of cultural disconnect that impacts the quality of care.

As mentioned earlier, it is also vital to develop culturally competent care that acknowledges historical complexities and their ongoing impacts on Native peoples. The "collective traumatic past of American Indian and Alaska Natives and subsequent responses merit consideration in the design and delivery of clinical interventions and research with these populations."[269] Health systems serving Indigenous populations should be cognizant of the ongoing impacts of the settler colonial state.[270]

IHS has also acknowledged the important role Native healers can play in improving Native health.[271] As far back as 1979, the agency established a policy acknowledging the importance of traditional Native healing methods and has supported traditional training programs for medicine men.[272] Ultimately, if healthcare providers and systems are not educated as to the culture of their patients, that can perpetuate adverse outcomes for both the patients and the facilities where they seek care.

C. Tribally Operated Health Systems

Despite the moral and legal obligations of the federal government to provide health care to Native peoples, Tribal Nations are increasingly recognizing that they cannot wholly rely on the federal government to provide adequate health care. An increasing number of Tribes are entering into self-determination contracts and self-governance compacts to take over operations of federally funded healthcare facilities. As a result, Tribes now operate nearly six

267. *Id.*
268. *Id.*
269. Brave Heart et al., *supra* note 131, at 283 (2011).
270. *See generally* Wispelwey et al., *supra* note 157 (arguing that an analysis based on settler colonialism can help explain and remediate persistent health inequities).
271. Heather Tanana, *Protecting Tribal Public Health from Climate Change Impacts*, 15 N.E. UNIV. L. REV. 89, 157 (2023).
272. *Id.*; *see also* Johnson & Rhoades, *supra* note 31, at 82 (discussing IHS participation in and support for Native healing methods starting in the 1970s).

hundred healthcare facilities with federal funds.[273] Tribes located in the same region have also formed coalitions of inter-Tribal health boards to serve their region.[274]

Tribes with successful economic endeavors such as gaming often apply that revenue to fund the provision of healthcare services.[275] Some Tribes have also made generous donations to general hospitals in their regions to support the provision of health care to the entire community.[276] However, not every Tribe is in the economic position to provide this degree of funding to healthcare services, nor should they be expected to. While Indian gaming tends to be the most successful economic driver for Tribes that can engage in this form of economic development, the majority of Tribes (over three hundred) do not own or operate gaming operations.[277] Tribes

273. *IHS Profile*, INDIAN HEALTH SERV. (Oct. 2024), https://www.ihs.gov/newsroom/factsheets/ihsprofile/ [https://perma.cc/5DXS-XXDZ] (indicating that as of June 2023, Tribes operated 22 hospitals, 331 health centers, 76 health stations, 147 Alaska Village clinics, 7 school health centers, and 6 youth regional treatment centers).

274. *See, e.g.*, *NIHB Member Organizations*, NAT'L INDIAN HEALTH BD., https://www.nihb.org/about_us/area_health_boards.php (on file with the *Columbia Human Rights Law Review*) (providing a list of member organizations of the National Indian Health Board, including the Alaska Native Health Board, Great Lakes Area Tribal Health Board, Great Plains Tribal Leaders' Health Board, etc.).

275. DEJONG, *supra* note 31, at 163.

276. *See, e.g.*, *Loma Linda University Children's Hospital Receives $25 Million Gift from San Manuel Band of Mission Indians*, SAN MANUEL BAND OF MISSION INDIANS (Feb. 22, 2019), https://sanmanuel-nsn.gov/news/loma-linda-university-childrens-hospital-receives-25-million-gift-san-manuel-band-mission [https://perma.cc/V5M3-SNSW] (describing San Manuel's $25 million gift to Loma Linda University Health as an ongoing part of "more than a century of friendship" between the Tribe and hospital); *Morongo Tribe Makes $5.6 Million Donation to Banning Hospital*, DESERT SUN (Mar. 18, 2022), https://www.desertsun.com/story/news/2022/03/18/morongo-tribe-makes-5-6-million-donation-banning-hospital/7094998001 [https://perma.cc/P6HA-FQR4] ("The Morongo Band of Mission Indians donated $5.6 million to the San Gorgonio Memorial Hospital Foundation . . . , enabling the medical center in Banning to procure equipment that will enhance its stroke treatment facilities."); Ken Stone, *Jamul Indian Village Donates $75,000 to Health-Care Projects, Reservations*, TIMES OF SAN DIEGO (Jan. 4, 2021), https://timesofsandiego.com/life/2021/01/04/jamul-indian-village-donates-75000-to-health-care-projects-reservations [https://perma.cc/CM8V-KRYX] (describing how Jamul Indian Village of California donated $45,000 to Sharp Grossmont Hospital, $15,000 to the Southern Indian Health Council, and $15,000 to Indian Health Council Inc.).

277. In Fiscal Year 2022, 243 federally recognized Tribes operated a total of 527 gaming operations on Indian land in twenty-nine states. NAT'L INDIAN GAMING COMM'N, ANNUAL REPORT FY 2022, at 7 (2022),

near major metropolitan areas and tourist destinations often see greater economic gains,[278] although some casinos are located in more rural areas.[279] Additionally, the economic success of some Tribes should not be utilized to justify any abandonment or decrease of federal support of Indian health services.

1. Tribes as Public Health Jurisdictions

In the United States, there are currently 574 federally recognized Tribes,[280] each of which governs itself under a unique legal framework that is generally separate from state and municipal governments. Tribal Nations are recognized as "distinct, independent political communities"[281] with a "plenary and exclusive power over their members and their territory subject only to limitations imposed by federal law."[282] As sovereigns, Tribal governments have the inherent authority to enact their own laws[283] that reflect internal healthcare policies and priorities. This power makes them well-poised to operate as public health jurisdictions. Additionally, both federal and state laws recognize Tribal Nations as public health jurisdictions.[284] As public health jurisdictions, Tribal governments

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https://www.nigc.gov/images/uploads/FY22_Annual_Report_Final.pdf [https://perma.cc/6JMZ-KKCC].

278. Chambers, *supra* note 136, at 736.

279. *See Map of Indian Gaming Locations*, NAT'L INDIAN GAMING COMM'N, https://www.nigc.gov/map [https://perma.cc/Y3RU-H8GB] (providing a detailed map of Indian gaming facilities).

280. Indian Entities Recognized by and Eligible to Receive Services from the United States Bureau of Indian Affairs, 87 Fed. Reg. 4636 (Jan. 28, 2022).

281. Worcester v. Georgia, 31 U.S. 515, 559 (1832); *see also* Michigan v. Bay Mills Indian Cmty., 572 U.S. 782, 788 (2014) ("Indian tribes are 'domestic dependent nations' that exercise 'inherent sovereign authority.'") (quoting Cherokee Nation v. Georgia, 30 U.S. 1, 17 (1831)); United States v. Lara, 541 U.S. 193, 204–05 (2004) (affirming Supreme Court's "traditional understanding" of each Tribe as "a distinct political society, separated from others, capable of managing its own affairs and governing itself") (quoting Cherokee Nation v. Georgia, 30 U.S. 1, 16 (1831)).

282. COHEN'S HANDBOOK, *supra* note 15, §§ 4.01(1)(b), 4.01(2); *see also* United States v. Mazurie, 419 U.S. 544, 557 (1975) ("Indian tribes are unique aggregations possessing attributes of sovereignty over both their members and their territory . . . .").

283. Williams v. Lee, 358 U.S. 217, 220 (1959) (noting the authority of Tribes "to make their own laws and be ruled by them"); United States v. Wheeler, 435 U.S. 313, 322–23 (1978) (noting Tribes maintain "inherent powers of a limited sovereignty which has never been extinguished").

284. *See, e.g.*, 45 C.F.R. § 164.501 (2024) (defining "public health authority" as, among other authorities, "an Indian tribe . . . that is responsible for public

can have "many legal 'levers' designed to prevent injury and disease and to promote the public's health."[285]

For instance, the enactment of public health laws is one of the more straightforward, foundational elements of public health.[286] Public health laws can create public health offices and define the scope of their authority, mandate the collection and tracking of crucial data, and regulate potentially dangerous activities that threaten public health—all essential parts of directing human behavior to promote and protect public health.[287] However, aspects of Tribes' sovereign powers, particularly jurisdiction over nonmembers, have been restricted by certain congressional acts, treaties, and decisions of the U.S. Supreme Court. In the civil context, under the Supreme Court case *Montana v. United States*, Tribes' inherent sovereign powers do not generally extend to the activities of nonmembers, with two exceptions: (1) nonmembers who enter "consensual relationships" with the Tribe or its members "through commercial dealing, contracts, leases, or other arrangements" and (2) non-Indians whose conduct threatens or directly affects "the political integrity, the economic security, or the health or welfare of the tribe."[288]

At the moment, there is very little case law discussing how this civil jurisdiction framework may apply in the context of public health in Indian Country.[289] However, it is worth noting that many Tribes who sought to enforce COVID-19 response laws over non-Indians faced significant challenges from state and local governments.[290] For instance, South Dakota Governor Kristi Noem

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health matters as part of its official mandate"); Wash. Rev. Code § 43.70.512(1) (2019) (defining the governmental public health system as comprised of sovereign Tribal nations and Indian health programs in addition to state and local health entities); LAW IN PUBLIC HEALTH PRACTICE 239, 252 (Richard A. Goodman et al. eds., 2d ed. 2007) (noting that federal, Tribal, state, and local public health agencies engage in public health practice activities).

285. LAW IN PUBLIC HEALTH PRACTICE 11 (Richard A. Goodman et al. eds., 1st ed. 2003).

286. *See id.* at xxviii (discussing the importance of public health laws).

287. *Id.*; *see also* Aila Hoss, *Exploring Legal Issues in Tribal Public Health Data and Surveillance*, 44 S. ILL. U. L.J. 27, 27 (2019) ("An essential component to public health practice includes the collection and surveillance of health data.").

288. Montana v. United States, 450 U.S. 544, 565–66 (1981).

289. Hoss, *supra* note 138, at 121.

290. *See* Katherine Florey, *Toward Tribal Regulatory Sovereignty in the Wake of the COVID-19 Pandemic*, 63 ARIZ. L. REV. 399, 407–08, 419–20 (2021) (discussing limits of Tribes' exclusion power when seeking to protect their members from the spread of COVID-19); Lindsey Schneider, Joshua Sbicca, &

threatened legal action over checkpoints on state highways entering the reservation meant to inhibit the spread of the disease.[291] The jurisdictional restraints of the *Montana* framework and ambiguity surrounding its scope complicated Tribes' ability to respond effectively as public health authorities during the pandemic,[292] suggesting that Tribes may face similar challenges to their jurisdiction when seeking to enforce important public health laws in the future.

Jurisdiction over non-Indians is also a necessary component for Tribes "to realistically and successfully self-regulate the provision of health care services on tribal lands"[293] if they provide care to non-Indians, as Tribally owned facilities sometimes do.[294] The most straightforward approach for Tribes to establish jurisdiction over non-Indians would be to "obtain[] explicit consent to jurisdiction," per *Montana*'s first exception.[295]

At least thirty Tribal Constitutions also explicitly reference the "health" or "welfare" of their Tribal members.[296] In order to

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Stephanie Malin, *Native American Tribes' Pandemic Response Is Hamstrung by Many Inequities*, CONVERSATION (June 1, 2020), https://theconversation.com/native-american-tribes-pandemic-response-is-hamstrung-by-many-inequities-136225 [https://perma.cc/CP5R-HXGT].

291. *See* Madeleine Carlisle, *South Dakota Governor Demands Tribe Leaders Remove Checkpoints Set Up to Prevent the Spread of COVID-19,* TIME (May 9, 2020), https://time.com/5834749/south-dakota-governor-native-american-tribes-coronavirus [https://perma.cc/FL6N-FHM5] (describing letters sent by the governor demands to the Cheyenne River Sioux and Oglala Sioux Tribes' leadership demanding the removal of the checkpoints and threatening "necessary legal action" if the Tribes did not do so within forty-eight hours).

292. *See* Florey, *supra* note 290, at 437 ("While tribes have had some success fighting back a virus that remains a grave threat to them, the uncertainty of tribal regulatory jurisdiction over all people and land within reservations has complicated the tribal response.").

293. Strommer et al., *supra* note 104, at 137.

294. *See* INDIAN HEALTH SERV., U.S. DEP'T HEALTH & HUM. SERVS., INDIAN HEALTH MANUAL, ch. 1, pt. 2, § 2-1.2(B), https://www.ihs.gov/ihm/pc/part-2/chapter-1-eligibility-for-services/#2-1.2 [https://perma.cc/BEU5-37AG] (describing eligibility for non-Indians to receive care and treatment from IHS); WIS. DEP'T OF ADMIN., DIV. OF INTERGOV'TAL RELS., TRIBES OF WISCONSIN 41 (2024), https://doa.wi.gov/DIR/Tribes_of_Wisconsin.pdf [https://perma.cc/QLZ7-5J3P] (discussing how the Forest County Potawatomi Community's healthcare services are open to all residents, with an estimated 60% of services being provided to non-Native Americans).

295. Strommer et al., *supra* note 104, at 141.

296. Hoss, *supra* note 138, at 126–27; *see* STANDING ROCK SIOUX TRIBAL CONST. art. IV, § 1(c) (1959) ("The Tribal Council shall exercise the following

prevent the spread of disease, some Tribes have implemented public health laws requiring healthcare providers to report occurrences of infectious diseases.[297] Additionally, in response to COVID-19, many Tribes implemented mask mandates and curfews and sought to close their borders.[298] However, as noted, the *Montana* framework creates ambiguity around Tribes' powers to stop nonmembers from bringing infectious diseases to the reservation.[299] A number of Tribes have enacted occupational health and safety laws to institute internal standards for providing safe and healthy working conditions for Tribal employees.[300]

Tribes are also pursuing creative legal strategies to address some of the underlying social determinants of health, including by implementing policies to encourage the consumption of healthy foods.

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powers . . . [t]o promote and protect the health, education and general welfare of the members of the Tribe . . . .").

297. Hoss, *supra* note 138, at 35; *see, e.g.*, FORT PECK COMPREHENSIVE CODE OF JUSTICE, tit. 14, § 608 (2024) (requiring physicians and healers to report communicable diseases to the Tribal Health Officer); SAC & FOX TRIBE OF THE MISS. IN IOWA CONST. & CODES § 12-4201 to -4203 (2007) (requiring healthcare providers to report diseases to the Health Director).

298. *See, e.g.*, Schneider et al., *supra* note 290 ("Native communities are taking decisive action to reduce the spread of COVID-19. They're imposing aggressive quarantine measures like lockdowns, curfews and border closures. Communities are ramping up health care capacity and elder support services, and banishing nontribal members who violate travel restrictions."); Lynda V. Mapes, *Makah Tribe Fights Coronavirus with Self-Reliance and Extreme Isolation*, SEATTLE TIMES (May 3, 2020), https://www.seattletimes.com/seattle-news/makah-tribe-fights-coronavirus-with-self-reliance-and-extreme-isolation (on file with the *Columbia Human Rights Law Review*) (describing the isolation measures taken by the Makah Tribe during the pandemic).

299. *See supra* notes 288–295 and accompanying text (discussing *Montana* and its potential implications); Florey, *supra* note 290, at 406–07 (describing Tribes' powers to institute COVID-19 health measures as "a never-tested argument in an area of law where massive uncertainties exist about the particulars").

300. *See, e.g.*, Workers Protection Code, LAW & ORDER CODE OF THE KALISPEL TRIBE, § 23-1.01 to -9.03 (2017) (setting forth workforce safety measures, including an insurance requirement and a Tribal Workers Protection Advisory Council); Navajo Nation Occupational Safety and Health Act, NAVAJO NATION CODE, tit. 15, ch. 15, § 1401–574 (2010) (establishing "Occupational Safety and Health regulations applicable to all workplaces within the territorial jurisdiction of the Navajo Nation"); Occupational Safety and Health Program Act of 2002, HO-CHUNK NATION CODE, tit. 6, § 8 (amended 2022) (establishing workplace health and safety programs and standards); Oneida Safety Law, ONEIDA CODE OF LAWS, tit. 3, ch. 303.1-1 (establishing workplace health and safety standards for Tribal employees).

In 2014, the Navajo Tribal Council passed the Healthy Diné Nation Act, which implemented a 2% junk food tax on foods with minimal to no nutritional value.[301] This tax was the first of its kind implemented by a Tribal Nation and one of the first in the United States.[302] The tax revenue was then disbursed to each of the 110 Navajo Nation chapters for "local wellness programming such as farming, traditional food demonstrations, exercise equipment, walking trails, and community cleanup."[303] The tax was initially set to expire at the end of 2020 but was reauthorized on December 31, 2020.[304]

2. Tribally Operated Health Facilities

Similar to political sovereignty and cultural sovereignty,[305] the exercise of Tribal health sovereignty through increased control over Tribal health systems is imperative for the continued existence of Tribal Nations. In the past forty years, a number of Tribes have transitioned from using federally provided health systems to developing their own "complex tribal health care delivery systems that offer the highest level of health care possible."[306] By November 2019, the federal government was operating 109 IHS facilities, and

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301. The Healthy Diné Nation Act of 2014, NAVAJO NATION CODE, tit. 24, ch. 11, § 1101–19 (2014); *see* Del Yazzie et al., Ctrs. for Disease Control & Prevention, Research Brief, *The Navajo Nation Healthy Diné Nation Act: A Two Percent Tax on Foods of Minimal-to-No Nutritious Value, 2015–2019*, 17 PREVENTING CHRONIC DISEASE, at 1, 4 (2020), https://www.cdc.gov/pcd/issues/2020/pdf/20_0038.pdf [https://perma.cc/4NDU-B7G8] (noting that revenue from the junk food tax declined, on average, 3% per year, possibly signaling a reduction in consumption of unhealthy foods).

302. Berkeley, California, was the first United States jurisdiction to pass a sugar-sweetened beverage tax in 2014. *See generally* Jennifer Falbe et al., *Implementation of the First US Sugar-Sweetened Beverage Tax in Berkeley, CA, 2015–2019*, 110 AM. J. PUB. HEALTH 1429, 1429 (2020) (discussing implementation of the Berkeley tax and finding that the "policy package, context, and implementation process facilitated translating policy into public health outcomes").

303. Yazzie, *supra* note 301, at 1.

304. *The Navajo Nation Junk Food Tax and the Path to Food Sovereignty*, NAT'L INST. ON MINORITY HEALTH & HEALTH DISPARITIES (Oct. 7, 2022), https://www.nimhd.nih.gov/news-events/features/community-health/navajo-nation-junk-food-tax.html [https://perma.cc/AE8W-BFPU].

305. Wallace Coffey & Rebecca Tsosie, *Rethinking the Tribal Sovereignty Doctrine: Cultural Sovereignty and the Collective Future of Indian Nations*, 12 STAN. L & POL'Y REV. 191, 210 (2001) (defining cultural sovereignty as "encompass[ing] the spiritual, emotional, mental, and physical aspects of [Native peoples'] lives").

306. Strommer et al., *supra* note 104, at 115.

Tribes were operating 667 healthcare facilities with federal funding.[307] While there is still a need for a long-term comprehensive study of the successes and challenges that have occurred in Tribally operated health facilities, the initial results have shown generally favorable outcomes.[308] For example, in a study conducted by the National Indian Health Board of eighty-three Tribally operated health facilities, 86% of surveyed Tribal leaders of Tribes with self-governance compacts reported believing that the quality of care had gotten "better" over the course of three to four years.[309] The preliminary results of a 2009 study by Harvard also indicated that "tribes have significantly improved their citizens' access to health services."[310]

The benefits of Tribal administration are clear. With well over five hundred unique Tribal communities, Tribes are often the best judge of the particular needs of their communities; the needs and priorities of a village group in Alaska can often be vastly different from the needs and priorities of a Tribe in South Dakota. Additionally, Tribal governments that are accountable to their constituents are more likely to be responsive to concerns raised by the people they serve. Overall, studies have demonstrated that Tribes often operate federal programs more efficiently than federal agencies.[311]

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307. U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-20, INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE OVERSIGHT OF FEDERAL FACILITIES' DECISION-MAKING ABOUT THE USE OF FUNDS 5 (2020), https://www.gao.gov/assets/gao-21-20.pdf [https://perma.cc/Z52E-YUZP].

308. *See, e.g.*, Ruiz-McGill, *supra* note 102.

309. *See* Shelton et al., *supra* note 103, at 7–8.

310. MILLER, *supra* note 20, at 141 (citing Jaime Arsenault & Stephanie Carroll Rainie, *Tribal Management Key to Improved Health Service*s, ICT NEWS (July 18, 2009), https://ictnews.org/archive/arsenault-and-rainie-tribal-management-key-to-improved-health-services (on file with the *Columbia Human Rights Law Review*)); *see also* HARVARD PROJECT ON AM. INDIAN ECON. DEV., HONORING NATIONS: 2003 HONOREE – NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD 2 (2004), https://nnigovernance.cals.arizona.edu/sites/nnigovernance.arizona.edu/files/2022-09/2003_HN_NW_portland_area_indian_health_board.pdf [https://perma.cc/QR4Y-2RV7] (recognizing the success of the Northwest Portland Area Indian Health Board in improving the health status of its member Tribes).

311. MILLER, *supra* note 20, at 53 (citing Matthew B. Krepps, *Can Tribes Manage Their Own Resources? The 638 Program and American Indian Forestry*, *in* WHAT CAN TRIBES DO? STRATEGIES AND INSTITUTIONS IN AMERICAN INDIAN ECONOMIC DEVELOPMENT 182–83, 199 (Stephen Cornell & Joseph P. Kalt eds., 1992)); *see also* Washburn, *supra* note 88, at 207 (stating that "[t]he broad

Described as the "most successful model of self-determination,"[312] the Alaska Native Tribal Health Consortium (ANTHC) is often looked to as a blueprint for how Tribal Nations may successfully take over the operations of their hospitals. Alaska Native Tribes and Tribal health organizations began assuming management of IHS-administered programs in the 1970s through self-determination contracts.[313] Bristol Bay Area Health Corporation made history in 1980 when it assumed exclusive responsibility for its service area, making it the first Tribal group to manage an IHS facility.[314] In 1994, twenty-five Tribes and nonprofit Tribal health entities entered into the Alaska Tribal Health Compact with IHS, setting forth the terms and conditions for Alaska Native Tribes and Tribal organizations to assume responsibility for the administration of health services. By 2012, IHS was contracting or compacting 99% of its entire Alaska program.[315]

In 1997, Southcentral Foundation, an Alaska Native-owned nonprofit healthcare organization, assumed complete management of primary care and other health programming at the Anchorage Native Primary Care Center.[316] Currently, the ANTHC and Southcentral Foundation jointly manage the award-winning Alaska Native Medical Center.[317] Southcentral Foundation's healthcare system is also now

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consensus is that tribal self-determination contracting has dramatically improved federal services to Indian people" and discussing possible reasons).

312. Mark Walker, *Fed Up with Deaths, Native Americans Want to Run Their Own Health Care*, N.Y. TIMES (Oct. 15, 2019), https://www.nytimes.com/2019/10/15/us/politics/native-americans-health-care.html (on file with the *Columbia Human Rights Law Review*).

313. Joaqlin Estus, *National Panel Praises Alaska Tribal Health System Successes*, ICT NEWS (May 4, 2023), https://ictnews.org/news/national-panel-praises-alaska-tribal-health-system-successes (on file with the *Columbia Human Rights Law Review*).

314. ALASKA NATIVE TRIBAL HEALTH CONSORTIUM, OUR HEALTH IN OUR HANDS: THE PATH TO TRIBALLY MANAGED HEALTH CARE IN ALASKA: 1950S TO TODAY 6, https://www.anthc.org/wp-content/uploads/2021/01/Our-health-in-our-hands.pdf [https://perma.cc/W4K3-5RF5].

315. CASE & VOLUCK, *supra* note 89, at 235.

316. *About Us*, SOUTHCENTRAL FOUND. NUKA SYS. OF CARE, https://scfnuka.com/about-us [https://perma.cc/8GJH-KUJL].

317. ALASKA NATIVE MED. CTR., https://anmc.org [https://perma.cc/5D9C-X54Q] (noting that the medical center is award-winning); *History*, SOUTHCENTRAL FOUND. NUKA SYS. OF CARE, https://www.southcentralfoundation.com/about-us/history-2 [https://perma.cc/9FTW-Z52X] ("In 1999, Southcentral Foundation and the Alaska Native Tribal Health Consortium signed an agreement to take over ownership and management of the entire Alaska Native Medical Center (ANMC).").

titled "Nuka," an Alaska Native word for strong, giant structures and living things, and is recognized as one of the world's leading models of healthcare redesign.[318] As part of the redesign, the Nuka System of Care focuses on relationship-building and shared decision-making, referring to patients as customer-owners.[319] This paradigm shift of placing individual Alaska Natives in a position of ownership over their own health care has been transformative, with a 97% customer-owner satisfaction rate and remarkable improvements in the overall health of the population.[320]

The Nuka System of Care has also served as a learning model for nearly three thousand organizations in forty-five countries, including the Cherokee Indian Hospital Authority, the Kenaitze Indian Tribe, and Canada's First Nations Health Authority.[321] In 2012, the Cherokee Indian Hospital, managed by the Eastern Band of Cherokee Indians, implemented the Nuka System of Care, tailoring this integrated care model to their own culture and health needs.[322] In 2015, the Eastern Band of Cherokee Indians also opened the new Cherokee Indian Hospital, which the Tribe fully funded.[323] Developed with input from the Tribal community, the design of the state-of-the-art facility "incorporates several Tribal elements" and is intended to "promote[] healing."[324] The care that the Tribe put into this design demonstrates how Tribes are creating health systems that reflect their unique cultural sovereignty.[325]

In celebrating the successes of Tribal self-determination, it is equally worthwhile to acknowledge that Tribal administration is not without its own complex challenges. First, Tribes will continue

318. *About Us*, SOUTHCENTRAL FOUND., *supra* note 316.

319. *Id.*

320. *Id.* ("After the system transformation that established the Nuka System of Care, SCF saw a dramatic decrease in ER visits and hospital discharges for customer-owners.").

321. SOUTHCENTRAL FOUND. NUKA SYS. OF CARE, https://scfnuka.com [https://perma.cc/KY7F-VZVG].

322. Katja Ridderbusch, *How the Eastern Cherokee Took Control of Their Health Care*, KFF HEALTH NEWS (July 22, 2019), https://kffhealthnews.org/news/how-the-eastern-cherokee-took-control-of-their-health-care [https://perma.cc/6VXX-VRDG].

323. *Cherokee Indian Hospital*, INDIAN HEALTH SERV., https://www.ihs.gov/dentistry/newsletters/cherokee-indian-hospital [https://perma.cc/F435-W5BB].

324. *Id.*

325. Coffey & Tsosie, *supra* note 305, at 210 (defining cultural sovereignty as "encompass[ing] the spiritual, emotional, mental, and physical aspects of [Native peoples'] lives").

operating with the same budgetary constraints as the federal government, unless they are able to supplement their healthcare systems with other revenue. Tribal self-governance in the provision of health care does not inherently increase the number of resources available to provide Indian health services; indeed, Tribal Nations may still be constrained by the same budgetary restraints if their primary or sole source of funding remains with the federal government. However, it may alter the way funding is distributed, as Tribes to date have demonstrated they tend to be more efficient in applying funding to priority areas. Additionally, when Tribes take over federal programs, they face the same complex and often daunting social problems that the federal government has grappled with for decades. [326] They are often tasked with taking over already struggling health systems to address complicated and demanding health issues. For instance, even though all healthcare systems reached various breaking points during the COVID-19 pandemic,[327] Tribal health systems were particularly strained as they struggled with staffing shortages, funding gaps, and a lack of sufficient infrastructure, including bandwidth for telemedicine.[328] However, the rapidly growing number of Tribes entering into self-determination contracts evinces how it is of paramount importance to Tribes that they play a lead role in their healthcare systems.

As Tribes assume greater responsibility for the provision of health services, another apparent complexity is that the federal government has, in some instances, tried to limit its degree of responsibility in response.[329] As mentioned in Part III, there has been

326. Washburn, *supra* note 88, at 224 ("In short, tribes now must face the same social problems that the federal government has tried for decades to address. It should be no wonder that tribes will sometimes fail too.").

327. *See* Stephen J. Thomas, *The Covid-19 Pandemic Is Breaking the U.S. Healthcare System*, FORBES (Jan. 19, 2022), https://www.forbes.com/sites/coronavirusfrontlines/2022/01/19/the-covid-19-pandemic-is-breaking-the-us-healthcare-system—but-thats-only-a-symptom-of-the-underlying-disease [https://perma.cc/SY4D-KTC4] (noting U.S. healthcare system issues, such as dissatisfaction of healthcare workers, that were exacerbated by the pandemic).

328. *See* Ivy Hurwitz et al., *Disproportionate Impact of COVID-19 Severity and Mortality on Hospitalized American Indian/Alaska Native Patients*, 2 PNAS NEXUS 259, 259 (2023) (discussing how the COVID-19 pandemic has exacerbated challenges faced by AI/AN "in accessing quality healthcare due to geographic remoteness, limited healthcare infrastructure, socioeconomic constraints, historical trauma, and discriminatory policies").

329. *See* Washburn, *supra* note 88, at 200 (describing the federal government's general trend toward shirking its trust responsibilities).

a trend of judicial narrowing of the federal trust responsibility as Tribal self-determination expands. For instance, in 2021, the D.C. Circuit found that IHS was not responsible for the operational costs of an alcohol treatment center under the Cook Inlet Tribal Council's self-determination contract.[330] In the aftermath of that decision, IHS reduced by 90% the funding for the Fort Defiance Indian Hospital, a Tribally operated hospital in New Mexico, amounting to a $16 million decrease during the ongoing pandemic.[331] This decision sent shockwaves across Indian Country.[332] In May 2022, a federal judge ordered IHS to reimburse the full amount,[333] and the parties reached a "tentative settlement" in early 2023.[334] However, since the Supreme Court's holding in *Becerra v. San Carlos Apache Tribe*,[335] the Fort Defiance Indian Hospital Board has filed a new lawsuit arguing that HHS underpaid its fiscal year 2016 funding request for contract support costs.[336]

In addition to funding shortfalls, lack of accessibility remains one of the most significant challenges to actualizing the right to health, especially in rural areas.[337] However, Tribal governments are often uniquely positioned to develop and support health systems in rural areas to meet the community's needs. For instance, the Cherokee Nation's health initiatives have proven transformative for the rural areas of Oklahoma it occupies. Cherokee Nation Health

330. Cook Inlet Tribal Council, Inc. v. Dotomain, 10 F.4th 892, 896 (D.C. Cir. 2021).

331. Victoria McKenzie, *Tribal Hospital Sues Gov't for Cutting Funding by 90%*, LAW360 (Feb. 14, 2022), https://www.law360.com/articles/1464631 (on file with the *Columbia Human Rights Law Review*); Fort Defiance Indian Hosp. Bd., Inc. v. Becerra, 604 F. Supp.3d 1187, 1198 (D.N.M. 2022).

332. McKenzie, *supra* note 331 (stating that the decision to cut support for the hospital "caused reverberations across Indian County," with some calling for a congressional investigation, congressional amendments, and for IHS to reverse course).

333. *Fort Defiance Indian Hosp. Bd.*, 604 F. Supp.3d at 1263 (requiring IHS to comply with Fort Defiance's proposed 2022 self-determination contract and to reimburse the hospital $16.6 million, prorated monthly).

334. Hailey Konnath, *Ariz. Tribal Hospital, IHS Reach Settlement in Funding Spat*, LAW360 (Jan. 23, 2023) www.law360.com/articles/1568509 (on file with the *Columbia Human Rights Law Review*).

335. Becerra v. San Carlos Apache Tribe, 602 U.S. 222, 242–43 (2024) (holding that when Tribes incur administrative costs in furtherance of the healthcare services under their self-determination contracts with IHS, IHS must pay contract support costs).

336. Fort Defiance Indian Hosp. Bd., Inc. v. Becerra, No. 1:24-cv-00606 (D.N.M. 2024 filed June 14, 2024).

337. Moore et al., *supra* note 218, at 778.

Services is the most extensive Tribally operated healthcare system in the United States.[338] In December 2021, Cherokee Nation Principal Chief Chuck Hoskin Jr. signed legislation authorizing $440 million for healthcare capital improvement projects.[339] On April 6, 2023, the Cherokee Nation broke ground on the construction of a $400 million hospital in Tahlequah, Oklahoma, the capital of the Cherokee Nation.[340] Chief Hoskin stated that:

> Pushing for excellence in health care also means pushing the United States to live up to its commitment in health care . . . I think as we do that at Cherokee Nation, show that we're going to put our own resources on the table, show that Native people can take care of themselves, particularly if they're afforded the resources, I think it helps all of Indian country.[341]

In order to address issues of access, sufficient staffing in rural areas, and training of physicians to provide culturally competent care, the Cherokee Nation has also partnered with Oklahoma State University (OSU) to create the first Tribally affiliated medical school in Tahlequah, Oklahoma.[342] The Cherokee Nation funded the facility that opened in 2021, and OSU has provided staff and educational technology for the college.[343] The OSU College of Osteopathic Medicine at the Cherokee Nation is the first Tribally affiliated medical school on Tribal land, with a mission to train physicians to

338. *Health Services*, CHEROKEE NATION, https://health.cherokee.org [https://perma.cc/A8LL-CBAN].

339. Lindsey Bark, *CN Breaks Ground on New $400 Million Hospital to Replace Existing Facility*, CHEROKEE PHOENIX (Apr. 12, 2023), https://www.cherokeephoenix.org/health/cn-breaks-ground-on-new-400-million-hospital-to-replace-existing-facility/article_b117e028-d960-11ed-8fb9-afc0216889c4.html [https://perma.cc/T88F-P7CE].

340. *Id.*

341. *Id.* (quoting Cherokee Nation Principal Chief Chuck Hoskin Jr.).

342. Sara Plummer, *Historic Inaugural Class Graduates from OSU College of Osteopathic Medicine at the Cherokee Nation*, OKLA. STATE UNIV. (May 17, 2024), https://news.okstate.edu/articles/health-sciences/2024/osu-graduates-inaugural-class-com-cherokee-nation-tribal-medical-school.html [https://perma.cc/UY7Y-4WS7].

343. Gretel Kauffman, *'A Life-Changing Partnership': First Tribally-Affiliated Medical School in the U.S. Builds Workforce Pipeline to Underserved Communities*, RURAL HEALTH INFO. HUB (Jan. 11, 2023), https://www.ruralhealthinfo.org/rural-monitor/tribally-affiliated-medical-school [https://perma.cc/KQ9G-ACU6].

work in underserved rural and Tribal communities.[344] With that mission in mind, the school prioritizes cultural competence, offering a unique Tribal medical track that includes education about Native American cultures and prepares students to practice in Tribal and rural areas.[345] This unique partnership between a Tribal Nation and medical school serves mutually beneficial goals of increasing the number of doctors in rural and Tribal areas of Oklahoma who truly understand the unique needs of those regions. This program serves as a model for increasing access to culturally competent care by facilitating an educational pipeline straight into Indian Country.

Another example of a Tribe responding to the health priorities of their community includes the Swinomish Tribe's implementation of a dental therapist program. In 2016, the Swinomish Indian Tribal Community began employing a dental therapist to provide oral health services under a Tribal licensing and regulatory scheme.[346] The Tribe did so in recognition of the fact that "too many Swinomish Tribal members – particularly children – [suffer] unnecessarily and potentially [face] life-threatening conditions because they lack access to dental care[.]"[347] Exercising the Tribe's sovereign powers to license and regulate new providers has the potential to address one of the more pressing health challenges the Tribe currently faces.

Inter-Tribal coalitions and health boards also play an important role in transitioning to Tribally led health care. In July of 2019, the Great Plains Tribal Chairmen's Health Board, a nonprofit organization representing eighteen Tribal communities in the four-state region of North Dakota, South Dakota, Nebraska, and Iowa,[348]

344. Kristi Eaton, *First Tribally-Affiliated Medical School Bridging Gaps in Indian Country, Rural America*, DAILY YONDER (Aug. 16, 2021), https://dailyyonder.com/first-tribally-affiliated-medical-school-bridging-gaps-in-indian-country-rural-america/2021/08/16 [https://perma.cc/B8HK-L282].

345. *Id.*; *OSU COM at the Cherokee Nation*, OKLA. STATE UNIV., https://medicine.okstate.edu/cherokee [https://perma.cc/PUD6-JEHU] (providing an overview of the mission and programmatic offerings of the Tribally affiliated medical school, including the Tribal Medical Track).

346. Strommer et al., *supra* note 104, at 150–51.

347. Strommer et al., *supra* note 104, at 152 (quoting Press Release, Swinomish Indian Tribal Cmty., Swinomish Become First Tribe in Lower 48 to Use Dental Therapists to Address Oral Health Crisis in Indian Country (Jan. 4, 2016), http://www.swinomish-nsn.gov/media/49613/20160104-pressrelease-swinomishhirefirstdentalhealthaidetherapist.pdf [https://perma.cc/E57W-UAHX]).

348. *About Great Plains Tribal Leaders' Health Board*, GREAT PLAINS TRIBAL HEALTH, https://www.greatplainstribalhealth.org/about-us.html [https://perma.cc/366G-QG9D] (enumerating the organization's eighteen member Tribes).

took over operations of the Sioux San Indian Health Service Hospital in Rapid City.[349] Before this, the Sioux San Hospital faced intense scrutiny for years due to inadequate care, a series of closures, and challenges with understaffing.[350] In 2014, the Oglala Sioux Tribe, Cheyenne River Sioux Tribe, and Rosebud Sioux Tribe started negotiations to take over the management of the Rapid City Service Unit.[351] In February 2023, the Health Board opened the new Oyate Health Center, replacing the Sioux San Hospital building and expanding services offered to the local communities.[352]

The Navajo Nation has also sought to create a Native American healthcare offering under New Mexico's Medicaid program. In 2019, the Naat'aanii Development Corporation, a business arm of the Navajo Nation, announced its intent to contract with Molina Healthcare to develop a Tribally managed healthcare entity.[353] The general intent is to broaden access to government-subsidized medical services.[354] This initiative represents just one innovative strategy the Navajo Nation has pushed forward to increase access to affordable health care for its members. The Navajo Nation Tribal Council has long "articulated a new vision of Indian health self-determination: 'The day will arrive when a more effective health-care delivery system utilizing Indian professionals will replace the current system.

349. *About Oyate Health Center*, OYATE HEALTH, https://www.oyatehealth.com/about-ohc [https://perma.cc/NEU9-PAW2].

350. Walker, *supra* note 312 ("Five government investigations have found that patients have died at Sioux San from inadequate care . . . . The troubles were so severe that Sioux San's emergency room and inpatient unit were shut down by the Indian Health Service and Congress in 2017.").

351. OYATE HEALTH, *supra* note 349.

352. Press Release, Great Plains Tribal Leaders' Health Bd., New Oyate Health Center Opens Feb 6, 2023 (Jan. 20, 2023), https://www.greatplainstribalhealth.org/news/new-oyate-health-center-opens-feb-6-2023-184.html [https://perma.cc/TBQ8-SLEF].

353. *Navajo Nation to Create "One-of-Kind Medicaid Program"*, AP NEWS (Dec. 18, 2019), https://apnews.com/general-news-21cca3fc520d6cb8f0c0e2fbd28e3408 (on file with the *Columbia Human Rights Law Review*).

354. Alexandra Kelley, *Navajo Nation to Create First Native American Health Care*, HILL: CHANGING AMERICA (Feb. 7, 2020), https://thehill.com/changing-america/well-being/prevention-cures/475275-navajo-nation-to-create-first-native-american [https://perma.cc/TBU7-6QQG].

The day will arrive when the American Indian will determine what his own health standards and services should be.'"[355]

CONCLUSION

Native American communities are currently facing some of the worst health outcomes in the United States, resulting from centuries of destructive federal policies and compounded by the lack of adequate federal funding for Indian health care. The failure of the federal government to adequately invest in the provision of health care to Native Americans amounts to no less than a failure to uphold its most basic trust obligations and a breach of its treaty promises. Because of the profound importance of ensuring the health and well-being of Native people, Congress codified the federal government's trust responsibilities owed to Tribal Nations in both the Snyder Act and the Indian Health Care Improvement Act. However, federal courts are currently divided on whether a judicially enforceable trust obligation exists for the federal government to provide adequate health care to Tribal Nations.

Whether or not such a relationship exists would not alleviate the federal government from its moral obligation—and, in many circumstances, its legal obligation—to provide adequate health care in Indian Country. However, it is clear that Tribes cannot solely rely on federal courts to hold the federal government accountable for promises made. This healthcare crisis is far too urgent. The enactment of the Indian Self-Determination and Education Assistance Act in 1975 has since enhanced Tribes' ability to assume control over their healthcare destinies by providing them with the opportunity to take over these federal health services with federal funding. Tribes' sovereign powers make them well-positioned to enact and enforce public health laws and develop Tribal health systems. As demonstrated in Part III, Tribes can leverage their status as sovereign governments and pursue creative avenues to both acknowledge a right to health for their membership and establish Tribally owned and managed health systems that provide culturally competent and adequate health care for their people. The obstacles in achieving these goals are complex. However, mounting evidence is demonstrating that solutions rooted in the exercise of Tribal health self-determination are improving outcomes for the populations they

355. Jones, *supra* note 3, at 2130 (citing Navajo Health Authority, Position Paper (located in Box 11, Folder 1, p.5 of the Walsh McDermott Papers held at the New York Weill Cornell Medical Center Archives)).

serve. Ultimately, these practices remain well worth pushing forward to improve Indian health systems and ensure a healthier future for Tribal communities.