VI

CONTEMPORARY HEALTH CARE CRISIS

The Current Health Care Situation

Over the last several years some major changes in the patterns of health care delivered to Indian communities have been either instituted or studied for future implementation. Some of these changes and policies have directly impacted the scope of care or services provided by the Puyallup Tribal Health Authority.

Continued concerns over balancing the federal budget have led to several years in which Indian Health Service (IHS) budgets have been either reduced, frozen at past levels, or increased at such minimal levels that inflation has reduced real dollars available for health care.

Non-Indian spouses of Indian people have been barred from receiving care except under very stringent guidelines. Canadian Indians and people of non-recognized tribes have been denied health benefits. The Contract Care system has been changed to a "priority one" situation in which care is available only for life-threatening conditions. In the Northwest, this has led to the development of a "deferred services" list in which Indian people with conditions which are not life threatening are placed in a waiting line.

In recent years, such essential programs as the Community Health Resource program, have been threatened with elimination from the IHS budget. The renewal of the Indian Health Care Improvement Act, which authorized a broad range of direct and supportive health care services including health care for urban Indians, was delayed by the veto of then President Reagan. Implementation of the Gramm-Rudman-Hollings legislation, requiring a balanced federal budget, led to reductions in social support programs across the nation including Indian Child Welfare programs.

In 1986, a massive study of the IHS was completed by the congressional Office of Technology Assessment (OTA); it contained a broad series of recommendations for changes within the IHS (Office of Technology Assessment, 1986). The IHS also offered a report on parity of Indian health services in May of 1986 (Indian Health Service, 1986a).

In response to budget concerns or the contents of these reports, basic changes within the IHS were proposed as experimental changes in the existing IHS 638 Self-Determination contracting. Changes in Resource Allocation Methodologies were proposed by the IHS; some of these changes would have penalized tribal entities for their ability to generate or secure funding or support from resources other than the IHS. The original Congressional intent in authorizing tribes and the IHS to generate funds through third party collections (including Social Security, Medicare/Medicaid, and

private insurers) was that these funds would augment Congressional appropriations. It was not that these funds would be used to offset and reduce governmental responsibilities. Yet, the Office of Management and Budget continues to press for reductions in budget appropriations in conflict with the original legislative language.

Changes in existing Contract Care reimbursement patterns, which would reduce rates of reimbursement to health care providers, were also proposed in 1986. In addition, the IHS considered implementation a means test for eligibility for care; under this proposal if individuals were not poor enough, they would be ineligible for health care. A system of billing individual Indians for health care was also considered, although the existing Ambulatory Patient Care data system of IHS is not compatible with billing purposes. Heavy tribal opposition nationwide forestalled the implementation of both the means test and individual billing.

Finally, in 1986, the IHS proposed a new set of eligibility criteria that would drastically limit the existing service population. Currently an Indian person is eligible for direct health services through IHS if he or she is a descendant of a member of recognized tribes. The new regulations, which have yet to be implemented because of continued tribal opposition, require that anyone receiving medical care from IHS prove that they are:

> 1. A member of, or eligible for membership in, a federally recognized Indian tribe, and,
>
> 2. Of one-quarter (1/4) or more Indian or Alaska Native ancestry, and,
>
> 3. Residing within a designated health service delivery area (National Indian Health Board Health Reporter, 1986b, p. 1).

Under these guidelines, if a person is not a member of, or eligible for membership in, a federally-recognized Indian tribe, then that person must prove one-half or more Indian or Alaska Native ancestry, and must reside within a designated health service area.

It has been estimated through the Northwest Portland Area Indian Health Board that upwards of 34.6% of the existing service population of IHS in the Northwest would no longer be eligible for health care should these guidelines be implemented (Northwest Portland Area Indian Health Board, March 13, 1986). Within Washington State, which has an Indian population estimated at 75,000 individuals, approximately 25,000 Indians would be declared ineligible for care and be forced to seek care from the State of Washington or other health resources (Puyallup Tribal Health Authority, 1986). The direct impact upon the Puyallup Tribal community has not been calculated in real numbers, but a significant number would be declared ineligible for IHS care.

The IHS invited tribal comment dealing with these proposed changes, especially regarding such issues as: the impact of the proposal on the eligibility of tribal members for IHS care; unusual local circumstances regarding a tribe's health program and service population; the minimum blood quantum requirement; alternatives to the proposed changes; and recommendations regarding what steps the IHS might take to facilitate the transition for persons who may no longer be eligible under the new rules. This chapter is a response to these issues.

Legal and Historical Basis for Indian Health Services

The Puyallup Tribal Council offered its endorsement of the position paper submitted by the Northwest Portland Area Indian Health Board and the Affiliated Tribes of Northwest Indians (Northwest Portland Area Indian Health Board, February 11, 1986). The legal and historical basis for health care delivery is aptly addressed in that paper. In the case of the Puyallup Tribe, health care is a treaty right guaranteed by Article 10 of the Medicine Creek Treaty of 1854 and consistent with federal court decisions regarding other treaty rights such as fishing and hunting. It is, indeed, unfortunate that the trust responsibility of the federal government to provide high quality, comprehensive health care should be eroded through the process of administrative and budgetary limitations and reduction. The Medicine Creek Treaty does not state that Puyallup Tribal members have rights to limited health care based on available funding.

The current situation in the Northwest perpetuates historically inadequate funding and access to care in which the ability to receive medical attention depends on the administrative delivery system and the availability of dollars, and not upon medical necessity. The "deferred services" lists for contract health services in the Pacific Northwest are a painful reminder of the inadequacies of the current system and the limited appropriations available to fulfill this important trust responsibility. At a time when tribal communities are expanding at rates in excess of 2% a year, the administration and the Office of Management and Budget proposed freezes and further reductions in funds to provide needed care.

It would be relatively simple to state the Puyallup Tribe's needs for new facilities, expanded personnel, and service support in an effort to improve the Tribe's funding levels. However, the realities of the current situation dictate that should Puyallup programs expand, these local advances would be made at the expense of other tribal programs. This is not the time to argue for individual tribal advances.

The efforts of the federal government to blame inadequacies in the IHS system upon budgetary restrictions seemed to be a poorly camouflaged attempt to terminate federal trust responsibility. Even at 1986 levels, available care was unable to hold its own against inflation. Across the nation the costs of medical care were and are inflating at a disturbing rate. Proposed federal attempts to control costs through limiting eligibility for care

were part of an attack upon tribal sovereignty; they ignored the recognized concept of Tribal self-determination.

The concept that other resources would fill the gaps in needed health care services must be shown for what it is. The federal "safety net" became a hole in the ground. In a broader sense, the limitations of available health care are a nationwide problem of the poor and disenfranchised. "There is no more compelling social problem facing this state [Washington] than the increasing lack of adequate health care for a sizeable segment of the population." (Health Care Gap Widening, 1986, p. A14). More than $100 million were cut from Washington State payments to hospitals for the care of poor people during 1985 (A Problem, 1986). "Dumping" of uninsured or "non-paying" patients by hospitals was and is on the upswing.

Puyallup Tribal Health Authority Programs, especially those of the Mental Health and the Substance Abuse Treatment Center, are increasingly a dumping ground for patients not wanted by third party resources. Steep pay cuts, unemployment, and limited health insurance coverage resulting from a transformation of the economy during the Reagan administration continued to limit the ability of individuals to provide for their own needed health care. Within Indian country, the economic crisis was much more severe; 1986 unemployment rate within the Puyallup Tribal community, for example, was reported at 66.2% (Bureau of Indian Affairs, 1986). There is every indication that the situation will continue to deteriorate without concerted support from the Bush Administration and Congress.

The Puyallup Tribal Position Summarized

The Puyallup Tribal Council opposed and continues to oppose any reductions in the IHS budget. The Council also opposes any changes in the eligibility criteria for the IHS not generated directly from tribes themselves. The Puyallup Tribe maintains that the right to adequate comprehensive health care services is a Treaty right and a federal trust responsibility, supported and reaffirmed by history and by law. The Puyallup Tribe continues to ask Congress to increase and expand health services. The Puyallup Tribe continues to offer its sympathy to the non-Indian community of poor people who do not have the benefit of Treaty protection.

Privileged citizens of the United States enjoy some of the best medical care in the world. Hundreds of people are walking around with new hearts, thousands with new kidneys and livers. We have a problem, however, in delivering some of the most basic services to the most needy people (Editor's Note, 1986). The United States remains the only Western industrial nation outside of South Africa that has failed to guarantee health care as a right of citizenship (Starr, 1982; Signs Point, 1986). Some say there are too many doctors; some say the new technology costs too much; some would blame the insurance industry; many blame the state of the economy. Whatever the network of reasons, it remains the responsibility

of Congress to honor the obligations affirmed by Treaty, trust responsibility, and law.

The Medicine Creek Treaty and Medical Care: A Federal Responsibility

The following is the text of Article 10 of the Medicine Creek Treaty of 1854 between the United States and the Nisqually, Puyallup, Steilacoom, Squaxin, Samamish, Stehchass, T'Peeksin, Squiatl, and Sahehwamish Tribes:

> The United States further agree to establish at the general agency for the district of Puget's Sound, within one year from the ratification hereof, and to support, for a period of twenty years, an agricultural and industrial school, to be free to children of the said tribes and bands, in common with those of the other tribes of said district, and to provide the said school with a suitable instructor or instructors, and also to provide a smithy and carpenter's shop, and furnish them with the necessary tools, and employ a blacksmith, carpenter, and farmer for the term of twenty years, to instruct the Indians in their respective occupations. And the United States further agree to employ a physician to reside at the said central agency, who shall furnish medicine and advice to their sick, and shall vaccinate them; the expense of the said school, shops, employees, and medical attendance, to be defrayed by the United States, and not deducted from the annuities.

The agency is definitely differentiated from the school. The school has a 20 year limitation, while the agency does not. The entire intent of the first sentence in Article 10 is to create an educational institution "to instruct the Indians in their respective occupations." The intent of the second sentence, up to the semicolon, is to provide medical care for the Indians of the Puget Sound Agency. There is no time limitation stated or implied upon the delivery of health care, just as there is no time limitation placed upon the existence of the agency itself. The intent of the portion of sentence two in Article 10 following the semicolon is to assure that the United States defray the entire cost of all of the services outlined in Article 10, including health care.

The Puyallup Tribe was the aboriginal nexis of the traditional trade and migration routes for southern Puget Sound (Smith, 1940b). The historic and logical choice for the site for the delivery of regional health care and federal administrative "agency" responsibilities was the Puyallup Reservation. In the years immediately following the Treaty (1854 through 1863), medical care was intermittent at best due to the lack of adequate salary for

a physician. The first doctor to remain any significant length of time as the local practitioner began his practice in 1863. The first Indian clinic associated with a school in the southern Puget Sound region was established sometime following the opening of the Puyallup Indian School in 1864. The Puyallup Indian School, renamed the Cushman Trade School in 1910, changed from a reservation to a non-reservation school in 1912. Thus, the Puyallup Reservation clinic treated children from all parts of the Northwest, including Alaska. A regional Indian Hospital was established in 1929 and continued providing care until its closure (despite vocal Indian protest) in 1959. The Puyallup Tribal Health Authority continues to provide regional medical care; currently more than 150 separate tribal entities are represented in the patient population.

The medical portions of Article 10 have been repeatedly ignored by the federal government, which historically limited health care to students of the school only. Benefits have been denied through the limitation of funds and through allowing frequent vacancies in physician positions. Other problems have included the elimination of clinical and hospital facilities, forcing the sale of individually-allotted Indian land and timber assets to defray the costs of medical care and care for the elderly, the use of proceeds from land sales to defray school and medical costs, and--in 1986--proposing "racial purity" in order to receive medical care.

The past pattern of interpreting Indian treaty rights, and the historic interpretation of the meanings of individual terms of the treaties, have repeatedly been upheld by the courts as being the broadest possible meaning understood by the tribal groups at the time of signing. In the case of the Puyallup, in the Medicine Creek Treaty, the choice was made by Governor Stevens to negotiate the treaty in the trade jargon, Chinook, which some authorities indicate only had 300 words, rather than in the indigenous language/dialects, even though more than one of the members of the Stevens negotiating team were known to be speakers of the Puyallup/Nisqually language (American Friends Service Committee, 1975, p. 23, Morgan 1979, p. 95).

Therefore, provision of a physician to "furnish medicine, and advice to their sick" must be interpreted as the provision of biomedical and psychosocial medical services generally. The role of the traditional medicine practitioners (shamans, sucking doctors, and herbalists) provided an analogous range of indigenous medical and psychosocial medical services. Even among the general population of the United States in 1854, the accepted role of the physician was to provide virtually all existing medical/social/psychological interventions. This included counseling for interfamilial disputes, problems of drug addiction, counseling to the elderly in their loss of social role, support for displaced children, dental care, emotional support, and simple medicinal and surgical support. Traditional healing was outlawed in the Washington Territory in 1871 partly because the role of the shaman was in direct conflict with the role of the western physician (Gunther, 1949).

Medical care to the Medicine Creek Treaty Tribes is prepaid. Part of the payment for non-time bounded medical care was the concessions made in Article 1 of the Medicine Creek Treaty:

> The said tribes and bands of Indians hereby concede, relinquish, and convey to the United States, all their right, title, and interest in and to the lands and country occupied by them bounded and described as follows, to wit: Commencing at the point of the eastern side of Admiralty Inlet, known as Point Pully, about midway between Commencement and Elliot Bays; thence running in a southeasterly direction, following the divide between the waters of the Puyallup and Dwamish, or White Rivers, to the summit of the Cascade Mountains; thence southerly, along the summit of said range, to a point opposite the main source of Skookum Chuck Creek; thence to and down said creek to the coal mine; thence northwesterly, to the summit of the Black Hills; thence northerly to the upper forks of the Satsop River; thence northeasterly, through the portage known as Wilkes's Portage, to Point Southworth on the western side of Admiralty Inlet; thence around the foot of Vashon Island, easterly and southeasterly, to the place of beginning.

The Snyder Act of 1921 was not the authorizing legislation for the provision of medical care among the Medicine Creek Treaty Tribes. A system of medical care required by the Treaty was initiated many years prior to this legislation and remains, regardless of subsequent appropriations and legislation.

Puyallup Response to Proposed Eligibility Criteria

For the Puyallup Tribe to approve a change in policy which requires that one group of its citizens become more equal than another is not only distasteful but unthinkable. The situation is very similar to Orwell's "Animal Farm." If these changes in IHS eligibility are initiated, "all animals will be equal, but some animals will be more equal than others."

A further provision proposed under new regulations provides that the IHS maintain a list of names and addresses of eligible persons and that these eligible individuals be issued "beneficiary identification cards." "[T]his will enable the IHS to have an accurate count of beneficiary populations for purposes of budget allocations. In addition, use of such cards will help local IHS officials identify beneficiaries and carry out other administrative tasks related to admitting patients for treatment," the proposed regulations state (National Indian Health Board Health Reporter, 1986b, p. 2).

The federal government, in this decision, has "administratively assimilated" tribal members for whom they no longer wish to provide services. However, given ongoing discrimination, persistent poverty, generations of avoidance of state support systems, coupled with federally-enforced dependence upon health care from federal agencies, little is available for Indians.

Tribal communities must be careful of changes in patterns of health care delivery that are generated not through changes in need but through limits articulated by the Office of Management and Budget. Should the eligible service population of IHS be redefined to limit the size of the population, the next target for "savings" would likely be a reduction in funding to provide service to this smaller population. Over the last several years, per capita expenditures for Indian health care have not kept pace with those of the general population as a whole. Tribal communities should be wary of any proposed changes that might serve to further reduce available funds.

Given the pattern of Indian unemployment and general lack of third party insurance coverage, it seems that the burden for providing care will fall upon the State of Washington. Within the Pacific Northwest, the lack of care for low income individuals has already become a major legislative issue at the State level.

What basis is there for "grandfathering" in as eligible for care any individual currently eligible for and receiving health care with the understanding that future generations might have to meet the newly- imposed blood quanta guidelines? The National Indian Health Board has supported the inclusion of such a grandfather provision, which would not interrupt continuity in the existing system of care. At least such a provision would seem equitable in terms of legal precedent; even under zoning laws, existing buildings and individuals do not have to be retrofited to meet newly-imposed codes. Although this compromise is distasteful to the Puyallup Tribal government, it would maintain the existing levels of care for the existing IHS "treated" population.

A large portion of the population directly affected by the pending change in eligibility includes elders who have always received care from IHS facilities. What are Tribal programs to do with these individuals, turn them rejected, ineligible, and ill into the sunset?

Some strange things become possible as care is limited to blood quantum levels. At what point does the IHS physician refuse to care for the newborn child of a three-eights Indian woman delivering a three-sixteenth Indian child? Must the doctor cease care upon delivery? Is this not a "racial" decision when the blood quantum levels become the qualifiers and not membership in a federally recognized tribe? The historic basis for delivery of health care rests on the government-to-government relationships of tribes to the United States, and not upon individuals' ability to prove that they are "1/4 blood registered" American Indian "stock" and, that they are living in the right "pasture". The proposed half blood requirement for

those "without membership" becomes even more racial and arbitrarily discriminatory. Allowing or denying service upon the percentage of racial purity and not based upon the government to government relationship which exists between tribes and the United States government ignores some very basic Constitutional precepts upon which the strength of our country depends.

Another interesting issue that arose as the blood quantum issue was discussed within tribal communities is the impact upon the freedom of choice of tribal members to meet, marry, mate and procreate with whomever they choose. Individual Indians may be forced to consider the necessity of marrying someone with a fixed racial inheritance to maintain federal medical care for their children.

We take no issue with each Tribal entity defining their own criteria for membership; such powers are within the pervue of individual Indian nations. However, when a guardian imposes such regulation on its wards, such an imposition is a gross abuse of power and a sharp departure from past policies of continuity of care and Tribal self-determination.

Institution of "one-quarter blood" quantum levels for its own membership, is fine, and the government of the United States should accept this definition. When the tribe defines membership based on something less than one-quarter blood, the United States should accept this definition also. The proposed criteria accept some portions of tribal law (membership in the Tribe) and not some other portion of tribal law (Tribally determined blood requirements). Is this federal choice arbitrary? Probably not. It becomes a strange cross of tribal and federal law, tribal membership/citizenship with federal eligibility requirements of "blood purity." This one-quarter blood level is magnified to one-half in the proposed guidelines if an individual does not have tribal citizenship. What types of care will be available to descendants of tribes and Alaskan Native corporations which no longer accept enrollment though the descendant be one-quarter blood or more, but less than half?

Such changes would also seem to impact the need for existing facilities. It is our considered opinion that existing IHS hospital facilities in some areas would suffer such a reduction in their eligible service population as to force their closure. This makes their previous construction a waste of funds, time, and energy.

Indian health cannot be improved by reducing the number of eligible Indians or tribal members of an arbitrary blood quanta. The health status of tribal members who are barred from care will most surely decrease. Would it not make better sense to consider the need for care instead of the availability of funds? Does the one-eighth Puyallup with a life-threatening or debilitating condition warrant less care than a one-quarter blood Indian person with a less serious disorder? The proposed changes do not seem medically sound. Neither is it medically sound to force patients onto the welfare rolls so that their children may receive direct medical services. In fact, the now-outdated system of Contract Care delivery that depends on

medical priorities (under which life-threatening conditions are treated in lieu of less serious disorders) is a much more acceptable basis for determining the distribution of care. We are not arguing that this old system should be reinstituted, but that some meaningful measure of medical need--and not racial purity--should be incorporated into the decision-making process.

The residency requirements also offer a "catch 22" situation for such programs as the Tribal Treatment Center. The Puyallup Alcohol Treatment Center currently receives referrals from all over Washington State, Oregon, and Idaho. Under the pending regulations, such regional facilities would not exist. IHS would be forced to build small inpatient facilities at each reservation or service unit. This would not be cost effective and would likely cause a decrease in the quality of care provided since the range of care givers at these local centers would necessarily be limited. Eligibility for support services like outpatient medical and dental care would also be adversely impacted.

The Indian Community Clinic provides direct care to members of surrounding tribal communities, including the Muckleshoot and the Nisqually. Should the clinic be forced to deny care to those living outside its service area, many people would have to seek care through the more costly Contract Care system. Further, the tribes of the Puget Sound continue to be traditionally linked through a system of exogamous marriage blurring the boundaries from tribe to tribe.

The residence requirements also seem to impose an undue hardship on a traditionally mobile population. During the summer and during the powwow season, out-of-area Indians would be ineligible for care at local facilities. According to the pending guidelines, sick or injured individuals would be forced to return to their home reservations for care. This places an undue hardship upon a generally poor population, forcing them to exhaust needed energy and resources on unnecessary travel. It also increases the risk of medical conditions worsening while in transit, and increases exposure between healthy individuals and someone with an infectious disease.

The delivery of holistic, family based medical care becomes interrupted by these rulings, making some portions of nuclear family units eligible for care and others not. If the object of providing care is to maintain a healthy family and the health of individuals becomes psychologically assaulted by creating a new group of "Indians, but not really" is this then good medicine?

On one hand the federal government has proposed to strengthen the ability of tribes to govern themselves and to determine their own destinies by expanding and reinforcing the Indian self-determination and Educational Assistance provisions. In fact, President Reagan spoke publicly of his desire to reinforce tribal self-determination. On the other hand, IHS rules adopted during his administration--but not yet implemented--completely ignore the ability and desire of tribes to determine who are their members and to determine how tribal resources shall be expended or distributed.

Termination of historically provided benefits through regulations based on race is not consistent with the intentions of 638 Self-determination contracting, nor is it acceptable to the Puyallup Tribe. The Puyallup Tribe is able to determine who are its members and, therefore, who is eligible for Tribal benefits. Tribal entities are political and cultural institutions, and not "racial" ones. This federal proposal is analogous to suggesting that there is a "racial basis" for becoming a "certified and registered" American.

Puyallup Response to Contract Care Payment Limitation on Reimbursements to Medicare Rates

The Puyallup Tribal Council has offered its full endorsement and support for the Northwest Portland Area Indian Health Board positions regarding the use of medicare rates for the Contract Health Care Program (Northwest Portland Area Indian Health Board, May 8, 1986). The Council has opposed limiting Contract Health Care reimbursement rates to those of allowable Medicare rates. Since there is no IHS hospital in the Pacific Northwest, the Northwest Area depends completely upon Contract Care for the provision of hospital services. The implementation of Medicare rates does not seem to be consistent with the nationwide IHS goal of providing the "highest possible health status to Indians."

Such a regulation of payments would reduce the quality of care available. Seventy-eight percent of the physicians in the Tacoma/Pierce County area in 1986 were specialists (Indian Health Service, 1986b). Physicians in Pierce County in many cases have been proven reluctant to accept uninsured, Medicare, and Medicaid patients. A recent directory prepared by the Puyallup Tribal Elders Program staff in cooperation with the local Area Agency on Aging was able to list only one physician who accepted Medicare patients under such necessary specialties as proctology, thoracic surgery, vascular surgery, orthopedic surgery, oncology-hematology, plastic and reconstructive surgery, and psychiatry (Puyallup Tribal Elders Program, 1986). Under these conditions, it would be nearly impossible to acquire a second opinion.

Continuity of care for existing contract care patients would be threatened also, forcing some patients to seek care from physicians whom they do not choose to see. It is not only possible but probable that access to care would be reduced. The number of physicians currently refusing to treat Medicare patients within the general population of Washington State has become a well publicized and legislatively debated problem. Forcing the Indian population to join the ranks of the walking wounded shuffled from hospital to hospital and from provider to provider is not in the best interests of the Puyallup population. Further, the addition of Indians to the medically indigent group would add to the more general problem of who will deliver care to individuals whose "coverage" does not pay the full going rate.

Consider what might be in store for the Indian community should these rates be adopted and implemented (Staff, 1986). In some states,

obstetricians are threatening to refuse to deliver the babies of poor women because of the high costs of malpractice insurance and the low rates of reimbursement. The utilization of Diagnostically Related Groups for billing purposes has led to some noted cases of early discharge in which patients have been sent home for the hospital's convenience. Billing irregularities and over-charging seem to run rampant in the system. Peer Review Organizations, which monitor quality of care and admission practices, were widely criticized in 1984 as focusing too much on cost reductions and too little on quality protections. Too many patients are "dumped" from hospital to hospital and from provider to provider. The Puyallup Tribal Council has stated, "This is not a system into which we wish our patient population to be discarded" (Puyallup Tribal Council,1986).

The Perspective of Anthropology

The long term tendencies of the convergence of local Indian orientations with federal policy seem to coincide at least at the level of the acceptance of "racial" identity. There is a "well-defined" stigma attached to being light in a dark world or a dark system. Too light, indeed, means that one is a "want-to-be" and not a member of the community, no matter of the tribal identity.

The danger of Tribes agreeing to the proposed federal definition of "racial" identity is that Indian people will eventually be denied their rights because they have agreed to follow the "racial" guidelines originally imposed by colonial powers and reinforced by current federal policies. It is necessary for the national Indian community to reassume the legal definitions and the power implicit in cultural definitions of tribal identity.

The limitations imposed upon "real" tribal membership implicitly place the off-spring of every Indian person, regardless of blood quantum, at high risk of being denied legal rights. What level of blood purity will eventually be enough to guarantee that the provisions of treaties will be exempt from the tinkerings of the federal government? Historically, every tribe has assumed the "political and cultural" right to include members who bore no racial or familial relationships to them. This means that indigenously, there existed the concept that a person could assume political and cultural membership based on behavior and community acceptance, regardless of their "racial" relationship to the tribal entity. Did race exist as an indigenous concept? It seems that only political and social membership were important for group identity. The concept of race is not even an accepted scientific premise, having been rejected by physical anthropologists (Winick, 1970).

Further, race, is irrelevant to qualification for entrance into American citizenship. Only countries like Nazi Germany and South Africa have attempted to establish national political identity, human rights, or eligibility for various privileges in racial terms. The tragedy of abuse that such an assumption allows is a matter of historic record.

For Indian people to assume racial criteria for tribal identity is self-defeating and a disastrously European point of view. They are certainly buying into Herbert Spencer, the "comparative method," and social Darwinism generally. Traditional Indian metaphysics does not even accept the premise that they were evolved from apes, or tossed out of the Garden of Eden. For the federal government to promote the concept of racial identity is a contradiction to Constitutional precepts in the Bill of Rights and various civil rights amendments. The United States of America recognizes no concept of race or racial privileges; they do recognize political treaties with other foreign political and cultural groups.

The fact that Indian tribes were internally colonized does not abrogate their legal rights as separate nations. Tribes define membership within their political and cultural group. These nations are not racially defined; at the times of the ratifications of the treaties, members of other cultural and political backgrounds ("races") were included in tribal membership. In terms of classic sociological theory, there was a consensus definition of ingroup identity. No one from the outside either had the right or the ability to define ingroup membership. The Indian Reorganization Act further asserted the right of tribes to determine their own membership. Membership within the group was certainly not determined by the location of residence, but by socially recognized linkages; descendence, intermarriage, adoption, group consensus, and ritually reinforced rites of passage.

The original legal agreements between the federal government and tribes recognized local Indian cultures as distinct and independent political entities. Indian cultures surely have changed as all cultures do, but they exist today as truly as they existed in the past. Culture can be defined as a set of learned and shared behaviors, beliefs, values, meanings, and their products in the forms of institutions and technologies. Therefore, original treaties are with the political representatives of continuously existing cultures. "Race," in most cases, bears an undefinable and tangential relationship to culture. Consider the diverse relationship between "race" and culture in defining Jewish identity, or, for that matter, the "racial" qualities of being an American or an Indian. Where in any existing legal statutes is there a provision and legal commitment to a particular genotype? In fact, constitutional law forbids such definitions of rights to exist.

Tribes have always exercised the right to define those who are not members. Individuals from enemy tribes often were known as only the "enemy" and not necessarily recognized as human beings, let alone members of "similar racial stock" or "racial" cohorts. The real meaning of membership was tied to relationship: familial and tribal, klanship or societal (warrior society, etc.). Still, these relationships and direct linkages through marriage or past relationship allow and "require" admission into the group. There are numerous examples of whites or blacks being married in and carried as relations. For example, among Puyallup allottees were French Canadians, Hawaiians, and others. Among the Puyallup, the words of a prayer ("all our relations") still signify a deep sense of commitment to

extremely distant extended kin. No matter of blood purity; these people are family.

Tribes entered into their unique relationship to the federal government separately, through many and several different wars, with many and several different sets of allies, with many and several different sets of defined and formal relationships to other foreign governments, and with many and several different sets of heroes, martyrs, and common enemies.

Indians were not treated or treatied as a single homogenous governmental group; there was no "united Indian" nation. The negotiation of treaties was not to "Indians" as an entire united "racial" entity. There is and has been no united Indian country, dealt with in the same ways politically, socially, or through Indian administrative law. The levels of delivery of care, and the levels of service available in any particular Indian nation are not the same. Within the IHS various levels of service and access exist from tribe to tribe and from region to region (Office of Technology Assessment, 1986). Such diversity is a recognition of the differences between tribes of the differences in levels of community health. While we do not necessarily agree that differential levels of access to care are equitable, they are perhaps legal and practical.

Treaties with separate and independent Indian nations occurred over a long period of time, while the individual rights of separate nations were evolving. The various rights and provisions of these treaties are still being interpreted by the judicial system. Most treaties carry different provisions: the Puyallup treaty of Medicine Creek is among the 4% that include provisions (under Article 10) for medical care. The way in which each specific treaty tribe has been dealt with in the past has been decidedly different and some tribal experiences much more bitter in character and in congressional intent. However, this was true and "legal" because the United States government in each instance was dealing with particular and unique Indian governments as distinct entities. The government was not dealing with a total and "well-defined (in mathematical terms)" population or racial group united in status, "race," length of "fiduciary" and trusteeship relationship to the United States.

Should Any Tribe Support the Quarter Blood IHS Criteria?

The Department of Health and Human Services (OHHS) maintained that in examining 213 tribal constitutions, "only 50 had no specific minimum blood quantum requirements for tribal membership" (National Indian Health Board Health Reporter, 1986b, p. 2). However, this means that nearly 25% of the tribes scrutinized had no minimum blood level for membership. We maintain that this percentage is not worthy of the adjective, "only." An additional 22 required one-eighth blood or more, and another 7 required one-sixteenth or more for membership. Of the 213 constitutions examined, 79 required less than one-quarter blood for mem-

bership; this is over 37% of the tribes examined--hardly an inconsequential percentage.

DHHS also reported that in response to the original 1983 federal register notice, "the comments from tribal groups generally supported use of a blood quantum requirement for IHS eligibility . . ." and that "the majority of the tribes responding stated that if we [IHS] adopt a blood quantum criterion, that it be one-quarter (1/4) blood" (National Indian Health Board Health Reporter, 1986b, pp. 2-3.). Of the total 242 responses received to the 1983 notice, 28 were from tribal governments and 4 were from tribal organizations. We might point out that "only 28" tribal governments responded. This is only a little more than 13% of the total number of tribal constitutions examined for blood quanta requirements. The "majority" which the Department speaks of that support one-quarter blood quantum could be as few as 15 tribal governments. Another key word in the Departmental statement is the "if." These tribal governments could have opposed changes, but "if" blood becomes the issue, then let it be quarter-blood. Also consider that only 32 tribal groups "generally" supported use of blood quantum requirements. However, different criteria regarding appropriate blood quanta guidelines would surely be supported by diverse tribes. The groups that responded in the affirmative could have "generally" supported the institution of quanta guidelines which approach their own tribal membership guidelines. The Puyallup Tribe can also say this.

Does the United States honor its treaty obligations with other nations only if the citizen of that nation is of one-quarter blood purity? Would the United States government refuse to allow a citizen of Canada the right to free movement across our adjoining borders if the citizen of Canada in question were only one-eighth blood "true Canadian," though a citizen of that nation? Of course not. Agreements between nations are government to government, based upon citizenship and treaty, not upon race. The rights and privileges of citizenship are not dependent upon the ability to prove racial purity. Neither should an outside power, an outside country, have the right to determine which of our Indian Tribal citizens is a "true" Indian. Each tribe has in place a list of its citizens. One who is a member of a federally recognized tribal entity, has the same rights and privileges as every other member of that Tribal entity as a matter of citizenship, not as matter of race.

States are required by the federal government to recognize the rights and privileges of treatied tribes, regardless of the blood quantum of any individual tribal member. These rights have been repeatedly upheld by federal courts. How, then, can the federal government conveniently reregulate and redefine these rights to services through imposing guidelines based upon racial purity and not membership within the political entity? States will be forced to assume the responsibilities of service provision for federally excluded Indians in each individual state.

Could such decisions leave the door open to denying other rights and privileges currently defined by membership within Indian tribal entities? Could the federal government refuse to affirm the hunting and fishing rights

of Indians who are less than one-quarter blood? Can the guardian nation do this legally or morally?

The newest and unprecedented requirement (pending implementation) from the federal government is that non-members must prove one-half Indian blood to become eligible for health care. The next step, should this one-half blood provision be implemented, is that it be installed as a threshold criteria for receiving care, even though only the most severe tribes require one-half blood for tribal membership. Half blood for everyone to be a "real eligible Indian" could become the rule for all tribal benefits. This half blood provision has never been mentioned before in law. If tribal nations allow it to be utilized, then they may expect that this precedent will be turned upon them no matter what criteria are accepted for individual tribal citizenship. If it is implemented, we can be sure that it will be used, just as the one-quarter blood criteria is now awaiting Congressional implementation for all individual tribes, regardless of every tribe's own sovereign tribal law.

The Duties of The Trustee

The 1986 Office of Technology Assessment (OTA) report (National Indian Health Board Health Reporter, 1986b, p. 3-4) indicated that all three options identified for changes in IHS eligibility could and should be taken by "congressional action," and not by the administrative changes initiated by the OMB through the HHS, the umbrella organization for the IHS. It should be noted that none of the options considered or proposed by OTA indicated that action should be taken administratively, but congressionally.

Similar programs or benefit packages used as examples in the OTA report are heavily weighted toward existing or former military models, such as the Veterans Administration. The abuses, inequities, and simple lack of "care" available in these systems; the heavily weighted bureaucracy in place; and the examples of medical incompetence that exist within the Veterans Administration and within the military health delivery system: these make the models unattractive to the Indian community. Consider a recent report that "more than half the incidents that apparently caused the deaths [of Veterans Administration heart surgery patients] were 'classified as being preventable' errors (Errors Reported, 1986b, p. A6)."

The IHS position that federal health care is a "residual" source of care has already been challenged successfully in United States District Court in Montana (National Indian Health Board Health Reporter, 1986c, p. 5):

> In reaching its determination, the court reviewed the Snyder Act and the Indian Health Care Improvement Act and found that "those statutes, read in conjunction with the trust doctrine, place the burden, in the first instance, upon

> the IHS programs to assure reasonable care for eligible members."

The OTA "carrot" of increasing the scope of available care, establishing a "more comprehensive services package," creating a "trust fund similar to Medicare," or making "health care become an explicit part of the trust responsibility" is hollow given the history of federal neglect and avoidance of responsibility. Changes in eligibility criteria have been proposed to save money, and for no other reason.

If one argues that health care is a trust responsibility, then it is based upon the government-to-government relationship between tribes and the federal government. Health care already is a part of that trust responsibility. "Blood quantum" is a thinly disguised euphemism for "racial purity," and an administrative means of disregarding Indian tribal citizenship criteria for the purpose of reducing budgets. The only governmental motivation for utilizing blood quantum criteria is to limit the size of the population and thereby limit the cost of health care. It is not for improving health care.

However, when the population is limited, it is likely that funding will decrease. And as there are fewer "racially pure," "eligible" Indians, there is less tribal power or influence in the governmental process, and the population becomes more manipulable.

If the government wishes to universalize health care benefits to tribes, then they should consider the most beneficial and broad basis for delivering this care. Since health care is a treaty right for the Puyallup Tribe, as indicated in the Medicine Creek Treaty, it could be argued that health care was "intended" to be a Treaty Right of each and every tribal entity with a treaty. It also could be argued that this aspect of trust responsibility has been historically overlooked, ignored and underfunded.

If eligibility is limited and made more restrictive, as indicated in OTA option three, and the government-to-government relationship between tribes and federal health care is made "closer," how is it that some of the tribal citizens may be terminated from this government-to-government relationship? The government-to-government relationship cannot be strengthened by assaulting tribal sovereignty. It seems quite obvious that the intent of the OTA report, from its initiation, was to justify reducing the cost of the IHS to Congress. It also seems obvious that the staff responsible for preparing the report were unfamiliar with the history of IHS or the tenets upon which both tribal sovereignty and the right to health care as "an explicit part of the trust responsibility" are based.

Our independent analysis is supported in a recent article:

> Critics of the blood quantum standard have argued that such a requirement undermines the Federal-Indian government-to-government relationship by establishing a racial criterion as the basis for eligibility for health care; represents an encroachment on the authority of tribal

> governments by determining who among their members is eligible for services; is tantamount to termination for a portion of the Indian population; fails to meet the "rational and proper" standard mandated by the Supreme Court in *Morton v. Ruiz*; and cannot be effectively administered due to incomplete and inaccurate blood quantum data. (National Indian Health Board Health Reporter, 1986b, p. 2)

It is not the choice of the single trustee of various agreements and sets of citizens to treat each of its separate and different wards in exactly the same manner. There exist several laws and multiple treaties over time which mediate the trustee's choices. The various treaties and agreements are not, have never been, and perhaps should never be the same. Every culture, every tribe has the right to define itself, as does every recognized nation.

Regardless of past precedents, oversights, and misunderstandings, involving "racial" guidelines as qualifiers for care, that particular criteria remains decidedly wrong. Because an agency of the trustee has violated human rights in the past and has not been brought before courts for trial or the public for censure, should the court refuse to hear the case involving the most recent violation?

In this case, the abuses have been committed against a perceived "race" of people by their trustee, and these specific abuses have nearly always been defended in the name of the public good, or at least in the name of the good of the trustee. But does not the trusteeship relationship mean that the governments and citizens of tribes are the wards, and that the responsibility lies not with defending what's good for the trustee, but what is good for the wards? This relationship is not based on "racial" criteria, but upon legal and governmental responsibilities.