Jumping Through Hoops: Traditional Healers and the Indian Health Care Improvement Act

Holly T. Kuschell-Haworth

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INTRODUCTION

There is nothing to a person that can’t be cured if you get what it takes to do it. We come out of the earth, and there’s something in the earth to cure everything . . . . Maybe it takes some herbs. Maybe it takes some touching. But most of all, it takes faith.

_Vernon Cooper, Lumbee healer_

Traditional Indian medicine has been a part of Native American health and well-being for hundreds of years. For centuries, Native American people have looked to their tribal healers to prevent or cure physical, mental and/or spiritual ailments through the use of a complex pharmacology and/or ceremony. For many Native Americans, reliance on traditional healers and medicine continues amid modern technological advances in Western medicine. Thus, the practice of traditional healing continues to play an important role in the health status of modern Native Americans.

The Indian Health Care Improvement Act (IHCIA) was implemented in 1976 with the purpose of improving the health status of Native Americans. Recognizing the unique trust relationship between the

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*Staff Writer, _DEPAUL JOURNAL OF HEALTH CARE LAW_, B.A., Michigan State University, 1992; J.D., DePaul University College of Law, 1999.

1_VERON COOPER & HARVEY ARDEN_, _WISDOM KEEPERS_ 58 (1990).

Federal government and Indian tribes as established through treaties for ceded lands, agreements, legislation, and case law, Congress created the IHCIA to provide appropriations for health services and facilities for Native American people. The health services established through the IHCIA are based on a modern Western model of medicine and health care. Nowhere in the act are there provided appropriations specified for traditional Indian healing practices. Because of this omission, the IHCIA is lacking in comprehensive health care for the benefit of Native Americans, contrary to its stated purpose.

The purpose of this article is to analyze the intent and purpose of the IHCIA as it relates to the exclusion of traditional Indian healing practices. The beginning will give a brief overview of the history of Indian health care, the IHCIA, and traditional Indian medicine. Then the article will analyze the relationship between the IHCIA and traditional Indian medicine. Finally, it will suggest changes in federal legislation to include traditional Indian medicine as part of Congress' stated intent to provide Native Americans with the highest health status possible.

BACKGROUND: THE HISTORY OF FEDERAL INDIAN HEALTH CARE

The Federal Government and Indian Tribes: A Special Relationship

The governmental duty to provide health services to Indian tribes derives from many sources. These sources include negotiated treaties to ceded Native American lands, settlements, agreements, and legislation. Significantly, there are specific treaties signed by the federal government and Indian tribes, exchanging Native American land and resources for federal promises of health care and other services. The generally

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4 See § 2, 25 U.S.C. § 1601 (b) (1976); (“A major national goal of the United States is 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”). Id.
5 Id.
7 Task Force Six, supra note 3.
accepted premise of government responsibility to Native Americans is based upon the destruction of Native American civilization and the poverty and disease which followed in its wake. While this obligation is widely accepted, it has not been upheld by courts as a basis for a Native American legal entitlement to benefits. Thus, responsibility for Native American health care as recognized by Congress has been subject to judicial and administrative disavowal at the expense of Native American people.

The Origins of Federal Native American Health Care

Attention to Native American health care began in the nineteenth century when contagious diseases, such as smallpox, threatened the once substantial populations of Native American people. The Federal government's earliest goals were to prevent disease and to speed Native American assimilation into the general population by promoting Native American dependence on Western medicine and by decreasing the influence of traditional Indian healers. In 1849, responsibility for Native American health was transferred from the War Department to the Bureau of Indian Affairs (BIA). The BIA oversaw the use of congressional appropriations for the establishment of health programs for Native Americans. Responsibility for Native American health has since endured many organizational transfers, and now resides with the Indian Health Service (IHS), an operating division of the Department of Health and Humans Services (DHHS).

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8 TASK FORCE SIX, supra note 3; Betty Pfefferbaum, et al., Learning How to Heal: An Analysis of the History, Policy, and Framework of Indian Health Care, 20 AM. INDIAN L. REV. 365, 368 (1996) [hereinafter Learning How to Heal].

9 See Gila River Pima-Maricopa Indian Community v. United States, 427 F.2d 1194, 1198 (Ct. Cl. 1970), cert denied, 400 U.S. 819 (1970) ("[The Indian Claims Commission Act §§ 1, 25 U.S.C.A. § 70 (1964), has] no language which we would construe as creating a guardian-ward type relationship even under liberal rules of construction. Moreover, there was no other special relationship or obligation here which created liability on the part of the United States."); see also Morton v. Ruiz, 415 U.S. 199 (1974).

10 TASK FORCE SIX, supra note 3, at 28.


12 TASK FORCE SIX, supra note 3, at 29.

13 Id.

14 Office of the Secretary, Statement of Organization, Functions, and Delegations of Authority, 60 Fed. Reg. 56,605 (Dep't of Health & Human Servs. 1995).
The principal legislation authorizing federal funds for health services to Native American tribes is the Snyder Act of 1921. In ratifying the Snyder Act, the federal government intended to provide appropriations "for the benefit, care and assistance . . . and for the relief of distress and the conservation of health . . . for Indians tribes throughout the United States." Following the Snyder Act, Congress created a process for transferring BIA and IHS health programs to tribal governments through the Indian Self-Determination and Education Assistance Act of 1975. In doing so, Congress noted the past inadequacies of Native American health care, and reaffirmed its intention to involve tribes in health care programs through tribal self-governance.

**Federal Native American Health are Today**

In 1976, Congress enacted the IHCIA to provide "the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy." In passing the Act, Congress noted the government’s "unique legal relationship with, and resulting responsibility to" Indians, necessitated the creation of a comprehensive health care system. The IHCIA set forth the following goals for the IHS:

1. to assure Native Americans access to high-quality comprehensive health services in accordance with need;
2. to assist tribes in developing the capacity to staff and manage their own health programs and to provide opportunities for tribes to assume operational authority for IHS programs in their communities; and
3. to be the primary federal advocate for Native Americans with respect to health care matters and to assist them in accessing programs to which they are entitled.

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Snyder Act § 1, 42 Stat. at 208.
Id.
Subsequent amendments in 1992 extended the purpose of the IHCIA to raising the health status of Native Americans over a specified period of time to the level of the general United States population. Additionally, the IHCIA sought a high level of participation by Indian tribes in the planning and management of IHS programs, services, and demonstration projects under subsequent self-determination amendments.

The IHS provides health care services to approximately 1.43 million Native Americans on reservations, in rural communities and in urban areas. The IHS health care system consists of health centers, hospitals, and health stations which are managed by 144 service units and eleven Area Offices. IHS services are delivered in three ways: through direct (IHS) services; through tribal services; or by contract with non-IHS service providers.

The annual appropriation for IHS is approximately $2 billion. The amount, and invariably, the effectiveness of the appropriations varies with frequent changes in IHCIA legislation. Appropriations are made based on the assumption that IHS health care will be provided in combination with public programs such as Medicare and Medicaid, for which Native Americans qualify as United States and state citizens. However, access to public programs by Native Americans is often denied or delayed based on the erroneous belief that Indians are only entitled to IHS health care. Additionally, the erratic funding of the IHCIA has made it very difficult for the IHS to fulfill its goals of providing Native Americans with the best care necessary to achieve the "highest health status possible."

Traditional Indian Health Care

Old Kangi-Shunka, he was a lonely man of the prairie. He goes by the sun and moon, the stars and the winds. He harvests from the

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25 Id. at 4.
28 Indian Health Care Improvement Act § 3, 90 Stat. at 1401.
29 Learning How to Heal, supra note 8, at 385.
30 Indian Health Care Improvement Act § 3, 90 Stat. at 1400.
earth and the four-legged ones. He’s a buffalo man, a weed man, a pejuta wichasha. He sees an herb and he hears the herb telling him, “Take me for your medicine.” He has the kind of spirit and words out of which you create a nation.

Crow Dog, Lakota medicine man

For centuries, certain individuals of Indian tribes have used their knowledge or “medicine” to cure or prevent the physical, mental and spiritual ailments of their people. These individuals are generally called medicine men or women, healers, holy men or women, and doctors. Native American medicine people are thought to have been given their gift of healing or “doctoring” through dreams or visions sent by the Creator, or helper spirits. The power to heal comes unsought to many healers. Therefore, unlike physicians within the Western medical model, Native American healers are believed to have been chosen to their practice through an act of divine or spiritual intervention. For example:

When Charlie was thirty-two or thirty-three, he got his healing song... the Creator came down and touched me here on my hands, then He taught Charlie his healing song, He taught me how to heal. He showed me how to use the eagle feather to find the sick place in a person.

Charlie Knight, Ute medicine man

According to the gift of healing each Native American doctor has been given, he or she will learn songs, ceremonies, and herbal cures which may be used to help his or her people. Because many “gifts” are individual in nature, many doctors were “specialists” in certain forms of healing, such as herbal remedies, women’s concerns and fertility, or spiritual doctoring.
Native American medical practitioners make or apply medicine in a variety of ways. Native American medicine can include an herb taken orally, the touch of a spirit or a feather, a sacred song, or even a handshake. In this manner, there is a vast difference between the ways Native American and Western doctors cure their patients. For example, in the Western medical model, disease has a rational, scientific basis and cause. These causes may include viruses, bacteria, old age, cancer, inherited defects, and accidents. A Western doctor will try to cure a person by prescribing drugs or treatments to stop the symptoms or the continuance of a specified cause. Additionally, the Western medical model may speak of depression or stress as a source of illness rather than as a condition of an illness of the whole or part of the soul.

Traditional Indian medicine is based upon the cure of all parts of the person, including his or her soul. There is no healing of a person without a complete or holistic cure which addresses the physical, mental, environmental and spiritual aspects of the person. Therefore, a Native American doctor may be called upon to perform a myriad of functions for a patient, including prescribing herbal remedies, “touching,” and/or performing “sings” or ceremonies. For example, in traditional Lakota medicine, there are three types of healing ceremonies. These are the Lowanpi ceremony, or “Sing,” the Yuwipi, or “they tie them up” ceremony, and a generalized Wapiye' ceremony. A fourth method of doctoring involves the Pejuta Win, or herb doctors, who heal the sick principally by means of traditional pharmaceuticals. “The plants used as remedies may need special songs learned in dreams to unleash their healing power; without the songs they are just plants.” Using methods like these, Native American doctors have cured all manner of disease, from mental problems to cancer, in their respective communities.

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39Id. at 29.
40Id.
42ST. PIERRE & LONG SOLDIER, supra note 32, at 28.
43Id.
44Id.
45Id.
46Id.
47Id.
THE IHCIA/TRADITIONAL HEALER RELATIONSHIP

IHCIA Intent and Language as it Applies to Traditional Native American Medicine

As discussed above, the purpose of the IHCIA is to provide Native Americans with the highest health status possible within a specified period of time.\(^4\) In determining what kind of health care would be most effective in reaching the intended health status for Native Americans, it would be sensible to consider the kind of health care most accepted and accessible by Native American people as a whole. Perhaps the most obvious source of health care for Native Americans is that which sustained them for hundreds of years, namely their own traditional medicine. However, the IHCIA is silent about the role of traditional healers in Native American health care. That is, the Act does not contain provisions expressly granting or prohibiting IHS the authority to use its appropriations to provide Native Americans with the services of traditional Indian practitioners.\(^4\) The legislative history of the IHCIA, however, reflects an implied prohibition of the use of the IHCIA funds for traditional native medicine, contrary to the stated purpose of the Act.

First, the health care programs and appropriations granted by Congress prior to the enactment of the IHCIA were prohibitive of traditional medicine practices.\(^5\) Early Native American health care programs were created out of the governmental concern over the continued spread of contagious diseases within and around Indian tribes.\(^5\) In order to arrest disease, the government aspired to teach Native Americans to be dependent on Western medicine by decreasing the influence of traditional Indian healers.\(^5\) To this effect, the practices of medicine men were often declared offenses punishable by imprisonment.\(^5\)

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\(^{49}\) Telephone interview with Capt. Craig Vanderwagon, M.D., Director, Division of Clinical Preventative Services, Indian Health Service (Oct. 23, 1998).
\(^{50}\) \textit{Learning How to Heal}, supra note 8, at 370.
\(^{51}\) \textit{Id.} at 368.
\(^{52}\) U.S. \textsc{Pub. Health Serv.}, \textsc{Health Services for American Indians} 86, 87 (1957).
\(^{53}\) \textit{Learning How to Heal}, supra note 8, at 372, quoting Thomas J. Morgan, Rules for Indian Courts, in \textsc{Documents of the United States Indian Policy} 160 (Francis P. Prucha ed., 2d ed. 1990).
Second, there is a noticeable lack of discussion in prior legislative history regarding the validity of traditional Indian medicine as an appropriate source of health care for Native Americans under the Act. Part of the reason for this omission is that many of the contributing drafters of the IHCIA were either legislators who did not understand traditional Indian medicine or physicians who had labeled Indian medicine as "second class health care."54 Another reason is that many contributors viewed Indian medicine as a religious issue which involved church and state separation issues that were not applicable to health care.55 Therefore, traditional Indian medicine was not given a voice in the drafting of the IHCIA even though it has been the primary source of health care for Native Americans for centuries.

Finally, regulations set forth under the IHCIA have expressly prohibited the use of IHS policy for the services of traditional Indian healers.56 For example, in 1997 the Department of Health and Human Services (DHHS) issued a General Notice adopting rate quotations as an alternate acquisition method to establish reimbursement rates for health care services purchased under IHS Contract Health Services Program.57 The rate quotation policy was created to increase the number of formal agreements IHS has with contract health care providers.58 However, the Notice expressly states: "[t]his policy will apply only to contract health services programs administered by the IHS, and will not apply to services rendered by traditional Indian medicine men and women...."59 Without further explanation of this exception, the DHHS regulation reflects a prohibitive view with respect to the inclusion of traditional Indian medicine under IHS direct or contractual services.

**IHCIA Health Service Contracts**

One way that IHS centers and tribes have been able to access funds provided under the IHCIA for traditional Indian healers is through the use of the health service contracts. The Act allows IHS or tribes to contract

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54Telephone interview with Capt. Craig Vanderwagon, M.D., Director, Division of Clinical Preventative Services, Indian Health Service (Oct. 23, 1998).
55Id.
57Id.
58Id.
59Id.
with non-IHS, non tribal providers for health care services not available through their direct care systems. All funding for third-party provider contracts derives from the IHS Contract Health Services Fund which receives appropriations directly from Congress. Because of severe budget limitations on funding, contract services are rationed by the IHS in conformity with medical priority determinations and with the requirement that services are first sought through non-IHS providers (i.e., alternative sources). Furthermore, contract services are only available to contract health service delivery areas (CHSDA) as determined by the IHS. However, because of the limitation in services available through the IHS and tribes due to lack of resources, third-party provider contracts are an extremely important component of the IHS health care system.

The IHCIA requires that all services provided through IHS contracts must be those which the IHS is authorized to administer for the benefit of Native Americans. That is, all health care services purchased under IHCIA contract provisions must fall within the scope of IHS health care. Currently, there is no language within the IHCIA defining traditional Indian medicine as a health profession or traditional healers as health care providers. Therefore, traditional Indian medicine and healers are, literally, excluded from consideration for contract services. However, both the IHS and tribes have contracted with traditional healers by designating them as "social work technicians" or "mental health/health care consultants" on contract applications. Thus, while in practice, traditional Indian health care services have not been wholly suppressed by the IHS, they are only permitted to be used "under the table." Moreover, because the lack of funding for IHS contracts requires stringent medical priority determinations, traditional healers must stand in a long line behind other contract providers.

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60 Indian Health Care Improvement Act § 2, 90 Stat. 1400 (1976).
61 90 Stat. 1400.
63 Providing for Health Care, supra note 6, at 235.
64 Id.
65 Indian Health Care Improvement Act § 2, 90 Stat. 1400 (1976).
66 Telephone interview with Capt. Craig Vanderwagon, M.D., Director, Division of Clinical Preventative Services, Indian Health Service (Oct. 23, 1998).
67 Id.
EXCLUDING TRADITIONAL INDIAN MEDICINE/HEALERS FROM IHCIA HEALTH CARE CRIPPLES THE GOAL OF PROVIDING THE HIGHEST HEALTH STATUS POSSIBLE TO NATIVE AMERICANS

Why the Exclusion of Traditional Indian Medicine and Healers Does Not Promote the Goals of the IHCIA

The IHCIA states that "a major national goal of the United States is 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" [emphasis added]. To achieve this goal, the IHCIA set up a system of services based on a Western medical model. The services offered include internal medicine, pediatrics, obstetrics and gynecology, social work, psychology, etc. The only "non-Western" medical services included under the Act are allopathic medicine and chiropractic medicine, both considered by many to be components of "alternative" health care. The exclusion from the IHCIA of the health care system that Native Americans have relied on for hundreds of years departs from the purpose of providing quantity and quality health services with the maximum Indian participation by limiting accessibility.

Health care accessibility is limited in four principal ways:

(1) by excluding Native Americans who wish to receive traditional Indian health services;
(2) by limiting geographic access to health care;
(3) by excluding those Native Americans who are fearful or mistrustful of IHS/government services; and
(4) by excluding traditional Indian health services which effectuate or promote the goals of the IHCIA.

First, the exclusion on traditional Indian medicine from the IHCIA promotes the denigration of the cultural values that Native Americans

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63 Indian Health Care Improvement Act § 2, 90 Stat. 1400 (1976).
70 Id.
associate with healing, thereby narrowing their choice of treatment. This effectively makes IHS health services less accessible to Native Americans overall by excluding traditional Natives who wish to be treated by Indian healers.

The traditional belief of [Native American] and Alaska Native people regarding wellness, sickness and treatment are very different from the medical model of public health approach used in training health care providers today. The beliefs, traditions, and customs handed down through many generations played the principal role in the establishment of individual and collective Native American identity. The effectiveness of any health care approach is greatly affected by the inherent beliefs of the patient.72

Thus, where the IHCIA authorizes medical services strictly under the Western medical model, health care only reaches the portion of Native Americans who wish to undergo Western medical treatment. Arguably, the exclusion of traditional Indian medicine is imperialistic in nature. This concept can be understood best when used in a more familiar scenario. What if non-Native Americans (excluding Chinese-Americans) who received Medicare or Medicaid services were told that they could only receive traditional Chinese medicine, rather than the modern Western medicine they trust or are accustomed to?

The exclusion of traditional Indian medicine from the IHCIA is particularly relevant in light of the lack of sources and alternatives available to Native Americans who wish to receive traditional Indian health care. Because IHS contract services are based on a payer-of-last-resort system and medical priority determinations, Native Americans who wish to use them are left very few alternatives. Most alternative health care providers, such as Medicare or Medicaid, do not provide for traditional Indian medicine. Therefore, the patient’s list of payers is limited to tribal services or IHS services.73 Tribal health services are often limited by resource or are based upon IHS contracts,74 hence the patient seeking traditional health care is moved to an even more limited funding pool. Once a patient finally seeks funding for traditional medicine

73Providing for Health Care, supra note 6, at 235.
74Id.
through IHS contracts, the patient is put in line behind medical priority concerns, such as emergency care, due to IHS budgetary constraints. In the process, both the patient and healer are discouraged from seeking or practicing traditional Indian health care because it is onerous to do so.

The second principle is that where IHS health services reach a geographically limited number of Native Americans, the exclusion of traditional healers who can reach those patients limits the scope of overall Native American health care. There are over two million Native Americans in the United States, according to the 1990 United States Census. In 1997, the IHS had a service population of approximately 1.43 million Native Americans within geographically defined service unit areas centering around reservations or concentrated population areas. Based on these estimations, it is clear that almost half of all Native Americans in the United States either did not or could not access IHS provided health care. Whether the substantial lack of service to the overall Native American population resulted from lack of access due to geography is undetermined. However, it is clear that in order to provide Native Americans with the highest health status possible, more Native Americans must be given health care. One logical way to do this is to encourage the use of local Indian healers by including them as “health professionals” under the IHCIA. In this fashion, IHS may extend its reach to Native American communities that are under the care of traditional Indian practitioners. By excluding traditional Indian medicine healers from the IHCIA scope, the goal of improving Native American health care can only go so far.

Third, by excluding traditional Indian medicine, the IHCIA neglects those Native Americans who fear or mistrust government-run health services. Throughout United States/Native American history, there has been much mistreatment and negligence inflicted upon Indians who have passed through BIA/IHS health service doors. Some mistreatment was

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75 Id.
78 Id.
80 Learning How to Heal, supra note 8, at 371.
due to overzealous assimilation policies, some through inadequate health care.81

One well-known example of IHS mistreatment of Native Americans involves the forced sterilization of Native American women during the 1970s.82 In 1975, the United States General Accounting Office (GAO) conducted an investigation into the accusations aimed at the IHS by physicians, tribal leaders, and women who had experienced or witnessed forced sterilizations.83 While the GAO did not ultimately find the IHS responsible for the forced sterilizations, it did note that IHS medical consent procedures were inadequate in more than three thousand cases of sterilization.84

Furthermore, many Native Americans who are accustomed to low-cost traditional Indian health services are mistrustful of the rates of services charged by IHS health providers:

God gave us medicine to share with people, but if the White Man gets his hands on it he'll charge you a great price and will let you die if you don't have it. God's medicine is free.

Mathew King, Lakota traditionalist84

While the IHS has come a long way in the treatment and services of Native American people, many Native Americans still remember IHS mistreatment to themselves or their family members.86 Therefore, Native American mistrust and fear of IHS services is a significant obstacle to the improvement of Native American health. This can only be remedied by

82Mary Crow Dog, a Lakota from the South Dakota remembers "My sister Barbara went to the government hospital in Rosebud to have her baby and when she came out of anesthesia found that she had been sterilized against her will. The baby lived only for two hours, and she had wanted so much to have children. No, it isn't easy." CROW DOG & ERDOES, supra note 34, at 4.
83England, supra note 81.
84Id.
85WALL & ARDEN, supra note 1, at 32.
86CROW DOG & ERDOES, supra note 31, at 4; Learning How to Heal, supra note 8, at 365, quoting former Cherokee Chief Wilma Mankiller: "My rage came mainly from the frustration caused by the way I feel about Western medicine, the way it generally dehumanizes patients," WILMA MANKILLER & MICHAEL WALLIS, Keeping Pace with the Rest of the World, MANKILLER: A CHIEF AND HER PEOPLE 232-33 (1993). See also generally St. Pierre & Long Soldier, supra note 31, at 28.
health services which either accompany their belief systems, or are coupled with excellent Western health care, or a combination of both. In the interest of the health goals set forth under the IHCIA, both types of remedies would help reach the reluctant or fearful Native American in order to provide them with adequate health care. By excluding traditional Indian medicine and healers, the IHCIA, again, fails to provide access to the overall Native American population, contrary to its stated purpose.

Finally, by excluding traditional Indian medicine and healers, the IHCIA fails to include health services which effectuate or promote its stated health goals. The IHS Declaration of Health Objectives states that it intends to reduce death and incidences related to: obesity, alcohol, drugs, pregnancy, suicide, mental disorder, child abuse and neglect, spousal abuse, fetal alcohol syndrome, sexually transmitted disease, cigarette smoking, etc.\(^\text{57}\) While this list is a significant departure from the vast number of objectives the Act has listed, it is chosen to demonstrate a significant point. Every one of the objectives listed above is connected to a lapse in a person/community’s social or mental (and perhaps spiritual) conditions. Observing the role of a traditional healer in serving the physical, mental, environmental and spiritual needs of his or her community, one would conclude, at the very least, that such services might touch upon any one of the above objectives. For example:

For the tribal peoples of this land, balancing between two worlds can be very precarious, both spiritually and physically. What many of today’s medicine men and women do most is help people who are “injured” by living as a colonized tribal people. In effect, they doctor depression, lack of positive identity, suicidal behavior, drug abuse, alcoholism, family crises, spouse abuse, and street-related illnesses that are effects of colonization. They also doctor “standard” types of illnesses such as cancer as well, but most “obvious” problems are left to run their course or are treated by a white physician.\(^\text{88}\)

In essence, traditional healers are helping to reach IHS goals by improving the health of their local communities. Why then, are traditional healers excluded from the IHCIA?

\(^\text{57}\)Indian Health Care Improvement Act, 25 U.S.C.A. § 1602(b) (1998).
\(^\text{88}\)ST. PIERRE & LONG SOLDIER, supra note 32, at 34.
A New Approach

In order to attain the highest health status possible for the Native American, the IHCIA must be amended to include traditional Indian healers as health care providers. While third-party provider contracts may be fashioned to include traditional Indian healers into the IHS service system, it is not enough. The lack of budgetary funding, medical priority determinations, and lack of alternative payers, places too high a burden on the healer and patient who wish to provide/access traditional Indian health care. By including traditional Indian medicine and healers in the IHCIA, results would include: better health care to Native Americans who wish to receive traditional care; better access to geographically limited Native Americans; more outreach to Native Americans who are fearful or mistrustful of IHS services; and more health care services to effectuate the health objectives of the Act. Additionally, the health services of traditional healers are often much less costly than services provided by the IHS. Therefore, the use of traditional healers would cost the IHS less than would most Western medicine providers, allowing the remaining funds to be used to reach more Native Americans who need health care. Finally, including traditional healers under the IHCIA allows Native Americans a wider choice of health services, contributing to overall Native American self-determination. Thus, were the IHCIA amended to include traditional Indian healers as “health providers,” the IHS could improve in providing “quality and quantity” health care with the maximum participation of Native Americans under the spirit and intent of the IHCIA.89

The concept of including traditional Native healers in government-funded health care is not a new one. In 1994, the Health Resources and Services Administration (HRSA) issued funds under the Native Hawaiian Health Care Improvement Act of 1992 (NHHCIA), to provide comprehensive disease prevention and primary health service to Native Hawaiians.90 Through the NHHCIA, Congress authorized that appropriations could be used for grants or contract services with any qualified entity, including traditional Native Hawaiian healers,91 for the purpose of

91"Traditional Native Hawaiian healer" is defined as: (1) a practitioner who is of Hawaiian ancestry; (2) has the knowledge, skills, and experience in direct personal health care of individuals; (3) whose knowledge, skills, and experience are based on demonstrated learning of Native Hawaiian healing practices acquired; by (4) direct practical association with Native Hawaiian
providing comprehensive health promotion, disease prevention, and health services to Native Hawaiians. In interpreting the NHHCIA by regulation, the HRSA stated:

The integration of traditional health healer concepts with western medicine is encouraged. It is anticipated that the primary care and health promotion and disease prevention components will be integrated into one system of care and that existing health resources of the community will be used to the greatest extent possible.

Furthermore, the Act specifies that all entities considered for funding must be qualified Native Hawaiian health care systems as recognized by the Papa Ola Lokahi, the Native Hawaiian tribal government.

This example demonstrates government commitment to at least one Native health care system to provide traditional Native healers and medicine. It also addresses an area of concern to some tribal constituents with regard to including traditional Native American health care in government-funded health services, namely problems of church-state separation and healer autonomy. In the Hawaiian example, all entities who receive funding must be first approved by the Native Hawaiian Papa Ola Lokahi. By allowing this, the control and determination of health care given to Native Hawaiian people are left in the hands of the Native tribal government, rather than the federal United States government. The IHCIA could be amended to work the same way, including and encouraging the use of traditional healers and medicine with the initial approval for their funding placed in the hands of tribal governments. Hence, the federal government would not need to make decisions regarding the use or regulation of traditional Indian healers within the tribal community. Furthermore, where tribal governments are familiar with and support traditional Indian medicine and healers, there is more room for healer autonomy and practice. Like the services provided under the NHHCIA, the inclusion of traditional medicine and healers in the

elders; and (5) oral traditions transmitted from generation to generation. See The Native Hawaiian Health Care Improvement Act, 42 U.S.C. § 11701(12)(10).

42 U.S.C. §§ 11701(6) (a) and (b)(c) (a)(3).


4Id. at 14,663.

5Id.
IHCIA would effectuate the IHCIA health objective goals and grant Native American tribes health service self-determination.

**CONCLUSION**

Traditional Indian medicine and healers have been excluded, albeit silently, from IHCIA-funded health care. Through statutory omission, regulatory exclusion and stringent contract limitations, traditional Indian health care has been prevented from contributing to the goal of achieving the highest health status possible for Native Americans. While the IHCIA has helped to improve the health status of Native Americans, it can only reach a portion of all Native Americans in the United States. In order to effectuate the goal of the IHCIA of achieving the highest health status possible for Native Americans, the IHCIA must provide more access to its health services. One way that this may be done is by amending the Act to include traditional Native American healers as "health care providers." The inclusion of traditional Indian healers in the IHCIA will help to provide: health care to Native Americans who wish to receive traditional care; better access to geographically limited Native Americans; more outreach to Native Americans who are fearful or mistrustful of IHS services; more health care services to effectuate the health objectives of the Act; less costly service which would allow for wider use of funds; and Native American self-determination in choosing health services. The 1992 amendments to the IHCIA will "sunset" at the end of the 1999 fiscal year, and re-authorization discussions are currently underway. Therefore, the voices of Native American tribes and traditional healers will need to be strong to accomplish a change. In any case it is clear that to provide the best and most effective health care to Native Americans, the IHCIA must be amended to include traditional Indian medicine and healers.

What is important for us is that the old ways are correct and if we do not follow them we will be lost and without a guide.

*Thomas Yellow Tail, Crow Holy Man*[^99]

[^96]: Indian Health Care Improvement Act § 2, 90 Stat. 1400 (1976).
[^99]: ST. PIERRE & LONG SOLDIER, supra note 32, at 7.