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Koral E. Fusselman

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Native American Health Care: Is the Indian Health Care Reauthorization and Improvement Act of 2009 Enough to Address Persistent Health Problems Within the Native American Community?

Koral E. Fusselman*

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I am an Omaha Indian and have been working as [a] medical missionary among the Omahas I know that if you knew the conditions and circumstances to be remedied you would do all you could to remedy them.¹

Letter from Dr. Susan La Flesche Picotte
to Commissioner of Indian Affairs,
Francis Leupp, November 15, 1907

Introduction

Through ninety years of legislation, Congress has provided piecemeal solutions to the rampant health problems affecting Native Americans and Alaskan Natives.² While the health status of Native Americans has improved over the years, it remains at a level astonishingly below that of most Americans.³ The American people, including many scholars, frequently proclaim the negative effects of alcohol on the Native American

1. DAVID H. DEJONG, “IF YOU KNEW THE CONDITIONS”: A CHRONICLE OF THE INDIAN MEDICAL SERVICE AND AMERICAN INDIAN HEALTH CARE, 1908–1985, 1 (2008).

2. See Snyder Act of 1921, 25 U.S.C. § 13 (2011) (providing financial assistance “for the benefit, care, and assistance of the Indians”); see also Indian Health Care Improvement Act of 1976, Pub. L. No. 94-437, 90 Stat. 1400 (1976) (codified at 25 U.S.C. § 1603 (2010)) (providing financial support and directives to improve “the services and facilities of Federal Indian health programs”).

3. See DEP’T OF HEALTH & HUMAN SERV., INDIAN HEALTH SERVICE: FISCAL YEAR 2010 JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES CJ-141, CJ-147 (2009), available at http://www.ihs.gov/nonmedicalprograms/budgetformulation/documents/IHS_CJ_2010_Final_Submission.pdf (providing statistics of the high vacancy rates of physicians and nurses on IHS and tribal health sites); see also U.S. COMM’N ON CIVIL RIGHTS, BROKEN PROMISES: EVALUATING THE NATIVE AMERICAN HEALTH CARE SYSTEM, 11 (2004), available at <http://www.usccr.gov/pubs/nahealth/nabroken.pdf> (explaining the higher rates of mental health problems among Native Americans); see also INDIAN HEALTH SERV., 2009 NATIONAL SUMMARY, PERFORMANCE MEASUREMENT: IMPROVING HEALTHCARE FOR AMERICAN INDIANS AND ALASKA NATIVES, GOVERNMENT PERFORMANCE AND RESULTS ACT 8 (2009), available at <http://www.ihs.gov/cio/crs/documents/2009ExecutiveSummary.pdf> (supplying statistics of the high rates of diabetes within the Native American population).

population, but few realize that alcoholism is but one of a multitude of health problems plaguing the population.⁴

Native Americans are diagnosed with and die from diabetes at rates staggeringly higher than those found in the general population.⁵ Depression, substance abuse, alcoholism, and other mental health disorders are extremely prevalent within the Native American population,⁶ and suicide ranks among the top killers of Native American children and adolescents.⁷ Alongside all of these health problems runs a history of inadequate staffing of nurses, physicians, and dentists.⁸ While Americans decry the deplorable health conditions in developing countries, they are blissfully unaware of the staggering health problems of Native Americans within our borders.

The Snyder Act of 1921⁹ represented the first acknowledgement by the federal government of the need to provide for the well-being and health care needs of Native Americans.¹⁰ Beginning with appropriations to federal agencies charged with assisting Native Americans,¹¹ the federal government

4. See Philip A. May, *The Epidemiology of Alcohol Abuse Among American Indians: The Mythical and Real Properties*, in CONTEMPORARY NATIVE AMERICAN CULTURAL ISSUES 227, 228 (Duane Champagne ed., 1999) (explaining that many Americans are aware of the effects of alcoholism on the Native American population, but are unaware of health problems).

5. See INDIAN HEALTH SERV., *supra* note 3, at 8 (explaining that in 2009 the unadjusted diabetes prevalence rate was twelve percent as compared to the national average of eight percent).

6. See U.S. COMM'N ON CIV. RTS., *supra* note 3, at 11–12 (explaining that Native Americans have a higher risk of mental health disorders than other subsets of the population); see also *id.* at 12 (“The most significant health concerns today are the prevalence of substance abuse, depression, anxiety, violence, and suicide.”).

7. See *id.* at 13 (explaining that the rate of suicide among Native American children is two and one-half times the rate for white children).

8. See Memorandum from Nat'l Indian Health Bd., *How the Indian Health Care Improvement Act Addresses Health Issues in Indian Country* (July 2009) (providing that the vacancy rates for physicians, nurses, dentists, and pharmacists range from eleven to twenty-six percent in 2009) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

9. See Snyder Act of 1921, 25 U.S.C. § 13 (2011) (providing appropriations as needed to the Bureau of Indian Affairs to assist Native Americans in many respects, including “relief of distress and conservation of health”).

10. See *id.* (“The Bureau of Indian Affairs . . . shall . . . expend such moneys as Congress may from time to time appropriate, for the benefit, care and assistance of the Indians . . .”).

11. See Transfer Act, Pub. L. 83-568, § 1, 68 Stat. 674 (1954) (codified at 42 U.S.C. § 2001 (2011)) (transferring the Bureau of Indian Affairs, Secretary of the Interior, and the Commissioner of Indian Affairs to the Public Health Service).

slowly assumed increasing responsibility for providing health care to Native Americans. Despite these steps, no legislative act directly addressed the health problems facing Native Americans or provided specific provisions on how best to combat the issue. The Indian Health Care Improvement Act of 1976 (IHCIA)¹² represented the first comprehensive Congressional response to the failing health status of Native Americans.¹³ This initial legislation attempted to address the myriad of problems faced by the Indian Health Service (IHS or “the Service”), the primary provider of health services to Native populations throughout the United States.¹⁴ The IHCIA provided funding for health care programs through fiscal year 1980, with additional appropriations through 1984 to be authorized through subsequent legislation.¹⁵ Funding continued to be appropriated annually through a series of amendments to the IHCIA authorizing future funds through fiscal year 2000.¹⁶ After 2000, however, the IHS again relied upon Congress to annually authorize funds to support and continue IHS’s operations.¹⁷

12. See Indian Health Care Improvement Act of 1976, Pub. L. No. 94-437, § 402, 90 Stat. 1400 (1976) (codified at 25 U.S.C. § 1603 (2010)) (establishing the basic framework for the administration of health care services to Native Americans).

13. See Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 216 (1997) [hereinafter R. Pfefferbaum, *Providing for Health*] (describing the comprehensive nature of the Indian Health Care Improvement Act and the Act’s acknowledgement of the “special responsibilities and legal obligations” owed by the Federal government to the Native American people).

14. See Indian Health Care Improvement Act of 1976 §§ 3–4, (explaining that the policy of the Act is to “provid[e] the highest possible health status to Indians” and to increase resources to the IHS to effectuate that policy).

15. See *id.* § 103(d) (appropriating funds for fiscal year 1980 and authorizing appropriations only for fiscal years 1981, 1982, 1983, and 1984).

16. See Indian Health Amendments of 1988, Pub. L. No. 100-713, § 4, 102 Stat. 4784 (1988) (codified at 25 U.S.C. §§ 1601 et seq. (2011)) (authorizing appropriations only as are provided in appropriations acts); see also *id.* §§ 101–03 (showing that most sections throughout the Act provide appropriations for fiscal years 1989 through 1992); see also Indian Health Amendments of 1992, Pub. L. No. 102-573, § 123, 106 Stat. 4526 (1992) (codified at 25 U.S.C. §§ 1601 et seq. (2011)) (“There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.”).

17. See Elayne J. Heisler & Roger Walke, *Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, CRS REP. FOR CONGRESS 2 (2010), available at [http://www.npaihb.org/images/resources_docs/weekly_mailout/2010/april/week4/IndHlthCareCRS%20\(2\).pdf](http://www.npaihb.org/images/resources_docs/weekly_mailout/2010/april/week4/IndHlthCareCRS%20(2).pdf) (explaining that while the IHS has continued to receive funding since 2000, it has only received these appropriations on a year to year basis).

The IHCIA was finally reauthorized in March 2010 with the passage of the Patient Protection and Affordable Care Act (PPACA).¹⁸ Under the PPACA, the IHCIA is reauthorized “permanently and indefinitely” with funds appropriated through fiscal year 2010 and every fiscal year thereafter until all federal funds are expended.¹⁹ Despite the continued progress made through the Reauthorization Act, much must still be done to address the persistent health problems affecting Native American and Alaskan populations.

This Note will look at the Reauthorization Act as it addresses the continued disparities between the health status of Native Americans and Alaskans as compared to the general population of the United States. The Note will focus primarily upon the Reauthorization Act’s response to the high vacancy rates of health professionals at IHS and tribal health sites, high rates of diabetes within the population, and the treatment and prevention of behavioral health and substance abuse. It will evaluate how the reauthorization differs from previous legislation and will provide recommendations drawn from other academic sources to propose issue-specific reforms to the Act to address these three health problems.

Part I of the Note will focus on the unique historical relationship between the Native Americans and the federal government and the basis of federal involvement in Indian health care. Part II will consider three major health care problems still facing Native American populations and the IHS; high vacancy rates among health care professionals and practitioners, elevated rates of diabetes, and widespread behavioral health problems which continue to plague the IHS’s attempts to address the health status of Native Americans and Alaskans. Part III will analyze the reauthorization of the IHCIA through the PPACA and how its provisions and amendments address the identified health care problems. Part IV of the Note will provide recommendations for future legislation to continue to improve the health status of Native Americans. This Note recommends the use of traditional belief systems and healing practices to address the enduring behavioral health problems and increasing prevalence of diabetes within the

18. See Patient Protection and Affordable Care Act, Pub. L. 111-148, § 10221, 124 Stat. 119 (to be codified at 42 U.S.C. §§ 18001 et seq. (2012)) (enacting the Indian Health Care Improvement and Reauthorization Act); see also Indian Health Care Improvement Reauthorization and Extension Act of 2009, S. 1790, 111th Cong. §§ 101, 825 (2009) (enacted) (reauthorizing permanently the Indian Health Care Improvement Act and authorizing appropriations indefinitely).

19. See Patient Protection and Affordable Care Act, § 10221 (enacting the Indian Health Care Improvement and Reauthorization Act).

population. Additionally, the Note recommends that the IHS utilize advanced practice nurses to address the high vacancy rates preventing the Service from providing effective health care to thousands of Native Americans.

I. Origins of the Federal Government's Obligation for Indian Health Care

A. Historical Foundations

By the 17th century, diseases introduced by European colonists, missionaries, and explorers had decimated the native populations of North and South America.²⁰ In 1605, just eighty-six years after Spanish conquest, the native populations of Mexico and the Southwestern United States were reduced to just under five percent of the estimated population at the start of European conquest.²¹ As common European diseases ripped through Native populations, the United States government gradually stepped in to address the rampant health problems. In the centuries since European settlement of the New World, the health status of Native Americans has slowly, but by no means entirely, improved.

Initially, the federal government was only concerned with gathering accurate data as to the current population size of Native Americans and making a determination of the number of natives affected or killed by disease.²² Gradually, the federal government began to recognize a stronger obligation owed to Native Americans as a result of the “negotiated treaties, agreements, legislative enactments and compacts” made between the government and the various native tribes.²³ Initial efforts focused largely on preventing the spread of small pox and other contagious diseases, particularly in areas where Indians and non-Indians frequently came into contact, such as military posts.²⁴

20. See Plutarco Naranjo, *Epidemic Hecatomb in the New World*, in COLUMBUS AND THE NEW WORLD: MEDICAL IMPLICATIONS 19, 21 (Guy A. Settipane ed., 1995) (describing a population drop of nearly 24,000,000 in the Native populations).

21. See *id.* (detailing the demographical fall of Native populations following conquest).

22. See Thomas S. Williamson, *The Diseases of the Dakota Indians*, 4 NW. MED. AND SURGICAL J. 410, 418–19 (1873) (explaining that most governmental interest in the health status of Native Americans related only to their interactions with colonists and the effects of these interactions on Native populations).

23. R. Pfefferbaum, *Providing for Health*, *supra* note 13, at 213.

24. See 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, 368–69 (1995)

The first legislative act to address the status of Native Americans was the Snyder Act of 1921.²⁵ Coming at a time of increased concern for health care at all levels of government,²⁶ the Snyder Act authorized the Bureau of Indian Affairs (BIA) to utilize Congressional appropriations for “the benefit, care and assistance of the Indians throughout the United States.”²⁷ The Snyder Act provided a limited number of programs and authorized the BIA to “direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care and assistance of the Indians” for, among other things, the “relief of distress and conservation of health.”²⁸ Not without its faults, the Act failed to define specific programs for assistance and eligibility requirements, and did not represent a general entitlement to services.²⁹

In the 1950s, health services for Native Americans were transferred from the BIA to the Department of Health, Education, and Welfare,³⁰ now the Department of Health and Human Services (HHS).³¹ Widely opposed at the time, this transfer would ultimately result in “increased funding, greater access to care, and better care overall” for Native Americans.³² Native American health care management now resides with the Indian Health Service (IHS).³³

[hereinafter B. Pfefferbaum, *Learning How to Heal*] (explaining the selfish motives behind early health care provided to Native Americans).

25. See Snyder Act of 1921, 25 U.S.C. § 13 (1921) (providing for congressional appropriations for the care and benefit of Native Americans).

26. See R. Pfefferbaum, *Providing for Health*, *supra* note 13, at 215 (explaining that the American public was greatly concerned with increased health and public safety at the turn of the 20th century). This concern manifested itself in a series of legislative acts directed at improving the health and safety of all Americans. *Id.*

27. Snyder Act of 1921 § 13.

28. *Id.*

29. See R. Pfefferbaum, *Providing for Health*, *supra* note 13, at 377 (explaining that this initial legislation merely provided for the possibility of health services, but did not go so far as to establish any specific programs).

30. See Transfer Act, Pub. L. 83-568, § 1, 68 Stat. 674 (1954) (codified at 42 U.S.C. § 2001 (2011)) (transferring several agencies, including the BIA to the Public Health Service).

31. See Department of Education Organization Act, Pub. L. 96-88, § 301, 93 Stat. 668 (transferring the Department of Health, Education, and Welfare to the Department of Health and Human Services).

32. B. Pfefferbaum, *Learning How to Heal*, *supra* note 24, at 382 (explaining that the care for Native Americans remained with the Bureau of Indian Affairs until it was transferred to the Indian Health Service).

33. See Office of the Secretary and Public Health Services; Statement of Organization, Functions, and Delegations of Authority, 60 Fed. Reg. 56,605 (Jan. 3, 1995) (describing the

B. Indian Health Care Improvement Act of 1976 and Subsequent Amendments

In 1975, Congress enacted the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA),³⁴ authorizing tribal involvement in the administration of federal agencies, including the IHS, and reaffirming the need for comprehensive health care for Native Americans. The ISDEAA helped to increase the number of Native Americans serviced by the IHS, but funding was arbitrary and failed to address the increased usage of federal programs by Native Americans.³⁵ In response, Congress enacted the Indian Health Care Improvement Act of 1976 (IHCIA 1976).³⁶

Although it was a relatively short document, the IHCIA 1976 was comprehensive, authorizing numerous programs aimed at “providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to affect that policy.”³⁷ The Act found that the health needs of Native Americans were severe and the health status of Native Americans was far below that of the general population.³⁸ The potential for shrinking this health gap was threatened by several issues including inadequate and outdated facilities, personnel shortages, the inability of many Native Americans to access “health services due to remote residences,” and inadequate and dangerous transportation systems.³⁹

Congress aimed to develop programs and authorize funds to correct problems not adequately addressed under existing federal programs.⁴⁰ The

transfer of Native American affairs from the Bureau of Indian Affairs to the Indian Health Service).

34. See Indian Self-Determination and Education Assistance Act, Pub L. No. 93-638, § 2, 88 Stat. 2203 (codified as amended in scattered sections of 5 U.S.C. and 25 U.S.C.) (authorizing Native American involvement in the administration of agencies affecting their well-being).

35. See B. Pfefferbaum, *Learning How to Heal*, *supra* note 24, at 384 (explaining that funding for the IHS was not adequate and that the IHS was forced to rely on subsequent appropriations at the will of Congress).

36. See Indian Health Care Improvement Act of 1976, Pub. L. 94-437, § 1, 90 Stat. 1400 (authorizing appropriations and creating health care service programs through the IHS).

37. *Id.*

38. See *id.* § 2(d) (“[T]he unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.”).

39. *Id.* § 2(f)(5).

40. See B. Pfefferbaum, *Learning How to Heal*, *supra* note 24, at 386 (explaining that

Act “establish[ed] the basic programmatic structure for delivery of health services to Native Americans” by the IHS.⁴¹ The IHCIA authorized scholarship programs, aimed at bringing more Native Americans into the IHS and health professions generally, created urban health care programs, and “amended the Social Security Act to permit reimbursement [to Native Americans through] Medicare and Medicaid.”⁴² These programs and others were provided congressional appropriations for the fiscal years 1978 through 1984, with future appropriations to be provided through subsequent acts or amendments.⁴³

The IHCIA 1976 largely focused on the issues of inadequate health care “manpower” affecting the administration of health care.⁴⁴ Title I of the Act dealt with Indian Health Manpower and authorized recruitment programs, scholarship programs, internships, and allowances for continuing education.⁴⁵ The largest program under Title I was the Health Professions Scholarship Program. Receiving close to \$19 million in appropriations during its first three years, the Scholarship Program hoped to incentivize physicians, nurses, and other health professionals to provide services to Native Americans.⁴⁶ The Health Professions Recruitment Program for Indians, another substantial portion of Title I, was authorized to identify Native Americans with academic potential in health care fields, advertise sources of financial aid available to Native Americans, and establish programs to encourage Native American enrollments in health care programs.

The 1976 Act did not address diabetes prevention and treatment, but does briefly address mental health and substance abuse programs. Title II of the Act provides for separate appropriations for community, inpatient, and residential health programs and authorizes funding for the “training of traditional Indian practitioners in mental health.”⁴⁷ Additionally, the Act

one of the goals of the IHCIA was to address needs unmet by existing programs).

41. U.S. COMM’N ON CIV. RTS., *BROKEN PROMISES*, *supra* note 3, at 24.

42. *Id.*

43. *See* Indian Health Care Improvement Act of 1976, Pub. L. 94-437, § 103(d), 90 Stat. 1400 (1976) (codified at 25 U.S.C. § 1603 (2010)) (providing the IHS with funds for fiscal years 1978 through 1980 and authorizing appropriations for fiscal years 1981 through 1984).

44. *See id.* §§ 101–06 (establishing scholarships, recruitment programs, externship programs, and allowances for continuing education).

45. *Id.*

46. *See id.* § 104 (establishing the scholarship program and appropriating funds for 1976 through 1980).

47. *Id.* § 201(c)(1)–(4).

provided appropriations for the “treatment and control of alcoholism among Indians.”⁴⁸ The Act does not, however, provide for any additional guidance or authorize the IHS to establish new programs or make improvements to established programs.

In 1988, Congress enacted the Indian Health Care Improvement Amendments of 1988.⁴⁹ The 1988 Amendments extended appropriations to the IHS through the 1992 fiscal year and clarified much of the language surrounding the IHICIA’s manpower provisions. These manpower amendments eased the requirements necessary for Native Americans to qualify for scholarships and internships⁵⁰ and expanded the breadth of programs covered by scholarships.⁵¹ Many new programs to encourage Native American involvement in the health profession were created including scholarships for Native Hawaiians,⁵² a Community Health Representative Program,⁵³ and the creation of loan repayment programs for individuals who work for IHS or tribal health programs.⁵⁴

The 1988 Amendments were the first to address the need for diabetes prevention and treatment within the Native American population.⁵⁵ The 1988 Amendments required the IHS Secretary to conduct studies to determine the prevalence of diabetes within the population and to screen individuals for diabetes or precursor conditions.⁵⁶ Mental health problems

48. *Id.* § 201(c)(5).

49. *See* Indian Health Care Amendments of 1988, Pub. L. 100-713, § 4, 102 Stat. 4784 (1988) (codified at 25 U.S.C. §§ 1601 et seq. (2011)) (developing additional health care programs for the benefit of Native Americans and authorizing appropriations through 1992).

50. *See id.* § 102(d) (“The Secretary shall not deny scholarship assistance to an eligible applicant . . . if such applicant has been admitted to, or maintained good standing at, an accredited institution.”).

51. *See id.* § 104(a) (adding new programs eligible for scholarship assistance including osteopathy, podiatry, psychology, dentistry, environmental health and engineering, optometry, and social work).

52. *See id.* § 106 (establishing the Native Hawaiian Health Scholarship program to assist Native Hawaiians in obtaining health care education).

53. *See id.* § 107 (providing for the training of health paraprofessionals to assist in “health care, health promotion, and disease prevention services”).

54. *See id.* § 108 (creating a “‘Loan Repayment Program’ in order to assure an adequate supply” of trained professionals). The program provides for payment of the “principal, interest and related expenses on governmental and commercial loans.” *Id.* § 108(g)(1).

55. *See id.* § 203(4)(l)(4) (defining “disease prevention” as including the “prevention and control of diabetes”).

56. *See id.* § 204(b) (“The Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic.”).

are referenced throughout the 1988 Amendments as areas to which the Secretary should direct funds and provide services, but no specific provisions are included in the 1988 Amendments.⁵⁷ While no alcohol or substance abuse treatment programs were established, the 1988 Amendments do identify alcoholism⁵⁸ and Fetal Alcohol Syndrome⁵⁹ as being among the health problems that must be remedied.

Congress again amended the Indian Health Care Improvement Act in 1992.⁶⁰ The 1992 Amendments included more specific health goals for Native Americans.⁶¹ The 1992 Amendments included many administrative provisions,⁶² but also continued to expand the scope of federal scholarships. Scholarships could now be applied to nursing schools and clinics and a recovery fund was established for the scholarship and loan repayment programs.⁶³ The 1992 Amendments also created the Community Health Aide Program for Alaska.⁶⁴ This program provided training for Alaska Natives to provide health services in the rural regions of Alaska.⁶⁵

Substantial changes relating to behavioral health were also included in the 1992 Amendments. Inpatient, outpatient, emergency care, and suicide prevention programs for children were established.⁶⁶ Most attention,

57. *See id.* §§ 201(a)(4)(d), 205(a)(2)(A), 799A(d)(3)(B) (defining mental health services as a service to be provided by the IHS, developing mental health demonstration programs, and providing mental health services to rural communities).

58. *See id.* § 203(4)(k) (defining “health promotion” to include reducing alcohol and drug abuse).

59. *See id.* § 714 (adding reduction of Fetal Alcohol Syndrome to the Service’s objectives and defining reduction goals for each area office).

60. *See* Indian Health Care Amendments of 1992, Pub. L. 102-573, 106 Stat. 4526 (1992) (codified at 25 U.S.C. §§ 1601 et seq. (2011)) (amending the IHCA and “authoriz[ing] appropriations for Indian health programs, and for other purposes”).

61. *See id.* § 3(b) (adding specific health objectives including reducing obesity, deaths resulting from cirrhosis or drugs, mental disorders in children, and suicide).

62. *See id.* § 107(b) (requiring the Secretary to assign individuals for recruitment activities).

63. *See id.* § 108A(a), (c)(1) (establishing the “Indian Health Scholarship and Loan Repayment Recovery Fund,” authorized to make payments to tribes or tribal organizations who employs a scholarship recipient or has a need for a health professional).

64. *See id.* § 119 (creating the “Community Health Aide Program for Alaska,” designed to provide health care and disease prevention to rural Alaskan natives and authorizing the use of telecommunications to assist health practitioners).

65. *See id.* § 119(a)(1) (“[T]he Service provides for the training of Alaska Natives as health aides or community health practitioners.”).

66. *See id.* § 209(m)(1) (authorizing the IHS Secretary to make grants “to provide intermediate mental health services to Indian children and adolescents, including . . . suicide prevention”).

however, was diverted to the treatment of alcohol and substance abuse.⁶⁷ The 1992 Amendments provided grants to the IHS to develop services for the treatment of alcohol and substance abuse⁶⁸ and authorized the creation of demonstration projects by the IHS.⁶⁹ The 1992 Amendments also continued the model diabetes projects created under the 1988 Amendments, but added no additional programs and provided no further guidance to the IHS.⁷⁰

The 1992 Amendments provided appropriations through the 2000 fiscal year.⁷¹ Since 2000, however, Congress has continued to appropriate funds on only an annual basis.⁷² Despite numerous attempts, no subsequent amendments or long-term appropriations had successfully been passed by Congress until the Patient Protection and Affordable Care Act in March 2010.⁷³

II. Problems Plaguing Native Populations

A. High Vacancy Rates of Health Practitioners

While the Native American population is plagued by numerous healthcare related problems, the extremely high vacancy rates of health care practitioners on IHS and tribal sites are of particular detrimental effect to IHS's administration of health services.⁷⁴ In 2008, the IHS vacancy rate for

67. *See id.* §§ 701–14 (adding “Title VII—Substance Abuse Programs” to the IHCA and creating programs aimed at determining the scope of abuse problems within the community, community training and education, and establishing youth programs).

68. *See id.* § 511 (providing grants for “Alcohol and Substance Abuse Related Services” that promote treatment, rehabilitation and “community-based education”).

69. *See id.* § 512 (treating demonstration programs as “service units” when allocating resources from the IHS).

70. *See id.* § 204(c)(1) (“The Secretary shall continue to maintain through fiscal year 2000 each model diabetes project in existence on date of enactment of the Indian Health Amendments of 1992 . . .”).

71. *See id.* § 117 (amending section 123 of the Indian Health Care Improvement act to authorize congressional appropriations “for each fiscal year through fiscal year 2000”).

72. *See* Heisler & Walke, *supra* note 17, at 2 (explaining that appropriations were reauthorized annually after year 2001); *see, e.g.*, Omnibus Indian Advancement Act, Pub. L. No. 106-568, § 815, 115 Stat. 2868 (codified at 25 U.S.C. § 4101 et seq.) (authorizing appropriations through 2001).

73. *See* Heisler & Walke, *supra* note 17, at 2–3 (explaining that IHCA reauthorization bills have been considered in Congress since 1999).

74. *See* Memorandum from Nat'l Indian Health Bd., *supra* note 8 (providing that the IHS experiences high vacancy rates primarily as a result of remote geographic locations).

dentists was twenty-five percent; for nurses, twenty-three percent; for physicians, twenty-four percent.⁷⁵ These reported vacancy rates for IHS dentists, nurses, physicians, and optometrists are in the range of seven to thirteen percent over the national vacancy rates of non-IHS federally funded health centers.⁷⁶ In total, the IHS has nearly 1,000 unfilled health care positions.⁷⁷

In addition to combating low retention rates, the IHS must also struggle with the short average stay of practitioners at IHS sites.⁷⁸ With an average stay of just 8.1 years, the IHS must hire nearly 1,200 practitioners annually to fill the 900 vacancies the agency averages each year.⁷⁹ Vacancy rates at local levels are even more staggering.⁸⁰ According to the Director of Health for the Navajo Nation, nursing vacancies within the Navajo Nation exceed twenty-five percent.⁸¹

The unique circumstances of Native American health care sites are a primary cause of the extremely high vacancy rates reported.⁸² Distant and rural locations combined with inadequate facilities, lack of pay parity, inadequate housing, and insufficient local opportunities for spouses and children have discouraged many eligible and well-qualified candidates from accepting positions with the IHS.⁸³ These external factors negatively affect the quality of care provided by IHS and tribal sites. As a result of this chronic understaffing, Cheyenne River Sioux Tribe leaders reported four to six hour wait times, inadequate testing, and, in one instance, a misdiagnosis

75. *See id.* (explaining that in 2008 the IHS experienced vacancy rates ranging from eleven percent to twenty-six percent).

76. *See* DEP'T OF HEALTH & HUMAN SERV., *supra* note 3, at CJ-147-48 (providing statistics of vacancy rates and commenting that the dentist vacancy rate remains critical and the physician vacancy rate has increased dramatically).

77. *See id.* (listing that there are 105 dentist vacancies, 725 nurse vacancies, 379 physician vacancies, and 24 optometrist vacancies).

78. *See* U.S. COMM'N CIVIL RIGHTS, *supra* note 3, at 77 (explaining that the average stay for IHS physicians is 8.1 years).

79. *See id.* (explaining that due to the short average stay the IHS must annually hire nearly 1,200 physicians to fill 900 vacant positions).

80. *See id.* at 78 (explaining that conditions on local levels are often worse than the IHS's agency-wide vacancy rates).

81. *See id.* ("The director of the Division of Health for the Navajo Nation report nursing vacancy rates exceeding 25 percent.").

82. *See id.* (noting that it is often difficult to recruit and retain health care professionals due to the geographic remoteness of IHS health service sites).

83. *See id.* at 78 (providing a list of recruitment obstacles relating to the "lack [of] usual conveniences" in "remote tribal communities").

that nearly resulted in the deaths of three infants.⁸⁴ The current level of vacancies within the IHS is unacceptable and continues to negatively impact the health status of Native Americans.

Low numbers of Native American students attending post-secondary schools or, more crucially, entering medical or health care education programs may contribute to the insufficient number of practitioners working at IHS or tribal sites.⁸⁵ Students of health professions from “rural communities and inner cities are more likely than other students to return to practice in those areas, and minority students are more likely to serve minority populations.”⁸⁶ In 2007, Native Americans accounted for just one percent of all students attending post-secondary schools.⁸⁷ Perhaps most startlingly, this percentage has risen just 0.03% in the last thirty-seven years.⁸⁸ IHS has made great strides at improving the opportunities for and funding of Native American participation in medical and health educational programs.⁸⁹ Despite these improvements, increased tuition costs have limited the scholarship funds available to health students and burdened the loan repayment programs aimed at recruiting and retaining professionals on IHS and tribal sites.⁹⁰

B. High Rates of Diabetes

With a prevalence rate of twelve percent, Native Americans suffer from diabetes at a rate four percent higher than the national average for all

84. *See id.* (explaining the result of the IHS health site being “swamped with children with Influenza A, RSV [Respiratory Syntactical Virus], and one fatal case of meningitis”).

85. *See* Linda H. Aiken & William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 AKRON L. REV. 187, 190 (1992) (explaining that students from rural or inner city areas who attend medical programs are likely to return to their communities after graduation).

86. *Id.*

87. *See* U.S. DEP’T OF EDUC., NATIONAL CENTER FOR EDUCATION STATISTICS, DIGEST OF EDUCATION STATISTICS 2008, 278, 297–99 (2008), *available at* <http://nces.ed.gov/pubs/2009/2009020.pdf> (providing statistics for attendance at post-secondary schools based upon race, gender, and age).

88. *See id.* (demonstrating that the rate of Native Americans attending post-secondary schools was 0.7% in 1970 and was 1.0% in 2007).

89. *See* DEP’T OF HEALTH & HUMAN SERV., *supra* note 3, at CJ-142 (explaining that the IHS scholarship program awarded over 2,000 scholarships between 2004 and 2008).

90. *See id.* at CJ-142–46 (explaining that tuition, fees, and other school related costs continue to rise annually and increasingly burden the IHS scholarship budget).

rac⁹¹. The most prevalent form of diabetes within the population is “non-insulin-dependent diabetes mellitus (NIDDM),” often referred to as Type 2 diabetes.⁹² Having one of the highest prevalence rates in the world,⁹³ Native Americans are diagnosed with diabetes at a rate 2.3 times higher than Caucasians.⁹⁴ In some native communities, more than half the adult population suffers from diabetes.⁹⁵ As a result of the high prevalence of the disease, the death rate of Native Americans from diabetes is nearly 200% higher than that seen in the general population.⁹⁶ Even this astoundingly high rate may mask the true effect of the disease; diabetes often plays a role in many deaths attributed to other causes and is severely under-diagnosed within the population.⁹⁷

Native American youth and adolescents are also suffering from Type 2 diabetes at alarming rates, far above those of children from other demographics.⁹⁸ In an acute turnaround from reports as recently as 1967, Native American children are now more often diagnosed as overweight or obese than undernourished.⁹⁹ Some youth populations now have obesity

91. See INDIAN HEALTH SERVICE, 2009 NAT'L SUMMARY, *supra* note 3, at 8 (explaining that the prevalence rate of diabetes among Native Americans is twelve percent while the national average is eight percent).

92. Brooke Olson, *Meeting the Challenges of American Indian Diabetes: Anthropological Perspectives on Prevention and Treatment*, in MEDICINE WAYS 163, 164 (Clifford E. Trafzer & Diane Weiner, eds., 2001).

93. See U.S. COMM'N ON CIVIL RIGHTS, *supra* note 3, at 9 (“American Indians and Alaska Natives have some of the highest rates of diabetes in the world, with more than half of the adult population in some communities having the disease.”).

94. See Memorandum from Nat'l Indian Health Bd., *supra* note 8 (“[American Indians and Alaska Natives are] diagnosed with diabetes at [a] rate 2.3 times higher than whites.”).

95. See U.S. COMM'N ON CIVIL RIGHTS, *supra* note 3, at 9 (explaining that “Native Americans and Alaskans have some of the highest prevalence rates of diabetes in the world”).

96. See Memorandum from Nat'l Indian Health Bd., *supra* note 8 (explaining that the Native American death rate for diabetes was 190% in 2009).

97. See U.S. COMM'N ON CIVIL RIGHTS, *supra* note 3, at 9–11 (explaining that many deaths attributed to heart disease are caused by diabetes and that many Native Americans with diabetes remain undiagnosed); see also INDIAN HEALTH SERVICE, 2009 NAT'L SUMMARY, *supra* note 3, at 8 (explaining that “[d]iabetes is a major risk factor for cardiovascular disease”).

98. See U.S. COMM'N ON CIVIL RIGHTS, *supra* note 3, at 10 (determining that Type 2 diabetes has “become a significant threat to Native American children”).

99. See George R. Brennenman, *Maternal, Child and Youth Health*, in AMERICAN INDIAN HEALTH: INNOVATIONS IN HEALTH CARE, PROMOTION AND POLICY 138, 145 (Everett R. Rhoades, ed., 2000) (explaining that as recently as 1967, Native American children were diagnosed as being underweight or undernourished, but some Native populations now have obesity rates from two to ten percent).

rates two to ten times the rates found among the general population of the United States.¹⁰⁰ With these higher rates of obesity and Type 2 diabetes come increased risk factors for cardiovascular, kidney, and other health problems.¹⁰¹

Many scholars believe that acculturation is largely to blame for the relatively recent increase in diabetes within the Native American population.¹⁰² As recently as the 1940s and 1950s, the incidence of diabetes in Native populations was extremely low.¹⁰³ The onset of “urban, industrialized, and sedentary lifestyles” have “accelerated lifestyle changes” in Native Americans that are commonly associated with diabetes and related diseases.¹⁰⁴ With these lifestyle changes came a transition from “traditional” diets to more modern, high-fat foods.¹⁰⁵

Additionally, genetic research has suggested that Native peoples may be more susceptible to diabetes due to the presence of a “thrifty genotype.”¹⁰⁶ This genotype is believed to have developed as “an adaptation to hunting and gathering lifestyles.”¹⁰⁷ Cycling between periods of food availability and unavailability, Native Americans may have adapted to store fat more quickly so as to sustain themselves during periods of relative famine.¹⁰⁸ It is thus believed by some scholars that a combination of genetic, cultural, and societal factors contribute to the staggering statistics of diabetes among Native Americans.¹⁰⁹ Whether diet or genetics

100. *See id.* (providing that in some populations, Native American children have obesity rates ranging from two to ten percent).

101. *See* Dorothy M. Gohdes & Kelly Acton, *Diabetes Mellitus and Its Complications*, in *AMERICAN INDIAN HEALTH: INNOVATIONS IN HEALTH CARE, PROMOTION AND POLICY* 221, 225 (Everett R. Rhoades, ed., 2000) (explaining that Native American children with Type 2 diabetes will likely be at a great risk of experiencing other health problems as adults).

102. *See* Olson, *supra* note 92, at 165 (explaining that acculturation and the introduction of sugar-based foods may have contributed to the rise in diabetes within the Native American population).

103. *See id.* (“Before the 1940s and 1950s, diabetes was rare in Indian populations.”).

104. *Id.*

105. *See* Mary Story et al., *Nutritional Health and Diet-Related Conditions*, in *AMERICAN INDIAN HEALTH: INNOVATIONS IN HEALTH CARE, PROMOTION AND POLICY* 201, 213 (Everett R. Rhoades, ed., 2000) (explaining that traditional foods are now only consumed occasionally and have been replaced with foods high in sugar and fat).

106. *See* Olson, *supra* note 92, at 167 (explaining the hypothesis of the “thrifty genotype” and its possible connection with the high rates of diabetes).

107. *Id.*

108. *See id.* (explaining the theory behind the “thrifty genotype” hypothesis).

109. *See id.* (clarifying that this “thrifty genotype,” if it does exist, is unlikely to be the sole cause for the high rates of diabetes).

are to blame, a culturally sensitive diabetes program would effectively address both causes while providing additional benefits to Native Americans facing severe behavioral health issues.

C. Behavioral Health Programs

Native Americans are at a “higher risk for mental health disorders than other racial or ethnic groups in the United States.”¹¹⁰ Among the most widespread behavioral health problems facing Native Americans are “the high prevalence of substance abuse, depression, anxiety, violence and suicide.”¹¹¹ These health issues are now being regularly reported even among young children and adolescents.¹¹²

Alcohol abuse, perhaps the most well-known health problem facing Native Americans, continues to plague the population.¹¹³ The rate of alcoholism among Native Americans has been consistently above that of the general population for decades.¹¹⁴ This rate varies across tribes and is more common among men than women.¹¹⁵ Depression, loneliness, and other mental health disorders, however, are commonly linked to alcohol abuse in both men and women.¹¹⁶

110. U.S. COMM’N ON CIVIL RIGHTS., *BROKEN PROMISES*, *supra* note 3, at 11.

111. *Id.* at 12.

112. *See id.* (“Native Americans use and abuse alcohol and other drugs at younger ages, and at higher rates, than all other ethnic groups.”).

113. *See Confronting the Impact of Alcohol Labeling and Marketing on Native American Health and Culture: Hearing Before the Select Comm. on Children, Youth and Families*, 102nd Cong. 7 (1992) (explaining the continued problems with alcoholism faced by Native Americans).

114. *See id.* (demonstrating the prevalence of alcoholism among Native Americans in the 1990s); *see also* Lawrence S. Wissow, *Suicide Among American Indians and Alaska Natives*, in *AMERICAN INDIAN HEALTH: INNOVATIONS IN HEALTH CARE, PROMOTION, AND POLICY* 260, 269–70 (Everett S. Rhoades, ed., 2000) (documenting alcoholism from the 1970s onward).

115. *See* Department of Health and Human Services, *Minority Women’s Health: Alcoholism and drug abuse*, available at <http://www.womenshealth.gov/minority-health/american-indians/alcoholism-drug-abuse.cfm> (“American Indians and Alaska Natives have the highest rates of binge drinking, although this problem is more common among men than women.”) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

116. *See* Matthew O. Howard et al., *Alcoholism and Substance Abuse*, in *AMERICAN INDIAN HEALTH: INNOVATIONS IN HEALTH CARE, PROMOTION, AND POLICY* 280, 284 (Everett S. Rhoades, ed., 2000) (explaining that other mental health problems are commonly linked to alcoholism in both men and women).

Nearly nineteen percent of Native Americans ages twelve and older reported using illegal drugs compared to just under twelve percent of the general U.S. population.¹¹⁷ Some findings indicate that the use of “hard” drugs may in fact be higher than previously reported as many early studies only looked at rural or reservation areas with more limited access to illegal drugs.¹¹⁸ Youths are also using an array of the most volatile substances available.¹¹⁹ Increasingly popular, especially among pre-teen Native American youth, is the abuse of inhalants.¹²⁰ Inhalant abuse has also been strongly associated with future alcohol dependency and abuse of other illegal drugs.¹²¹

Suicide and depression rates have been on the rise within the Native American population in recent years, especially among Native youths.¹²² The rate of suicide among Native American children is nearly 2.5 times that of Caucasian children.¹²³ Among fourteen to twenty-four year olds, the suicide rate was twice that of the general population.¹²⁴ The rate jumps to nearly three times that of the general population for five to ten year olds.¹²⁵ Suicide prevention, both for children and adults, needs to be a major focus of future legislation. Additionally, culturally-attuned behavioral health programs will address more fully the underlying issues causing both depressive or suicidal behaviors and substance abuse.

117. *See id.* at 282–83 (finding in a study of Native American high school seniors that “[I]ndian men and women had higher annual rates of using marijuana, hallucinogens, lysergic acid diethylamide, heroin, stimulants, sedatives, barbiturates, and tranquilizers than did other groups of the same age”).

118. *See* Howard, *supra* note 116, at 283 (explaining that the findings of many studies of drug use among Native Americans may not accurately represent the prevalence of substance abuse).

119. *See* Warren Skye, *E.L.D.E.R.S. Gathering for Native American Youth: Continuing Native American Traditions and Curbing Substance Abuse in Native American Youth*, 29 J. SOC. & SOC. WELFARE 117, 125 (2002) (stating that many Native American youths are increasingly abusing “volatile substances”).

120. *See id.* (finding that “inhalants are fast becoming one of the most widely abused substances, particularly within the pre-teen Native population”).

121. *See id.* (“Inhalant use is said to be well on its way to replacing marijuana as the ‘gateway’ substance for those who develop a dependency on alcohol and/or other drugs.”).

122. *See* U.S. COMM’N ON CIVIL RIGHTS, *BROKEN PROMISES*, *supra* note 3, at 13 (“The suicide rate for Native Americans continues to escalate and is 190 percent of the rate of the general population.”).

123. *See id.* (finding that the rate of suicide among Native American youths is higher than that of the general population).

124. *See id.* (explaining the suicide rates for various youth age groups).

125. *See id.* (finding that in 2002, “the youth suicide rate for Native Americans was . . . three times as great among 5 to 10-year-olds, as it was in the general population”).

III. Indian Health Care Improvement Reauthorization and Expansion Act of 2009: How Does the Reauthorization Act Address Health Issues Affecting Native Americans?

A. How the Reauthorization Addresses High Vacancy Rates

The combination of inadequate numbers of students entering medical or health education programs and the difficulty of recruiting and retaining practitioners at IHS and tribal sites has caused a severe shortage of health professionals and has hampered the IHS's ability to adequately address the health needs of local Native Americans.¹²⁶ The original IHCIA and its subsequent amendments created a basic framework for increasing "the number of Indians entering the health professions and [assuring] an adequate supply of health professionals to the [IHS], Indian tribes, tribal organizations, and urban Indian organizations."¹²⁷ The Reauthorization Act predominantly maintains this framework including the recruitment program,¹²⁸ scholarship programs,¹²⁹ externship programs,¹³⁰ and loan repayment programs.¹³¹ The Reauthorization Act does not, however, provide appropriations to continue these programs, but rather just authorizes the continuation of these programs and the possibility of future appropriations.¹³²

The Reauthorization Act makes three major changes to the existing policies related to Indian Health Manpower and the retention of health professionals. The first change authorizes "Health Professional Chronic Shortage Demonstration Programs."¹³³ This authorization enables the IHS

126. *See id.* at 78 (finding that the remote locations of IHS health sites have proven difficult obstacles in recruiting and retaining health professionals and has contributed to the "historical difficulty IHS has experienced in staffing rural health facilities").

127. Indian Health Amendments of 1992, Pub. L. No. 102-573, § 101, 106 Stat. 4526 (1992) (codified at 25 U.S.C. §§ 1601 et seq. (2011)).

128. *See* Indian Health Care Improvement Reauthorization and Extension Act §§ 102, 109–10 (maintaining recruitment programs enacted through the IHCIA of 1976, the 1988 Amendments and the 1992 Amendments).

129. *See id.* §§ 103–04 (maintaining the scholarship programs established by the IHCIA of 1976 and its subsequent amendments).

130. *See id.* § 105 (preserving the externship program created under previous versions of the IHCIA).

131. *See id.* §§ 108–08A (sustaining previously established loan repayment programs).

132. *See id.* § 101 ("There are authorized to be appropriated such sums as are necessary to carry out this Act for fiscal year 2010 and each fiscal year thereafter, to remain available until expended.").

133. *See id.* sec. 112, § 123 (creating a demonstration program to "provide direct

Secretary to fund demonstration programs that provide “clinical and practical experience” for students,¹³⁴ improve access to health professionals,¹³⁵ provide academic and scholarly opportunities and resources,¹³⁶ and provide training for “alternative provider types, such as community health representatives, and community health aides.”¹³⁷

The second amendment provides a licensing exemption for licensed health professionals working for the IHS or another tribal health program.¹³⁸ If the health care professional is licensed in any other state, that professional is exempt from “the licensing requirements of the State in which the tribal health program performs the services.”¹³⁹

The third, and most substantial amendment, affects the Alaskan Community Health Aide Program. Most importantly, the amendment authorizes nationalizing the program beyond the rural Alaskan villages previously covered.¹⁴⁰ Essentially the same as set forth in the 1992 Amendments, the Reauthorization Act reinforces the program’s goals of training Alaskan natives—and purportedly now all Native Americans—as “health aides or community health practitioners” who will provide “health care, health promotion, and disease prevention services.”¹⁴¹ These programs also aim to establish telecommunication abilities in rural villages and health clinics.¹⁴²

Finally, the amendments modify the program by authorizing dental health programs in addition to the previously authorized general health

clinical and practical experience” to students and improve the quality and access to health care professionals).

134. *Id.* § 123(b)(1).

135. *See id.* § 123(b)(2) (defining one of the purposes of the demonstration program as being “to improve the quality of health care for Indians by ensuring access to qualified health professionals”).

136. *See id.* § 123(b)(3) (defining one demonstration goal as being the provision of “academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region”).

137. *Id.* § 123(b)(4).

138. *See id.* § 123(b)(4) (defining provider types eligible for training and support as including “community health representatives, and community health aides”).

139. *Id.* at sec. 132, § 221.

140. *See id.* sec. 111, § 119(d) (“[T]he Secretary . . . may establish a national Community Health Aide Program . . .”).

141. *Id.* § 119(a)(1)–(2).

142. *See id.* § 119(a)(3) (authorizing the IHS to “provide[] for the establishment of teleconferencing capacity in health clinics located in or near those villages for use by community health aides or community health practitioners”).

programs.¹⁴³ The use of advanced practice nurses will provide a more immediate response to the critical IHS areas experiencing high vacancy rates.

B. Reauthorization Approach to High Rates of Diabetes

Very few changes were included in the Reauthorization Act to address the extremely high rates of diabetes within the Native American population. Within the definitions provided by the Reauthorization, “disease prevention” activities now include “controlling the development of diabetes.”¹⁴⁴ More indirectly, the Act inserts a definition for the term “health promotion” activities which include “providing adequate and appropriate programs for diet and nutrition”¹⁴⁵ and “exercise and physical fitness.”¹⁴⁶

Beyond these definitional additions, the Reauthorization Act maintains the programs developed by the 1992 Amendments. These programs required automatic diabetes screenings for all Native Americans receiving treatments for diabetes or treatments for symptoms or conditions highly correlated with future development of diabetes.¹⁴⁷ Additionally, the 1992 Amendments required the continuation of model diabetes projects at numerous health centers and hospitals and allowed the establishment of additional projects at other locations. Finally, the Amendments required control officers in each area office,¹⁴⁸ data collection of diabetes and related complications,¹⁴⁹ and a registry of all individuals affected by diabetes “to track the incidences of diabetes and the complications from diabetes.”¹⁵⁰

143. *See id.* § 119(b)(7) (authorizing basic dental treatments only after consulting a dentist to determine “the procedure is a medical emergency” and prohibiting the “perform[ance of] all other oral or jaw surgeries” except “pulpal therapy . . . and extraction[s] of adult teeth”).

144. *Id.* sec. 104, § 4(7)(B)(i)(1).

145. *Id.* § 4(11)(G)(v).

146. *Id.* § 4(11)(G)(viii).

147. *See* Indian Health Amendments of 1988, Pub. L. No. 100-713, § 204(b), 102 Stat. 4784 (1988) (codified at 25 U.S.C. §§ 1601 et seq. (2011)) (requiring diabetes screening for Native Americans receiving treatment for diabetes or presenting symptoms commonly associated with diabetes).

148. *See id.* § 204(d)(1) (establishing requirements for control officers in area IHS offices).

149. *See id.* § 204(d)(3) (requiring IHS control officers to maintain records of the prevalence of diabetes within the Native American population).

150. *Id.* § 204(d)(2).

No additional steps are explicitly provided for under either the IHCA or the Reauthorization Act.

*C. Amendments to Behavioral Health Programs through the
Reauthorization Act*

Previously focusing only on substance abuse and alcoholism, the Reauthorization Act departs from this approach and aims towards a more collaborative “Behavioral Health” model, “blending [the treatment] of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment for the purpose of providing comprehensive services.”¹⁵¹ The Reauthorization Act creates new definitions and programs aimed at addressing all mental health, dysfunctional behaviors, and substance abuse issues within the Native American population. One such definition is that of “dual diagnosis,” a term denoting the “coexist[ence of] substance abuse and mental illness” in patients commonly known as mentally ill chemical abusers (MICAs).¹⁵²

Through the Reauthorization Act, the IHS Secretary is authorized to “develop [] comprehensive behavioral health prevention and treatment program[s within the IHS, Indian tribes, and tribal organizations] which emphasize[] collaboration among alcohol and substance abuse, social services and mental health programs.”¹⁵³ The new approach provides the IHS with authority to create and operate “community-based programs which include identification, prevention, education, referral, and treatment services.”¹⁵⁴ Through this new authority, the IHS must work to ensure equal access to behavioral health services for Native Americans,¹⁵⁵ develop local and tribal plans to create behavioral health services,¹⁵⁶ and provide

151. See Indian Health Care Improvement Reauthorization and Extension Act sec. 104, § 4(2)(A) (redefining behavioral health to include both alcohol abuse prevention and mental illness treatment).

152. *Id.* § 701(4).

153. *Id.* § 702(a)(1).

154. *Id.* § 702(a)(4).

155. See *id.* § 702(a)(5) (defining one of the purposes of the Behavioral Health program as being “to ensure that Indians . . . have the same access to behavioral health services to which all citizens have access”).

156. See *id.* § 702(b)(1) (authorizing the IHS Secretary to encourage Indian tribes and tribal organizations to develop plans for behavioral health treatment).

technical assistance to tribes and organizations attempting to implement these plans.¹⁵⁷

Programs created under the Reauthorization Act must provide a comprehensive “continuum of behavioral health care” which should include, to the maximum extent possible, detoxification programs, inpatient, outpatient, and residential treatment programs, transitional living programs, and preventative care.¹⁵⁸ The Reauthorization Act creates several programs aimed at addressing the unique problems associated with mental health disorders and substance abuse among children, adults, and the elderly through specialized approaches and treatments.¹⁵⁹ Additionally, family care programs are created that address the need for “early intervention, treatment and aftercare for affected families” as well as treatment for “sexual assault and domestic violence.”¹⁶⁰

The Reauthorization creates several new alcohol-specific programs, despite the changed focus towards comprehensive behavioral health. The Act creates an aftercare program aimed at preventing relapse and transitioning the individual back into society.¹⁶¹ Programs have been authorized to treat the full spectrum of fetal alcohol disorders, including fetal alcohol syndrome (FAS), partial FAS, alcohol-related birth defects (ARBD), and alcohol-related neurodevelopmental disorders (ARND).¹⁶² The Indian Women Treatment Programs, authorized under the 1992 Amendments to the IHCA, are also maintained under the Reauthorization and continue to support the treatment of women to prevent fetal alcohol conditions in their children.¹⁶³

157. *See* Indian Health Care Improvement Reauthorization and Extension Act § 702(b)(3) (requiring the IHS Secretary to provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations to assist these organizations in providing behavioral health services).

158. *Id.* § 702(c)(1).

159. *See id.* § 702 (c)(2)–(3), (5) (establishing behavioral health treatment programs for children, adults, and the elderly and recognizing the unique treatment challenges faced by each age group).

160. *Id.* § 702 (c)(4) (establishing family care programs for the treatment of substance abuse, sexual assault, domestic violence, and promoting healthy alternative parenting and lifestyle guidance).

161. *See id.* § 702(c)(3)(A) (establishing adult behavioral health services to provide “early intervention, treatment, and aftercare”).

162. *See id.* § 701(c)(1), (5)–(6) (providing definitions of Alcohol-Related Neurodevelopmental Disorders (ARND), Fetal Alcohol Spectrum Disorders, and Fetal Alcohol Syndrome (FAS) and their symptoms).

163. *See id.* § 707 (authorizing the Secretary to make grants to support “comprehensive behavioral health program[s] . . . that specifically address[] the cultural, historical, social,

Finally, Title VII now includes an entirely new subtitle aimed at preventing suicide among Native American youth.¹⁶⁴ The Reauthorization Act authorizes the IHS Secretary to create psychiatric and psychological treatment programs aimed at treating Native American youth.¹⁶⁵ The subtitle authorizes grants to develop demonstration and treatment programs for Native American youths who “have expressed suicidal ideas, have attempted suicide or have mental health conditions that increase or could increase the risk of suicide.”¹⁶⁶ In addition to these prevention and treatment programs, the Act authorizes “Life Skills” demonstration programs.¹⁶⁷ These programs utilize school curriculum teaching life skills to prevent youth suicide.¹⁶⁸ The life skills program must be “culturally compatible,” but the Act provides no direction or definition as to how this is to be accomplished or what it should include.¹⁶⁹ This “cultural compatibility” directive is a step in the right direction, but a more specific declaration of how this compatibility should be achieved will assist the IHS in addressing the issues underlying behavioral problems.

IV. Recommendations for Further Legislation to Address Health Care Problems

A. Utilizing Advance Practice Nurses and Other Recommendations to Combat High Vacancy Rates

The Reauthorization Act amends the 1992 Amendments of the IHCA in three major ways: the creation of chronic shortage demonstration programs, a licensing exemption for health professionals working for IHS or tribal health programs, and the expansion of the Alaskan Community

and child care needs of Indian women, regardless of age”).

164. *See id.* Title VII, Subtitle B (recognizing findings that Native American youths are more susceptible to suicide than non-Native youths and establishing authority in the Secretary to develop programs aimed at addressing this problem).

165. *See id.* § 707(b)(1) (authorizing demonstration programs to experiment with various treatment techniques).

166. *Id.* § 723(a)(1).

167. *See id.* § 726 (authorizing demonstration programs to “test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide”).

168. *See id.* § 726(a) (authorizing the use of school curriculum to address adolescent suicide).

169. *Id.* § 726(a).

Health Aide Program to all Native Americans.¹⁷⁰ The Act maintains the scholarship, externship, and loan repayment programs of the 1992 Amendments.¹⁷¹ While these programs provide incentives and assistance to Native Americans desiring to attend health education programs, more must be done to attract and retain health professionals on IHS and tribal health sites.

Loan repayment programs, grant programs, and scholarships are three of the most common solutions.¹⁷² Many states have also experimented with creating specialized programs to combat nursing shortages. Florida initiated a grant program to fund “exploratory nursing education programs in middle schools or career and technical nursing education programs in high schools.”¹⁷³ In a different vein, West Virginia developed a scholarship program for individuals who pursue a master’s degree in nursing and agree to teach two years in nursing school following graduation.¹⁷⁴ While these programs encourage students to enter medical fields, increases in tuition have put a financial strain on scholarships provided by the IHS.¹⁷⁵ These financial constraints must be addressed through larger congressional appropriations if the increases in Native American participation in health education programs are to be sustained.

A major problem plaguing IHS health programs is the extremely low numbers of both physicians and registered nurses.¹⁷⁶ One possible solution is the use of advanced practice nurses, especially in rural areas.¹⁷⁷

170. *See id.* §§ 119, 123, 221 (creating chronic shortage demonstration programs, exempting health professionals working on IHS sites from state licensing requirements, and authorizing the nationalization of the Alaskan Community Health Aide Program).

171. *See id.* §§ 102–05, 108–10 (maintaining loan repayment programs, grant programs, and scholarship programs established under earlier versions of the IHCA).

172. *See* Kristin M. Mannino, *The Nursing Shortage: Contributing Factors, Risk Implications, and Legislative Efforts to Combat the Shortage*, 15 LOY. CONSUMER L. REV. 143, 154 (2002) (finding that loan repayment programs, grant programs, and scholarship programs are effective means of combating nursing shortages).

173. *Id.* at 154.

174. *See id.* at 155 (describing programs developed in some states to combat chronic nursing shortages).

175. *See* DEP’T. OF HEALTH & HUMAN SERV., *supra* note 3, at CJ-142–46 (explaining the increase in tuition in recent years, providing projections of future tuition increases, and describing the strain these increases have placed on the scholarship programs).

176. *See id.* at CJ-147 (finding that in 2009 the physician vacancy rate was twenty-four percent and the nursing vacancy rate was twenty-three percent).

177. *See* Aiken & Sage, *supra* note 84, at 189–90 (arguing that advanced practice nurses are a good solution for rural areas experiencing extreme physician and nurse shortages).

Advanced practice nurses, including nurse practitioners and midwives, provide a myriad of benefits to programs utilizing their services.¹⁷⁸ Trained to be primary care providers, advanced practice nurses learn a more holistic approach to health care treatment and may be better equipped to handle the various ailments requiring treatment in rural locales.¹⁷⁹

The cost of using advanced practice nurses is generally much lower than comparable services provided by a physician.¹⁸⁰ Advanced practice nurses generally “prescribe fewer drugs, use fewer tests, and select lower cost treatment options and settings than physicians.”¹⁸¹ Additionally, the cost of training and educating advanced practice nurses is considerably lower than that of physicians and can be completed in an average of six years, as compared with the average eleven years of training required for physicians.¹⁸²

Advanced practice nurses, however, face some barriers unique to the specialty. Many states require physician supervision in order for advanced practice nurses to practice and some states prevent advanced practice nurses from prescribing medication.¹⁸³ Additionally, Medicare and Medicaid do not cover nurse practitioner care and pose a considerable barrier to their use by impoverished groups that rely upon these programs for health care.¹⁸⁴ However, both barriers could be overcome by a Congressional exemption applicable to the IHS and tribal health sites.

Whatever the means employed to encourage students to enroll in health care programs, Congress must make long term investments in infrastructure, equipment, facilities, support staff, and technology as well as increased compensation to retain professionals who choose to work at IHS and tribal health sites.¹⁸⁵

178. *See id.* at 196 (explaining that advanced practice nurses can provide cost-effective solutions and treatments to rural and inner-city communities).

179. *See id.* at 196–97 (finding that advanced practice nurses “emphasize[] interpersonal skills, continuity of care, management of symptoms and maintenance of function” and are trained as primary care providers).

180. *See id.* at 196 (explaining that advanced practice nurses are cost-effective due to focusing their practices on lower cost treatments and inexpensive training).

181. *Id.* at 196–97.

182. *See id.* at 197 (providing statistics of the differing educational periods for advanced practice nurses and physicians).

183. *See id.* at 200 (explaining impediments advanced practice nurses face when establishing their practices).

184. *See id.* at 204 (describing the Medicaid and Medicare barriers facing advanced practice nurses).

185. *See id.* at 189–92 (explaining challenges faced by practitioners working in rural

B. Use of Traditional Dietary Habits and Lifestyle Patterns to Address High Diabetes Rates

Research suggests that a focus on traditional dietary habits and lifestyle patterns would be extremely effective at reducing the high rates of diabetes among Native Americans.¹⁸⁶ Diabetes among Native American populations is a relatively new phenomenon, appearing gradually within the last 100 years.¹⁸⁷ Traditional diets among most Native tribes consisted largely of foods high in fiber and complex carbohydrates.¹⁸⁸ As tribes assimilated and abandoned traditional hunting, gathering, and subsistence farming in favor of food acquired through trading posts and governmental programs, the diet content shifted in favor of foods “high in refined carbohydrates (especially refined sugars), fat, and sodium and low in milk products, fruits, and vegetables.”¹⁸⁹

Federal food programs, such as the Supplemental Food Program for Women, Infants, and Children (WIC) and Food Stamps, contribute substantially to Native American diets.¹⁹⁰ Despite this influence, various non-governmental programs focusing on traditional dietary and lifestyle habits have shown progress in correcting the modern, assimilative behaviors associated with diabetes.¹⁹¹ These programs aim to be more culturally in tune with traditional Native beliefs and utilize these beliefs to

communities and inner cities).

186. See Story et al., *supra* note 104, at 213–14 (describing how traditional foods and culture have been effective in treating diabetes among Natives).

187. See *id.* at 212 (describing the slow progression of diabetes within the Native American population and providing possible explanations for this progression).

188. See *id.* at 212 (explaining the change in diet commonly found in Native American populations over the last fifty years).

189. *Id.*; see also Steven C. Moore & Catherine E. Wilson, “Like Pinning Fog to a Wall”—*Emerging Issues in Indian Health Care: How Ongoing Indian Health Care Reform Will Mesh with the Clinton Administration’s National Health Care Reform Agenda*, 27 CLEARINGHOUSE REV. 854, 855 (1993) (finding that “traditional food supplies [have been] destroyed or [are] inaccessible” forcing many Native Americans “to depend on rations issued by local Indian agents, which in many cases were insufficient or unsanitary”).

190. National Heart, Lung, and Blood Institute, *Obesity Prevention in American Indians/Alaska Natives: Field Center*, 21 NIH GUIDE NO. 31 (1992), available at <http://grants.nih.gov/grants/guide/rfa-files/rfa-nih-92-hl-008-p.html> (explaining the significant contributions of WIC and food stamps to Native American diets) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

191. See Story et al., *supra* note 104, at 213–14 (describing how re-introduction of traditional foods and cultural activities related to food, including “celebrations, feast days, powwows, and religious ceremonies,” have proven effective at treating diabetes in many Native tribes).

educate modern Native Americans about proper dietary and lifestyle choices.¹⁹²

One such program was developed with the Zuni tribe in New Mexico.¹⁹³ The program encouraged exercise and weight loss by utilizing “the cultural history of the Zuni as long-distance runners.”¹⁹⁴ By emphasizing the education of their traditional identity, the community-based program was extremely successful, producing significant weight loss in many members of the tribe and “decreas[ing] or even eliminat[ing] the need for insulin” in many diabetic tribe members.¹⁹⁵

One important factor in developing community-based programs is understanding the focus on indirect, rather than direct learning, among non-Western societies.¹⁹⁶ Indirect learning utilizes “life examples, stories, metaphors, myths and experiences . . . to teach important concepts and ideas.”¹⁹⁷ In a diabetes program adapted for Canadian Natives, a campaign to convey educational diabetes information was modified to emphasize the cultural tradition of storytelling.¹⁹⁸ The program communicated important information to the listener, without overwhelming him, by disguising medical terminology within stories and narratives.¹⁹⁹ One such program transformed insulin into “heroes defeating monsters and other threats to the people (i.e., diabetes).”²⁰⁰

By focusing on educating Native Americans on traditional cultural practices, these programs utilize a novel approach to effectively address the diabetes epidemic within the Native American population. By incorporating proper diet with historical cultural beliefs, the programs provide an additional incentive to eat properly and reunite modern Native Americans with their past; a process that provides benefits both in terms of diabetes and behavioral health.

192. See Olson, *supra* note 91, at 168 (detailing elements of the indirect learning style common among non-Western cultures).

193. See *id.* at 173 (describing the diabetes program developed by the Zuni tribe of New Mexico).

194. *Id.*

195. *Id.*

196. See *id.* at 168 (explaining the common elements of indirect learning and providing examples of how it is employed).

197. *Id.*

198. See *id.* at 173 (noting the effectiveness of storytelling in explaining both the nature of diabetes and the methods of control and treatment).

199. See *id.* (explaining the benefits of using storytelling to explain medical treatments for diabetes).

200. *Id.*

C. Focusing on Traditional Belief Systems to Treat Behavioral Health Issues

Scholars have developed a myriad of theories to explain the extremely high rates of depression, suicide, and substance abuse within the population. Many believe that the loss of traditional culture coupled with Native American's exposure to and domination by modern American culture has caused emotional dissonance within adolescents and adults alike.²⁰¹ This process of Americanization began in the seventeenth century.²⁰² As Native American children were forced into boarding schools, "elements of their identities and heritage [were] systematically and permanently stripped away."²⁰³ This separation of self is believed to lead to an internal conflict of "neither being fully allowed to participate in [modern society], nor fully wanting to do so."²⁰⁴ Many, especially men, find themselves overwhelmed with feelings of loneliness and helplessness.²⁰⁵ This psychological view only serves to hinder the treatment and recovery process.²⁰⁶ Traditional healing practices have been shown to effectively treat the manifestations of these psychological issues: alcoholism, substance abuse, mental illnesses, and suicide.²⁰⁷

Drug and alcohol abuse has become a cultural norm for Native Americans.²⁰⁸ Starting at an early age, Native American youth experience childhood traumas beyond those experienced by most children.²⁰⁹ After

201. See Wissow, *supra* note 114, at 267–69 (describing the popular theory that the loss of traditional culture "relates to a loss of the support and structure inherent in traditional culture").

202. See Paul Rock Krech, *Envisioning a Healthy Future: A Re-becoming of Native American Men*, 29 J. SOC. & SOC. WELFARE 77, 82 (2002) (providing a brief history of Americanization among Native Americans).

203. *Id.*

204. *Id.* at 78.

205. See *id.* at 83 (describing the effect that this separation of self has on male Native Americans).

206. See *id.* (explaining the negative effect this psychological viewpoint has on treatment of substance abuse and depression).

207. See Troy Johnson & Holly Tomren, *Helplessness, Hopelessness and Despair: Identifying the Precursors to Indian Youth Suicide*, in *MEDICINE WAYS* 234, 237 (Clifford E. Trafzer & Diane Weiner, eds., 2001) (describing the manifestations of psychological issues and proposing the use of traditional healing practices).

208. See Krech, *supra* note 202, at 83 (noting how alcoholism and substance abuse have become "a cultural norm for many Native people"); see also Johnson & Tomren, *supra* note 207, at 237 (explaining the negative effects of alcoholism on "traditional values and lifestyles").

209. See Johnson & Tomren, *supra* note 207, at 237 (describing stress events common

feeling forced to choose between two conflicting societies, many children devolve into self-destructive behaviors.²¹⁰ Family histories of alcoholism, socioeconomic factors, and a lack of understanding or support from schools and leaders exacerbate the isolation felt by these children.²¹¹ These self-destructive behaviors quickly lead to feelings of hopelessness and isolation that contribute to the extremely high suicide rates within the population.²¹²

Many “mainstream substance abuse” programs do not adequately address the needs of Native American youth.²¹³ Without awareness of the unique cultural environments in which these children grow up, the mainstream programs fail to address the underlying psychological issues that cause substance abuse.²¹⁴ These youths live in “two world” communities—their local, Native communities and the more dominant, majority “community” embodying dominant American society.²¹⁵ The dichotomous perspectives embodied by both “communities” lead many Native Americans to develop a “split-self, where he both sees and despises himself, and other Native[s], through the eyes of the oppressor” breeding “poisonous contempt, shame, anger, self-hatred, and violence.”²¹⁶ This self-hatred often manifests itself in suicidal thoughts,²¹⁷ alcoholism,²¹⁸ and substance abuse.²¹⁹

Created by Iroquois elders and volunteers, the E.L.D.E.R.S. program in upstate New York aimed to educate Native youth about the traditional beliefs of their ancestors through sports, food preparation, basket weaving,

among Native American youth). These stress events include “death among the immediate or extended family members, failure in school or job, or conflict between white social values and deep-seated cultural beliefs.” *Id.*

210. *See id.* at 238 (describing the pressure on adolescent Native Americans to choose between these two cultures and the resulting self-destructive behaviors).

211. *See id.* (describing the many factors that cause isolation among Native American children and youths).

212. *See id.* (explaining that isolating feelings can lead to suicidal thoughts and are likely the cause for high suicide rates among Native American youths).

213. Skye, *supra* note 119, at 125.

214. *See id.* (“Mainstream substance abuse prevention programs have minimal effect when attempting to address the Native American youth population.”).

215. *See id.* at 122 (describing the two worlds in which Native American children grow up and the challenges associated with this “two world” experience).

216. Krech, *supra* note 202, at 80.

217. *See id.* at 84 (explaining the role of self-hatred in Native American suicide).

218. *See id.* at 82 (describing how internal imbalance contributes to Native American alcoholism).

219. *See id.* at 83 (describing the prevalence and causes of alcoholism and drug abuse among Native Americans).

dancing, and ceremonies.²²⁰ The program began as a week-long camping event designed to teach the traditional rituals of the Iroquois, but eventually the focus shifted to addressing the prevalence of substance abuse among native youth.²²¹ Many Native youths are almost entirely without knowledge of traditional beliefs.²²² By cultivating an understanding of traditional Native American life and practices, Native youth begin to develop an appreciation for their history and culture, and begin to understand the basic issues underlying their self-hatred; as a result, this self-hatred begins to subside.²²³ After attending the program, many participants report “[making] conscious efforts to refrain from substances and to modify their lifestyle[s].”²²⁴

In addition to educating the youth about traditional beliefs and practices, the program also aims to reestablish the “traditional extended family system [and] communal child rearing practices” destroyed by seventeenth century governmental programs.²²⁵ These governmental programs left many children feeling abandoned and lost within their communities, an issue that has been found to contribute significantly to “suicide, substance abuse and risky health behaviors.”²²⁶

Some programs combine traditional Native beliefs with the more modern twelve-step style programs.²²⁷ These programs incorporate twelve-step programs with efforts to encourage participants to “focus on positive happenings, the value of a caring community, and possibilities to begin the healing process themselves.”²²⁸ Utilizing techniques such as drum-singing, sober drums, storytelling, and celebration to encourage and facilitate the treatment,²²⁹ the modified programs are especially successful for men who

220. See Skye, *supra* note 119, at 117–19, 128 (describing the various traditional cultural practices used in treatment).

221. See *id.* at 123 (describing the origins of the E.L.D.E.R.S. program and the transformation of the program over the years to focus on substance abuse).

222. See *id.* at 118 (explaining that many Native youths “hav[e] never been exposed to the beliefs of their ancestors”).

223. See *id.* at 122–30 (explaining how developing an understanding of their heritage has helped many Native American youths cope with the issues of self-hatred).

224. *Id.* at 118.

225. *Id.* at 125–26.

226. *Id.* at 126.

227. See Krech, *supra* note 202, at 86 (“Many contemporary helping professionals observe that a combination of traditional teachings and core values dovetails with the twelve-step philosophy in developing a suggested program of living.”).

228. *Id.* at 87.

229. See *id.* at 87–89 (describing the various traditional practices used as teaching and

are less likely to seek professional help and more likely to commit suicide than their female counterparts.²³⁰ By encouraging participation in traditional male practices, many men develop an understanding of the “way of being an Indigenous man: knowledgeable, respectful [and] sober.”²³¹

The incorporation of traditional healing practices not only provides a novel means of approaching the problems, but also serves to alleviate many of the causes of behavioral health problems.²³² With the high rates and severity of behavioral health problems within the Native American community, governmental initiatives must utilize the whole breadth of possible solutions and treatment plans available; traditional healing practices represent an underutilized and noteworthy option that should receive both consideration and support.

V. Conclusion and Final Recommendations

While the Reauthorization of the Indian Health Care Improvement Act represents a step in the right direction for future legislative action, it fails to utilize many techniques or solutions that have proven successful in other health care areas.²³³ The Reauthorization’s structure for addressing the exceedingly high vacancy rates at IHS and tribal health sites follows the general recommendations of many scholars;²³⁴ for example, the Act expands the Alaskan Community Health Aide Program to the contiguous United States.²³⁵ This approach addresses the IHS vacancy issues from a

treatment tools).

230. *See id.* at 84 (assessing the high suicide rates among men compared to their relatively low rates of seeking treatment and describing the efficacy of using traditional practices in treatment).

231. *Id.* at 87.

232. *See* Skye, *supra* note 119, at 122–30 (explaining how traditional practices treat the underlying issues that cause substance abuse, alcoholism, and depression).

233. *See* Aiken & Sage, *supra* note 85, at 194–210 (explaining the benefits of advanced practice nurses in rural and underserved populations); *see also* Skye, *supra* note 119, at 125–32 (explaining the use of traditional culture in treating substance abuse, depression, and diabetes); *see also* Krech, *supra* note 202, at 86–92 (explaining the use of traditional cultural practices in treating alcoholism, substance abuse, and depression).

234. *See* Mannino, *supra* note 172, at 153–57 (describing popular state efforts as including scholarship funds, loan repayment programs, and intern or externship programs).

235. *See* Indian Health Care Improvement Reauthorization and Extension Act S. 1790 111th Cong. § 119(d) (2009) (authorizing the nationalization of the Alaskan Community Health Aide Program, a program that encourages Native American community health practitioners to service their local communities).

novel angle. While this does not immediately address the vacancy issues faced by the IHS, it provides an alternative source of health care that will address concerns of overworked staff, decreased efficiency, and, occasionally, misdiagnoses.²³⁶

Reliance on alternative health care providers seems to be the next logical choice for the IHS. Despite many federal barriers, including the lack of recognition by Medicare and Medicaid, advanced practice nurses are an ideal source from which the IHS should consider drawing personnel. Advanced practice nurses require less training and utilize less expensive treatment techniques.²³⁷ A congressional exemption for advanced practice nurses practicing at IHS health care sites, similar to the licensing exemption given to physicians,²³⁸ would allow many to practice not only at established IHS health sites, but work in local communities to address these health issues.

Cultural consciousness is essential in the treatment of all medical problems facing Native Americans. Numerous programs have proven successful in treating diabetes, substance abuse, and mental health disorders when they incorporate traditional belief systems in their educational programs.²³⁹ Congress would be well advised to consider and adopt measures similar to the E.L.D.E.R.S program adopted by the Iroquois²⁴⁰ and the diabetes prevention and treatment program adopted by the Zuni.²⁴¹ By addressing both the physical and psychological problems faced by many

236. See U.S. COMM'N ON CIVIL RIGHTS., *supra* note 3, at 78 (explaining the consequences of understaffing at IHS health sites).

237. See Aiken & Sage, *supra* note 85, at 196–98 (describing how using advanced practice nurses is cost-effective both in the training stage and when used in rural or inner city communities).

238. See Indian Health Care Improvement Reauthorization and Extension Act S. 1790 111th Cong. § 123(b)(4) (2009) (creating a licensing exemption for physicians which allows them to practice in an IHS health site if they are licensed in any state, even if that state is different than the location of the IHS health site).

239. See Skye, *supra* note 119, at 125–32 (explaining the use of traditional culture in treating substance abuse, depression, and diabetes); see also Krech, *supra* note 202, at 86–92 (explaining the use of traditional cultural practices in treating alcoholism, substance abuse, and depression).

240. See Skye, *supra* note 119, at 118 (describing the origin, purpose, and success of the E.L.D.E.R.S. program developed by the Iroquois and open to Native Americans of any tribe).

241. See Olson, *supra* note 92, at 173 (describing the diabetes treatment program developed by the Zuni that encouraged exercise by emphasizing the Zuni's history as long distance runners).

Native Americans, treatment of diabetes and behavioral health problems becomes increasingly effective.²⁴²

Additionally, Congress should consider appropriating federal funds to traditional, Native American healers. Currently, federal funding is prohibited from being used by these traditional healers, but evidence suggests that many Native Americans would respect and utilize these healers extensively.²⁴³ Forcing Native Americans to utilize modern, Western medicine is akin to forcing most Americans to utilize solely traditional Chinese medicine.²⁴⁴ The internal beliefs of a patient can have an extreme effect on the efficacy of a treatment.²⁴⁵ By refusing to allow traditional healers to participate on IHS and tribal health sites, Congress is limiting both the efficacy of IHS treatments and the number of individuals willing to utilize it.²⁴⁶

The Native American population should also consider addressing their collective health problems through private, in addition to federal, sources. With the current restrictions placed by Congress on the use of federal funds, many programs shown to be effective, including the use of traditional healers, are unable to gain footing.²⁴⁷ By looking to outside sources, Native Americans may be able to more efficiently address the problems at hand and, over time, convince Congress of the effectiveness of these programs.

The final puzzle piece in this picture is raising public awareness. Most Americans only know that alcoholism is a problem within Native American communities. But with the staggering rates of diabetes, suicide, and abuse of other substances, more must be done to educate the American people of the true health status of Native Americans and the actions necessary to resolve these disparities. Public support will only assist the IHS in its effort

242. *See id.* (showing the effectiveness of traditional beliefs in treating diabetes); *see also* Skye, *supra* note 119, at 118 (describing the efficacy of teaching traditional cultural practice in treating diabetes, substance abuse, alcoholism, and depression).

243. *See* Holly T. Kuschell-Haworth, *Jumping Through Hoops: Traditional Healers and the Indian Health Care Improvement Act*, 2 DEPAUL J. HEALTH CARE L. 843, 850 (1997) (“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.”).

244. *See id.* at 854 (analogizing the forcing of Western medicine upon Native Americans as akin to requiring Americans to utilize Chinese medicine).

245. *See id.* (“The effectiveness of any health care approach is greatly affected by the inherent beliefs of the patient.”).

246. *See id.* (noting that “health care only reaches the portion of Native Americans who wish to undergo Western medical treatment”).

247. *See id.* at 850 (describing the “implied prohibition” on traditional healers written into the IHCA).

to address and fix the health disparities within the Native American population.