A Storied Past Demands Greater Access to Health Care Now and Into the Future

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I. INTRODUCTION

The future health of the United States will largely be determined by how effectively the federal government eliminates health disparities that disproportionately burden vulnerable populations, including the American Indians and Alaska Natives (AI/AN).\textsuperscript{1} There has been a longstanding campaign to educate many new generations to see this population’s access to health care in its fullest expression: as a right to basic human capabilities. With the success of the Patient Protection and Affordable Care Act (ACA), it appears as if now, more than ever before, financial help for health coverage may be able to reach this widely displaced and underfunded population.\textsuperscript{2} Although the ACA was designed to adequately meet the basic needs of most individuals in the aggregate, it is inadequate in meeting the basic needs of those most vulnerable, especially AI/AN. This shortfall represents the everlasting tensions and complex relationship between the United States government and AI/AN, as well as trends of AI/AN disenfranchisement.\textsuperscript{3}

This article will examine the time-honored issues surrounding AI/AN’s

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access to health care and will demonstrate why, under a traditional as well as sufficiency of capabilities approach to distributive justice, the U.S. government has a heightened duty to provide sufficient funding to programs designed to reach these populations and eliminate foreseeable deterrents to AI/AN enrollment in ACA-expanded Medicaid as a means of elevating their health to a just threshold level.4 Part II of this article will examine the unique relationship between the U.S. government and AI/AN, concentrating particularly on AI/AN’s unique health care needs. Part III will address how the ACA affects AI/AN and the roles of the states in expanding their health coverage. Finally, Part IV will address why justice demands increased access to health care for AI/AN. Although much of what will be described regarding AI/AN health disparities and the law is straightforward, other parts of this article may involve more contemplation as they are set forth with a very broad and visionary view of how improved health care access stems from an awareness of past harms experienced by these populations.

II. THE FEDERAL TRUST RESPONSIBILITY: A FEDERAL-TRIBAL RELATIONSHIP WARRANTING INCREASED FUNDING TO ADDRESS LOOMING HEALTH CONCERNS

The contours of the relationship between the federal government and tribal governments are shaped by hundreds of years of legal precedent.5 The status of federally recognized tribes as sovereign entities with a unique gov-


ernment-to-government relationship with the United States holds important weight in the balance of intergovernmental relations.\textsuperscript{6} It is weighed against the accompanying fact that AI/AN are beneficiaries of certain federal programs due to the special debt the United States owes this population for their 400 million acres of land secession.\textsuperscript{7} Although challenging, striking equilibrium between self-governance and special beneficiary must be seriously considered when creating and funding for a culturally competent and satisfactory health care program.

A. Brief History of the Socio-Political Arrangement Creating a Right to Health

The relationship between the sovereign tribes and the federal government greatly hinges on the latter’s fulfillment of its federal trust responsibility. The federal trust responsibility is the United States’ fiduciary obligation to protect tribal treaty rights, lands, assets, and resources as well as to carry out the mandates of federal law that relate to AI/AN.\textsuperscript{8} The discussion below briefly chronicles how the federal trust responsibility has been executed, how its shortcomings have been remedied with follow-up legislation, and how one general theme prevails throughout: federal underfunding.

There are currently 562 federally recognized tribes spread across thirty-five states.\textsuperscript{9} The federal government has provided American Indians (AI) health care based on their membership in one of these tribes.\textsuperscript{10} Generally noting that, “an American Indian person is someone who has blood degree from and is recognized as such by a federally recognized tribe or village

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  \item \textsuperscript{6} Alex Dyste, It’s Hard Out Here for an American Indian: Implications of the Patient Protection and Affordable Care Act for the American Indian Population, 32 LAW & INEQ. 95, 96 (2014).
  \item Id.
  \item Id.
  \item See id.
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and or the United States.\textsuperscript{11} As of January 2012, the total population of AI/AN, including those of more than one-race, was 5.2 million or 1.7% of the total U.S. population.\textsuperscript{12}

In 1921, the federal government enacted the Snyder Act to fulfill its federal trust responsibility and provide AI with health care.\textsuperscript{13} Many consider this legislation to have been the leading AI/AN welfare law of the early twentieth century because it authorized federal appropriations for this population’s health services.\textsuperscript{14} Although the Snyder Act categorized the responsibility to administer health services as under Congress’ purview, it only required Congress to do this “from time to time,” whenever they considered it proper for the benefit, care, and assistance of this population.\textsuperscript{15} Soon after, Congress passed the Indian Citizenship Act of 1924 to expand AI’s citizenship status to full U.S. citizens and, by extension, their eligibility for bene-

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\item American Indian People and Tribes, Indian Health Serv. 6, available at http://www.ihs.gov/bemidji/documents/resources/minnesota/Am_Indian_People_Tribes.doc (last visited Oct.14, 2014).
\item Blood Quantum Influences Native American Identity, Native Village, available at http://www.nativevillage.org/Messages%20from%20the%20People/Blood%20Quantums%20for%20Native%20Americans.htm (“The term was first used in the 1700s by Colonial Virginia. Those who were more than 50% Native American had their rights restricted. Today, the federal government uses [the term] to determine the benefit a tribe receives based on its population.” However, blood quantum requirements differ depending on an individual tribe’s requirements for membership, making membership in some tribes harder than others. For instance, to be a member of the Apache Tribe of Oklahoma requires 1/8 degree blood quantum whereas membership in the White Mountain Apache Tribe of Arizona requires 1/2 degree blood quantum.).
\item Koral E. Fusselman, 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?, 18 WASH. & LEE K. CIV. RTS. & SOC. JUST. 389, 395 (2012) (“The Snyder Act provided a limited number of programs and authorized the BIA [Bureau of Indian Affairs] 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.’”). U.S. Dep’t of State, Office of the Historian, Milestones, available at https://history.state.gov/onlinebds/milestones/1866-1898/alaska-purchase (The Snyder Act of 1921 predated Alaska becoming a state in 1959, so this section is generally about Congress’ right to administer health care to the AI population.).
\item See NW. Portland Area Indian Health Bd., supra note 9, at 14.
\item Dyste, supra note 6, at 103.
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fits that are only available to full citizens. The Snyder Act was insufficient at fulfilling this federal trust obligation to AI, so in the 1950s, the responsibility over health services for AI transferred over to the Department of Health and Human Services (HHS).

In 1955, the government created the Indian Health Service (IHS) as a federal agency within the HHS responsible for delivering health services to AI in accord with the federal trust responsibility by raising “the health status of [AI] to the highest level.” Currently the IHS is organized into twelve federally designated geographic service areas and operates a system of health facilities. In 1975, the Indian Self-Determination and Education Assistance Act (ISDEAA) was created to uphold the federal trust responsibility, establish tribal involvement in the administration of federal agencies, and reaffirm AI/AN’s need for health care. The ISDEAA gave tribes the option of staffing the IHS programs within their communities under self-governance compacts. These compacts instilled greater administrative power in the tribes over the development of the IHS even though the federal

16. Id.
17. Indian Health Serv., The First 50 Years of the Indian Health Service: Caring and Curing, 3 (2005), available at http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/GOLD_BOOK_part1.pdf (“The health status of Indians remained poor during the following three decades. Several studies of Indian health, including those by the Institute for Government Research (1928), the Hoover Commission (1948), and the American Medical Association found high infant mortality and excessive deaths from infectious disease. Based on these studies, efforts were made to transfer the Indian health program from the BIA to the United States Public Health Services (USPHS) in the Department of Health, Education, and Welfare. [. . .] On July 1, 1955, about 2,500 health program personnel of the BIA, along with 48 hospitals, 18 health centers, 62 stations, 13 school infirmaries, and other locations, came under the jurisdiction of the newly created Indian Health Service.”). See Fusselman, supra note 13, at 395.
20. Fusselman, supra note 13, at 396 (Although the federal government is in charge of the IHS, the tribes are involved in the staffing and administration of the IHS’ programs.).
government is the authorizer of this program.\textsuperscript{22} Funding for the ISDEAA, however, failed to grow in unison along with the number of AI/AN serviced by the IHS.\textsuperscript{23} In response to this dwindling funding, Congress enacted the Indian Health Care Improvement Act of 1976 (IHCIA) to authorize programs aimed at achieving the policy goal of elevating AI/AN’s health status to its highest possible level.\textsuperscript{24} The IHCIA sparked more research into AI/AN’s health needs and Congress increased funding as a way to incentivize health care practitioners to treat this population of patients.\textsuperscript{25}

In 1988 and 1992, Congress enacted several amendments to the IHCIA to address AI/AN’s health concerns, particularly diabetes, alcoholism and Fetal Alcohol Syndrome.\textsuperscript{26} The 1992 IHCIA amendments included health goals for the Alaska Native (AN) population as well as appropriations for healthcare projects through 2000.\textsuperscript{27} “Since 2000, however, Congress has continued to appropriate funds only on an annual basis. [With the successful passing of the ACA in 2010, Congress finally amended this arrange-
The ACA includes a permanent reauthorization of the IHCIA, but does not provide appropriations to continue the IHCIA’s programs, including the IHS. However, the permanent reauthorization could mean future funding that will be given to the IHCIA to authorize programs that are better equipped to meet the mission of elevating the health status of AI/AN. Although the reauthorization in the ACA represents a step in the right direction for meeting the federal trust responsibility, there are still several weaknesses that merit consideration for finally improving AI/AN’s access to health care.

B. Historical Health Disparities Plaguing the AI/AN Population

With the advent of the IHS in 1955 came the opportunity to track the health issues particular to the AI/AN population. Even the earliest collected information remains useful as a baseline from which to measure any health change or disparities over the last nearly seventy years. The research from the 1950s indicated that AI had a higher mortality rate compared to the general population and were more likely to die from communicable diseases. Data such as this, combined with newly collected information, illustrates not only that the health disparities between AI/AN and the rest of the United States have deep roots, but also that these disparities have persisted over time.

The current research suggests that there are several physical health issues that are especially prevalent in the AI/AN demographic that have generally

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28. *Id.* at 400.
30. NAT’L CONGRESS OF AM. INDIANS, *supra* note 26 (“The passage of the IHCIA on March 23, 2010 represented a fourteen year-long effort by NCAI, tribal leaders, and advocates to make permanent the legislative commitment by the federal government to deliver health care for [AI/AN].”).
33. *Id.* at 268.
not subsided over time relative to other demographic groups. For instance, AI have historically battled with diabetes rendering this population 420% more likely than the general population to die from diabetes. Also, AI youth suffer from diabetes at alarming rates, far above the rate of children in other demographic groups. Additionally, AI are estimated to be 650% more likely to die from tuberculosis, 280% more likely to die from accidents, and 52% more likely to die from pneumonia or influenza. This population’s limited access to appropriate health facilities, poor access to health insurance, insufficient federal funding, quality of care issues, disproportionate poverty and poor education, are key factors contributing to these health disparities. Furthermore, these health issues largely cannot be divorced from the behavioral and mental health problems that are also identified to be very prevalent in the AI/AN demographic.

Behavioral and mental health problems such as substance and alcohol abuse, suicide, and domestic violence are especially burdensome on the tribes both emotionally and economically. Consequently, depression, anxiety, violence, and suicide are regularly reported among all age groups. AI are reportedly 770% more likely to die from alcoholism than the general population. Also, the very geographic isolation of the AN villages from the remainder of the state has resulted in limited access to an already scarce

34. Dyste, supra note 6, at 101 (The author of this article realizes that categorizing the rest of America as non-American Indian, white or non-white dismisses the many nuances in race, ethnicity and identity that are so important in sociological studies such as this one. Therefore, in attempt to not trivialize the significance of these often blurred racial categories, the author has chosen to use the terms, “other demographic groups,” and “general population,” to signal the counterpart categories that are compared to AI/AN throughout this subsection.).
35. Id.
36. Fusselman, supra note 13, at 403.
37. Dyste, supra note 6, at 101.
38. Id.
39. Id.
40. Id.
41. Fusselman, supra note 13, at 405.
42. Dyste, supra note 6, at 101.
number of mental health professionals.\textsuperscript{43} A rampant issue exists particularly with youth suicide and violent death in these areas.\textsuperscript{44} That said, most AI do not actually live rurally as 66\% of the population lives in urban areas, but these too are underserved by the IHS due to federal underfunding.\textsuperscript{45}

While AI/AN are in dire need of healthcare providers, the IHS has a very difficult time fulfilling this need on tribal sites.\textsuperscript{46} Even when physicians are brought onto the sites, the IHS struggles with a very low retention rate.\textsuperscript{47} In fact, the average employment period is 8.1 years, forcing the IHS to hire nearly 1,200 new practitioners annually to fill the 900 vacancies that arise every year.\textsuperscript{48} The IHS is responsible for eliminating these health disparities, but chronic underfunding has made doing so a persistent challenge.\textsuperscript{49} Compounding the difficulty of provider-vacancy are community leaders who seek to ensure that when care is provided, it will be highly culturally competent.\textsuperscript{50} This adds an increased challenge as providers are requested to provide both traditional holistic and western medicines.\textsuperscript{51}

III. THE ACA AND THE ROLE THE STATES HAVE IN ADDRESSING THE ACCESS ISSUES

The ACA is a complicated piece of legislation generally intended to address how health care is unique in being a market that most individuals participate in eventually, even if unintentionally, and that requires shared fund-

\textsuperscript{43} Nw. Portland Area Indian Health Bd., supra note 9, at 7.
\textsuperscript{44} Id.
\textsuperscript{45} Caryn Trombino, Changing the Borders of the Federal Trust Obligation: The Urban Indian Health Care Crisis, 8 LEGIS. & PUB. POLICY 129, 146 (2004).
\textsuperscript{46} Fusselman, supra note 13, at 400.
\textsuperscript{47} Id. at 401 ("The unique circumstances of Native American health care sites are a primary cause of the extremely high vacancy rates reported. 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.").
\textsuperscript{48} Id.
\textsuperscript{49} Dyste, supra note 6, at 101.
\textsuperscript{50} Nw. Portland Area Indian Health Bd., supra note 9, at 10.
\textsuperscript{51} Id.
The ACA entrusts individual states with the responsibility to provide Medicaid to adults with incomes up to 138% of the federal poverty level (FPL), including AI/AN. The ACA also specifically has qualifications that address the AI/AN population, including the elimination of cost sharing for services provided to certain enrollees at or below 300% of the FPL or for services provided by the IHS regardless of the enrollee’s income. Further, the ACA exempts AI/AN from being subject to a federal tax if they do not obtain health insurance from the federal government. This exemption extends also to AI/AN who are not enrolled in a federally recognized tribe but who are eligible for services from the IHS. Although obvious issues within this current framework include the failure to extend cost sharing and thus accountability over one’s health to all AI/AN, the goal for the remainder of this section is to address how the risks in failing to expand Medicaid in states where there is a high AI population are outweighed by the benefits of expansion.

### A. States Have Too Much Ability to Diminish the Federal Trust Relationship

Whether individual states expand Medicaid will determine AI/AN’s Medicaid eligibility and whether some of the financial burden put on the IHS will be alleviated. “Excluding those already enrolled, potential new enrollment in Medicaid could exceed [27%] for those identifying as AI/AN alone, and almost [25%] for those identifying as AI/AN alone or in combination with another race.” Of those AI/AN who are identified with a federal tribe, about 16% will be newly eligible under the ACA and about 11%
are currently eligible but not enrolled. This latter statistic is especially indicative of why the states need to adopt strategies to increase the enrollment and fulfill the federal government’s trust responsibility. Of the twelve existing IHS service areas, there are some located in states that may not expand their Medicaid programs in the near future. Of particular concern is Oklahoma because this state has historically catered to the largest AI population but has yet to expand its Medicaid program. The issues with Oklahoma’s choice to not expand its Medicaid program can be extrapolated to address all other states that have AI populations but are choosing not to expand.

Since 2012, Oklahoma opted out of expanding its Medicaid program. Oklahoma Governor Mary Fallin decided not to participate in the expansion because it would be unaffordable. The current Oklahoma program under Governor Fallin’s wing called “Insure Oklahoma,” is designed to cover adults earning up to 200% of the FPL but it does not have all of the features that the Centers for Medicare and Medicaid Services (CMS) require to keep the state program running and it is scheduled to be shut down in one year. Therefore, Oklahoma may need to expand its Medicaid program in order to keep those beneficiaries they currently provide coverage for regardless of the state’s budget concerns. The 2014 potential new enrollment

59. Id.
64. Millman, supra note 63.
in Oklahoma’s Medicaid program would have surpassed an estimated 76,000 for individuals who identify solely as AI/AN and over 137,000 for those identifying as AI/AN alone or in combination with another race. The health issues plaguing AI/AN combined with incredible federal underfunding for the IHS necessitate an increased amount of effort to secure health coverage for these individuals. Proper Medicaid coverage will allow AI/AN’s health care needs to be addressed while properly reimbursing their service providers at IHS. Also, the ongoing lack of funding hinders IHS’s ability to conduct proper outreach initiatives to at least increase the Medicaid membership to those currently eligible individuals, even without the expansion.

Oklahoma’s decision not to expand Medicaid interrupts the federal government’s federal trust responsibility to care for AI/AN’s health. The federal government has promised to pay the full expansion coverage costs for each state until 2016 and then reduce their assistance only 10% in 2022 and beyond. The financial burden that this puts on the state is outweighed by the drastic health care needs that the largely underfunded IHS service area requires. Furthermore, any financial burden is secondary to the federal trust promise to AI that predates as well as preempts the state-centric views of legislative autonomy.

IV. DISTRIBUTIVE JUSTICE: MORALLY JUSTIFIED INEQUALITY TO MEET THE MOST NEED

AI/AN depend on the federal government for their access to health care but they are also residents of the states in which they live. This incredibly ambiguous political identity combined with the past secession of several hundred million acres of land warrants an unequally higher distribution of

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65. U.S. Gov’t Accounting Office, supra note 19, at 7.
66. Id. at 6.
67. Young, supra note 63.
68. Dyste, supra note 6, at 116.
69. Id. See also Indian Health Serv., supra note 11, at 7.
healthcare funding to these populations.\textsuperscript{70} Although it may have been considered a benefit to excuse AI/AN from the ACA mandate, in all actuality, this is not likely the case given the low AI/AN enrollment in Medicaid.\textsuperscript{71} Given the ACA-related AI/AN provisions are subject to the states’ opting-in to expand their Medicaid programs, Congress did not do enough by only reauthorizing the ICHIA in the ACA because they did not also provide the increased funding necessary to overcome any state Medicaid expansion hurdles.\textsuperscript{72}

The ACA Medicaid expansion could be especially beneficial to AI/AN because of the qualification statistics mentioned earlier.\textsuperscript{73} However, the Medicaid expansion overlooks the fact that many AI/AN hesitate to enroll in public programs.\textsuperscript{74} Some AI/AN may not enroll because they generally hold the federal government accountable for making sure that their health care needs are met.\textsuperscript{75} “This perspective stems from [AI]’s view that they purchased health care at the lofty cost of 400 million acres of land, and the cumbersome Medicare and Medicaid registration and enrollment processes are not a burden they bargained for.”\textsuperscript{76} Relatedly, other past infringements on AI/AN land and peoples has understandably created a great distrust in the government and the thought of government control over AI/AN health is worrisome for many members of this population.\textsuperscript{77} There is also a pre-

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\item \textsuperscript{70} Dyste, \textit{supra} note 6, at 114 (referencing the 400 million acres of land that this population has ceded in the past).
\item \textsuperscript{71} See id.
\item \textsuperscript{72} Id. at 117.
\item \textsuperscript{73} U.S. Gov’t Accounting Office, \textit{supra} note 19, at 6. Dyste, \textit{supra} note 6, at 101 (“At the end of the day, the benefits that the ACA can realize are too tremendous to risk.”).
\item \textsuperscript{74} Dyste, \textit{supra} note 6, at 113 (“Native Americans, historically do not enroll in public programs such as Medicare and Medicaid.”).
\item \textsuperscript{75} Id.
\item \textsuperscript{76} Id.
\item \textsuperscript{77} Id.; Andrew Boxer, \textit{Native Americans and the Federal Government}, Hist. Rev. (Sept. 2009), available at http://www.historytoday.com/andrew-boxer/native-americans-and-federal-government (The following are just three examples of past harms to AI/AN by the federal government. During the late 19th century, the U.S. government policy was to assimilate AIs into mainstream American society as a way to introduce them into “civilized life,” even if that meant without the consent of AIs. During WWII, the tribal reservations lost fur-
vailing stigma in program enrollment as it may signal that the individual is lazy or needy.\(^7^8\) Additionally, several incidents have occurred where social workers or other staff have mistreated these populations to the point where they feel this is a barrier to their health care access.\(^7^9\)

$5.5 billion was designated for IHS improvements within the ACA budget.\(^8^0\) Funding should not be capped at this amount if it ends up being inadequate for elevating the health and wellbeing of AI/AN. In light of innumerable past harms to AI/AN, this population’s justifiable distrust with government-sponsored programs, and the reasonable foreseeability that some states would not opt to expand their Medicaid programs all suggests that the federal government has a heightened responsibility to provide more funding to the IHS.\(^8^1\) Arguments of distributive justice, both traditional and otherwise, can best demonstrate why the federal government has a heightened obligation to the AI/AN population to finally meet their health care needs.\(^8^2\)

A. Rawls: A Social Contract Based on the Difference Principle

John Rawls’ idea of a reflective equilibrium and distributive justice is the basis for the argument that the federal government has a heightened duty to AI/AN to meet their health care needs. In particular, the portion of Rawls’ theory known as the “difference principle,” suggests that when there are finite resources, such as healthcare funding, there is a greater need to distribute these resources in a just and equitable way.\(^8^3\) Rawls argues that if we were to think of constructing the most optimal social arrangement or institu-
tion from behind a veil of ignorance, a space of economic, social and political neutrality, it would be in everyone’s best interest to permit only those inequalities that work to the advantage of the least well off members. In fact, Rawls holds that it is only from behind this veil that we can see the importance of distributing limited resources in a way that minimizes the potential harms and maximizes the prospects of individuals who are the worst off. When put to practice, those who are least well off deserve any inequalities in the distribution of benefits or goods that will elevate their status.

AI/AN are a particularly disenfranchised population given their comorbid health issues as well as their turbulent history of colonialism, and consequently require greater access to health care. While the ACA indefinitively extends the IHCIA, Congress should have also provided the necessary appropriations for improving the success of the programs the ICHIA authorizes in the event that some of the states did not to expand their Medicaid programs. In order to account for the total amount of funding needed, the $5.5 billion designated for IHS improvements should only be a starting point rather than a cap. The reasonable foreseeability of some states opting not to expand their Medicaid programs combined with this lack of necessary increased funding has led to severely unequal access to health care for AI/ANs. The IHS’ mission, which rests on the federal trust responsibility, is to elevate the health of the AI/AN population. Under a Rawlsian theory of

84. Id. (“Since each desires to protect his interests, his capacity to advance his conception of the good, no one has a reason to acquiesce in an enduring loss for himself in order to bring about a greater net balance of satisfaction.”). See Michael J. Sandel, Justice 141 (2009).
85. Rawls, supra note 4, at 13 (“I shall maintain instead that persons in the initial situation would choose two rather different principles: the first requires equality in the assignment of basic rights and duties, while the second holds that social and economic inequalities, for example inequalities of wealth and authority, are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society.”).
86. Id.
87. See Dyste, supra note 6, at 100.
88. Indian Health Serv., supra note 11.
distributive justice, until and unless the goal of elevating the health of the AI/AN population is met, a disproportionally high amount of federal funding for the IHCIA is recommended.

B. Ram-Tiktin’s Functional Capabilities to Health Care as Right

The federal trust responsibility is accepted as the promise of health care to the AI/AN population. As discussed above, Rawls’ account of justice warrants a disproportionate amount of federal funding to the IHS to address AI/AN health care needs and correct the disparities. Next, Martha Nussbaum’s capabilities theory of justice asks and answers questions such as “what is the quality of life?” and “what is the relevant type of equality that we should consider in political planning?” Nussbaum lists “a good enough human life” as a capability central for achieving a flourishing life. Below this threshold, Efrat Ram-Tiktin’s claims of injustice can apply. Ram-Tiktin’s concern is in bridging the qualitative differences to health care access amongst people.

“If people have the basic capabilities needed to live a good life, the quantitative differences among them are not a concern of justice. Therefore, state health institutions are not obligated to equalize peoples’ states of health […] but to guarantee them sufficiency of capabilities that will enable them to implement their life plans and exercise positive freedom. In this view, only those beneath the basic human functional capabilities threshold level or in jeopardy of falling beneath […] have a claim-right

89. Dyste, supra note 6, at 118.
90. RAWLS, supra note 4, at 13.
91. See Nussbaum, supra note 4, at 279 (The author of this article acknowledges that there is so much more to be said about Nussbaum’s long and broad lists of rights and capabilities, but for the purposes of this article, the author seeks to tailor the conversation to a very modern take on Nussbaum’s theory and how it would address this article’s concerns about health care access.).
93. Id.
94. Id. at 340 (“According to my account, our moral concern is toward qualitative rather than quantitative differences among people. The fact that person A has better capabilities than B […] is not morally troubling as long as person B has the basic ability to walk.”).
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Ram-Tiktin acknowledges nine biological factors of human functional capabilities including thinking, emotions, and metabolism, but this is not particularly important for the purposes of this article. What is important, however, is Ram-Tiktin’s claim that government has a duty to assure that every individual has the entire range of capabilities needed to exercise positive freedom to the furthest extent possible. Any individual lacking in these capabilities is below the threshold, and individuals farther beneath the sufficiency-threshold have a stronger claim to justice by the state than those just beneath the threshold. A key to the goal of elevating those below the sufficiency threshold is to maximize the net benefit, not necessarily the number of beneficiaries. This means that where the greatest need is, not the greatest number, ought to dictate how to best allocate finite healthcare resources.

This theory generally applies to the AI/AN populations in a couple of ways. AI/AN do not comprise more than 1.7% of the total U.S. population. Therefore, the number of individuals to benefit from a disproportionate allocation of funding under a Rawlsian theory of justice is not going to be great, even though we can consider this population to be amongst the worst off in terms of health. Therefore, given the overwhelming number of health issues that are plaguing AI/AN, it is the net benefit of their increased

95. Id.
96. Id. at 341 (“In identifying the basic human functional capabilities, I explored human physiology and identified nine key systems of physiological and psychological capabilities necessary for individuals to lead good lives: thinking and emotions, senses, circulation, respiration, digestion and metabolism, movement and balance, immunity and excretion, fertility, and hormonal control. Each system of capabilities is important in itself, and a higher capability in one system does not invalidate someone’s claim for compensation if there is some functional deficiency in another system.”).
97. Id.
98. See id. at 342-343.
99. Id. at 343.
100. See id. at 349.
101. INDIAN HEALTH SERV., supra note 11.
access to health care that will greatly improve their capabilities of achieving human flourishing. Under this double-tiered distributive justice model, the U.S. government has a moral obligation to fund for the health care of the AI/AN population because of the severity of AI/AN’s health care needs in addition to AI/AN centralization in states where there is a high demand for health care, but no Medicaid expansion.102

V. CONCLUSION

Questions about Congress’ legislative commitment to fulfilling the federal government’s promise to AI/AN have given way to more specific questions about how Congress can actually guarantee the funding for improving AI/AN’s access to health care. The federal government has a fiduciary obligation towards meeting AI/AN’s health care needs. This fiduciary obligation is best understood as a heightened duty to elevate AI/AN’s access to health care given past harms, the number of benefits to be gained, and the overall distrust that needs to be remedied for there to be a prosperous future relationship.103 Given the underutilization of Medicaid by AI/AN, the federal government can finally meet its federal trust obligation through the ACA’s permanent reauthorization of the IHCIA by increasing its program funding. One suggestion for how the government can do this is to redistribute the funding they would have given states that have chosen to not expand their Medicaid programs to go towards the IHS. By doing so, the federal government can dedicate funding to a program that will be most effective in reaching AI/AN and is best equipped to give culturally competent care.104

By having a firm grasp on what seems to be a set of perennial issues surrounding the federal trust responsibility, we may be better able to overcome the turbulence of the past and move in a new direction for the future.

102. See generally Young, supra note 63.
103. See generally Dyste, supra note 6, 111-15.
104. Nw. Portland Area Indian Health Bd., supra note 9, at 10.