

**THE OGLALA LAKOTA AND
THE RIGHT TO HEALTH:
THE FORGOTTEN AMERICANS**

Katherine Farrell Ginsbach*

* Katherine Farrell Ginsbach is an Associate at the O’Neill Institute for National and Global Health Law and Georgetown University Law Center. Much gratitude to Diane Desierto and her course on Economic, Social and Cultural Rights, The Farrell Family, especially Jane, Patrick Ginsbach, Robert Brave Heart, Sr., Tashina Banks Rama, and the Oglala Lakota Sioux Tribe.

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QUINNIPIAC HEALTH LAW

[Vol. 24:3

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I. Introduction

In 1952, while working as a librarian at the Veterans Administration Hospital in Hot Springs, South Dakota, Margaret Farrell contracted tuberculosis. Margaret Farrell is the author's grandmother and she shared her experience of the disease and treatment with her descendants.¹ Margaret Farrell was lucky; she lived near a community that housed a sanatorium for tuberculosis.² Lucky may be a bit of a stretch; she was still quarantined for a year.³ Effective chemotherapy treatment for tuberculosis was still a few years away, and Rifampin was not available clinically until 1966.⁴ And so, she remained in the sanatorium for 12 months; each Wednesday her husband would visit in the evenings, and on Sunday he would bring their toddler, so Margaret could wave to her from behind a window.⁵ During the course of her quarantine she had one nurse who did not believe Margaret was allergic to penicillin, a mistake that nearly killed her.⁶ Otherwise, she was prescribed rest and nutrition and made a full recovery.⁷ In the spring of 1953, she gained her freedom but was met with isolation from the community; she talked about being socially ostracized the way early HIV patients were.⁸ Years later, she was admitted into the social clubs, but the emotional scars from the early shunning did not disappear, although she never shared them outside of her family.⁹ Her husband was a lawyer for the water company in town and was able to gain insurance for her through his employment, although most insurance companies denied her coverage for what we see today as pre-existing conditions.¹⁰ Margaret continued to get chest X-Rays in her hometown for a few

¹Telephone Interview with Jane Farrell, Daughter of Margaret Farrell (Apr. 25, 2019) (Transcript of interview on file with author).

²See John F. Murray, Dean E. Schraufnagel & Philip C. Hopewell, *Treatment of Tuberculosis: A Historical Perspective*, 12 ANNALS AM. THORACIC SOC'Y 1749, 1751 (2015) (establishing that as of 1953, there were 839 sanatoriums with over 136,000 beds).

³Telephone Interview with Jane Farrell, *supra* note 1.

⁴Murray, Schraufnagel & Hopewell, *supra* note 2, at 1754.

⁵Telephone Interview with Jane Farrell, *supra* note 1.

⁶*Id.*

⁷*Id.*

⁸*Id.* See generally Sushil Baral, Deepak Karki & James Newell, *Causes of Stigma and Discrimination Associated with Tuberculosis in Nepal: A Qualitative Study*, 7 BMC PUB. HEALTH 211 (2007). Today, the disease remains highly stigmatized due to the perceived risk of infection; perceived links between TB and other causes of discrimination, particularly poverty and low caste; perceived links between TB and disreputable behavior; and perceptions that TB was a divine punishment. *Id.*

⁹Telephone Interview with Jane Farrell, *supra* note 1.

¹⁰*Id.*

years, but eventually doctors decided it had been long enough without any spots.¹¹ Margaret went on to live a long and healthy life before passing away in 2013 at the age of 93.¹² Margaret Farrell contracted tuberculosis nearly seventy years ago and was one of the last in the community to suffer from it.¹³ Health officials once predicted the eradication of tuberculosis by the year 1915.¹⁴ They were wrong, but with the advent of antibiotics, “tuberculosis has been on the decline [in the U.S.] since 1992.”¹⁵ “[T]here’s a vague perception that it is a historic disease – long since cured and largely forgotten.”¹⁶ If Americans think about tuberculosis at all, it is in places of far off destinations: the Russian prison system, India, and South Africa as a co-infection with HIV. It is a disease of history, removed from the American landscape. Roughly 10 million people throughout the world contract tuberculosis each year, but “the history of tuberculosis control is really one of forgetting.”¹⁷

This is not a paper about Margaret Farrell, her community, or tuberculosis. This paper instead is about a community that is talked about in similar ways as tuberculosis: isolated, historic, and forgotten. Located 60 miles away from Hot Springs, South Dakota is the town of Pine Ridge, South Dakota that is located within the boundaries of the Pine Ridge Indian Reservation and is home to the Lakota Sioux Tribe.¹⁸ This paper is about their community and their right to health as is articulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights.¹⁹ The first section of this paper will provide background on the current Lakota Sioux Tribe demographics, which will provide a stark contrast to those found in Hot Springs, followed by significant historical background including pieces of legislation and treaties that have impacted and shaped the Lakota life that is found today to place the community in context of their current health status. The scope of the

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ Adrienne Lafrance, *The Dangers of Ignoring Tuberculosis*, THE ATLANTIC (Aug. 3, 2016), <https://www.theatlantic.com/health/archive/2016/08/tuberculosis-doomsday-scenario/494108/>.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ See *Pine Ridge Indian Reservation*, RE-MEMBER, <https://www.re-member.org/pine-ridge-reservation.aspx> (last visited Feb. 12, 2021).

¹⁹ See International Covenant on Economic, Social and Cultural Rights, art. 12, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR]. After reading this paper, the reader may find that Margaret Farrell received better health care in 1952 than the residents of Pine Ridge receive today.

paper will then expand out to provide an overview of the status of Indigenous health in the United States, with a brief overview of Indigenous health issues globally.²⁰ It will then move into the Right to Health as is enumerated in Article 12 of the Covenant on Economic, Social and Cultural Rights. The last section of this paper will address how the Right to Health has been violated for the Oglala Lakota Sioux, not through numbers but through a document analysis that includes news stories, personal narratives, and failed legislation.

II. Background

Hidden in the southwest corner of South Dakota lies Pine Ridge Indian Reservation. The land contains a mix of prairie that contrasts with badlands and bluffs. The prairie gives way to the Black Hills (Paha Sapa) and extends out to Badlands National Park, situating this desolated area of land between two premier tourist destinations. Tucked away from most routes that carry the millions of travelers into the Black Hills each year are the people of the Oglala Lakota Nation.²¹

A. Oglala Lakota Demographics

Today, Oglala Lakota County remains unorganized.²² The county does not have an official county seat but contracts with Fall River County for its administrative operations.²³ The county's largest community is Pine Ridge. The entirety of Oglala Lakota County is within the borders of the Pine Ridge Indian Reservation and contains

²⁰ The UN has not adopted an official definition of "indigenous," but the system has developed a modern understanding of the term based on the following: self-identification; historical continuity with pre-colonial; strong link to territories and surrounding natural resources; distinct social, economic and political systems; distinct language, culture and beliefs form non-dominant groups of society, and resolves to maintain and reproduce their ancestral environments. *See Factsheet: Who Are Indigenous Peoples?* U.N. PERMANENT F. ON INDIGENOUS ISSUES, https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf (last visited Feb. 12, 2021).

²¹ *See Understanding the Great Sioux Nation*, AKTA LAKOTA MUSEUM & CULTURAL CENTER, <http://aktalakota.stjo.org/site/News2?page=newsArticle&id=9017> (last visited Feb. 12, 2021). The Oglala Lakota are part of a larger nation of American Indians, the Oceti Sakowin (the Seven Council Fires). Within the Oceti Sakowin, there are three tribal divisions: the Dakota, the Nakota, and the Lakota. Within those divisions are different bands that make up the western division. *See id.*

²² *See* OGLALA LAKOTA COUNTY, SOUTH DAKOTA, <https://oglalalakota.sdcounties.org/> (last visited Feb. 12, 2021).

In 2015, the county changed their name from Shannon County to Oglala Lakota County. *Id.*

²³ *Id.*

part of the Badlands National Park²⁴; it is South Dakota's only dry county.²⁵

Today, the total land area of the reservation is 2.1 million acres, with 1.7 million acres held in trust by the United States government.²⁶ Those who live on the reservation have the lowest life expectancy in the United States, with men and women having an average life expectancy of forty-seven years and fifty-five years, respectively.²⁷ Oglala Lakota County has one of the lowest per capita incomes in the country and consistently ranks within the top five poorest counties in the nation.²⁸ Additionally, this county ranked last in the state of South Dakota for quality of life and health behaviors.²⁹

The population from the 2010 U.S. Census recorded 18,834 individuals living on Pine Ridge Reservation; the South Dakota Department of Tribal Relations reported a total tribal enrollment of 38,332, with 19,639 living on the reservation.³⁰ 42.4% of the population

²⁴ *Id.*

²⁵ See Evan Comen, *These 9 States Still Have Dry Counties*, 24/7 WALL ST, <https://247wallst.com/special-report/2019/12/12/states-that-still-have-dry-counties/3/> (last updated Mar. 20, 2020). Previously, more than 3.5 million cans of beer (12,329 cans a day) were sold annually in White Clay, Nebraska, across the border, 4 miles from the reservation. Whiteclay has six or seven residents and primarily served as a beer store for those on the reservation. White Clay lost their liquor license on April 19, 2017, with the Nebraska Liquor Control commission citing the lack of adequate law enforcement and an increase in the number of assaults that have happened there. See Paul Hammel, *Dry for a Year, Whiteclay Has Cleaned Up. But Some Alcohol Problems Have Moved Elsewhere*, OMAHA WORLD-HERALD (May 1, 2018), https://www.omaha.com/news/nebraska/dry-for-a-year-whiteclay-has-cleaned-up-but-some/article_ccf057c7-d9f1-5661-aaad-23b8ccd15b74.html.

²⁶ *Pine Ridge Indian Reservation*, *supra* note 18 (stating by land area it is the seventh largest in the United States).

²⁷ *Id.* (reporting that this is the second lowest life expectancy in the western hemisphere, behind Haiti).

²⁸ *Id.* (reporting that per capita income is \$7,773; per capita income for all reservations is \$10,543; and the US average is \$27,599).

²⁹ *Id.*

³⁰ *Id.* The total population of Pine Ridge is difficult to accurately calculate, due to its enormous area and the remoteness of many houses and settlements. Residents may also intentionally avoid participation for fear of violating Housing and Urban Development Regulations. Estimates have put the total upwards of 30,000. See Joseph Stromberg, *Lands of the Lakota: Policy, Culture, and Land Use on the Pine Ridge Reservation* 39 (2010) (senior honors thesis, Washington University in St. Louis) (on file with author).

is identified as being younger than twenty years old.³¹ 19.8% of the population is identified as being older than fifty years old.³²

In 2005, the Department of the Interior reported an 89% unemployment rate for the tribe, with only 3,131 people employed, and a total of 12% of the residents having earned a bachelor's degree.³³ Pine Ridge High School has an enrollment of 295, with average daily attendance at 50%. The school drop-out rate is over 70%.³⁴ Only 28.7% of the population on Pine Ridge Reservation reports having attained a high school diploma, GED, or alternative.³⁵

Oglala Lakota County ranked fifty-ninth out of sixty counties in South Dakota for overall health outcomes in 2017.³⁶ One in four children born on Pine Ridge are diagnosed with either Fetal Alcohol Syndrome or Fetal Alcohol Spectrum Disorder.³⁷ The Oglala Lakota Sioux Tribe is disproportionately affected when it comes to health outcomes. Some striking statistics include these facts: they are 800% more likely to develop Tuberculosis than Americans as a whole; they have a 300% higher rate of infant mortality than Americans as a whole; they have 150% higher rates of teen suicide than America as a whole; 85% of Lakota families are affected by alcoholism; 58% of grandparents of Lakota families are raising their grandchildren; 50% of Lakota adults over the age of forty have diabetes; and they are 420% more likely to develop diabetes than Americans as a whole.³⁸

The Pine Ridge Health Service Unit under Indian Health Services has one hospital, the Pine Ridge Hospital; two health centers, Kyle Health Center and Wanblee Health Center; and two health stations, Manderson and Lacreek.³⁹ The Pine Ridge Hospital serves more than 17,000 Lakota. There are forty-five beds and sixteen physicians, making

³¹ *The Housing Crisis on Pine Ridge*, INDIGENOUS GENERATIONAL HOUSING, <https://www.olceri.org/indigenous-generational-housing> (last visited Feb. 12, 2021) (comparing the tribal demographics with the state of South Dakota's demographics which show that overall, 27.8% of South Dakotans are younger than twenty years old).

³² *Pine Ridge Indian Reservation*, *supra* note 18 (comparing the tribal demographics with the state of South Dakota's demographics which show that overall, 33.8% of South Dakotans are older than twenty years old).

³³ *The Lakota Today*, OUR STORY, OUR SUCCESS, WICHÓOYAKE NA WÓOKIHI UDKÍTHAWAPI KID, <https://www.redcloudschool.org/page.aspx?pid=474> (last visited Feb 12, 2021).

³⁴ *Pine Ridge Indian Reservation*, *supra* note 18.

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Pine Ridge Service Unit*, U.S. DEP'T OF HEALTH & HUM. SERVS., INDIAN HEALTH SERV., <https://www.ihs.gov/greatplains/healthcarefacilities/pineridge/> (last visited Jan. 14, 2021).

it the largest hospital in the Great Plains Area.⁴⁰ Kyle Health Center is an ambulatory care center with outpatient services, located fifty miles east of Pine Ridge and has 14.5 providers available.⁴¹ Wanblee Health Center is located forty miles northeast of Kyle and ninety miles from Pine Ridge Hospital. The center is located on the eastern edge of the Pine Ridge Reservation and is classified as a business occupancy ambulatory outpatient health care facility.⁴² The healthcare is administered by the Indian Health Services; this arrangement came to be through a series of broken treaties and pieces of legislation.⁴³

III. Historical Significance

Even before the use of treaties, the United States Constitution's commerce and treaty clauses specifically addressed the federal government's primary role in dealing with Indians. Supreme Court cases, such as *Cherokee Nation v. Georgia*, specifically addressed the relationship between tribes, states, and the federal government.⁴⁴ Out of this case and others, the guardian/ward relationship that forms the basis of the trust relationship was created. As white settlers pushed west onto Sioux lands, multiple treaties were made and broken, with the Sioux retaliating, resulting in three major wars and numerous other battles and conflicts.⁴⁵ In 1851, the first Fort Laramie Treaty was signed between

⁴⁰ *Id.*

⁴¹ *Pine Ridge Service Unit*, *supra* note 39.

⁴² *Id.* Business Occupancy is a designation that can apply outpatient clinics, ambulatory care centers, and other medical facilities. The designation "ambulatory outpatient health care facility" means that in an emergency situation, the facility provides anesthesia or other treatment that leaves the patient unable to care for himself. *Ambulatory Care Occupancy or Business – What's the Difference*, MADISON MEDICAL CONSTR. CORP. (Nov. 18, 2013), <http://www.madisonmedicalconstruction.com/ambulatory-care-occupancy-or-business-whats-the-difference/>.

⁴³ See *Basis for Health Services*, U.S. DEP'T OF HEALTH & HUM. SERVS., INDIAN HEALTH SERV. (JAN. 2015), <https://www.ihs.gov/newsroom/factsheets/basisforhealthservices/>.

⁴⁴ *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). The Cherokees brought an original action in the Supreme Court against Georgia. The ability of the tribe to bring such a suit depended on it being a "foreign state" within the meaning of Art. II, Sec. 2 of the Constitution. Supreme Court Chief Justice Marshall, found that the tribe had succeeded in demonstrating that it was a "state", "a distinct political society separated from others, capable of managing its own affairs and governing itself," and that the treaties between the tribe and the United States had so recognized it; but determined that tribes could not be considered "foreign" states, characterizing the tribes as "domestic dependent nations." *Id.* at 61-62.

⁴⁵ *The Indian Wars and the Battle of Little Bighorn*, KHAN ACADEMY, <https://www.khanacademy.org/humanities/us-history/the-gilded-age/american-west/a/indian-wars> (last visited Feb. 12, 2021).

the Sioux and the U.S. Government.⁴⁶ The treaty defined boundaries between Indian Tribes of the Great Plains and granted the government the right to build a road through the area.⁴⁷ In exchange for the U.S. acknowledging the Sioux's sovereign rights to the Black Hills and annual federal payments of \$50,000 for 50 years to the tribes along with food provisions and livestock, the Sioux agreed to safe passage of white settlers across the territories.⁴⁸ Not even a year later, the U.S. violated the 1851 Treaty when the U.S. Senate decreased the payment of \$50,000 to the Sioux people from fifty to ten years.⁴⁹ In 1862, "the US began building the Bozeman Trail through Sioux Territory as well as army forts along the trail – both actions in direct contradiction of the 1851 Fort Laramie Treaty."⁵⁰

A. Fort Laramie Treaty of 1868

In June of 1866, Chief Red Cloud and other chiefs met with Army officers at Fort Laramie to discuss the Bozeman Trail.⁵¹ While some of the chiefs signed a non-aggression treaty, Red Cloud left to prepare for war.⁵² What resulted was the most successful war against the United States ever fought by an Indian nation.⁵³ Red Cloud's strategies were so successful that in 1868, the U.S. Government agreed to the Fort Laramie Treaty.⁵⁴ The Treaty acknowledged the tribe's sovereign status

⁴⁶ WILLIAM C. CANBY, *AMERICAN INDIAN LAW IN A NUT SHELL*, (5th ed., West 2009); *See Johnson v. M'Intosh*, 21 U.S. 543, 573 (1823) (The Supreme Court laid down the doctrine of aboriginal title and the Doctrine of Discovery; discovery of new lands gave the discovering European sovereign a title good against all other Europeans, and along with it "the sole right of acquiring the sole from natives." The Indians retained their right of occupancy, which only the discovering sovereign could extinguish either by purchase or by conquest. This ruling recognized the legal right of Indians in their lands against third parties, but existing at the toleration of the federal government).

⁴⁷ Stromberg, *supra* note 30, at 9-10 (referring to the area being the western half of present-day South Dakota, as well as parts of Nebraska, Wyoming, Montana, and North Dakota).

⁴⁸ Gayle Olson-Raymer, *The Federal Government and the Lakota Sioux*, HUMBOLDT STATE, <http://users.humboldt.edu/ogayle/sed741/lakota.html> (last visited Feb. 12, 2021).

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ During the Treaty of 1851, Red Cloud was chosen as the head chief for the Oglala Lakota. *See Red Cloud, New Perspectives on the West*, PBS (2001), https://www.pbs.org/weta/thewest/people/i_r/redcloud.htm.

⁵² *Id.* Chief Red Cloud is marked as one of the most important Lakota leaders of the nineteenth century. His mother was Oglala and his father was a Brule. He gained prominence within the Lakota nation for his leadership in territorial wars against the Pawnees, Crows, Utes, and Shoshones. *Id.*

⁵³ *See Red Cloud, supra* note 51 (finding that Red Cloud launched a series of assaults on the forts, included handing a crushing defeat to Lieutenant Colonel William Fetterman's eighty men); *see also* Olson-Raymer, *supra* note 48 (discussing the 1868 Treaty and the preceding battles).

⁵⁴ *Red Cloud, supra* note 51.

and established boundaries again for the Great Sioux Reservation, further reducing the land but still encompassing the western present-day South Dakota that contained the Black Hills.⁵⁵ Article 13 stated, “The United States hereby agrees to furnish annually to the Indians the physician, teachers, carpenter . . . and that such appropriations shall be made from time to time, on the estimate of the Secretary of the Interior, as will be sufficient to employ such persons.”⁵⁶ The tribe was also promised rights in the areas outside of South Dakota that had been part of the 1851 Treaty. Again, the government promised rations, cattle, and annuity payments in exchange for the Oglala Lakota’s halting attacks on military personnel and ceding land.⁵⁷

In 1874, gold was discovered in the Black Hills.⁵⁸ The Allison Commission was sent to purchase the area for \$5 million from the Oglala Lakota, but the Tribe refused.⁵⁹ In response, Congress disregarded the 1868 Treaty, allowing for settlement in the Black Hills. Furthering their retaliation for refusal, Congress cut off rations until the Black Hills were ceded.⁶⁰ The intensified awareness of white encroachment as well as the federal government’s willingness to break treaties led to the Great Sioux War of 1876-1877.⁶¹ In an attempt to obtain an agreement that would cede the Black Hills, U.S. soldiers used violence, alcohol, and

⁵⁵ Fort Laramie Treaty of 1868, art. 2, U.S.-Sioux Nation of Indians, Apr. 29, 1868, 15 Stat. 649. The treaty stated: “absolute and undisturbed use of the Great Sioux Reservation...No persons...shall ever be permitted to pass over, settle upon, or reside in territory described in this article, or without the consent of the Indian...No treaty for the cession of any portion or part of the reservation here in described...shall be of any validity of force...unless executed and signed by at least three-fourths of all male Indians, occupying or interested in the same.” *Id.* See also Olson-Raymer, *supra* note 48; Stromberg, *supra* note 30, at 10.

⁵⁶ Fort Laramie Treaty of 1868, art. 13, April 29, 1868, U.S.-Sioux Nation of Indians.

⁵⁷ See Stromberg, *supra* note 30, at 10 (citing MARLA POWERS, OGLALA WOMEN: MYTH, RITUAL AND REALITY (1986)).

The rations were promised for the loss of the tribe’s previous food base, which was the upper Great Plains as a whole; these rations were promised until the tribe could support itself agriculturally. *Id.*

⁵⁸ The Lakota have an intimate relationship with the Black Hills, deeply connected through stories that demonstrate the sacredness of the land. It is inherent in Lakota spiritual and cultural understanding that this land holds infinite significance, and thus the obligation of the people of the earth to protect and preserve its sanctity. Justine Epstein, *Black Hills – Stories of the Sacred*, COLORADO COLL. (Nov. 2012), <http://sites.coloradocollege.edu/indigenoustraditions/sacred-lands/the-black-hills-the-stories-of-the-sacred/>.

⁵⁹ Stromberg, *supra* note 30, at 11.

⁶⁰ *Id.*

⁶¹ *Id.*

incomplete translation to coerce 10% of adult males to sign the petition. Congress enacted this treaty into law as the Black Hills Act of 1877.⁶²

B. The Black Hills and Dawes Act

The Black Hills Act took 7.7 million acres away from the Lakota Sioux.⁶³ The Act established a permanent reservation that excluded the entirety of the Black Hills and marked a transition from military to procedural instruments for taking land.⁶⁴ As part of The Act, the Office of Indian Affairs (OIA), an agency within the Department of Interior, was charged with overseeing all reservations.⁶⁵ The OIA had wardship giving them power over every possession the Oglala Lakota had, including their lands. Rations were leveraged to obtain compliance with policies.⁶⁶ Eradication of culture and forced assimilation took many forms. Oglala Lakota were *encouraged* to wear white people's dress styles and live in log houses instead of tipis.⁶⁷ Traditional dances and ceremonies became punishable offenses.⁶⁸ Many children were sent to boarding schools where their traditional hair and clothing were forcibly removed, and speaking Lakota was forbidden. These schools emphasized manual labor rather than academic training while working alongside OIA in forcibly assimilating children.⁶⁹

As part of the assimilation effort Congress passed the General Allotment Act, or the Dawes Act. The act provided that "each [native] family would receive 160 acres of tribal land and each single person

⁶² See Olson-Raymer, *supra* note 48; see also Stromberg, *supra* note 30, at 11. This designation opened the land up to white settlement and divided the Lakota into five separate reservations: Standing Rock, Cheyenne River, Pine Ridge, and Upper and Lower Brule. Any Native Americans who refused to be confined to reservations were declared "hostile" while the surplus land was available for public purchase for white ranchers and homesteaders. Olson-Raymer, *supra* note 48.

⁶³ This action rested on the discovery doctrine. See Stromberg, *supra* note 30 at 11. The discovery doctrine was affirmed in *Johnson v. M'Intosh*, 21 U.S. 543 (1823)..

⁶⁴ Stromberg, *supra* note 30, at 11.

⁶⁵ *Id.* at 12. As a whole, the OIA's early relationship with the Oglala Lakota was defined by paternalism, prejudice, and direct rule, stemming from the precedent that Native Americans were "wards" of the states, incapable of fending for themselves. OIA was tasked with "helping them to walk the road to progress." It placed Natives into a category with juveniles and mental incompetents. *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.* at 13.

⁶⁸ *Id.* at 13-14.

⁶⁹ *Id.* at 14; see also MARLA POWERS, OGLALA WOMEN: MYTH, RITUAL AND REALITY 117 (1986); JAMES V. FENELON, CULTURICIDE, RESISTANCE, AND SURVIVAL OF THE LAKOTA ("SIOUX NATION") (1998).

would receive 80 acres.”⁷⁰ Supporters of the Dawes Act saw the assimilation practice as “an alternative to the extinction of [Native Americans].”⁷¹ In reality, however, it was an attempt to eradicate the collective use of land that the supporters viewed as communistic and backwards. Individual ownership of private property was argued to be an essential part of civilization that would give Native Americans a reason to stay in one place, cultivate land, disregard the cohesiveness of the tribe, and adopt the habits, practices, and interests of the American settler population.⁷² President Cleveland authorized the act, which included a provision allowing that if the amount of reservation land exceed the amount needed for allotment, the federal government could negotiate to purchase the land from the tribes and sell it to non-Indian settlers.⁷³ “As a result, 60 million acres were either ceded outright or sold to the government for non-Indian homesteaders and corporations as ‘surplus lands.’”⁷⁴

C. Snyder Act through Present Day

In 1921, Congress passed the Snyder Act (25 U.S.C. § 13). This act authorized “funds for ‘the relief of distress and conservation of health’ among American Indians. The act defines the government’s responsibility for American Indian health care and is one of several legislative reforms [that was passed] to improve the living conditions . .

⁷⁰*History and Culture: Allotment Act – 1887*, AM. INDIAN RELIEF COUNCIL, http://www.nativepartnership.org/site/PageServer?pagename=airc_hist_allotmentact (last visited Feb. 12, 2021).

⁷¹ *Id.*

⁷² *See Land Tenure History*, INDIAN LAND TENURE FOUND., <https://iltf.org/land-issues/history/> (last visited Feb. 12, 2021). It has been argued that many people simply thought Native Americans had too much land and “they were eager to see [Native American] lands opened up for settlement as well as for railroads, mining, forestry, and other industries.” *Id.*

⁷³ *Id.*

⁷⁴ *Id.* Indian land ownership differed from white ownership; while whites had complete fee simple ownership, enabling them to sell or alienate their land, under the Dawes Act, Indian allottees were declared “incompetent” to handle their land affairs. The United States retained legal title and acted as trustee, leaving Indian landowners with only beneficial title, enabling those owners to simply use the land, but not lease it or sell it without the government’s permission. *Id.* Today, there are still issues on reservations regarding access to capital through collateral loans. Since they do not technically own their land, they have little resources to be able to access a loan. *See* Monica Pickering & Kathleen Terkildsen, *The Lakota Fund: Local Institutions & Access to Credit*, CULTURAL SURVIVAL Q. MAG. (Sept. 2001), <https://www.culturalsurvival.org/publications/cultural-survival-quarterly/lakota-fund-local-institutions-access-credit>.

. on reservations and in government boarding schools.”⁷⁵ The Snyder Act provided discretionary funding for American Indian healthcare. Up until the mid-Twentieth century, American Indian healthcare was provided with a hodgepodge of resources including the War Department, the U.S. Public Health Service, the Bureau of Indian Affairs, and starting in 1955, the Indian Health Services.⁷⁶ The Indian Healthcare Improvement Act (IHCA) of 1976 followed the Snyder Act, allowing the reimbursement by “Medicare and Medicaid for services provided to American Indians and Alaska Natives [(AI/AN)] in Indian Health Services (IHS) and tribal health facilities.”⁷⁷ IHCA became the legal cornerstone authority for the provision of healthcare to AI/AN and was made permanent as part of the Affordable Care Act, signed by President Obama in 2010.⁷⁸ “The federal government has historically invested some measure of resources in Native American healthcare,” as well as promulgated numerous laws, court cases, and Executive Orders that reaffirm the unique relationship between tribal governments and the federal government and create legal and economic precedent for continuing responsibility.⁷⁹

The U.S. has iterated multiple times that American Indians have the right to health and has also described the conditions for health, which include the “explicit right to medical care as outlined in treaties between the U.S. and individual tribal nations”⁸⁰ Despite this, “the United States has failed to adequately address the health needs of Native

⁷⁵1921: *Congress Funds American Indian Health Care*, NATIVE VOICES, <https://www.nlm.nih.gov/nativevoices/timeline/427.html> (last visited Feb. 12, 2021). American Indians were not granted citizenship until 1924. There was public sympathy for Native Americans after their combat service in WWI. Congress’s intent in granting citizenship remained multipurposed: assimilate tribal identities into mainstream culture, and, as much as granting citizenship seemed to be an attempt to protect and expand Indian rights, eventually do away with tribal identities. Many states kept most Indians from voting for twenty-five years more, or longer. It was not until Congress passed the Voting Rights Act in 1965, that voting rights were secured nationwide. Johanna Wickman, *Touring the Reservations: The 1912 American Indian Citizenship Expedition*, WYOHISTORY.ORG (Aug. 19, 2018), <https://www.wyohistory.org/encyclopedia/touring-reservations-1913-american-indian-citizenship-expedition>.

⁷⁶ Barbara Gurr, *The Failures and Possibilities of a Human Rights Approach to Secure Native American Women’s Reproductive Justice* 7 SOCIETIES WITHOUT BORDERS 1, 8-9 (2012).

⁷⁷*Indian Health Care Improvement Act*, MEDICAID.GOV, <https://www.medicare.gov/medicaid/indian-health-and-medicare/improvement-act/index.html> (last visited Feb. 12, 2021). The Act recognized that many Indian people were eligible for but could not access Medicaid and Medicare services without traveling, sometimes hundreds of miles, to Medicaid and Medicare providers off reservations. *Id.*

⁷⁸ *Id.*

⁷⁹ Gurr, *supra* note 76, at 8.

⁸⁰ *Id.* at 9 (citing MAZE OF INJUSTICE, AMNESTY INTERNATIONAL (2007)).

communities, and at times actively participates in the production of these health needs.”⁸¹ There still exists a belief that AI/AN are not citizens of their states, making them ineligible for state programs and benefits. This is an inaccurate belief, as they are citizens of the United States and eligible to participate in many public, private, and state health programs available to the general population.⁸²

Healthcare remains a concern for Oglala Lakota, with only 7% having any type of private medical insurance.⁸³ Funding remains a primary explanation for lack of adequate care – the IHS’s annual funding per person is roughly \$2000, less than half of what is designated for federal prisoners.⁸⁴ Because the hospital cannot provide all the services that are needed, IHS enters into Contract Health Services: services that are performed at off-reservation hospitals. However, due to the IHS’s limited funding, patients are often denied care at the reservation hospital, or if they are given care, they are later asked to pay the entire bill.⁸⁵ Those who do access services on the reservation are often met with racial discrimination from health care providers and staff.⁸⁶

The Aberdeen Area of IHS, which includes Pine Ridge Health Services, defines reasonable access to a health facility as a two to three hour drive.⁸⁷ Oglala Lakota County remains the second poorest county in the United States; meaning “access to private transportation may be limited and [off reservation] public transportation non-existent, thereby rendering a distance of two to three hours virtually inaccessible.”⁸⁸ Similar to many other IHS Areas, Pine Ridge Health Service Unit is “severely understaffed” and the doctors that are there are often gone in

⁸¹ *Id.* (citing MAZE OF INJUSTICE, AMNESTY INTERNATIONAL (2007)).

⁸² *Legislation*, U.S. DEP’T OF HEALTH & HUM. SERVS, INDIAN HEALTH SERV., <https://www.ihs.gov/aboutihs/legislation/> (last visited Jan. 13, 2021).

⁸³ Telephone Interview with Lakota Elder, Oglala Lakota Tribe (Mar. 18, 2019) (transcript on file with author). This can create a barrier of access: those who get a prescription from an outside IHS provider cannot have it filled at the IHS facility, requiring at least a 120-mile trip to pick up a prescription.

⁸⁴ Stromberg, *supra* note 30, at 45.

⁸⁵ *Id.* In addition, off reservation health care services are either in Rapid City or Sioux Falls, a 120-mile trip or a 300-mile trip one way to see a doctor. *See* Telephone Interview with Lakota Elder, *supra* note 83.

⁸⁶ Stromberg, *supra* note 30, at 45. (citing Kathleen Pickering & Bethany Mizushima, *Lakota Health Care Access and the Perpetuation of Poverty on Pine Ridge*, in THE ECONOMICS OF HEALTH AND WELLNESS: ANTHROPOLOGICAL PERSPECTIVES 11, 26 (2008)) (finding that over 24% have reported racial discrimination when seeking healthcare at an IHS facility).

⁸⁷ Gurr, *supra* note 76, at 10.

⁸⁸ *Id.*

a year or two making it: (1) difficult to see a doctor and (2) difficult to establish a long term relationship with a healthcare provider.⁸⁹

These problems are not unique to Pine Ridge Health Services or the Oglala Lakota. The next section will turn to American Indian and Alaska Native health challenges that persist across the US and then briefly touch on global issues, before focusing on Article 12 of the International Covenant on Economic, Social and Cultural Rights. Finally, after setting this foundation, the article will analyze the violations of the right to health of the Oglala Lakota.

IV. Indigenous Peoples' Health in the United States

“The appropriation and displacement of [American Indians] . . . and their subsequent marginalization from the rest of society is a historical reality with continuing repercussions today in the [United States].”⁹⁰ Social inequalities have resulted from a combination of ongoing socioeconomic deficits, including colonialization, globalization, migration, and disconnection from the land, as well as loss of language and culture.⁹¹ The severance of ties to their land, has impacted indigenous peoples' associated cultural practices and participation in traditional economics, all of which are essential for health and well-being.⁹² One of the lasting consequences of colonialism was the forced assimilation policy that included the “removal of indigenous children from their families to place them in government or church-run boarding schools,” with the sole purpose of erasing their indigenous activities.⁹³ What became known as Indian Boarding schools started in the 1880s and continued well into the mid-1900s, leaving a trail of “emotional, physical, and sexual abuse.”⁹⁴ The effects of boarding schools on generations of indigenous children cuts deep into

⁸⁹ *Id.*

⁹⁰ U.N. DEP'T ECON. & SOCIAL AFFS., *Access to Health Services By Indigenous Peoples in North America*, in STATE OF THE WORLD'S INDIGENOUS PEOPLES 105, 112 (2009) (citing Carolyn Stephens, John Porter, Cliv Nettleton & Ruth Willis, *Disappearing, Displaced and Undervalued: A Call to Action for Indigenous Health Worldwide*, 367 THE LANCET 2023 (2006)).

⁹¹ *Id.* (citing Malcolm King, Alexandra Smith & Michael Gracey, *Indigenous Health Part 2: The Underlying Causes of the Health Gap*, 374 THE LANCET 76 (2009)).

⁹² *Id.*

⁹³ James Anaya (Special Rapporteur on the Rights of Indigenous Peoples), U.N. DOC. A/HRC/21/47/Add.1., at 12 (Aug. 30, 2012). [hereinafter Rep. of the Special Rapporteur].

⁹⁴ *Id.* Incidences were reported of punishment for children speaking their languages or practicing their cultures. *Id.* at 13.

the identity of indigenous communities.⁹⁵ “Negative memories of this institutionalization are thought to have created a social climate of distrust of other government-funded institutions such as hospitals and clinics, resulting in avoidance until an illness is advanced.”⁹⁶

The report on Indigenous Peoples’ Health found the challenges for indigenous peoples in the United States are: “(1) take control of their own personal health to achieve balance in life; (2) assume authority and control over health and social services which impact their lives; and (3) design and implement a sustainable health system which meets their unique needs.”⁹⁷ Today, the United States recognizes and maintains what it refers to as government-to-government relations with 573 American Indian and Alaskan native tribes, with about 230 being Alaskan native groups.⁹⁸ Federally recognized tribes have reservations or other lands that have been left to them, over which tribes exercise their own powers of self-government.⁹⁹ The 2010 Census, reported “5.2 million people in the United States identified as American Indian [or] Alaska Native.”¹⁰⁰

While tribes have their own powers of self-government, the United States Federal Government has the responsibility for indigenous peoples’ health for individuals that meet the national registration criteria.¹⁰¹ While in theory this is what happens, in reality there is jurisdictional ambiguity and a lack of clarity of the respective roles and responsibilities between the federal and state governments for health and social services to indigenous peoples in North America.¹⁰²

⁹⁵ *Id.* Many believe that these boarding schools are the root cause of pervasive social problems such as alcoholism and sexual abuse and the widespread loss of language. *Id.*

⁹⁶ U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 112.

⁹⁷ Secretariat of the U.N. Permanent F. on Indigenous Issues, *Introduction to U.N. DEP’T ECON. & SOCIAL AFFS., STATE OF THE WORLD’S INDIGENOUS PEOPLES 1, 7* (2009).

⁹⁸ U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 106; *see also About IHS, INDIAN HEALTH SERVICES*, <https://www.ihs.gov/aboutihs/> (last visited Jan. 13, 2021).

⁹⁹ Rep. of the Special Rapporteur, *supra* note 93, at 5. It should be noted that the land “left” to them is land that was “given” to them after the government stole their lands. *Id.*

¹⁰⁰ TINA NORRIS, PAULA VINES & ELIZABETH HOEFFEL, *THE AMERICAN INDIAN AND ALASKA NATIVE POPULATION: 2010, 1* (2012).

¹⁰¹ *Frequently Asked Question*, ASS’N OF AM. INDIAN AFFS. (2006), <https://www.indian-affairs.org/general-faq.html>. Most of the tribes determine their own membership criteria; with most still requiring blood quantum levels to be recognized. Blood quantum is the amount of Native American blood that one possesses. While not addressed in this paper, some argue that it’s a continued form of colonialization. *Id.*

¹⁰² This ambiguity can happen for those who move off the reservation. But also, for those on the reservation who are trying to access services off the reservation, some states have limitations on who can access their Medicaid plans, and this can leave American Indians in coverage gaps if the service is not provided for at an Indian Health Service. *See generally* Stephen Cornell, *Indigenous Peoples*,

A. Indian Health Services

The United States Government commissions the Indian Health Services (IHS), an agency within the Department of Health and Human Services, to provide services to members of the 573 federally recognized tribes.¹⁰³ The relationship between the federal government and American Indian Tribes was established in 1787 and is based on Article 1, Section 8 of the Constitution. In addition to the Constitution, the guarantee of health services to tribes has been given shape and substance by numerous treaties, laws, Supreme Court Decisions and Executive Orders.”¹⁰⁴ The IHS is the principal federal health care provider for approximately 2.3 million American Indians and Alaska Natives in 37 states, with the majority of those living mainly on reservations and in rural communities.¹⁰⁵ Since 1972, IHS has expanded their initiative to fund health-related activities at off-reservation settings, in an attempt to make health care services accessible to urban Native Americans. IHS funds thirty-three urban health organizations and serves approximately 600,000 American Indians and Alaska Natives.¹⁰⁶ The services provided include “medical services, dental services . . . alcohol and drug abuse prevention, education and treatment, AIDS and sexually transmitted disease education and prevention services, mental health services, nutrition education and counselling services, pharmacy services, health education . . . and home health care.”¹⁰⁷

B. Disease Burden

Tribes of the United States are “diverse and geographically dispersed,” with the “large majority being economically disadvantaged.”¹⁰⁸ “Disease patterns among [Native Americans] are strongly associated with the adverse consequences of poverty, limited

Poverty and Self-Determination in Australia, New Zealand, Canada and the United States, JOINT OCCASIONAL PAPERS ON NATIVE AFFS., Jan. 2006.

¹⁰³ *About IHS*, *supra* note 99.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 111.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at 113.

access to health services, and cultural dislocation.”¹⁰⁹ Compounding these factors are “[i]nadequate education, high rates of unemployment, discrimination, and cultural differences” that all “contribute to unhealthy lifestyles and disparities in access to health care” for many American Indian/Alaska Natives (AI/AN).¹¹⁰ Although the United States Congress has appropriated funding for the provision of health care services to AI/AN populations, these individuals suffer from a disproportionate share of illness and disease.¹¹¹ While incidence and prevalence of infectious diseases have been decreasing as a result of clinical care and public health efforts, the chronic disease burden is substantially increasing, and threats such as diabetes, liver cirrhosis, heart disease, and other chronic conditions plague the population. Both communicable and non-communicable disease rates are experienced at a higher rate than by the rest of the population.¹¹² The data provided by Indian Health Services shows enormous health issues for AI/AN.¹¹³ Figure 1 shows the “Mortality Disparity Rates for American Indians and Alaska Natives in the IHS 2009-2011 and all US Races 2010.”

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Disparities*, US DEP’T OF HEALTH & HUM. SERVS., INDIAN HEALTH SERV. (Oct. 2019), <https://www.ihs.gov/newsroom/factsheets/disparities/>. American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellites, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease. *Id.*

¹¹³ *Id.*

	AI/AN Rate 2009-2011	U.S. All Races Rate – 2010	Ratio: AI/AN to U.S. All Races
ALL CAUSES*	999.1	747.0	1.3
Diseases of the heart (heart disease)	194.1	179.1	1.1
Malignant neoplasm (cancer)	178.4	172.8	1.0
Accidents (unintentional injuries)*	93.7	38.0	2.5
Diabetes mellitus (diabetes)	66.0	20.8	3.2
Alcohol-induced	50.5	7.6	6.6
Chronic lower respiratory diseases	46.6	42.2	1.1
Cerebrovascular disease (stroke)	43.6	39.1	1.1
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Influenza and pneumonia	26.6	15.1	1.8
Drug-induced	23.4	12.9	1.8
Nephritis, nephrotic syndrome (kidney disease)	22.4	15.3	1.5
Intentional self-harm (suicide)	20.4	12.1	1.7
Alzheimer's disease	18.3	25.1	0.7
Septicemia	17.3	10.6	1.6
Assault (homicide)	11.4	5.4	2.1
Essential hypertension diseases	9.0	8.0	1.1

Figure 1.¹¹⁴

The Indian Health Service has found that “[u]nintentional injuries are the leading cause of death among [AI/ANs] between the ages of 1 and 44 years and the third leading cause for all ages.”¹¹⁵ Injury mortality rates are 2.5 times greater than rates for other Americans.¹¹⁶ Unintentional injuries also include motor vehicle fatalities.¹¹⁷ AI/ANs have greater risk of fatal crashes than non-Natives, and they are at higher

¹¹⁴ *Id.*¹¹⁵ *Injuries*, US DEP’T OF HEALTH & HUM. SERVS., INDIAN HEALTH SERV. (2018), <https://www.ihs.gov/newsroom/factsheets/injuries/#1>.¹¹⁶ *Id.* (finding that unintentional injury is the “[f]ourth leading cause of death for infants . . . treatment costs = \$350 million per year . . . [and] 42% of years productive life lost for AI/ANs < 65 years old.”)¹¹⁷ U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 114.

risk of fatal single vehicle crashes than multiple vehicle crashes¹¹⁸ Some researchers also believe self-destruction and suicide could sometimes be to blame.¹¹⁹ “In some indigenous communities in North America, there are certain rituals and customs around death so suicide is regarded as taboo and as a result, suicides often go unreported or get classified by police as accidental death.”¹²⁰

One hundred years ago, chronic diseases such as diabetes were almost unheard of in AI/AN communities.¹²¹ In fact, “[a]s recently as 1955, diabetes was unrecognized as a leading cause of death [in AI/AN,] as evidenced by its absence in a listing of the 10 most frequent causes of death for this population.”¹²² With more than 16% of the AI/AN population diagnosed with diabetes, this group has the highest prevalence rate of all racial and ethnic groups in the United States.¹²³ Arizona’s Pima Indians suffer from “the highest rates of diabetes in the world, with more than 50% having a diagnosis of type 2 diabetes.”¹²⁴ Diabetes kills roughly four times as many AI/AN as it does members of the mainstream United States population.¹²⁵ As a result, “the mortality rate for AI/AN is growing faster than for the general U.S. population.”¹²⁶ Because of the disease burden, “IHS data show that [AI/AN] have a higher incidence of long-term complications of diabetes and that these problems develop earlier in life.”¹²⁷ Additionally, diabetes is a leading cause of disability in AI/AN communities, contributing to increased unemployment and poverty.¹²⁸ Cardiovascular disease (CVD) has

¹¹⁸ U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 115. (citing Philip A. May, *Suicide and Self-Destruction Among American Indian Youth*, 1 AM. INDIAN & ALASKA NATIVE MENTAL HEALTH RSCH. 68 (1987)).

¹¹⁹ *Id.*

¹²⁰ *Id.* More than 90 percent of all suicide cases are associated with mental health; however, it is much more likely to occur during periods of socioeconomic, family, and individual crisis.

See id. at 116 (citing Laurel Morales, *Native Americans Have Highest Rate of Suicide* (Aug. 31, 2012), <http://www.fronteraskdesk.org/content/native-americans-have-highest-rate-suicide>; JESSICA CRAIG & DEBORAH HULL-JILLY, CHARACTERISTICS OF SUICIDE AMONG ALASKA NATIVE AND ALASKA NON-NATIVE PEOPLE (2012)).

¹²¹ Sue McLaughlin, *Traditions and Diabetes Prevention: A Healthy Path for Native Americans*, 23 DIABETES SPECTRUM 272, 272 (2010).

¹²² *Id.*

¹²³ *Id.* (comparing the AI/AN percentage to 8.7% of non-Hispanic whites).

¹²⁴ *Id.*

¹²⁵ U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 116 (citing INDIAN HEALTH SERV., TRENDS IN INDIAN HEALTH, (2000-2001)).

¹²⁶ 62% for AI/ANs compared to 10% for the general U.S. population. *See* McLaughlin, *supra* note 124, at 273.

¹²⁷ *Id.*

¹²⁸ U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 116.

become the leading cause of death, and [AI/AN] with diabetes have a three to four times greater chance of developing CVD than AI/AN without the disease.¹²⁹ Diabetes has become “the leading cause of new blindness, end-stage renal disease, and lower-extremity amputation.”¹³⁰ Gestational diabetes is also an issue and occurs more frequently among AI/AN women than women in other minority groups.¹³¹ “Women who experience gestational diabetes have a 20 to 50 percent chance of developing type 2 diabetes in 5 to 10 years after pregnancy.”¹³² Their children are also at increased risk of developing type 2 diabetes.¹³³ Data from the IHS Diabetes Program between the years of 1990-2004 show a 160% increase in diagnosed diabetes for AI/AN’s between the ages of twenty-five and thirty-four years.¹³⁴ During this time there was a 77% increase for children less than fifteen years old with a 128% increase for those who were between fifteen and nineteen and a 94% increase for those twenty – twenty-four years old.¹³⁵

Diabetes is a disease that highlights how the social determinants of health are at play on reservations.¹³⁶ Policies that created reservations resulted in drastic lifestyle changes that continue to have profound negative health impact on health on AI/AN.¹³⁷ The prevalence of obesity in native populations is high, thereby increasing their risk for type 2 diabetes.¹³⁸ Nearly 70% of adult AI/ANs diagnosed with diabetes were obese.¹³⁹ Researchers have found that type 2 diabetes and obesity are caused primarily by behavioral and lifestyle factors, making them largely preventable.¹⁴⁰

It’s been estimated that native people expended more than 4,000 calories per day before being forced on reservations.¹⁴¹ This was done through hunting, foraging for food, and frequent native dances and powwows.¹⁴² The forced displacement onto reservations disrupted all

¹²⁹ See McLaughlin, *supra* note 124, at 273.

¹³⁰ *Id.*

¹³¹ *Id.* (citing *National Diabetes Fact Sheet: General Information and National Estimates on Diabetes in the United States*, CDC (2005), <http://www.cdc.gov/diabetes>).

¹³² U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 116.

¹³³ *Id.*

¹³⁴ McLaughlin, *supra* note 124, at 273.

¹³⁵ *Id.*

¹³⁶ See U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 114.

¹³⁷ See *id.* at 115.

¹³⁸ *Id.* at 116.

¹³⁹ *Id.*

¹⁴⁰ McLaughlin, *supra* note 124, at 273.

¹⁴¹ *Id.*

¹⁴² *Id.*

parts of their lives including restrictions on movements and their traditional hunting patterns.¹⁴³ Reservation life also brought about changes to their diet; food traditionally eaten before the reservation included wild game, berries, and root vegetables.¹⁴⁴ Today, the food consumption of many Northern Plains Indians is highly processed.¹⁴⁵ “Foods [consumed] are higher in fat—particularly saturated fat—and higher in sodium, added sugars, and dietary cholesterol, [while] fiber, vitamin, and mineral content has decreased dramatically.”¹⁴⁶ Often these dietary options are out of their control. Due to many factors—limited finances, lack of transportation, and many reservations being food deserts, many tribal members have limited access to grocery stores.¹⁴⁷ Convenience stores in small reservation communities often carry a large inventory of sodas, energy drinks, chips, and other snack foods and offer a paucity of high-quality fresh fruits and vegetables.¹⁴⁸ Until the systematic injustices are restructured, it is likely that diabetes and other diseases that feed off of social determinants of health will remain prevalent in AI/AN populations.

Native Americans and Alaska Natives continue to experience lower health status when compared with the rest of the population.¹⁴⁹ A multitude of factors (i.e., inadequate education, high rates of poverty, discrimination in delivery of health services, and cultural differences) can all lead to low life expectancy and a high disease burden for AI/AN.¹⁵⁰ “These are broad quality of life issues rooted in economic adversity and poor social conditions. . . .Despite inadequacies in the health care delivery system . . . the problems are entrenched in the history of relations between indigenous peoples and the nation state.”¹⁵¹ The recognition of the right to health care for indigenous peoples is urgently needed as the indigenous people’s health remains in crisis.¹⁵² Despite the monumental health challenges, indigenous peoples continue to demonstrate unparalleled resilience in the face of a system that continues to disenfranchise them.

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 273-74.

¹⁴⁵ *Id.* at 274.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*; see also Telephone Interview with Lakota Elder, *supra* note 83.

¹⁴⁹ See U.N. DEP’T ECON. & SOCIAL AFFS., *supra* note 90, at 127.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

V. Indigenous Peoples Health at the International Level

Both the United Nations Permanent Forum on Indigenous Issues and the World Health Organization have mandated health as an area of focus.¹⁵³ The United Nations Declaration on the Rights of Indigenous Peoples specifically address Indigenous peoples' right to health in Article 21(1), Article 23, Article 24(1), Article 24(2), and Article 29(3).¹⁵⁴ These rights include indigenous peoples' right to improve "their economic and social conditions in the area of health, with particular attention to the needs of indigenous elders, women, youth, children and persons with disabilities."¹⁵⁵ Expressed in the Articles is the right of indigenous peoples to determine and administer their health programs through their own institutions and maintain their traditional health practices.¹⁵⁶ It is important to note the rights recognized by the International Labour Organization (ILO) and their convention concerning Indigenous and Tribal Peoples. Article 3 of the ILO Convention 169, states that indigenous peoples must fully enjoy fundamental human rights without obstacles or discrimination.¹⁵⁷ Article 2 puts the responsibility on the government to ensure that all indigenous peoples have the same rights and opportunities as non-indigenous peoples.¹⁵⁸ Article 7 refers to the obligation that State parties have with

¹⁵³ Secretariat of the U.N. Permanent F. on Indigenous Issues, *supra* note 97, at 2. The WHO recognizes the right to health as a fundamental right in its constitution. *Id.*

¹⁵⁴ *Id.* See also G.A. Res. 61/295, Declaration on the Rights of Indigenous Peoples, arts. 21, 23, 24, 29 (Sept. 13, 2007) ("Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security."; "Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions."; "Indigenous peoples have the right to their traditional medicines and to maintain their health practices, include the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services."; "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view of achieving progressively the full realization of this rights."; "States shall also take effective measures to ensure, as needed, that programs for monitoring, maintaining, and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.").

¹⁵⁵ Secretariat of the U.N. Permanent F. on Indigenous Issues, *supra* note 97, at 1.

¹⁵⁶ G.A. Res. 61/295, *supra* note 159, arts. 23-24.

¹⁵⁷ INT'L LABOUR ORG. [ILO], *Indigenous and Tribal Peoples Convention* (no. 169), art. 3 (1989).

¹⁵⁸ *Id.* art. 2.

regard to the improvement of the conditions of life, work, levels of health, and education as a matter of priority in national plans.¹⁵⁹ Article 25 enumerates the obligations of states parties with regard to the right to social security and health which includes: the availability of health services to indigenous peoples; implementation of community-based services, which shall take into account traditional preventive care and healing practices and medicines; and the training of local community health workers.¹⁶⁰

When accessing public health systems, Indigenous peoples face obstacles such as “the lack of health facilities in indigenous communities and cultural differences with the health care providers such as difference in languages, illiteracy and lack of understanding of indigenous culture and traditional health care systems.”¹⁶¹ There is also an issue of lack of adequate health insurance and/or lack of economic capacity to pay for services.¹⁶² This creates a financial barrier to health care for indigenous peoples, even when health services are technically available.¹⁶³ The marginalization of indigenous peoples has resulted in their apprehension and aversion to participate in non-indigenous processes and systems at the community, municipal, state, and national levels.¹⁶⁴

Lack of data on indigenous peoples’ health and social conditions hinders efforts to solve this problem.¹⁶⁵ The existing data is often not disaggregated based on ethnicity or the geographic residency.¹⁶⁶ This gap results in a huge loss of information, analysis and evaluation of programs and services relating to indigenous peoples’ health situation.¹⁶⁷

“One of the important areas for health care for indigenous peoples lies in intercultural frameworks and models of care.”¹⁶⁸ In order to develop effective models of care and best practices, health care services should strive to be pluricultural. These programs must be

¹⁵⁹ *Id.* art. 7.

¹⁶⁰ *Id.* art. 25.

¹⁶¹ Secretariat of the U.N. Permanent F. on Indigenous Issues, *supra* note 97, at 3.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ Secretariat of the U.N. Permanent F. on Indigenous Issues, *supra* note 97, at 3.

¹⁶⁸ *Id.*

culturally and linguistically appropriate for indigenous peoples.¹⁶⁹ For this to happen, “indigenous peoples must be able to participate in the design and implementation of comprehensive health plans, policies and programmes.”¹⁷⁰ “Historically, indigenous peoples have suffered the impact of colonialization and assimilation policies as well as the imposition of foreign development models. Indigenous peoples continue to suffer discrimination in their own countries which has a major impact on their lives, in particular, their health.”¹⁷¹

VI. The Right to Health

“Health”, as first articulated in the 1946 Constitution of the World Health Organization, is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹⁷² The right to health is recognized in numerous international and regional instruments.¹⁷³ The Universal Declaration on Human Rights (UDHR) has the right to health in Article 25. “The International Convention of Economic, Social and Cultural Rights [ICESCR] provides the most comprehensive article on the right to health in human rights law.”¹⁷⁴ This information can be found in Article 12 of the covenant.¹⁷⁵ Unlike the WHO Constitution, the ICESCR acknowledges that the right to health is closely related and intertwined with a wide range of socio-economic factors that promote conditions in which people can lead a healthy life.¹⁷⁶ This section will focus on the Right to Health

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² WORLD HEALTH ORG. [WHO] CONST. (1946).

¹⁷³ U.N. ESCOR, Rep. of the Comm. on Econ., Social & Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, art. 12 ¶ 2, U.N. Doc. E/C.12/2000/4. (Aug. 11, 2000) [hereinafter *General Comment*].

¹⁷⁴ *Id.*

¹⁷⁵ See ICESCR, *supra* note 19, art. 12. Additionally, the right to health is found in article 5 of the International Convention on the Elimination of all Forms of Racial Discrimination of 1965; in articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women; article 24 of the Convention on the Rights of the Child; as well as several regional human rights instruments, including: article 11 of the African Charter on Human and Peoples’ Rights, the European Social Charter of 1961, and paragraph 5 of the Vienna Declaration and Program of Action. See *General Comment supra* note 178.

¹⁷⁶ See *General Comment, supra* note 178.

in Article 12 of the ICESCR.¹⁷⁷ Article 12 of the ICESCR enunciates the definitive formulation of the right to health:

- (1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - b. The improvement of all aspects of environmental and industrial hygiene;
 - c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - d. The creation of conditions which would assure to all medical services and medical attention in the event of sickness.¹⁷⁸

The right to health is inclusive, and while often associated with the right to access healthcare and hospitals, the right to health extends further.¹⁷⁹ The Committee on Economic, Social, and Cultural Rights include factors that can help lead to a healthy life, called the social determinants of health. These social determinants include: safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and

¹⁷⁷ Article 11 of the ICESCR specifically addresses key determinants of health: the right to “an adequate standard of living . . . including adequate food, clothing, and housing, and to the continuous improvement of living conditions.” The ICESCR further guarantees labor rights, social insurance, child protection, education, shared scientific benefits, and participation in cultural life. ICESCR, *supra* note 19, art. 11.

¹⁷⁸ *Id.* art. 12.

¹⁷⁹ *Human Rights and Health*, WORLD HEALTH ORG. (Dec. 29, 2017), <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>.

information; and gender quality.¹⁸⁰ The right to health is closely related to and dependent upon the realization of other human rights.¹⁸¹

The right to health is not to be misinterpreted as the right to be healthy.¹⁸² The right contains freedoms including the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization; the right to be free from torture and other cruel, inhuman or degrading treatment or punishment; and the right to control one's health and body including sexual and reproductive freedom.¹⁸³ Further, the right to health contains entitlements that include: the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health; the right to prevention, treatment and control of diseases; access to essential medicines; maternal, child and reproductive health; equal and timely access to basic health services; the provision of health-related education and information; and participation of the population in health-related decision making at the national and community levels.¹⁸⁴ The principle of non-discrimination is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health. Article 2.2 and Article 3 of the ICESCR proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement.¹⁸⁵ "Overt or implicit discrimination in the delivery of health services . . . acts as a powerful barrier to health services and contributes to poor quality care."¹⁸⁶ While resource limitation may prevent the states from

¹⁸⁰ *Id.*

¹⁸¹ See generally General Comment, *supra* note 178.

¹⁸² See WHO CONST. (1946).

¹⁸³ U.N. Secretary-General, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. A/64/272, ¶ 9 (Aug. 10, 2009). Informed consent is a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being. *Id.* See also *Human Rights and Health*, *supra* note 184.

¹⁸⁴ General Comment, *supra* note 178, art. 12.2(c) – (d); See also *Human Rights and Health*, *supra* note 184.

¹⁸⁵ ICESCR, *supra* note 19, arts. 2-3. "The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." *Id.* art. 2. "The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant." *Id.* art. 3.

¹⁸⁶ *Human Rights and Health*, *supra* note 184.

full implementation, the prohibition on discrimination does have an immediate positive effect on health access.¹⁸⁷

In recognizing resource limitation, states must “take steps, individually through international assistance and cooperation, especially economic and technical, to the maximum of [their] available resources, with a view to achieving progressively the full realization” of rights in the ICESCR.¹⁸⁸ The elements of progressive realization include: (1) expeditious progress; (2) maximum available resources; (3) international cooperation; and (4) minimum core obligation.¹⁸⁹

A. Right to Health Elements

The right to health contains four interrelated and essential elements which encompasses health care, public health, and the underlying determinants of health. The elements state health goods, services, and facilities must be (1) available; (2) accessible; (3) acceptable; and (4) good quality.¹⁹⁰

Availability means that functioning public health and health-care facilities have sufficient quantity.¹⁹¹ The nature of the facilities will vary depending on the State’s developmental level but should include the underlying determinants of health.¹⁹² States should pay particular attention to the availability of resources that fall within the realm of the

¹⁸⁷ LAWRENCE GOSTIN, *GLOBAL HEALTH LAW* 251 (2014). States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provisions of health care and health services, especially with respect to the core obligations of the right to health. Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favor expensive curative health service, but rather focus on primary and preventive health care benefiting a larger population. *See generally*, BEN SAUL, DAVID KINLEY & JACQUELINE MOWBRAY, *Introduction in THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: COMMENTARY, CASES, AND MATERIALS* (2014).

¹⁸⁸ ICESCR, *supra* note 19, art. 2; *See also* GOSTIN, *supra* note 192, at 251.

¹⁸⁹ General Comment, *supra* note 178 at 30. States must make steady progress, moving as expeditiously and effectively as possible towards full realization – the non-retrogression principle states that any deliberately retrogressive measures must be fully justified by the totality of rights. *Id.* States must realize rights to the maximum of their available resources; if resource constraints render it impossible to comply with full obligations, the state has the burden to justify that it has made every effort to use all available resources as a matter of priority. *Id.* at 32. States must cooperate toward achieving ICESCR rights, and those in a position to do so must provide economic and technical assistance. *Id.* States have a minimum core obligation to ensure, at the very least, minimum essential levels of each of the rights. *Id.*

¹⁹⁰ *Id.* at 12.

¹⁹¹ *Id.*

¹⁹² *Id.* Examples include safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, essential drugs, and trained medical personnel.

state's core obligations, including: health care facilities for women, especially facilities specializing in sexual and reproductive health; health care facilities for children; health care facilities for rural and indigenous communities; and appropriate provision for mental health.¹⁹³

Health facilities, goods and services must be accessible to everyone without discrimination.¹⁹⁴ Accessibility has four intersectional components: (1) non-discrimination; (2) physical accessibility; (3) economic accessibility; and (4) information accessibility. Non-discrimination calls for health facilities, goods and service to be accessible to everyone, including the most vulnerable or marginalized sections of the populations.¹⁹⁵

Physical accessibility requires that health facilities, goods and services be within safe physical reach for all sections of the population, but especially for vulnerable or marginalized groups, including indigenous populations. Accessibility is also meant to imply access to safe and potable water and adequate sanitation facilities.¹⁹⁶ Health facilities, goods and services must be affordable for all. Payment for services must be based on the principle of equity to ensure those services are affordable for all.¹⁹⁷ Information accessibility “includes the right to seek, receive and impart information and ideas concerning health issues.”¹⁹⁸

Acceptable health services are administered ethically, culturally, and with respect for privacy.¹⁹⁹ There is a particular duty with respect to indigenous peoples as “the right to specific measures to improve their access to health services and care . . . should be culturally appropriate, taking into account traditional preventative care, healing practice and medicines.”²⁰⁰

Health facilities, goods and services must be of good quality and scientifically appropriate.²⁰¹ “This requires . . . skilled medical

¹⁹³ SAUL, KINLEY & MOWBRAY, *supra* note 192, at 6; *see also* General Comment, *supra* note 178, at 19.

¹⁹⁴ General Comment, *supra* note 178 at 30.

¹⁹⁵ *Id.* at 12.

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*; *see also* GOSTIN, *supra* note 192, at 244 (“Health equity is the great unmet challenge of the health and human rights movement in our time”).

¹⁹⁸ General Comment, *supra* note 178 at 12. (This should not be interpreted to impair the right to have personal health data treated with confidentiality).

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 27.

²⁰¹ GOSTIN, *supra* note 192, at 259.

personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”²⁰²

General Comment Number 14 to the ICESCR offers three key principles: (1) equality and nondiscrimination in access to health services; (2) participation in the form of meaningful public engagement in health policy; and (3) accountability by the government to be answerable to the public on its implementation of the right to health.²⁰³

Pursuant to these principles, “[s]tates must respect, protect, and fulfill the right to health.”²⁰⁴ States respect the right by not interfering with people’s ability to realize this right.²⁰⁵ States have an obligation to “refrain from prohibiting or impeding traditional preventative care, healing practices and use of traditional medicines of indigenous peoples.”²⁰⁶ States must protect people from violations of the right to health by third parties²⁰⁷ and “ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.”²⁰⁸ Further, states must fulfill the right to health by taking affirmative actions that “create, maintain and restore the health of the population.”²⁰⁹ “State violations can occur through omission (e.g., failing to protect against private discrimination) and commission (e.g., public sector discrimination.”²¹⁰ States must ensure that doctors and medical staff are appropriately trained and that there are a sufficient amount of hospitals, clinics, and healthcare facilities.²¹¹ “Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all”²¹²

B. Minimum Core Obligations

The right to health requires states to meet minimum core obligations. Core obligations are irrevocable and represent the minimum

²⁰² General Comment, *supra* note 178 at 12.

²⁰³ GOSTIN, *supra* note 192 at 259.

²⁰⁴ *Id.*

²⁰⁵ *Id.* An example of such interference would be discrimination in state-provided health services.

²⁰⁶ General Comment, *supra* note 178 at 34.

²⁰⁷ GOSTIN, *supra* note 192, at 259 (such as when “private practitioners discriminate against vulnerable patients”).

²⁰⁸ General Comment, *supra* note 178 at 35.

²⁰⁹ GOSTIN, *supra* note 192, at 259 (this would include universal health coverage).

²¹⁰ *Id.*

²¹¹ General Comment, *supra* note 178 at 36.

²¹² *Id.*

essential levels which States are required to meet in order to be in compliance with the right to health.²¹³ Core obligations include positive and negative entitlements and address distribution and equity concerns.²¹⁴ In order to achieve the minimum core obligations, states should ensure that adequate funds are available for health and prioritize financing for health in order to meet at least the core obligations of the right to health.²¹⁵

Obligations of comparable priority to the minimum core include reproductive, maternal and child health care; prevention, treatment and control of epidemic and endemic diseases; education and access to information concerning health care in the community; and health care worker training on health and human rights.²¹⁶

The Committee addresses indigenous peoples' right to health by explicitly articulating that indigenous peoples have the right to specific measures to improve their access to health services and care.²¹⁷ "[H]ealth services should be culturally appropriate, taking into consideration traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health."²¹⁸ The health of the individual retains a "collective dimension" in indigenous communities, and individual health is often linked to societal health.²¹⁹ The Committee acknowledged that the displacement of indigenous peoples against their will from their traditional territories and environment, denying sources of nutrition and breaking their symbiotic relationships with their lands,

²¹³ General Comment, *supra* note 178 at 43 (listing core obligations, including access to health facilities, goods and services on a non-discriminatory basis; access to minimum essential food, which is nutritionally adequate and safe; access to basic shelter, housing, and sanitation, and an adequate supply of safe and potable water; provision of essential drugs as defined under the WHO Action Programme on Essential Drugs; equitable distribution of all health facilities, goods and services; the adoption and implementation of a national health strategy and plan of action addressing the health concerns of the whole population); *see generally* SAUL, KINLEY & MOWBRAY, *supra* note 192.

²¹⁴ SAUL, KINLEY & MOWBRAY, *supra* note 192, at 2.

²¹⁵ *Id.*

²¹⁶ General Comment, *supra* note 178 at 44.

²¹⁷ *Id.* at 27.

²¹⁸ *Id.* Primary health care is essential health care and should be accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of the community's development, in the spirit of self-reliance and self-determination. *See generally* SAUL, KINLEY & MOWBRAY, *supra* note 192.

²¹⁹ General Comment, *supra* note 178 at 27.

has detrimental effects on their health.²²⁰ Magnifying the detrimental health effects is the absence of health services in those areas. The Committee did an examination of the last twenty years, which revealed a chronic lack or absence of health care services in rural areas in many countries, as well as deep discrimination in service provision against indigenous groups where health care services do exist.²²¹ Another deficit in this area includes the essential social and welfare determinants of health, including adequate access to food, water and sanitation.²²²

C. United States Legally Bound

Human rights are interdependent, indivisible and interrelated. This means that violating the right to health may often impair the enjoyment of other human rights, such as the right to education or work, and vice versa.²²³ The importance given to the “determinants of health” shows that the right to health is dependent on, and contributes to, the realization of many other human rights.²²⁴ The United States is a signed party to the Convention, though they have not ratified it. However, this does not mean they are not bound by it. Article 38 of the Vienna Convention Law on Treaties states, “nothing in articles 34 to 37 precludes a rule set forth in a treaty from becoming binding upon a third State as a customary rule of international law, recognized as such.”²²⁵ Customary Law has two elements: (1) State practice, and (2) *opinio juris* necessitates – a sense of obligation.²²⁶ In order for a State practice to constitute the necessary *opinio juris*, the following two conditions have to be fulfilled: (1) the acts concerned amount to settled State practice and (2) the acts “must be carried out in such a way as to be evidence of a belief that this practice is rendered obligatory by the existence of a rule of law requiring it.”²²⁷ It is possible for a custom to bind even to those

²²⁰ See generally Maria Yellow Horse Brave Heart, Josephine Chase, Jennifer Elkins & Deborah B. Altschul, *Historical Trauma Among Indigenous Peoples of the Americas: Concepts, Research, and Clinical Considerations*, 43 J. PSYCHOACTIVE DRUGS, 282 (2011).

²²¹ General Comment, *supra* note 178 at 27.

²²² General Comment, *supra* note 178 at 4.

²²³ *Id.* at 3.

²²⁴ GOSTIN, *supra* note 192, at 264-65; see also General Comment, *supra* note 178, at 3.

²²⁵ Vienna Convention on the Law of Treaties art. 38, May 23, 1969, 1115 U.N.T.S. 331.

²²⁶ OPPENHEIM'S INTERNATIONAL LAW 28 (Robert Jennings & Arthur Watts eds., 9th ed. 2008).

²²⁷ *Id.* (citing North Sea Continental Shelf (Fed. Repub. Ger. V. Den & Neth), Judgment, 1969 I.C.J. 3 (Feb. 28)). The development of custom is a relatively slow process; however, universality

States that have not engaged in the practice in question, or who have not engaged in the practice absent the needed *opinio juris*. In order for a State to avoid being bound by the customary rule, it must be considered a persistent objector.²²⁸ The United States is a signed party and made no reservations at the time of signature; nor has it maintained status as a persistent objector against The Covenant.²²⁹ It is therefore bound under customary international law.

The facts established up to this point allow the reader to deduce the violation of the Oglala Lakota people's right to health. The high disease burden, the economic barriers, the cramped living quarters, and the inadequate funding from the federal government all paint a picture of the dire health status on the reservation. But the numbers only tell half the story: the next section will discuss the right to health in light of the individual experiences of the Oglala Lakota.

VII. Right to Health Violations

A. Mr. Weber

Pine Ridge is a tough location to sell to young doctors looking to practice, and because of this Pine Ridge Hospital remains chronically understaffed. Doctors who do go there to practice are often part of the IHS Loan Repayment Program.²³⁰ Even with the enticing option of that program, salaries are “materially below those paid by the government in its other activities concerned with public health and medical relief.”²³¹ In health facilities that are unable to fill permanent positions, temporary contract workers are used, rotating out every three to six months.²³²

of conformance with the custom is not required for the custom to become generally binding on States. *Id.*

²²⁸ *Id.*

²²⁹ ICESCR, *supra* note 19.

²³⁰ *Indian Health Loan Repayment Programs*, INDIAN HEALTH SERV., <https://www.ihs.gov/dentistry/index.cfm/financialandstudentopportunities/loanrepayment/> (last visited Jan. 13, 2021). IHS Loan Repayment Program requires a two-year commitment in the exchange for \$40,000 in loan repayments. Many doctors leaving medical school see this as an opportunity to ease their debt burden. *Id.*

²³¹ Andrew Siddons, *The Never-Ending Crisis at the Indian Health Service*, ROLL CALL (Mar. 5, 2018), <https://www.rollcall.com/news/policy/never-ending-crisis-indian-health-service>.

²³² *Id.*; see also *Reexamining the Substandard Quality of Indian Health Care in the Great Plains*, *supra* note 40, at 111 (Statement of James Red Willow, Executive Committee Member, Oglala Sioux Tribe). There is an additional burden and stress felt by having to rely on a new physician for health care; they might not be given the same treatment as by the previous physician or will be given different medication. *Id.*

In 1995, a pediatrician joined the full-time staff at Pine Ridge Hospital.²³³ Mr. Weber got his start in medicine as a Green Beret and, after finishing medical school in 1983, joined IHS and worked in Oklahoma, New Mexico, and Montana before moving to Pine Ridge.²³⁴ In his first months on the job, a parent complained about Mr. Weber's conduct to the top doctor at IHS's South Dakota regional office.²³⁵ Hospital staff referred the matter to law enforcement, and during the investigation, Mr. Weber was placed on administrative duties.²³⁶ The Federal Bureau of Investigation inquiry did not lead to any charges, and Mr. Weber returned to work.²³⁷ Around this same time period, the IHS manager at Pine Ridge learned that Mr. Weber had been investigated in Montana.²³⁸ He was allowed to continue to practice because he had never been charged or convicted.²³⁹

Pine Ridge residents heard about the teenage boys who frequently visited his home.²⁴⁰ Nurses provided statements that he checked boys into the hospital room the furthest from their station.²⁴¹ A former patient, now a South Dakota state inmate, stated that the pediatrician molested him starting in the late 1990s, when he was about eleven.²⁴² The same former patient talked about cutting his head open during a fight; Mr. Weber stitched him up at his house and gave him a bottle of narcotic pain medicine. After that, Mr. Weber would use pain

²³³ Christopher Weaver, Dan Frosch & Gabe Johnson, *A Pedophile Doctor Drew Suspicions for 21 Years. No One Stopped Him*, PBS (Feb. 8, 2019), <https://www.pbs.org/wgbh/frontline/article/patrick-stanley-weber-sexual-abuse-pine-ridge-blackfoot-reservation/>.

²³⁴ *Id.*

²³⁵ *Id.*

²³⁶ *Id.*

²³⁷ *Id.*

²³⁸ *Id.* Mr. Weber was in Montana for three years. After the clinic director learned a child patient stayed at his house, Mr. Weber was told to leave. He was not fired but instead transferred to the hospital in Pine Ridge. One of his Montana victims described the doctor sexually assaulting him on a hospital examination table when he was around 11, the same time that the victim's father had killed himself. Another former patient testified that the doctor had inserted a finger into his anus in an IHS exam room when he was about eight years old. The next visit, Mr. Weber inserted two fingers, and later his penis. *Id.*

²³⁹ Weaver, Frosch & Johnson, *supra* note 238. The CEO of the hospital in Montana said that she initially welcomed Dr. Weber; they "had been without a pediatrician for a while," and overlooked some initial suspicions, including hanging out with boys at Pizza Hut and talking about arranging a camping trip with his patients. Dr. Weber was not fired but was told to leave after he was assaulted by a relative of a young boy who had been spending time at his house. (The tribe has no jurisdiction to prosecute a non-Indian perpetrator of an alleged crime). *Id.*

²⁴⁰ *Id.* Mr. Weber later told investigators that he had hired them for garden chores. *Id.*

²⁴¹ *Id.*

²⁴² *Id.*

pills and money to coerce him into sex.²⁴³ One the night of November 14, 2006, the former patient and two other teenage boys knocked on Mr. Weber's door and upon answer, kicked it in, bashing Mr. Weber's face. They roughed the doctor up and stole a few hundred dollars. The former patient stated that it was a form of revenge and payback for what he was put through.²⁴⁴ The night of the assault, the CEO of Pine Ridge found Mr. Weber sitting on a gurney in the emergency room.²⁴⁵ The doctor refused to answer questions or talk to law enforcement about why his face was bloodied.²⁴⁶

A fellow pediatrician, Dr. Butterbrodt, at Pine Ridge contacted the South Dakota medical board in 2008. He alleged that Mr. Weber selectively chose to treat young teenage boys in the clinic. The board investigated, but nothing came of it.²⁴⁷ In 2009, "Dr. Butterbrodt documented the allegations in a letter to his IHS bosses, including the [clinical director]."²⁴⁸ A panel was appointed to investigate but could not find any hard evidence.²⁴⁹ IHS suspended Mr. Weber and referred the matter to a regional IHS administrator. When that investigation turned up nothing, Mr. Weber returned to work.²⁵⁰ Dr. Butterbrodt clashed with Mr. Weber in 2011, and within weeks, Dr. Butterbrodt was transferred to a remote facility in North Dakota and stripped of bonus pay.²⁵¹ Dr. Butterbrodt made one last attempt to protect patients when he called the new CEO at Pine Ridge Hospital, Wehnona Stabler, and made an anonymous complaint.²⁵² It was a dead end; Ms. Stabler took no action. In fact, in June 2017, Ms. Stabler was indicted in federal court for accepting a \$5,000 gift from Mr. Weber in 2013, which she did not report on a government ethics form.²⁵³

²⁴³ *Id.*

²⁴⁴ *Id.*

²⁴⁵ Weaver, Frosch & Johnson, *supra* note 238.

²⁴⁶ *See id.* The CEO has stated this his boss in the agency's regional office required him to seek permission to contact law enforcement about any concern. He did so and never heard back. The CEO did not feel like he could step outside the chain of command and independently report it to law enforcement, for fear he would lose his job. *Id.*

²⁴⁷ *Id.*

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ *Id.* The regional IHS administrator, was arrested later that year on child-pornography charges and convicted in 2012. *Id.*

²⁵¹ Weaver, Frosch & Johnson, *supra* note 238. IHS's then-top regional doctor reviewed the transfer and concluded he had been unfairly punished. The doctor asked follow-up questions regarding Mr. Weber's conduct but eventually dropped the probe. *Id.*

²⁵² *Id.*

²⁵³ *Id.*

It was only in 2015 that Mr. Weber was ousted – not by IHS but by tribal investigators.²⁵⁴ Elaine Yellow Horse, a tribal prosecutor, decided to look into the allegations she had heard years earlier from Dr. Butterbrodt.²⁵⁵ She identified a potential victim of Mr. Weber's: the inmate who had participated in the assault on him. The Inspector General of the Department of Health and Human Services began a criminal investigation.²⁵⁶ When Mr. Weber was tipped off, he resigned the following evening, effective immediately.²⁵⁷

“There are widespread accusations that the IHS places a higher priority on physician staffing than protecting patients from harm.”²⁵⁸ Resources are stretched thin, with little to no secretarial staff to support medical staff activities. The medical staff is tasked with seeing patients and secretarial duties, and the attention needed to take care of background check paperwork is not a priority when hiring physicians.²⁵⁹ IHS managers have the power to hire doctors, despite their troubled pasts, to fill vacancies in their physician openings.²⁶⁰ “Records show about 2.6% of IHS doctors have been punished by state boards — a rate more than four times the average for all government doctors and the highest of any federal agency.”²⁶¹ Not only do IHS doctors have questionable records, IHS doctors only need to be licensed to practice medicine in one state, not necessarily the state they work in.²⁶²

It is important to keep in mind the four interrelated and essential elements under the right to health: health goods, services, and facilities

²⁵⁴ *Id.*

²⁵⁵ *Id.*

²⁵⁶ *Id.*

²⁵⁷ Weaver, Frosch & Johnson, *supra* note 238.; *see also* Arielle Zionts, *Ex-IHS Doctor Indicted for Sexually Abusing Native American Patient*, RAPID CITY J. (Feb. 14, 2020), https://rapidcityjournal.com/news/local/crime-and-courts/ex-ihs-doctor-indicted-for-sexually-abusing-native-american-patients/article_7fb6d435-356c-52f4-b190-e0284d410a41.html (reporting that on Monday, February 10, 2020, Mr. Weber was sentenced to five life sentences plus forty-five years for sexually abusing four Native American boys over a twelve-year period; he is also serving an eighteen-year sentence for sexually abusing two Native American boys from the Blackfeet Reservation in Montana before he was transferred to Pine Ridge).

²⁵⁸ Richard L. Groffsky, *Revelations About Pedophile Doctor Show How Hospitals May be Negligent in Failing to Prevent Sexual Abuse*, SOMMERS SCHWARTZ BLOG (Feb. 21, 2019), <https://www.sommerspc.com/blog/2019/02/hospitals-negligence-failing-to-prevent-sexual-abuse/>.

²⁵⁹ Matt Kelly, *Trouble Doctors at IHS Still Hired*, THE MISSOULIAN (Mar. 5, 2002), https://missoulian.com/uncategorized/troubled-doctors-at-ihs-still-hired/article_c627f983-a714-5755-8040-b4bdb6a2e229.html (quoting Dr. Craig Vanderwage, the agency's chief medical officer).

²⁶⁰ *Id.*

²⁶¹ *Id.* (finding that by contrast, only 0.5% of doctors who provide care to military veterans at Department of Veteran Affairs hospitals have ever been disciplined).

²⁶² *Id.*

must be (1) available, (2) accessible, (3) acceptable, and (4) good quality. Faced with a general lack of available resources, the health center was so desperate to get a full-time pediatrician that they were willing to overlook the red flags that arose during his twenty-one-year tenure at the hospital.²⁶³ Accessibility was violated several ways. The availability of only one to two pediatricians, coupled with limited access to off-the-reservation facilities due to limited transportation and financial means, left parents who did not want to take their children to Mr. Weber with few viable alternatives other than not receiving care. The acceptable and good quality provision is violated because of government failure to act upon its heightened standard when dealing with the most vulnerable population, as well as government failure to fully investigate those providers so as to not allow people in positions of power to violate their trust. The employment of a child molester and predator is a form of retrogressive activity under the right to health. It is arguable that the population would have been better off not having a pediatrician than one that preyed on vulnerable children. Both the IHS and Congress have an obligation to do better, especially because substandard healthcare for Native Americans has persisted for more than a century.

B. Mr. Black Cat

Willard Black Cat is an enrolled member of the Oglala Lakota Sioux and has lived on the Pine Ridge Indian Reservation his entire life.²⁶⁴ Mr. Black Cat detailed his experience during the course of 2016. Mr. Black Cat, who suffers from diabetes and is an amputee, has faced a multitude of issues accessing health services from IHS.²⁶⁵ Transportation is often difficult to find, and when he does arrive at the hospital, even with an appointment, he has to wait hours to be seen; other times he will be told a doctor is not present in the clinic.²⁶⁶ Every time he goes to the hospital for a check-up, he is seen by a different doctor.²⁶⁷

²⁶³ See Weaver, Frosch & Johnson, *supra* note 238.

²⁶⁴ *Reexamining the Substandard Quality of Indian Health Care in the Great Plains: Hearing before the Committee on Indian Affairs United States Senate*, 114th Cong. 207-08 (2016) [hereinafter Statement of Willard Black Cat] (Statement of Willard Black Cat) (The authentication of this individual has not been verified by the author, who is relying on the congressional record).

²⁶⁵ *Id.* at 208.

²⁶⁶ *Id.*

²⁶⁷ *Id.* (finding that a common issue across IHS is how time consuming it is to go through your medical history every time you are seen by a new physician).

Every month his medication is changed, which results in a multitude of side effects.²⁶⁸ Mr. Black Cat takes a medical transport van to receive his dialysis treatment at Pine Ridge Hospital, but sometimes the van does not show up.²⁶⁹

Mr. Black Cat's most recent ailment started in his foot.²⁷⁰ He went to IHS where he received ointment and gauze to treat a cut and was sent home.²⁷¹ His condition did not improve, and he returned to Pine Ridge Hospital for follow up visits; they continued to bandage his cut and send him home.²⁷² He was unable to sleep from the pain and was finally able to secure a referral for a doctor in Rapid City Regional Hospital.²⁷³ The doctor in Rapid City (an off-reservation facility 120 miles away) found that he had gangrene and would require an amputation.²⁷⁴ His amputation required stents in his leg and the amputation of all his toes, with a graft from his heel.²⁷⁵

It is helpful to evaluate Mr. Black Cat's story by looking again to the four elements that are required for the right to health: (1) available, (2) accessible, (3) acceptable, and (4) good quality.

Available means that functioning public health and health-care facilities have sufficient quantity.²⁷⁶ Mr. Black Cat details showing up to the hospital, waiting for hours on end, only for his appointment to be cancelled because the doctor had not shown up. When talking about his diabetes, it is likely that the disease was brought on by a diet of limited means and availability, both in terms of finance and nutritional value.

Accessible means "health facilities, goods and services must be accessible to all" without discrimination.²⁷⁷ Mr. Black Cat's testimony

²⁶⁸ *Id.* The problem with medication changes has been reverberated by other elders in the community. When talking about the pharmacy available to them, elders say "they only offer generics and often what you get is not what your doctor prescribed but what the pharmacy has." Telephone Interview with Lakota Elder, *supra* note 83.

²⁶⁹ Statement of Willard Black Cat, *supra* note 270, at 208. Mr. Black Cat has also fallen in the van and broken his ribs, and the drivers do not help him get in and out of his wheelchair.

²⁷⁰ See *Slow Healing of Cuts and Wounds*, DIABETES.CO.UK (Jan. 15, 2019), <https://www.diabetes.co.uk/symptoms/slow-healing-of-wounds.html>. (discussing that high levels of blood glucose caused by diabetes can, over time, affect the nerves and lead to poor blood circulation, making it hard for blood (needed for skin repair) to reach areas of the body affected by sores or wounds).

²⁷¹ *Id.*

²⁷² *Id.*

²⁷³ Statement of Willard Black Cat, *supra* note 270, at 208. (the hospital was located 120 miles away from the reservation).

²⁷⁴ *Id.* (Mr. Black Cat had lost his other leg the year before).

²⁷⁵ *Id.*

²⁷⁶ General Comment, *supra* note 178 at 12.

²⁷⁷ *Id.*

states that he had difficulty accessing transportation to take him to and from his appointments, documenting his having fallen out of his wheelchair in the transportation van and damaging his ribs. When his infection persisted, he had limited means to get a second opinion off the reservation.

Acceptable health services are administered ethically, culturally, and with respect for privacy.²⁷⁸ By turning Mr. Black Cat away multiple times and letting Mr. Black Cat's infection persist, the hospital violated an ethical duty of care standard.

Good quality requires that health facilities, goods and services be of good quality and scientifically appropriate.²⁷⁹ Mr. Black Cat talks about his prescription drugs changing every month or every time he sees a new health care provider.²⁸⁰ It is also likely that given the hospital's limited resources, it was only able to provide support to Mr. Black Cat through literal band-aid help. This falls well below the standard of care, and he should have been referred for better care much sooner.

These two cases show larger structural issues at play that are systemically preventing the right to health from being fully recognized. In December 2016, Surveyors from the Centers for Medicare and Medicaid Services (CMS) found that Pine Ridge Hospital staff "didn't appropriately assess patients' conditions upon arrival at the emergency department, didn't adequately consider patient history in diagnosing conditions, made patients wait when they needed immediate care, and weren't properly trained to open patients' airways and provide artificial breathing."²⁸¹ Only a year earlier, the hospital was flagged for similar deadly deficiencies.²⁸²

²⁷⁸ *Id.* at 12.

²⁷⁹ GOSTIN, *supra* note 192 at 259.

²⁸⁰ Statement of Willard Black Cat *supra* note 270 at 208.

²⁸¹ Dana Ferguson, *Report Outlines Fatal Flaws at Pine Ridge Hospital*, ARGUS LEADER (Dec. 23, 2016), <https://www.argusleader.com/story/news/2016/12/23/report-outlines-fatal-flaws-pine-ridge-hospital/95789640/> (discussing the survey's finding that a "35-year-old patient wasn't adequately sedated before doctors tried to open his airway with a plastic tube to assist his breathing"; the patient died while being transported to Rapid City Regional Hospital).

²⁸² *Id.*

C. IHS Funding Issues

As a result of these findings and the lack of improvement, Pine Ridge Hospital lost its ability to bill to Medicare.²⁸³ The case that tipped the scales for CMS inspectors was a diabetic man who was triaged in the wrong priority level, ultimately delaying critical medical screening and treatment. The patient was transferred to another hospital and died a day later.²⁸⁴ While the hospital remains open, “the loss of certification acts as a catalyst for the underlying problems. The Pine Ridge Hospital is already chronically under-funded and relies on revenue from Medicare and Medicaid to cover budget shortfalls.”²⁸⁵

Over the past decade, IHS’s budget has increased overall, from \$4.1 billion in 2009 to just over \$5 billion in 2017.²⁸⁶ Supporters of IHS believe that at least \$6.4 billion is needed. An additional expense comes in referrals to specialists. Because most of IHS’s physicians are trained in primary care or family medicine, the service contracts come out of IHS’s specialty care budget.²⁸⁷ Congress, however, has provided only enough money for IHS to cover about two-thirds of these referrals, forcing IHS to ration care for the most urgent, life-threatening needs.²⁸⁸ In 2016, \$914 million was spent on referrals, but this fell approximately \$372 million short of what was needed, resulting in the denial of roughly 80,000 service requests that were deemed *less urgent*.²⁸⁹

²⁸³ Dana Ferguson, *Violated: Inside South Dakota’s Native American Health Care Crisis*, ARGUS LEADER (Dec. 5, 2018), <https://www.argusleader.com/story/news/2018/12/05/south-dakota-ihs-indian-health-service-history-native-american-healthcare-crisis/2128151002/>.

²⁸⁴ *Id.*

²⁸⁵ Kevin Abourezk, *Another Indian Health Service Hospital Placed in ‘Immediate Jeopardy’ Status*, INDIANZ.COM, (Nov. 6, 2017) <https://www.indianz.com/News/2017/11/06/another-indian-health-service-hospital-p.asp> (discussing CMS’s statement that its conditions of participation is the floor for acceptability); see also Siddons, *supra* note 236 (discussing CMS’s statement that they would “no longer pay for acute care services provided to Medicare beneficiaries at the Pine Ridge Hospital” and acknowledging that “while Medicare payments do not make up a huge portion of the health service’s budget – about \$29 million of the \$1.2 billion total that IHS brings in from insurance reimbursement – the termination was still an embarrassing blow”).

²⁸⁶ See Siddons, *supra* note 236.

²⁸⁷ *Id.*

²⁸⁸ Telephone Interview with Lakota Elder, *supra* note 83. As explained to the author; if one needs something done, one’s best chance, is at the beginning of the year because once the budget limit is met, that is it.

²⁸⁹ See Siddons, *supra* note 236 (finding that requests deemed less urgent include mammograms (which can easily turn into stage 2, 3, or 4 cancer if not caught) or joint replacements, which can suspend disability as well as impact mobility factors in areas that public transportation and other forms of mobility are hard to come by).

Beyond just health care expenses, the buildings are on average “four times older than facilities in the private health care sector.”²⁹⁰ It’s estimated that the agency’s facilities need \$500 million in repairs.²⁹¹ The primary issue is that most of the funding comes from discretionary appropriations, specifically through the Interior/Environment appropriations act.²⁹² These appropriations are divided into three accounts: (1) Indian Health Services, (2) Contract Support Costs, and (3) Indian Health Facilities.²⁹³ Since 1998, “IHS has received a mandatory appropriation each fiscal year to support the Special Diabetes Program for Indians.”²⁹⁴ This funding source was recently extended in the Bipartisan Budget Act of 2018.²⁹⁵ President Trump previously requested that these funds be moved to discretionary appropriations in fiscal year 2019.²⁹⁶ Keeping the majority of the funding for IHS in discretionary funding means that it will be funded annually from an appropriation act, under different sets of budget enforcement rules and processes from those that apply to mandatory spending.²⁹⁷ Medicaid and Medicare are entitlement programs, which result in mandatory spending.²⁹⁸ Congress has been in breach of their responsibility to provide healthcare for decades by refusing to fully fund IHS.

Funding remains a primary explanation for lack of adequate care and is described in all approaches of the right to health. This analysis would be different if the Oglala Lakota people resided within a resource-limited country, but even then, the State has the burden to justify that it has made every effort to use all available resources as a matter of priority. The evidence shows that the efforts to provide health care have severely fallen below the standards, resulting in a community that is isolated and rooted in historic trauma, and remains the “forgotten Americans.” Healthcare for American Indians and Alaska Natives

²⁹⁰ *Id.* (discussing “one hospital where an aging structure cause sewage to leak into the operating room after its old pipes corroded”).

²⁹¹ *Id.*

²⁹² *Indian Health Service (IHS) FY2019 Budget Request and Funding History: A Fact Sheet*, CONG. RES. SERV. (May 18, 2018), <https://www.everycrsreport.com/reports/R45201.html>.

²⁹³ *Id.*

²⁹⁴ *Id.*

²⁹⁵ *Id.* (the act provided “mandatory appropriations for FY2018 and FY2019”).

²⁹⁶ *Id.*

²⁹⁷ *What is the Difference Between Mandatory and Discretionary Spending*, CONG. BUDGET OFF., <https://www.cbo.gov/content/what-difference-between-mandatory-and-discretionary-spending> (last visited Jan. 13, 2021) (discussing that mandatory spending includes spending for entitlement programs and is generally governed by statutory criteria; it includes Social Security Programs, Medicare, and Medicaid).

²⁹⁸ *Id.*

remains plagued by the serious problems of underfunding, quality deficiencies, and a lack of leadership, representation and attention in Washington.²⁹⁹ Stories like Mr. Black Cat's will persist until the political willpower develops to change these historic injustices.

VIII. Conclusion

Rights, once guaranteed, are non-negotiable. The United States has failed to meet its minimum core obligations under the right to health provided in Article 12 of the ICESCR for indigenous people, especially the Oglala Lakota. Nor has it met its responsibility under the numerous domestic treaties, court cases, and pieces of legislation that all call for the provision of adequate, accessible, affordable and professional medical services, physicians, and hospitals for the care of American Indians and Alaska Natives.

The continuation of ascribing poor health outcomes and systematic failures primarily to indigenous individuals reinforces the notion that their health and well-being are separate from social determinants, participation and representation in governance, and accountability of economic and financial sectors. It is important not to subscribe to the notion that the Oglala Lakota and their troubles are isolated, historic, and forgotten. The fact that one is born a Native American or Alaska Native should not dictate when and how one will die. The government must be held accountable to the standards that they have proscribed in domestic and international treaties.

²⁹⁹ See Siddons, *supra* note 236.