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# The Irony of American Indian Health Care: The Pueblos, the Five Tribes, and Self-Determination, 1954–1968

**CHRISTOPHER K. RIGGS**

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The decades after World War II saw significant shifts in federal Indian policy in the United States. During the 1950s, the federal government pursued a termination policy, which sought to assimilate Native Americans by abolishing special federal status and services for Indians. By the mid-1960s, federal officials had largely abandoned termination and replaced it with a self-determination policy. Self-determination involved the maintenance of special federal services and status for American Indians while allowing Native peoples and governments greater opportunities to shape policy.

While there are numerous books and articles on the termination period, coverage of self-determination during the 1960s (at least prior to the emergence of the Red Power Movement) remains more limited.<sup>1</sup> This study seeks to help fill this gap by examining the implementation of Indian health improvement policies and how those policies affected and were affected by two groups: the Five Tribes of Oklahoma and the Pueblos of New Mexico. More commonly known as the Five Civilized Tribes because of their willingness to incorporate aspects of white culture into their societies, the Five Tribes include the Cherokee, Choctaw, Chickasaw, Creek, and Seminole tribes or nations. The nineteen New Mexico Pueblos consist of Acoma, Cochiti, Isleta, Jemez, Laguna, Nambé, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, San Juan, Santa Ana, Santa Clara, Santo Domingo, Taos, Tesuque, Zia, and Zuni.<sup>2</sup>

Admittedly, many factors influenced Indian health and the development and implementation of health care policies. Three key aspects of Indian health for the Five Tribes and the Pueblos during the period between 1954 and 1968, include gains in health levels, a continued gap between Indian

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health levels and those of the general population, and the expansion of Indian health services in response to these Natives' demands. The improvements in Indian health resulted largely from changes made by Congress in the Indian health care system—changes Congress saw as a prelude to termination. Ironically, the improvements in Indian health brought about by those changes, in combination with other factors, prompted the Five Tribes and the Pueblos to demand expanded services and to exert greater say over the development and delivery of those services. In other words, policies designed to lead to the termination of federal services instead resulted in expanded federal responsibility and greater Native American self-determination.

Throughout the 1950s, most federal officials favored assimilating Indians into the mainstream through a policy of termination. Termination referred to the abolition of special legal status and services for Native Americans. For example, much Indian land was held in trust for the tribes by the United States. Termination advocates favored abolishing that trust status, an act that would transform distinctive Indian communities into state counties subject to state taxes and state laws. In other words, Indians would lose their distinct status as tribal members. In the same vein, special services—such as economic development assistance, education, and the like—provided to members of recognized Indian nations would be abolished, and Indians would receive such services only through the state and federal agencies serving the general population.

In August 1954, Congress moved to implement the latter policy by passing Public Law 568 (PL 568).<sup>3</sup> Also known as the Transfer Act, the bill shifted responsibility for Indian health care services from the Interior Department's Bureau of Indian Affairs (BIA) to the Department of Health, Education, and Welfare's (HEW) Public Health Service (PHS). In part, Congress intended the transfer to improve Native American health care.

Such health care improvements were sorely needed. As historian James J. Rawls has pointed out, before Europeans came to North America, "the people of North America enjoyed excellent health," but "[e]xposure to diseases . . . introduced by European Americans took a heavy toll on the Native people."<sup>4</sup> The destruction of Indian economies and the subsequent onset of poverty throughout much of Indian country by the end of the nineteenth century further eroded Indian health. In the twentieth century, because of contact with whites and federal policies (such as concentrating Indian children in overcrowded schools), diseases like trachoma, which caused bumps to grow on the insides of the eyelids and impaired or destroyed vision, and tuberculosis, which typically damaged the lungs and other parts of the body, weakening and usually killing the victim, "became epidemic among the native population."<sup>5</sup> Much of the blame for poor health among Natives was placed on the federal government's poor health care provisions. Through the early twentieth century and the New Deal era of the 1930s, increased funding and more concerted efforts to improve health services did ameliorate Native health problems to an extent. In fact, advances in medical knowledge and the development of new treatments had reduced trachoma rates significantly among Native Americans by the mid-1940s. Nevertheless, historian Francis Paul Prucha concludes that even after World War II, "health conditions remained far from ideal, with scan-

dalously high morbidity and mortality rates." By the mid-1950s, Indians' health conditions "were comparable to those among the general population half a century earlier."<sup>6</sup> The number of Indian deaths from tuberculosis was almost nine times higher than the number for the general population, while infant death rates were three times higher.<sup>7</sup>

While improving Native Americans' health was one motive for the Transfer Act, members of both the House and Senate viewed PL 568 as a step toward termination. A House report characterized the transfer as a way "to effectuate the eventual termination of all Federal responsibility for providing Indians services."<sup>8</sup> Minnesota Senator Edward J. Thye, co-sponsor of the transfer bill, concurred. He stated that the move would "improve the health service for the Indian people" and "further the long-range objective of the integration of the Indian people."<sup>9</sup> In Thye's view, once Indians became healthy enough, the federal government would no longer need to make special provisions for their care. Oklahoma Senator A. S. "Mike" Monroney objected to the transfer on this basis, saying it would lead to the "liquidation of the Indian hospitals."<sup>10</sup> According to historian Donald L. Fixico, many Indians opposed the move, "fearing that this would lead to the termination of remaining health services."<sup>11</sup>

Federal bureaucrats apparently agreed that termination was the goal of the Transfer Act. Correspondence between Surgeon General Leonard A. Scheele and Commissioner of Indian Affairs Glenn L. Emmons characterized PHS's mission as "bettering the health of the nation's Indians" in a way that "contribute[d] to the Indian's spirit of self-reliance" and emphasized "his obligation to manage his own affairs."<sup>12</sup>

Congress developed other measures designed to improve Indian health and thus facilitate termination. Public Law 151, passed in 1957, allowed PHS to aid in the expansion of community hospital space if such expansion would benefit Indians. The 1959 Indian Sanitary Facilities Construction Act (PL 121) facilitated the construction or repair of sanitary facilities such as wells, community water systems, privies, septic tanks, garbage pits, kitchen sinks, bathtubs, hot water heaters, and other items.<sup>13</sup> PHS undertook the sanitation program with termination in mind, for the agency favored "*Gradually transferring the sanitation program for Indians to State and local health departments for integration into their programs for the general population.*"<sup>14</sup>

Nevertheless, the Pueblos and the Five Tribes benefited from PHS activity, much of it conducted through its Division of Indian Health (DIH), later renamed the Indian Health Service (IHS). In April 1956, PHS reported that it had contracted with the Phipps Institute of the University of Pennsylvania to study and treat tuberculosis among the Pueblos and other southwestern Indian children.<sup>15</sup> That same year, the Santa Clara Pueblo Tribal Council, encouraged by PHS, called for the development of a system for waste collection and disposal. As of 1957, residents of the Acoma Pueblo could use the Bernalillo County-Indian Hospital, which had contracted with PHS to serve Indians. PHS also operated an outpatient clinic one day a week and stationed a nurse at Acoma.<sup>16</sup>

Projects initiated in 1961 in Oklahoma ultimately provided sanitary facilities for 498 Indian families in Cherokee and Adair counties and for 138 fam-

ilies in Okmulgee and McIntosh counties.<sup>17</sup> By that time, PHS had built five new hospitals and “modernized and enlarged” another ten.<sup>18</sup> These included facilities at Santa Fe, New Mexico, and Claremore, Oklahoma. In 1963, field health stations at Jemez and Santo Domingo were in the planning stages or were being built.<sup>19</sup> A “sanitary aid course” at the Sandia Pueblo provided training for, on average, ten Indians per session.<sup>20</sup> Pueblos made up almost a third of the February 1963 graduating class of the federal government’s Indian School of Practical Nursing.<sup>21</sup> By 1963, 239 families served by the Choctaw agency of the BIA benefited from PHS projects that provided them with sanitary facilities.<sup>22</sup>

A network of PHS hospitals provided members of the Five Tribes with hospital and outpatient care. Most Chickasaws and Choctaws could utilize the PHS hospital in Talihina; others had to go to the PHS facility in Lawton or community hospitals that had contracted with PHS. Creeks could make use of PHS hospitals at Claremore or Tahlequah; outpatient care was available at the PHS health center at Okemah. The Cherokees also utilized the Tahlequah hospital, but some of them could obtain care at the Muskogee General Hospital, which had contracted with the PHS to provide services to Indians. For hospitalization, the Seminoles could go to the PHS hospital at Talihina, while a PHS facility at Shawnee provided outpatient care.<sup>23</sup>

By the early 1960s, the transfer of Indian health services to PHS had produced limited improvements in health. Infant death rates since 1955 had declined from forty-five to twenty-five per one thousand births; however, the rate was still three times the national average. The incidence of tuberculosis had declined 40 percent, but Indians suffered from the disease at a rate six times higher than the general population. Improvements in sanitation had produced a 50 percent reduction in the death rate from gastroenteric diseases.<sup>24</sup> The average Indian life expectancy was forty-two for Indians, but sixty-two for the general population. Indians’ infant mortality rate was about twice as great as that of the general population. In fact, 21 percent of all Indian deaths in a given year were infant deaths; for the general population, that figure was 6 percent.<sup>25</sup>

Native Americans also continued to suffer and die from high rates of disease. The Indian population suffered from tuberculosis at a rate seven times greater than the general population and died from the disease at a rate four times greater. The Native American death rate for gastroenteritis exceeded that of the non-Indian population by six or seven fold. Infectious diseases such as influenza and pneumonia killed Indians two to five times more often than non-Indians. Such figures led author Stan Steiner to comment that diseases “had a deadlier effect on the first Americans than did the Indian Wars.”<sup>26</sup>

Two other issues left over from the 1950s continued to affect Indian health care services well into the 1960s: PHS’s continued commitment to termination and a lack of adequate funding. Carruth J. Wagner, DIH chief, wrote in 1963 that the PHS sought “To conduct the Indian health program in such a way” that the Indian “become an active, participating member of the local community, receiving health services in the same way as other citizens in that community.”<sup>27</sup> The DIH chief reported the following year that “our resources

are severely strained, and often exceeded, accomplishing our primary health objectives for the Indian beneficiary."<sup>28</sup> Hence, PHS limited eligibility for services. For example, Indian women married to non-Indians had a lower priority in terms of access to health care than Indian women with Indian husbands. Individuals and families above a certain income level were ineligible for federal health services. Older Indians had limited or no access to dental care because PHS argued that it should channel its resources toward younger people. PHS continued this BIA policy of limiting access to health services to those individuals deemed to have a certain percentage—or quantum—of Indian blood. Such restrictions served to promote termination by limiting the number of Indians deemed eligible to receive federal services.<sup>29</sup>

Such problems notwithstanding, many Native peoples, including the Five Tribes and the Pueblo Nations, took an interest in health issues. Several tribal governments organized health committees; others contributed money, labor, and materials to the construction of sanitary facilities, and they appointed representatives to oversee maintenance activities, set fees for water and sewage services, and develop "sanitary code regulations." PHS characterized such Indian involvement as "vital to the improvement of Indian health."<sup>30</sup>

One Indian observer, however, questioned PHS's sincerity on that point. He complained that high-ranking PHS officials often failed to take Native American desires into account. "The PHS should confer with the Indians," he wrote, "instead of some 'white-collared' dude, that has a title of some description, installing rules and regulations without consultation [with the tribes]."<sup>31</sup>

Regardless of the government's commitment, or lack thereof, to Indian involvement, Native Americans took a clear interest in health care issues. As early as 1946, the National Congress of American Indians (NCAI), a national pan-tribal group founded in part by members of the Five Tribes, called for better health care services for Native Americans.<sup>32</sup> A PHS dentist observed that World War II Indian veterans who had received dental care during their tours of duty demanded better dental services upon their return to civilian life.<sup>33</sup> In January 1964, the NCAI informed the Lyndon B. Johnson administration of its desire that "hospital and medical services for American Indians...be substantially increased."<sup>34</sup> The All-Indian Pueblo Council (AIPC), a governing body including representatives of all nineteen Pueblos that had received funding from the Field Foundation, urged that "high caliber [medical] care be available to Pueblo Indians."<sup>35</sup> According to Philleo Nash, BIA commissioner from 1961–1965, AIPC Chairman Domingo Montoya "expressed a special interest ... [in] health and medical care for the Indians."<sup>36</sup> The Chickasaw Nation reported that medical care stood out as "one of the [tribe's] most acute needs."<sup>37</sup>

In large part, the growing demands for increased and improved health services reflected a growing shift in Indian policy—pushed by American Indians themselves—away from termination and toward self-determination. This new policy called for Indian nations to take more control over their own destinies through augmented self-government and increased opportunities to preserve Indian nations as culturally distinct entities. In large part, this preservation of Indian societies would occur through the maintenance of Native

Americans' distinct legal status. However, the new policy also called on the federal government to increase its support of the tribes through more appropriations, programs, and technical assistance. As one Indian leader put it, self-determination "must not be developed [by] supplanting Federal responsibility." Rather, Native Americans must "retain their firm hold on the heartstrings and pursestrings of their Great White Father until they can achieve economic security and cultural and political freedom on the highest, not lowest, level of American life."<sup>38</sup>

One of the ways American Indians sought to secure such increased federal assistance was through sanitation programs available through the federal government. Sanitation was critical to the improvement of Indian health because many diseases, such as tuberculosis, that plagued Indian country flourished in unsanitary conditions. Even in the early 1960s, the PHS estimated that unsafe water supplies stood out as "a very common cause" of Indian health problems.<sup>39</sup> To improve the health of the Santo Domingo Pueblo, PHS undertook a sanitary facilities project. By June 1964, the BIA reported that about 20 percent of the residents had installed facilities in their homes to make use of a water and sewage system installed through the efforts of the Pueblo and the PHS.<sup>40</sup> By August 1965, the AIPC's Health and Education Committee discovered that more time would be needed than originally thought to complete the project. Problems also stemmed from the fact that connections to the water and sewer lines were costing \$100 each instead of \$40 as originally anticipated.<sup>41</sup>

In addition to the sanitary facilities initiatives, AIPC wanted to be certain that "high caliber [medical] care be available to Pueblo Indians." So, the council called on PHS to insure that the agreement with the Bernalillo County-Indian Hospital made enough beds available for Indians.<sup>42</sup> AIPC also called on the federal government to provide sufficient funds to allow the Pueblos access to dental care, eyeglasses, and hearing aids. According to the council, by implementing these provisions, "our people's health would be improved so that they could obtain regular employment and thus become self-sufficient."<sup>43</sup>

That same year, PHS and the Cherokee Nation completed work on the Eucha Sanitation Project. Under the direction of Tribal Sanitation Representatives Johnson and Mary O'Field, the project resulted in the creation of thirty-four wells and other sanitation facilities such as septic tanks at Eucha, Oklahoma. At a ceremony on 20 August, ownership of the facilities was officially transferred to thirty-six families. As a result, two-thirds of the families had indoor toilets.<sup>44</sup>

Other Indians argued that more needed to be done, however. The Chickasaw Nation reported that the nearest government hospital was 135 miles away. Hence, the Chickasaws called on the PHS to establish clinics within the Indians' community.<sup>45</sup>

In July 1965, the Inter-Tribal Council of the Five Civilized Tribes—an organization representing the Cherokee, Choctaw, Chickasaw, Creek, and Seminole nations of Oklahoma—echoed the Chickasaws' concerns. The council made a unanimous recommendation that construction of a new hos-

pital at Talihina, Oklahoma begin as soon as possible. The body also urged that Indian hospitals provide dental care for all Indians regardless of age; that personnel reductions at the Talihina hospital stop; and that the government inform Native Americans of proposed changes in health care policies affecting Indian hospitals in eastern Oklahoma. Another recommendation called on DIH to give hiring preference to qualified Indians.<sup>46</sup> DIH Chief Wagner responded by giving assurances that Indian groups would be consulted about policy issues prior to implementation, and he stated that DIH already gave employment preference to “qualified Indians of 1/4 degree Indian blood.” In regard to dental care, however, he wrote that limited resources forced the DIH to give “primary emphasis” to children’s and young adults’ dental needs.<sup>47</sup>

In August 1965, AIPC—through its Health and Education Committee—again told DIH it had concerns over the quality of Indian health care. The committee cited a number of instances in which patients received poor treatment. In one case, a severely ill elderly man had to wait to be admitted to the hospital because of the time taken to verify his eligibility; he died the following day. A woman patient suffered bruises all over her body because of “force applied by [the hospital] attendants.” When a high-ranking PHS official was informed of the incident, the Pueblos said he responded, “What about the doctors who have been manhandled by patients?”<sup>48</sup>

The committee also expressed concern over the availability of health care. In response to Pueblos’ fears that some doctors might not provide treatment near the end of the fiscal year when funds were scarce, Forrest Gerard (Blackfeet) of DIH acknowledged that “it is the policy everywhere to defer marginal cases when funds are low.” The AIPC repeated its call for DIH to provide dental care, eyeglasses, and hearing aids for adults as well as children. Gerard responded that PHS only had enough in its budget to meet one-fifth of the total need and thus had given children priority over adults. Such funding problems probably explained the Pueblos’ inadequate medical coverage. The committee pointed out that the San Juan clinic needed to operate for more than one day a week and that the Santa Fe Indian Hospital needed more physicians to handle patients. In addition, some Pueblo communities had no clinics at all, which meant that residents had to travel long distances to receive medical care.<sup>49</sup> A few months later, perhaps in an attempt to offset the inadequate coverage, seven Native American public health aides began working with residents of the Cochiti, Jemez, Sandia, San Felipe, Santa Anna, and Zia Pueblos. These aides, however, were funded by the Office of Economic Opportunity (OEO), an agency created as part of the Lyndon B. Johnson administration’s War on Poverty in the mid-to-late 1960s.<sup>50</sup>

Despite often giving priority to children, inadequate medical coverage of children could be found at the PHS Indian Hospital in Tahlequah, Oklahoma. The hospital had a program to provide immunizations to all children born at the hospital. On the one hand, a study found almost 75 percent of those born at the hospital between 1 July 1960 and 7 September 1965 had been brought back to the hospital at some point for some inoculations. At the same time, “ONLY 2% OF THIS GREAT NUMBER OF INFANTS AND



PRESCHOOLERS ARE DEEMED COMPLETELY IMMUNIZED" against preventable diseases. Consequently, the study called for a "greater educational effort [to] be directed at parents" to convince them to get their children inoculated.<sup>51</sup>

The Oklahoma Cherokees reported that, by the end of 1966, PHS had provided many tribal members with sanitation facilities. Between 1964 and 1966, 144 families in Cherokee County and 162 families in Adair County were provided with facilities. PHS did the same for seventy families in Delaware County between 1965 and 1966.<sup>52</sup>

In response to the Oklahoma Chickasaws' repeatedly expressed concerns, federal officials expanded health care services for them in late 1966. By September, clinics funded by the OEO provided health care services to Indians and non-Indians in Johnson County. To supplement that care, PHS contracted with county welfare personnel, doctors, and pharmacists in Johnson and Coal counties to insure Indians' access to emergency care and medicine.<sup>53</sup> Chickasaw Governor Overton James observed that "This is far from what we felt we needed," but he acknowledged that "it is a start and if it proves satisfactory to meeting the medical needs of our people then fine and good."<sup>54</sup>

DIH expanded its services for the Pueblos as well. Fall 1966 saw the completion of a modern health center at Laguna Pueblo. The center had a full-time staff, including two physicians, a dentist, and field health workers. The latter individuals provided out-patient and preventative health services.<sup>55</sup>

Despite the center's construction, AIPC Chairman Montoya expressed ambivalence about PHS. On the one hand, AIPC had succeeded in getting PHS officials to agree to appoint a tribal affairs officer to serve as a liaison between PHS and AIPC. PHS also informed Montoya that it would back a request to Congress to fund an Indian hospital in Albuquerque. As a result, the chairman concluded that "the outlook for a new hospital at Albuquerque looks very favorable at this time."<sup>56</sup> However, Montoya stated that his people's experience with PHS "has certainly not been the best." He conceded that the medical personnel "had our best interests at heart but did not understand what our problems [were]."<sup>57</sup>

A few months later, Montoya elaborated on his views during public comments on a proposal to transfer all BIA functions to HEW. He opposed the transfer because, he said, when it came to relations between the Pueblos and HEW, "there [was] much to be desired for improvement in our relationship." He observed that "there is an endless cry for help from our Pueblo people" for medical care that HEW had not adequately met. Montoya also criticized PHS for failing to maintain the Pueblos' water and sewage systems.<sup>58</sup>

Indian frustration and conflict with DIH in Oklahoma came to a head in 1967 during a dispute over the appointment of a new executive officer for the Oklahoma City area office of DIH. According to the Inter-Tribal Council of the Five Civilized Tribes, DIH officials failed to consult with Oklahoma Indians when they decided to replace the outgoing director with an official from Anchorage, Alaska. The appointment sparked a storm of protest. Harry J. H. Belvin, principal chief of the Choctaw Nation, informed Representative Carl Albert that the Oklahoma branch of DIH announced the appointment a

day after members of the Inter-Tribal Council publicly stated that they did not want a non-Oklahoman to serve in the position. Belvin wrote that “We have had our share of unhappy experiences with administrators who were shipped here from far away places to try to mold the Oklahoma Indians to their concept” and who saw the Indians as “guinea pigs.”<sup>59</sup> Belvin followed up by writing that DIH officials had consistently ignored Indian wishes and that a good proportion of Indians’ problems stemmed from such treatment.<sup>60</sup> Most Indians wanted the open position filled by John Spaan, an Oklahoman with years of DIH experience, and they flooded Albert’s office with letters making their position clear. F. L. Lewis, Chickasaw housing authority chairman, stated that he and many of his people felt that Spaan “will do the job for them.”<sup>61</sup> The Inter-Tribal Council described Spaan as a “friend...with an unsurpassed dedication.”<sup>62</sup> By March 4, pressure from both area Indians as well as Albert’s office convinced the DIH chief to reopen the selection process. Ultimately, DIH filled the executive officer position with Calvin C. Beames, an Oklahoma Choctaw with several years experience working for the BIA and DIH in Oklahoma.<sup>63</sup>

Because several PHS officials attended a meeting of the Inter-Tribal Council held at the Talihina Indian Hospital in April 1967, members of the Five Tribes had an opportunity to express other concerns about health issues to the service directly. In particular, the Indians urged the expansion and improvement of health services. For many years, members of the Cherokee, Creek, Choctaw, Chickasaw, and Seminole tribes had to be classified as having one-half or greater Indian blood quantum to be eligible for DIH services. Choctaw Principal Chief Harry J. W. Belvin urged the DIH to lower the requirement from one-half to one-fourth. Chickasaw Nation Governor Overton James agreed, provided that services for full-blooded Indians would not be cut. The Choctaws also called for the removal of restrictions that barred otherwise eligible Indians from receiving health services and raised the amount of money one could earn to still be eligible for services.<sup>64</sup> As Overton James put it, “We feel the time has come for the U.S. Public Health Service to cut their program pattern to fit the Indian and not expect the Indian to conform to the pattern set by the U.S. Public Health Service.”<sup>65</sup>

At that meeting, E. S. Rabeau—who had replaced Wagner as the head of DIH—acknowledged that mistakes had been made. Oklahoma Indians were supposedly “the most acculturated of all American Indians, and therefore, you have no problems, and the Federal Government can withdraw...[W]e perpetuated this fallacy...that Oklahoma is ready for termination, particularly in the field of health services.” He acknowledged that, as a result, “we [in DIH] have neglected the health program here seriously,” but Rabeau now recognized that “much needs to be done.”<sup>66</sup>

This admission marked an important shift. Four years earlier, in 1963, the chief of DIH stated the agency’s commitment to termination. Four years later, DIH repudiated the use of termination as a guide to providing health services to Oklahoma Indians. Since Oklahoma Natives were typically perceived as more acculturated than most American Indians, PHS was probably less likely to view termination as a viable option for less-acculturated Indian groups in other parts of the country.

Not only did DIH repudiate termination, but it also moved to embrace self-determination by agreeing to the Five Tribes' demands to expand coverage. To insure greater consultation, he told the Inter-Tribal Council that the Indian health area director for Oklahoma would hold meetings and travel to Indian communities to learn firsthand about residents' health problems. "Program planning is absolutely worthless if the Indian people are not involved," Rabeau said.<sup>67</sup> As of 20 April 1967, the agency announced that blood quantum requirements would be lowered to one-quarter. Indians residing in Oklahoma City and Tulsa, as well as Indian wives of non-Indians and the children of such marriages, would no longer be barred from receiving services at DIH facilities. Income would no longer be considered in determining eligibility for services.<sup>68</sup>

DIH expanded services in other ways, too. By mid-1967, in an effort to improve dental coverage, twenty-four young women received training as dental assistants through PHS. A DIH official estimated that each assistant could increase a dentist's productivity by up to 30 percent. The agency also established satellite clinics at Wewoka and Wetumka, Oklahoma to provide better medical coverage.<sup>69</sup> Between 22 November and 1 December 1967, DIH opened new Indian clinics at Sallisaw and Sapulpa that would see patients twice a week.<sup>70</sup> According to one report on the socioeconomic status of the Seminoles in Wewoka, the tribe's capital city, several grants to the local health department "substantially reduced diabetes, tuberculosis, and other diseases prevalent among the Indians."<sup>71</sup>

By 1967, many members of the Five Tribes had participated in sanitation projects. In McCurtain County, 236 Choctaw homes—57 percent of the tribe's population—had benefited from the construction of sanitary facilities. The PHS estimated that another fifty homes in Pushmataha and Leflore counties would benefit as well by September 1967.<sup>72</sup> By October, sanitation improvements had been provided for 361 people (46 percent of the population in need) in Okmulgee County and 406 people (one-third of the population in need) in McIntosh County.<sup>73</sup> Another thirty-eight Cherokee families were provided with sanitary facilities in 1967.<sup>74</sup>

Results of health improvement efforts remained mixed, however. Among those served by the BIA's Tahlequah agency, a reported 75 percent had water facilities, but some of these facilities were inadequate. Among the Seminoles served by the Wewoka agency, an estimated 75 percent lacked sanitary facilities in 1967.<sup>75</sup> The Indian health area director for the Oklahoma City Area Office reported in January 1968 that many clinics did not adequately serve their clients' health care needs. Other clinics were being built. Unfortunately, the Claremore and Clinton facilities suffered from inadequate staffing and dental care. Budgetary freezes and contract restrictions had "severely curtailed" the construction of sanitary facilities.<sup>76</sup> Nevertheless, the positive changes pleased members of the Five Tribes. At a May 1968 NCAI meeting in Oklahoma City, attended by representatives of the Cherokee and Choctaw peoples, the Indians passed a resolution stating that "The Indians of Oklahoma are extremely pleased with the Public Health Service, Division of Indian Health, of involving the Indian people in planning and carrying out their programs."<sup>77</sup>

By 1968, AIPC and its constituents had reason to be “extremely pleased” as well. As with the Five Tribes, the Pueblos were experiencing improved living conditions as a result of increased federal actions—actions inspired to a significant degree by the American Indians themselves. Three “trachoma teams” examined Indians within the BIA’s Albuquerque area (which included the Pueblos) in an attempt to identify and treat those suffering from the disease.<sup>78</sup> At Zuni Pueblo, 98 percent of the homes had running water and 75 percent had sanitary facilities by the end of 1967. Nevertheless, many out-houses remained and “The removal of all privies is necessary to achieve the ultimate aim of assisting the [Zuni] people in improving the environmental health.” The Zunis also had “a dire need” for PHS “to extend waterlines and enlarge the sewer lagoons.”<sup>79</sup> All of the homes in the Pojoaque and Ildefonso Pueblos had individual home water facilities and sewage or sanitary facilities by 1967. In contrast, none of the homes in Nambe, San Felipe, Santa Anna, Taos, and Zia were similarly equipped.<sup>80</sup> The Nambe Pueblo governor reported the following year, however, that a sewer and water system would be dedicated. He wrote that this and other projects “greatly improved the living conditions of the Nambe Pueblo people.”<sup>81</sup>

Residents of Laguna Pueblo benefited from the activities of nine home health aides funded by OEO. During 427 home visits, the aides did housework for those in need of assistance due to such conditions as blindness or arthritis. They also publicized a cancer detection survey conducted by PHS physicians. The aides ran weekly meetings to help recovering alcoholics as well.<sup>82</sup>

In late 1968, AIPC Chairman Montoya reported that AIPC’s Health Committee, like the Inter-Tribal Council in Oklahoma, had successfully convinced DIH to expand services. After “many months” of lobbying, DIH—perhaps chastened by its experience with the Five Tribes in Oklahoma the previous year—agreed “to provide eye examinations and prescriptions.” The Pueblo committee members “were also instrumental in obtaining a clinic for Picuris Pueblo.” The Indians convinced PHS officials—“after many letters”—to provide an adequate number of nurses for Indian medical facilities. AIPC helped initiate a “Maternal Health Study Project” in cooperation with PHS and the University of New Mexico to reduce infant mortality.<sup>83</sup>

Domingo Montoya observed that, with better sanitation at Sandia Pueblo, the rates of disease (especially diarrhea) and death had been “reduced sharply.”<sup>84</sup> Government figures supported Montoya. By 1967, overall death rates for Native Americans from pneumonia and influenza had dropped 37 percent.<sup>85</sup> HEW reported in February 1968 that infant death rates had declined 28 percent over the previous several years.<sup>86</sup> From 1965 to 1970, deaths from tuberculosis and gastrointestinal diseases had gone down 39 percent and 40.5 percent, respectively.<sup>87</sup> A Choctaw nurse at the Talihina Indian Hospital concluded as well that federal policies had improved Indian health. She stated that “the government has really helped” to increase Native American living standards because of “a rural water system” and other sanitation projects.<sup>88</sup>

Several reasons help explain these improvements in American Indian health. Sanitation programs reduced conditions, such as tainted drinking

water, that allowed certain diseases to flourish and be more easily transmitted. The growth in health care facilities and personnel—as well as relaxed eligibility requirements—meant that services were more readily available and could accommodate more patients. These trends also stemmed from the fact that PHS proved more effective than the BIA at securing larger congressional appropriations. In addition, PHS offered better salaries and benefits than did the BIA, thus attracting a higher caliber of health care professionals.<sup>89</sup>

Despite improvements, American Indians' health status continued to lag behind that of the general population. In February 1968, HEW concluded that "The health level of the Indian people...is the lowest of any population group, despite considerable efforts by the Government to improve it." Infant death rates were one and one-half times greater than the rest of the country. The average Indian life expectancy was less than that for a member of the general population. More than one-half of all Indians continued to get water from contaminated sources.<sup>90</sup> Rates of death from pneumonia and influenza remained two and one-half times higher than the rest of the population.<sup>91</sup> Among the Pueblos in February 1968, rates of disease and death remained higher than for the general population, and there existed a significant problem with polluted water and mosquitoes. DIH officials argued, however, that much improvement had taken place since 1955.<sup>92</sup>

Several factors help account for the persistence of high disease and death rates among Indians. Indians continued to suffer from overcrowded and substandard housing, a major cause of health problems.<sup>93</sup> The significant growth of the Native American population during the twentieth century meant that there were more people needing medical care. The proportion of Indians utilizing federal health care services grew as well because of greater acceptance of Western medical practices and DIH education campaigns. At the same time, while the PHS offered higher salaries than the BIA, the federal agency still had a difficult time recruiting an adequate number of physicians and nurses because of the comparatively low pay and "unattractive reservation locations."<sup>94</sup>

Inadequate funding stood out as perhaps the most critical factor affecting Indian health levels at the end of the 1960s. As historian Robert A. Trennert's study of the Navajos has shown, the federal government has long failed to adequately fund Indian health services.<sup>95</sup> Even during the liberal administrations of John Kennedy and Lyndon Johnson, federal expenditures for Native health care, while growing, simply did not meet existing needs. The primary reason for this situation was that administration policymakers—in order to minimize opposition to expanded social welfare programs—requested funding levels for programs that proved, at least in retrospect, largely inadequate. For example, a presentation by Interior Secretary Stewart L. Udall to the Senate Appropriations Committee emphasized his and other executive departments' commitment to "frugal management," "thrift," and "dollar-value-of-benefits-from-dollar-spent."<sup>96</sup> As White House staffer James Gaither explained, Congressional resistance to social welfare spending led the administration to request amounts of money that "were really rather small compared to the nature of the problem.... [Despite this], we probably didn't get fifty percent of what we requested, yet alone a much larger sum that's really needed." To

make matters worse, the Congress brought to power by the 1966 election was "clearly not as committed to ending poverty" as the previous one.<sup>97</sup> Other issues, such as the Vietnam War and a "gold crisis" in 1968, worked to limit government spending as well.<sup>98</sup>

This inadequate funding was especially unfortunate given the increasing costs of health care in the post-1945 era. According to Robert F. Allison of Seminole Municipal Hospital, hospital costs were rising from 10 to 15 percent a year by the end of 1967.<sup>99</sup> A DIH analysis of contracted medical services revealed an almost 11 percent increase in hospital care costs and an 18 percent increase in doctors' fees.<sup>100</sup> From mid-1966 to mid-1967, PHS had \$90,813,000 to spend on health services for Indians. From mid-1967 to mid-1968, the PHS budget for Indian health care had risen to \$98,853,000.<sup>101</sup> Hence, funding for the agency primarily responsible for Indian health services increased less than 9 percent, while costs rose between 10 and 18 percent. To make matters worse, the Five Tribes' Inter-Tribal Council reported that Congress cut \$380 million from the HEW appropriation in early 1968.<sup>102</sup>

Despite their limitations, Indian health programs provided a vehicle through which Indians achieved greater self-determination. Not only had the Five Tribes and the Pueblos succeeded in gaining greater say over DIH decisions regarding personnel and policies, but the Johnson administration also had come to favor other Indian peoples having similar power. In early 1968, the White House instructed HEW Secretary Wilbur J. Cohen to make certain that, whenever possible, "a community participation' component be built into every Federal health program for Indians." Cohen reported that tribal councils exerted a growing influence over determining locations and priorities for health and sanitation projects. In addition, Indian community health organizations had played roles in solving operational problems. The secretary stated that PHS had a commitment to "encouraging tribal participation in health program matters" and that identifying areas where such participation could take place constituted "a permanent feature of the Division's activities."<sup>103</sup>

Others in the Indian service bureaucracy expressed such views. The acting commissioner of Indian affairs in September 1968 advised his subordinates that "Tribal involvement [in the creation and implementation of Indian programs] should be on as broad a base as possible and on a continuing basis."<sup>104</sup> Walter Olson, Albuquerque area director, wrote the following month that the area's tribes "regularly participate in program planning activities" and that "we should make certain that tribal involvement is carried [out] on a continuing basis."<sup>105</sup> In addition, by early 1969, Indians made up an estimated 50 to 60 percent of the federal Indian health services bureaucracy.<sup>106</sup>

Clearly, by the late 1960s, the Five Tribes and Pueblos had achieved greater self-determination over health care programs and policies. In large measure, such self-determination stemmed from an increase in Indian assertiveness. Yet such boldness came at a time when Indian health levels were improving overall, not when they were at their worst. The confluence of several factors accounts for this. Indians actively participated in the antipoverty

programs of the mid-to-late 1960s, and as historian James T. Patterson has pointed out, these programs encouraged empowerment and assertiveness among the poor.<sup>107</sup> According to John Echohawk (Pawnee), the director of the Native American Rights Fund (NARF), the antipoverty programs particularly benefited Native Americans. The local bureaucracies that developed from the operation of programs within Indian country gave Indians valuable administrative experience and a sense that they could successfully exercise control over their own lives. Johnson's War on Poverty's educational and legal services programs helped Indians learn that they had rights—such as those stipulated in treaties with the United States—and taught them how to protect those rights.<sup>108</sup>

These antipoverty programs in particular affected Indian health care in a positive way. War on Poverty funds often supplemented PHS expenditures for health care activities. As mentioned above, Office of Economic Opportunity (OEO) dollars subsidized clinics for Indians in Oklahoma as well as in other states. The agency paid for the training of American Indians to serve as community health aides in New Mexico. The OEO also funded local antipoverty agencies such as Oklahomans for Indian Opportunity (OIO), which in turn lobbied for improved health services.<sup>109</sup> For example, OIO leaders LaDonna Harris (Comanche) and Iola Taylor (Comanche) succeeded in getting DIH to open several additional clinics in Oklahoma by late 1967.<sup>110</sup>

Other factors, both internal and external, help shed light on how and why federal health care policies promoted Indian self-determination. Both the Five Tribes and the Pueblos had formal, representative, inter-group governmental structures: the AIPC and the Inter-Tribal Council. Such structures made it easier for the Indian peoples to present their wishes to federal officials in a credible fashion. As noted earlier, Native Americans made up a majority of the health care bureaucracy by the mid-to-late 1960s. Such numbers undoubtedly gave Indians greater opportunities to influence the development and implementation of health care policies and programs, especially as Native Americans like Calvin Beames and Forrest Gerard moved into higher-ranking positions.

Also important in the development of health care policy and self-determination were the actions of Black activists and the responses of policymakers and Indians to those actions. The willingness of the government to address the concerns raised by the African American civil rights movement and, to a lesser degree, the Black Power movement suggest that many officials in the 1960s were prepared to be more responsive than their predecessors and successors to the wishes of the poor and people of color. Historian Robert Dallek, for example, has argued that President Johnson had a sincere sympathy for "the suffering of the disadvantaged" and thus sought to protect the rights of non-whites.<sup>111</sup>

In addition, as scholar George Pierre Castile puts it, Black activism "raised the clout of all ethnic constituencies" and "provided Native American activists with models of the tactics of civil disobedience, confrontation, and demonstration."<sup>112</sup> Some Native Americans adopted these models and tactics to advance the causes of self-determination and improved health care, among other issues, into the 1970s. As early as 1967, NCAI Executive Director Vine

Deloria, Jr. (Standing Rock Sioux) informed federal officials that “Tribes seem to be watching the Negro make gains[,] and the younger Indians are beginning to get more militant as they think that violence is the only way to get attention.”<sup>113</sup> The rise of the American Indian Movement (AIM) the following year and the Red Power protests of the late 1960s and early ’70s—such as the occupation of Alcatraz Island, the Trail of Broken Treaties, the takeover of the BIA building in Washington, and the seizure of Wounded Knee—bore out Deloria’s prediction. In 1974, Deloria again emphasized to federal officials that these protests occurred “because many [Indian] people had become increasingly convinced that violence was the only way the federal government would pay attention [to Indians].”<sup>114</sup> This Red Power activism, according to sociologist Joane Nagel, played a role in the passage of several important pieces of Indian legislation in the 1970s, some of which increased Indian control over health care services.<sup>115</sup> Through the Indian Self-Determination and Education Assistance Act of 1975, tribes could contract with the federal government to run programs previously administered by government agencies. The Indian Health Care Improvement Act of 1976 increased federal funding for building and renovating health care facilities and for recruiting and training Indians to serve in the Indian Health Service.<sup>116</sup>

Perhaps the most important factor in the increasingly successful demands of Indians for expanded health services and greater control over those services was the “revolution of rising expectations” that took place in Indian country. As scholars James C. Davies and Crane Brinton have pointed out, movements for change often occur not when circumstances are at their worst, but when conditions begin to get better. Improvements create the realization that life can and should be different. If improvements fail to meet these rising expectations, then people are more likely to become dissatisfied and more likely to call for changes to meet their expectations.<sup>117</sup>

This is the irony of Indian health care in the 1950s and ’60s. Congress transferred Indian health services to PHS with the belief that the move would improve Indian health and thus prepare Indians for termination. While the action did not bring Indian health up to the same level as that of the general population, the transfer did help make Indian country a healthier place to live. These improvements created expectations among the Five Tribes, the Pueblos, and other Native Americans that their health and other aspects of their lives could and should be better. In fact, by February 1967, BIA Commissioner Robert L. Bennett (Oneida) observed that “the revolution of rising expectations has at last reached the reservation areas.”<sup>118</sup> As part of that “revolution,” the Cherokees, Choctaws, Chickasaws, Creeks, Seminoles, and Pueblos successfully pushed the federal government to increase rather than decrease health services and to allow Indian nations more say over the development and delivery of health-related services. In other words, the gains in health care after 1954—not simply the disparity of health levels between Indians and non-Indians—prompted American Indians to push for enhanced services and more self-determination.

This is not to say that Indians had no interest in improved health services before the 1960s. As mentioned earlier, the NCAI and Indian veterans had



demanded better health care as early as the mid-1940s. It is important to note, however, that such demands came after many Indians had experienced improved health care because of the New Deal and military service during World War II. Why did Indians not aggressively and publicly demand better health services before the 1930s and '40s? After all, in the early part of the twentieth century, in the words of historian Robert A. Trennert, there occurred "a rapid acceleration of deadly and debilitating diseases that dramatically increased Indian morbidity rates and brought about a new level of tribal suffering."<sup>119</sup> If recognition of the disparities between Indian and non-Indian health levels was the only force driving demands for better health care, many Indians should have made such demands in the 1910s and '20s. The reason that such "tribal suffering" did not spark numerous and loud Indian cries for better health services at that time was that the combination of factors was not in a place to allow Indians to make such demands effectively and to believe that federal officials could or would act upon such demands. That combination of factors included improvements in Indian health, the existence of effective organizations among the Five Tribes and Pueblos, the presence of large numbers of Indians within the federal bureaucracy, tribal empowerment fueled by the War on Poverty, and increased receptivity of the government to the expressed desires of the poor and people of color. Consequently, once these factors came to be in place in the 1950s and '60s, Indian demands became more forceful and effective, and federal officials became more responsive.

In his study of Indian policy from 1880 to 1920, historian Frederick Hoxie points out that racism retarded efforts to assimilate Native Americans in white society. As a result, Indians had a greater opportunity to preserve their distinctive cultures and societies.<sup>120</sup> Given the irony of that situation, it should come as no surprise that actions designed to terminate federal responsibility for Indian health care led to increased federal responsibility and greater Indian self-determination instead.

## NOTES

1. Works focusing exclusively on termination include Larry W. Burt, *Tribalism in Crisis: Federal Indian Policy, 1953-1961* (Albuquerque: University of New Mexico Press, 1982); Thomas W. Cowger, "The Crossroads of Destiny: The NCAI's Landmark Struggle to Thwart Coercive Termination," *American Indian Culture and Research Journal* 20:4 (1996): 121-144; Donald L. Fixico, *Termination and Relocation: Federal Indian Policy, 1945-1960* (Albuquerque: University of New Mexico Press, 1986); Larry J. Hasse, "Termination and Assimilation: Federal Indian Policy, 1943-1961," (Ph.D. diss., Washington State University, 1974); Kenneth R. Philip, *Termination Revisited: American Indians on the Trail to Self-Determination, 1933-1953* (Lincoln: University of Nebraska Press, 1999); R. Warren Metcalf, "Arthur V. Watkins and the Indians of Utah: A Study of Federal Termination Policy" (Ph.D. diss., Arizona State University, 1995); R. Warren Metcalf, "Lambs of Sacrifice: Termination, the Mixed-Blood Utes, and the Problem of Indian Identity," *Utah Historical Quarterly* 64 (Fall 1996): 322-343.

Works addressing self-determination exclusively include George Pierre Castile, *To Show Heart: Native American Self-Determination and Federal Indian Policy, 1960–1975* (Tucson: University of Arizona Press, 1998); Thomas F. Clarkin, “The New Trail and the Great Society: Federal Indian Policy, 1961–1969” (Ph.D. diss., University of Texas, 1998); Daniel M. Cobb, “Philosophy of an Indian War: Community Action in the Johnson Administration’s War on Indian Poverty, 1964–1968,” *American Indian Culture and Research Journal* 22:2 (1998): 71–102; Christopher Riggs, “Indians, Liberalism, and Lyndon Johnson’s Great Society, 1963–1969” (Ph.D. diss., University of Colorado, 1997); Stan Steiner, *The New Indians* (New York: Harper and Row Publishers, 1968); Wilcomb E. Washburn, “The Native American Renaissance, 1960–1995,” in *The Cambridge History of the Native Peoples of the Americas*, vol. I, North America, part 2, eds. Bruce Trigger and Wilcomb E. Washburn (Cambridge: Cambridge University Press, 1996).

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2. Because Indians who had relocated to urban areas generally were not eligible for federal Indian health care services, this article focuses on those who lived on the Pueblo reservations and the eastern Oklahoma communities of the Five Tribes.

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4. James J. Rawls, *Chief Red Fox Is Dead: A History of Native Americans Since 1945* (Fort Worth, TX: Harcourt Brace College Publishers, 1996), 82.

5. Robert A. Trennert, *White Man’s Medicine: Government Doctors and the Navajo, 1863–1955* (Albuquerque: University of New Mexico Press, 1998), 95.

6. Prucha, *Great Father*, 985, 1069.

7. Congress, House, Committee on Interior and Insular Affairs, Subcommittee on Indian Affairs, *A Review of the Indian Health Program: Hearings Before the Subcommittee on Indian Affairs*, 88th Cong., 1st sess., 23 May 1963, 5. As with most of the health statistics used in this article, it is unclear whether the numbers were adjusted for age.

8. Congress, House, “Transferring the Maintenance and Operation of Hospital and Health Facilities for Indians to the Public Health Service,” *House Report* no. 870, Serial Set 11667, 83d Cong., 1st sess., 1953: 14.

9. Congress, Senate, 83d Cong., 2d sess., *Congressional Record*, 1954, vol. 100, pt. 7, 8959.

10. Congress, Senate, 83d Cong., 2d sess., *Congressional Record*, 1954, vol. 100, pt. 7, 8961.

11. Fixico, *Termination*, 92.

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21. House, *Review of Indian Health Program*, 45–46.
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