

**INDIGENOUS HEALTH POLICY IN THE UNITED STATES AND LATIN
AMERICA: THE MARSHALL TRILOGY AND THE INTERNATIONAL
HUMAN RIGHTS APPROACH**

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* J.D. Candidate, James E. Rogers College of Law, University of Arizona, 2016. I dedicate this note to my parents, who have always supported my educational pursuits. In addition, I would like to thank Professor Christopher Robertson, who supervised this note. I also thank all of my professors who inspired my interest in indigenous peoples and the issues they currently face. I also greatly appreciate the contributions and hard work of my fellow colleagues at the *Arizona Journal of International & Comparative Law* who made this publication possible.

I. INTRODUCTION

A. The State of Indigenous Peoples' Health Today

On a global scale, indigenous peoples' health is significantly poorer than non-indigenous populations.¹ Traditionally, indigenous people have suffered from maternal and infant mortality rates, malnutrition, and infectious disease.² The Pan American Health Organization (PAHO) commented on the modern health problems indigenous people face: "as the [indigenous] populations become more mobile, less isolated, increasingly urban and located in border areas, chronic diseases and issues such as use of drugs and alcohol, suicide, sexually transmitted diseases, and loss of influence of traditional health practices have become increasingly important."³ The United Nations, in the *State of the World's Indigenous Peoples Report*, identified the major reasons for these poor healthcare outcomes: (1) environmental contamination and degradation; (2) high levels of poverty;⁴ (3) structural racism and discrimination inherited from colonial times;⁵ (4) loss of property and traditional lands;⁶ and (5) remoteness.⁷

To address these problems, countries implement laws and policies based on one of two models. The two major models are the International Human Rights Approach and the United States's Federal Indian Law Approach (the Marshall Model).⁸ A country will typically adopt one model based on its legal system. Civil law nations generally adopt the International Human Rights Approach, which they implement through international treaties and resolutions. Civil law countries are legally bound to these international instruments when the State

¹ U.N. DEPT. OF ECON. & SOC. AFFAIRS, STATE OF THE WORLD'S INDIGENOUS PEOPLES, at 161, ST/ESA/328, U.N. Sales No. 09.VI.13 (2009) [hereinafter STATE OF THE WORLD'S INDIGENOUS PEOPLES].

² Pan American Health Org., Health of the Indigenous Peoples of the Americas, at 3, 58th Sess., CD47/13 (Aug. 18, 2006) [hereinafter PAHO 2006].

³ *Id.*

⁴ The U.N. identified extreme poverty as a major barrier to accessing healthcare for indigenous people. This does not only apply to indigenous peoples. Eliminating extreme poverty is one of the Millennium Development Goals, meant to apply to all persons. According to the most recent Millennium Development Goals Report, the world has reduced extreme poverty by half. See U.N. DEPT. OF ECON. & SOC. AFFAIRS ET. AL., THE MILLENNIUM DEVELOPMENT GOALS REPORT, (2014), <http://www.un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20English%20web.pdf>.

⁵ The significant mental health disparity between indigenous and non-indigenous peoples has been attributed to effects of colonialism. Dispossession of traditional lands and prohibitions of cultural practices are particularly relevant to the mental disorders indigenous people's experience. See Karina Czyzewski, *Colonialism as a Broader Social Determinant of Health*, 2 INT'L INDIGENOUS POL'Y J. 5, 7 (2011).

⁶ STATE OF THE WORLD'S INDIGENOUS PEOPLES, *supra* note 1, at 163.

⁷ *Id.* at 173.

⁸ See DAVID H. GETCHES ET AL., CASES AND MATERIALS ON FEDERAL INDIAN LAW 952 (6th ed. 2011).

government signs and ratifies them.⁹ In contrast, common law nations typically do not sign or ratify international treaties and resolutions affecting the rights of indigenous peoples. Rather, common law countries rely on judge-made law.¹⁰ Recognizing international documents as having a binding effect on the legal system is contrary to the long history of judge-made law in the governance of indigenous peoples. Therefore, common law nations like the United States follow something analogous to the Marshall Model.

In this Note, I compare the Marshall Model in the United States against the International Human Rights Approach as adopted by Latin American countries.¹¹ I conclude that the Marshall model is theoretically the superior model for addressing health disparities. The International Human Rights Model places positive obligations on States to ensure a minimal standard of human health, while the Marshall Model places greater emphasis on indigenous self-determination and self-governance. Rather, State policies that promote self-determination and self-governance position indigenous peoples to directly address health disparities. The International Human Rights Model has focused on indigenous involvement in healthcare programs but has not done so as effectively as has the Marshall Model.

I begin by addressing why Latin America is a good basis for comparison with the Marshall Model. Section II discusses the Marshall Model, giving a brief background and an historical account of how it was used in regards to health. I then discuss how the government used the Marshall Model in the self-determination era and important legislation affecting the health of Native Americans.¹² Section III changes focus to the International Human Rights Model. I address its origins and the international documents affecting the rights of indigenous peoples. I describe how domestic courts have interpreted the International Labour Organization Convention 169 (ILO 169) to place an obligation on the State to fulfill the right to health. I then consider the Inter-American Court's interpretation of the American Convention on Human Rights' provision on the right to life that includes adequate health. Section IV compares the two models and their uses in addressing health disparities. I find that the Marshall Model is better at addressing health disparities because of its focus on self-determination and self-governance of indigenous peoples over healthcare. I conclude that indigenous peoples in Latin America can use the self-determination emphasis in domestic and regional courts to force the State to create community-

⁹ *What is a Treaty*, THE LIBR. OF CONGR. (Feb. 6, 2016), <https://www.loc.gov/rr/main/govdocsguide/TreatyDefinition.html> (“Under international law, a ‘treaty’ is any legally binding agreement between nations.”).

¹⁰ *The Common Law and Civil Law Traditions*, THE ROBBINS COLLECTION, <https://www.law.berkeley.edu/library/robbins/pdf/CommonLawCivilLawTraditions.pdf>.

¹¹ By Latin America, I am referring to all countries in North and South America whose primary languages are Spanish or Portuguese (the Latin languages).

¹² When I use the word Native American, I refer generally to Native Americans and Alaskan Natives.

based health services and meet the “minimum” standard of health under the International Human Right’s framework.

1. Why Latin America as a Basis for Comparison?

Limiting the scope of analysis between U.S. Federal Indian Law and the International Human Rights Approach in Latin America is of significant interest for at least two reasons. First, the U.S. and Latin American countries have large indigenous populations. The United States and Colombia have over 500,000 indigenous people, more than five percent of each country’s population.¹³ In Peru, Bolivia, Guatemala, and Ecuador, indigenous peoples represent more than 40% of the total population.¹⁴

Second, American countries are part of regional organizations and treaties that emphasize resolving domestic and international problems. The Organization of American States (OAS) is the most prominent of these. All 35 countries in the Americas are parties to the OAS, which was “developed to achieve an order of peace and justice, to promote solidarity, to strengthen their collaboration, and to defend their sovereignty, their territorial integrity, and their independence.”¹⁵ In addition, the OAS passed the American Convention on Human Rights (ACHR), an international human rights instrument, which emphasizes that all persons in the Americas are ensured full and free exercise of certain human rights and freedom.¹⁶ The OAS set up the Inter-American Commission of Human Rights to monitor American States that infringed upon these guaranteed rights and freedoms.¹⁷ Also, OAS established the Inter-American Court of Human Rights to adjudicate and advise on matters involving the ACHR.¹⁸ American States are also part of the PAHO. PAHO’s essential mission is to strengthen national and local health systems and improve health outcomes for all peoples in the Americas.¹⁹ While these organizations address

¹³ PAHO 2006, *supra* note 2, at Annex A.

¹⁴ *Id.*

¹⁵ Organization of American States, Charter of the Organization of the American States ch. I, art. 1, Feb. 27, 1967, O.A.S.T.S. No. 1-A, 721 U.N.T.S. 324 [hereinafter O.A.S. Charter].

¹⁶ Organization of American States, American Convention on Human Rights [Pact of San José], ch. I, art. 1, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123, <http://www.cidh.org/basicos/english/Basic4.Amer.Conv.Ratif.htm> [hereinafter O.A.S. Convention].

¹⁷ O.A.S. CHARTER, *supra* note 15, ch. XV, art. 106.

¹⁸ Organization of American States, *Statute of the Inter-American Court of Human Rights* (Jan. 1, 1980), <http://www.oas.org/en/iachr/mandate/Basics/statutecourt.asp>.

¹⁹ PAN AM. HEALTH ORG., BASIC DOCUMENTS OF THE PAN AMERICAN HEALTH ORG.: CONSTITUTION OF THE PAN AMERICAN HEALTH ORG., WORLD HEALTH ORG., at 9, Official Document No. 341 (2012), http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=18859&Itemid.

health concerns for indigenous peoples, the common law nations refuse to treat their actions as binding law. For example, the United States and Canada have not ratified the ACHR, although they are both members of the OAS.²⁰ These countries instead cling to their customary judge-made law. Therefore, these regional organizations can bind only some countries but not others.

II. THE MARSHALL TRILOGY IN THE UNITED STATES

U.S. Federal Indian law centers on four principles from three cases authored by Chief Justice Marshall: *Johnson v. McIntosh*, *Cherokee Nation v. Georgia*, and *Worcester v. Georgia*.²¹ These cases are often called the Marshall Trilogy, causing U.S. Federal Indian Law to be known as the Marshall Model. The Marshall Trilogy defines the rights Native Americans possess—or don't possess—by virtue of their conquered status. These cases provided the framework for Native American law for the next 150 years. The four principles are (1) congressional plenary power; (2) diminished tribal sovereignty (the implicit divestiture doctrine); (3) the trust doctrine; and (4) the canons of construction.

These principles are not unique to the United States. For instance, foreign countries in the 1800s formulated policy for indigenous peoples on the basis of the trusteeship doctrine.²² “In Brazil, legislation established Indians as wards of the state and set in motion government programs to manage their affairs and facilitate their adoption of Euro-Brazilian ways.”²³ Venezuela, in passing the 1915 Mission Act, delegated the responsibility of “civilizing” the Native Americans and moving them to established settlements to the Catholic Church.²⁴ However, these Latin American countries did not fully adopt the principles of the Marshall Model. Rather, Latin American countries have primarily adopted the principles of the International Human Rights Model, either in their constitutions or through the ratification of international agreements.

A. Native American Health Prior to 1961

U.S. Federal Indian policy and law can be divided into five periods: (1) the Formative Years (1789-1871);²⁵ (2) the Allotments and Assimilation Period

²⁰ O.A.S. Convention, *supra* note 16.

²¹ Matthew L.M. Fletcher, *The Iron Cold of the Marshall Trilogy*, 82 N.D. L. REV. 627, 627-28 (2006).

²² JAMES ANAYA, *INDIGENOUS PEOPLES IN INTERNATIONAL LAW* 25 (1st ed., 1996).

²³ *Id.*

²⁴ *Id.*

²⁵ GETCHES ET AL., *supra* note 8, at 74. Also known as the “Treaty-Making Era.” This is when treaties between Congress and the tribes defined the relationships, tribal boundaries, and limits of tribal sovereignty. *Id.*

(1871-1928); (3) the Period of Indian Reorganization (1928-1945); (4) the Termination Period (1945-1961); and (5) the Era of Self-Determination (1961 to present).²⁶

During the Formative Years, the federal government did not assume substantial administrative control to deal with health on the reservations.²⁷ However, there were instances where the federal government became involved in Native American health. Military physicians provided healthcare to Native Americans for infectious diseases such as smallpox.²⁸ In 1832, Congress provided \$12,000 for the immunization of smallpox for Native Americans.²⁹ Congress also created a program to provide health services for the Ottawa and Chippewa Native Americans.³⁰ Health services for Native Americans were consolidated in the War Department and transferred to the Department of the Interior.³¹

A significant change occurred in the Allotment and Assimilation Period. The emphasis in this period was to “make individual landowners and farmers of the Native Americans, without reference to tribe or traditional community life.”³² The idea was to assimilate Native Americans into the broader society. The Indian Allotment Act³³ was the major statute that defined the period. The four Marshall principles were affirmed in *Lone Wolf v. Hitchcock*³⁴ and *United States v. Kagama*.³⁵ In *Lone Wolf*, the Court justified Congress’s abrogation of past treaties

²⁶ *Id.* at 216-43.

²⁷ U.S. DEP’T OF HEALTH AND HUMAN SERVS., THE FIRST 50 YEARS OF THE INDIAN HEALTH SERVICE CARING & CURING, http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/GOLD_BOOK_part1.pdf. (last visited Mar. 20, 2016) [hereinafter THE FIRST 50 YEARS OF THE INDIAN HEALTH SERVICE]; see also S. LYMAN TYLER, A HISTORY OF INDIAN POLICY 95 (1973).

²⁸ COHEN’S HANDBOOK OF FEDERAL INDIAN LAW § 22.04 (Nell Jessup Newton ed. 2012) [hereinafter COHEN’S HANDBOOK].

²⁹ THE FIRST 50 YEARS OF THE INDIAN HEALTH SERVICE, *supra* note 27.

³⁰ *Id.*

³¹ *Id.* at 7-8.

³² LYMAN TYLER, *supra* note 27.

³³ 25 U.S.C.A. § 331 (1992). § 331 reads:

In all cases where any tribe or band of Indians has been or shall be located upon any reservation created for their use by treaty stipulation, Act of Congress, or Executive order, the President shall be authorized to cause the same or any part thereof to be surveyed or resurveyed whenever in his opinion such reservation or any part may be advantageously utilized for agricultural or grazing purposes by such Indians, and to cause allotment to each Indian located thereon to be made in such areas as in his opinion may be for their best interest not to exceed eighty acres of agricultural or one hundred and sixty acres of grazing land to any one Indian. . . .

³⁴ *Lone Wolf v. Hitchcock*, 187 U.S. 553 (1903).

³⁵ *United States v. Kagama*, 118 U.S. 375 (1886).

through Congressional plenary power.³⁶ *Kagama* upheld the implementation of the Major Crimes Act,³⁷ reasoning that because Native Americans were weak and dependent on the United States, it was constitutional for Congress to pass legislation that allowed federal courts to try certain criminal acts between Native Americans that occurred on reservation land.³⁸ These cases on the Congressional plenary power and the trustee doctrine gave Congress the power to break up reservations through the Allotment Act and, because of the weakness and dependence of the Native Americans, create programs, legislation, and administrative agencies to “look out for the Native Americans’ best interests.”³⁹ The foundations of the Indian Health Service arose in this period.⁴⁰

In 1911, a Native American health program became a regular activity of the Indian Office administration.⁴¹ Health surveys made in Native American schools and reservations revealed an alarming rate of tuberculosis and trachoma.⁴² The deplorable health conditions prompted President Taft to ask Congress to appropriate money to improve the health situation.⁴³ Using trusteeship doctrine language, President Taft wrote, “As guardians of the welfare of the Native Americans, it is our immediate duty to give the race a fair chance for an unmaimed birth, healthy childhood, and physically efficient maturity.”⁴⁴ From 1911–1918, the appropriations from Congress for Native American medical service increased from \$40,000 to \$350,000.⁴⁵ In 1921, Congress passed the Snyder Act, delegating to the Bureau of Indian Affairs the power to direct, supervise, and expend money from Congress for the benefit of Native Americans.⁴⁶ One purpose was “for relief of distress and conservation of

³⁶ Lone Wolf, 187 U.S. at 566. Congressional plenary power is not subject to higher levels of scrutiny but only to rational basis review, which can easily be met through trustee doctrine language such as “being in the best interests of the Indians.”

³⁷ 18 U.S.C. § 1153 (2013). Major crimes include “murder, manslaughter, kidnapping, maiming, a felony under chapter 109A, incest, assault with intent to commit murder, assault with a dangerous weapon, assault resulting in a serious bodily injury, an assault against an individual who has not attained the age of 16 years, arson, burglary, robbery, and a felony under section 661 of this title within the Indian country.” *Id.* at (a).

³⁸ *Kagama*, 118 U.S. at 383-84.

³⁹ See generally COHEN’S HANDBOOK, *supra* note 28, at § 1.04.

⁴⁰ Brett Lee Shelton, *Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States*, THE HENRY J. KAISER FAMILY FOUNDATION (Feb. 2004), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/legal-and-historical-roots-of-health-care-for-american-indians-and-alaska-natives-in-the-united-states.pdf>. There had been a previous attempt in 1873. *Id.* See also TYLER, *supra* note 32, at 107.

⁴¹ TYLER, *supra* note 32, at 107.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.* at 108.

⁴⁵ *Id.*

⁴⁶ 25 U.S.C. § 13 (2014).

health.”⁴⁷ The Snyder Act is still one of the principal laws authorizing funding for Native American healthcare services.⁴⁸

Even with this greater emphasis on Native American health, the *Meriam Report*, a comprehensive study of Native American conditions in all facets of life, exposed that health outcomes remained abysmal. The *Meriam Report* revealed that “Indians were living in grinding poverty, that Indian health and education were in an abominable state, and that government policies were not working.”⁴⁹ In response, Congress passed the Indian Reorganization Act (IRA).⁵⁰ The IRA gave tribes the option to establish their own governments and assume control over their affairs or to merge into white society.⁵¹ The Reorganization period sought to give Native Americans control of their affairs and property.⁵²

However, the IRA did not have the impact Congress had hoped for and the Termination Era resulted from the IRA’s failure. Thereafter, “with respect to government services, the policy of the Termination Era was to end the importance of the BIA by turning its responsibilities over to states, non-profits, and other federal agencies.”⁵³ During this period, the Indian Health Service (IHS) was transferred from control of the BIA to the Department of Health and Human Services (DHHS), where it remains today.⁵⁴

B. The Marshall Model and Health in the Self-Determination Era

Federal policies in the 1960s advanced the shift away from the Termination policies toward contemporary policy and the advent of the Self-Determination Era.⁵⁵ The emphasis in this era is for tribal organizations to gain control over federal programs to better respond to the needs of the community.⁵⁶

⁴⁷ *Id.*

⁴⁸ Donald Warne & Linda Bane Frizzell, *American Indian Health Policy: Historical Trends and Contemporary Issues*, 104 AM. J. PUB. HEALTH S263, S263 (2014), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035886/#bib16>.

⁴⁹ *Tribal Self-Government and the Indian Reorganization Act of 1934*, 70 MICH. L. REV. 955, 960 (1972).

⁵⁰ *Indian Reorganization Act*, ENCYC. BRITANNICA, <http://www.britannica.com/topic/Indian-Reorganization-Act>. (last visited Mar. 20, 2016). The Act was also known as the Wheeler-Howard Act. *The Indian Reorganization Act*, <https://tm112.community.uaf.edu/files/2010/09/The-Indian-Reorganization-Act.pdf>. (last visited Mar. 24, 2016).

⁵¹ ROBERTA ULRICH, AMERICAN INDIAN NATIONS FROM TERMINATION TO RESTORATION, 1953-2006 5 (2010).

⁵² COHEN’S HANDBOOK, *supra* note 28, at § 1.04.

⁵³ *Id.* at § 22.01.

⁵⁴ *Id.*

⁵⁵ *Id.* at § 1.07.

⁵⁶ *Id.* at § 22.01.

In the Self-Determination Era, Native Americans have had the most success via the legislative and executive branches.⁵⁷ The Self-Determination Era has been defined by a federal policy to implement legislation and programs that help tribal governments gain greater political control over their own lands.⁵⁸ The goal is to make reservations self-sufficient and economically sustainable enterprises.⁵⁹ This has included making major improvements to the administration of healthcare for Native Americans.

In 1975, Congress passed the Indian Self-Determination and Education Assistance Act (ISDEAA).⁶⁰ With regards to health, the act established two major goals: (1) to ensure the health of Native American people is at its highest level possible; and (2) to achieve maximum participation of Native American people within the healthcare field.⁶¹ It achieves these goals by allowing the Secretary of the Interior and the Secretary of Health and Human Service to enter into self-determination contracts.⁶² “Under Title V of ISDEAA, the funding agreement is a ‘638 compact’ and is essentially a block grant for a total budget amount, and the tribes have [great] flexibility in reprogramming resources to meet local health needs.”⁶³ These 638 contracts allow Native American tribes to take control of any program, function, service, or activity of the IHS.⁶⁴ Tribes administer approximately half of all funding for IHS programs, and “as of 2009 ran 15 hospitals, 254 health centers, 18 school health centers, 112 health stations, and 166 Alaska Native village clinics.”⁶⁵

Although the federal government made great strides with the ISDEAA, the biggest criticism of providing health services to Native Americans is that those services were, and still are, chronically underfunded.⁶⁶ In response, Congress passed the Indian Healthcare Improvement Act (IHCA) in 1976. The IHCA authorized Medicaid reimbursements to both increase funding for healthcare services and for healthcare facilities.⁶⁷ States are reimbursed up to “100% Federal Medical Assistance Percentage (FMAP)” for the payments they make to IHS and tribal 638 programs.⁶⁸ The IHCA also increased the scope of funding of Native

⁵⁷ See generally COHEN’S HANDBOOK, *supra* note 28, at § 1.07.

⁵⁸ *Id.* at § 22.01.

⁵⁹ *Id.*

⁶⁰ *Id.* at § 1.07.

⁶¹ Indian Self-Determination and Education Assistance Act, Pub. L. No. 93-638, 83 Stat. 2203 (codified as amended at 25 U.S.C. §§ 450-458dd2-2 (2010)).

⁶² Warne & Frizzell, *supra* note 48, at S264.

⁶³ *Id.*

⁶⁴ *Id.* (outlining administrative and financial advantages of a 638 contract).

⁶⁵ COHEN’S HANDBOOK, *supra* note 28, at § 22.04.

⁶⁶ Warne & Frizzell, *supra* note 48, at S264.

⁶⁷ N.D. *ex rel.* Olson v. Ctrs. for Medicare & Medicaid Servs., 403 F.3d 537, 539 (8th Cir. 2005).

⁶⁸ Warne & Frizzell, *supra* note 48, at S265. There has been some litigation on what services entitle States to reimbursement. The Eight Circuit held that the 100% FMAP only applies to those services that are actually provided in IHS facilities. North Dakota *ex*

American healthcare services by establishing Urban Indian Health Programs. These programs are “funded through grants and contracts from I.H.S., under Title V of the [IHCIA],” and provide services for those Native Americans who live in urban centers.⁶⁹ However, Urban Indian Health Programs are not eligible for 100% Federal Medical Assistance Percentage.⁷⁰

Following the goals of the ISDEAA, the policies set out in the IHCIA advocate Native American involvement in the healthcare field. For example, the policy findings section of the statute states some goals:

(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities. . . .

(5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination.⁷¹

The most recent legislation affecting Native American health came in the form of the Affordable Care Act (ACA). It makes the IHCIA a permanent statute.⁷² Previously, the IHCIA had expired in 2000, but it was extended through 2001.⁷³ Congress continued to fund the IHCIA programs after its expiration.⁷⁴ However, the ACA, under Title X, makes the IHCIA a permanent statute, meaning that the IHCIA will never expire.⁷⁵ Along with reauthorization, the new IHCIA was amended with some major changes.⁷⁶ For instance, it expands grant and contract programs to tribal organizations and urban Native American

rel. Olson, 403 F.3d at 540. The Ninth Circuit held the “costs eligible for a FMAP reimbursement rate of 100 percent are “limited to those ‘received through’ an IHS facility which offers, is responsible for and bills Medicaid for services provided.” *Ariz. Health Care Cost Containment Sys. v. McClellan*, 508 F.3d 1243, 1254 (9th Cir. 2007).

⁶⁹ *Office of Urban Indian Health Programs*, INDIAN HEALTH SERV., <http://www.ihs.gov/urban/> (last visited Apr. 18, 2015).

⁷⁰ Warne & Frizzell, *supra* note 48, at S265.

⁷¹ 25 U.S.C. § 1602 (3), (5) (2014).

⁷² *The Affordable Care Act and the Indian Health Service*, INDIAN HEALTH SERV., (Mar. 2, 2015), <http://www.ihs.gov/aca/>.

⁷³ ELAYNE J. HEISLER & ROGER WALKE, INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111–48) 2 (2010), <http://www.ncsl.org/documents/health/indhltcare.pdf>.

⁷⁴ *Id.*

⁷⁵ *Id.* at 3.

⁷⁶ *Id.* at 4.

organization that were not previously eligible for such grants.⁷⁷ Another benefit of the ACA is that it attempts to increase access to health insurance. Currently, the rate of uninsured Native Americans is 30%, double the rest of the nation.⁷⁸ The ACA allows Native Americans to purchase insurance on the Health Insurance Marketplace at any time.⁷⁹ In addition, “tribal members with incomes below 300% of the federal poverty level . . . are exempt from paying deductibles, and copays, so they can purchase the cheapest plans without worrying about out-of-pocket expenses.”⁸⁰

III. RIGHT TO HEALTHCARE AND THE INTERNATIONAL HUMAN RIGHTS MODEL

Beginning in the 1950s and 1960s, indigenous peoples appealed to the international forum to advance their interests.⁸¹ The United States’s disparate and abusive treatment of indigenous peoples was the cause of these appeals.⁸² Historically, domestic law has failed to support indigenous interests and actually undermines them in some instances.⁸³ For example, “[in] many states, domestic law has and continues to permit the forcible dispossession of indigenous communities from their traditional land base, or contamination of that land base, so as to enable resources development by non-indigenous actors.”⁸⁴

The international forum has not always pursued the realization of individual human rights. After World War II, norms of the global forum were changing.⁸⁵ Matters exclusively in state control were pushed into the international sphere, including the treatment of the world’s citizens by individual states.⁸⁶ The United Nations Universal Declaration of Human Rights (UDHR) reflects the commitment to ensuring a level of health to which all humans are entitled.⁸⁷ Article 25 provides, “everyone has the right to a standard level of living adequate

⁷⁷ *Id.* (describing other substantial changes).

⁷⁸ Christine Vestal, *Affordable Care Act a hard sell for Native Americans*, USA TODAY (Oct. 15, 2013, 3:01 PM), <http://www.usatoday.com/story/news/nation/2013/10/15/stateline-obamacare-native-americans/2986747/>.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ Constance MacIntosh, *Role of Law in Ameliorating the Global Inequalities in Indigenous Peoples Health*, 41 J. L. MED & ETHICS 74, 77 (2013).

⁸² *Id.* at 77-78.

⁸³ ANAYA, *supra* note 22, at 39-42. Anaya’s book also provides a comprehensive account of the process indigenous people went through to decide that the international forum is the best place to appeal for their interests. *Id.* at 45-46.

⁸⁴ MacIntosh, *supra* note 81, at 77.

⁸⁵ *Id.* at 78.

⁸⁶ *Id.*

⁸⁷ G.A. Res. 217 (III) A, art. 25, Universal Declaration of Human Rights (Dec. 10, 1948), <http://www.un.org/en/documents/udhr/>.

for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services. . . .”⁸⁸ Both common law nations and civil law nations have signed on to the UDHR.⁸⁹

Although the UDHR deals with all persons, the United Nations has focused on individual rights of indigenous peoples in the form of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).⁹⁰ The U.N. adopted UNDRIP in 2007.⁹¹ It was the result of 25 years’ discussion between states, the global community, and indigenous people over indigenous norms and rights.⁹² Article 24 contains two provisions relevant to indigenous health.⁹³ The first provision provides that indigenous people should be able to practice traditional medicine and to have access to all social and health services.⁹⁴ The second provision states that indigenous peoples have an “equal right” to the highest attainable standard of physical and mental health.⁹⁵ In realizing these rights, the provision demands that States take necessary actions to ensure access to this level of healthcare.⁹⁶ These two provisions reflect that (1) indigenous peoples are guaranteed certain rights to health; (2) indigenous peoples can determine what health is according to traditional practices; and (3) States have a positive obligation to ensure indigenous people have an equal right to attain the highest standard of health.⁹⁷ The United States, New Zealand, Australia, and Canada did not originally sign UNDRIP—all are countries with large indigenous populations sharing a common law heritage.⁹⁸

⁸⁸ *Id.*

⁸⁹ For a full list of signatories to the UDHR, see *Chapter IV: Human Rights*, U.N., (April 18, 2015), https://treaties.un.org/pages/viewdetails.aspx?chapter=4&src=treaty&mtmsg_no=iv-4&lang=en.

⁹⁰ G.A. Res. 61/295, United Nations Declaration on the Rights of Indigenous Peoples (Sept. 13 2007) [hereinafter UNDRIP].

⁹¹ *Id.*

⁹² MacIntosh, *supra* note 81, at 78.

⁹³ UNDRIP, *supra* note 90, at art. 24.

⁹⁴ *Id.* at art. 24 (1) (“Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including 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.”).

⁹⁵ *Id.* at art. 24 (2) (“Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. . . .”).

⁹⁶ *Id.* (“States shall take the necessary steps with a view to achieving progressively the full realization of this right.”).

⁹⁷ *Id.* at art. 24.

⁹⁸ Erin Hanson, *UN Declaration on the Rights of Indigenous Peoples*, UNIV. OF BRITISH COLUMBIA (Feb. 6, 2016), <http://indigenousfoundations.arts.ubc.ca/home/global-indigenous-issues/un-declaration-on-the-rights-of-indigenous-peoples.html>. In December 2010, President Obama announced the full UNDRIP support from the United States.

A. International Labour Organization 169

In 1989, 22 countries came together to create legally binding obligations on States to promote indigenous involvement in their own economic and social development. These obligations are recorded in ILO 169.⁹⁹ ILO 169 also promotes fundamental human rights so indigenous peoples may enjoy those rights to the same degree as other segments of their countries' populations.¹⁰⁰ Although only 22 countries have signed onto the agreement,¹⁰¹ James Anaya has said it has become a model for indigenous advocacy groups who desire fundamental human rights.¹⁰² Article 25 of ILO 169 deals with health-related rights. It states:

(1.) Governments shall ensure that adequate health services are made available to the peoples concerned or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.

(2.) Health services shall, to the extent possible, be community based. These services shall be planned and administered in cooperation with the peoples concerned and take into account their economic, geographic, social, and cultural conditions as well as their traditional preventative care, healthy practices, and medicines. . . .

(4.) The provision at such health services shall be co-ordinated with other social, economic, and cultural measures in the country.¹⁰³

A few American countries are signatories to ILO 169: Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Guatemala, Honduras, Mexico, Nicaragua,

⁹⁹ *Indigenous and Tribal Peoples Convention, C169*, INT'L LABOUR ORG. [ILO] (June 27, 1989), http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C169 [hereinafter ILO 169].

¹⁰⁰ *Id.* at Preamble.

¹⁰¹ The countries are Argentina, Bolivia, Brazil, Central African Republic, Chile, Colombia, Costa Rica, Denmark, Dominica, Ecuador, Fiji, Guatemala, Honduras, Mexico, Nepal, Netherlands, Nicaragua, Norway, Paraguay, Peru, Spain, and Venezuela. *See Ratifications of C169- Indigenous and Tribal Peoples Convention, 1989 (No. 169)*, ILO (Mar. 2, 2015), http://www.ilo.org/dyn/normlex/en/f?p=1000:11300:0::NO:11300:P11300_INSTRUMENT_ID:312314.

¹⁰² ANAYA, *supra* note 22, at 47-49.

¹⁰³ ILO 169, *supra* note 99, at art. 25(1), (2), (4).

Paraguay, Peru, and Venezuela.¹⁰⁴ Those countries are legally bound to its provisions.¹⁰⁵ These American countries will often interpret ILO 169 provisions with “[other] general human rights instrument[s], such as the American Convention of Human Rights.”¹⁰⁶

The Colombia Constitutional Court has used ILO 169 to find that the State government was required to deliver programming and services to indigenous communities.¹⁰⁷ In Judgment T-704/06, chiefs of indigenous communities in Colombia brought an action to the Constitutional Court of Colombia condemning national and municipal authorities for misallocating items to address the tribes’ extreme poverty living conditions.¹⁰⁸ The Court pointed to the obligation Colombia assumed when it signed the ILO 169. The Court mentioned that the state is obligated to take affirmative action for the full enjoyment of those rights by indigenous communities, underscoring the close relationship between the enjoyment of economic, social, and cultural rights, and the enjoyment of the right to subsistence and cultural identity.¹⁰⁹ The municipal and state authorities violated these rights when they did not deliver resources to the municipality.¹¹⁰ The court held federal and state authorities accountable because they inadequately supervised the delivery of funds to the communities.¹¹¹ The Court ordered the delivery of resources and used Article 25 to demonstrate that not only must local and state governments recognize and protect rights to ethnic and cultural diversity; they must make this right feasible in practice.¹¹² The Constitutional Court held that without any action, these fundamental rights, including Article 25’s provision to ensure adequate health services are available, would be merely words without meaning.¹¹³ This case demonstrates that domestic courts, legally bound by

¹⁰⁴ See *Ratifications of C169–Indigenous and Tribal Peoples Convention*, *supra* note 101.

¹⁰⁵ ILO 169, *supra* note 99, at art. 38(1). In contrast, the UDHR and UNDRIP are declarations that are not binding, but rather provide frameworks for international treaties. *Declaration on Human Rights Defenders*, U.N. HUM. RTS.—OFF. OF THE HIGH COMM’R, <http://www.ohchr.org/EN/Issues/SRHRDefenders/Pages/Declaration.aspx>. (last visited Mar. 20, 2016); *The UN Declaration on the Rights of Indigenous Peoples*, INT’L WORK GRP. FOR INDIGENOUS AFFAIRS, <http://www.iwgia.org/human-rights/international-human-rights-instruments/undeclaration-on-the-rights-of-indigenous-peoples>. (last visited Mar. 20, 2016).

¹⁰⁶ MacIntosh, *supra* note 81, at 82.

¹⁰⁷ Corte Constitucional [C.C] [Constitutional Court], agosto 22, 2006, Judgment T-704/06 (Colom.), *translated in* ILO, APPLICATION OF CONVENTION No.169 BY DOMESTIC AND INTERNATIONAL COURTS IN LATIN AMERICA: A CASEBOOK 110-15 (2009) [hereinafter Judgment T-704/06 (Colom.)].

¹⁰⁸ *Id.* at 110.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Judgment T-704/06 (Colom.) at 113.

¹¹³ *Id.* (“Article 25 underscores the importance of community-based nature in the organization of these [health] services, and also emphasizes the need to plan and administer

international instruments, will intervene to place a positive obligation upon the State to enforce a right to health.

Colombia is not the only country to have ruled that ILO 169 places positive obligations on the State to fulfill the right to health. In *Ombudsman v. National Government and another (Chaco Province)*, the Toba tribal communities of Argentina demanded that the State comply with its obligation to adopt affirmative action for them.¹¹⁴ The claim stated that “the indigenous population is in a very serious socio-economic situation, and because of this, most of the population suffers from endemic diseases that are the result of extreme poverty, as well as lack of sufficient food, access to drinking water, medical care, and housing.”¹¹⁵ The National Supreme Court of Justice held in a preliminary ruling that, as far as the right to adequate health is concerned, the State must inform the Court on “existing food and health care programs” and must appear before the Supreme Court to present and discuss that information. The Court, in language similar to Colombia’s Constitutional Court, required the State judiciary to guarantee the effectiveness of fundamental human rights promised by the international community.¹¹⁶

B. The Inter-American Court and Protecting Health Through the Right to Life

Placing positive obligations upon the State to ensure a right to health is not the only means that Courts address indigenous health. The Inter-American Court has found positive obligations by the State to provide the highest attainable standards of health in order to protect the right to life.¹¹⁷ The decisions of the Inter-American Court are legally binding upon the countries that have adopted the American Convention of Human Rights.¹¹⁸ In the *Yake Axa* and *Sawhoyamaxa* cases, the Inter-American Court confronted cases in which indigenous

these services in cooperation with the peoples concerned, and take into account ‘their economic, geographic, social and cultural conditions as well as their traditional preventative care, healing practices and medicine.’”).

¹¹⁴ Corte Suprema de Justicia de la Nación [CSJN] [National Supreme Court of Justice], 18/9/2007, “Ombudsman v. National Government and another (Chaco Province)/petición de prejudiciales,” (Arg.), *translated in* ILO, APPLICATION OF CONVENTION NO.169 BY DOMESTIC AND INTERNATIONAL COURTS IN LATIN AMERICA: A CASEBOOK 47 (2009).

¹¹⁵ *Id.*

¹¹⁶ *Id.* at 48.

¹¹⁷ See Steven R. Keener & Javier Vasquez, *A Life Worth Living: Enforcement of the Right to Health Through the Right to Life in the Inter-American Court of Human Rights*, 40 COLUM. HUM. RTS. L. REV. 595, 606-14 (2009).

¹¹⁸ See O.A.S. Convention, *supra* note 16, at art. 43. It is interesting to note the common law countries in the Americas have not ratified this treaty. *Signatories and Ratifications*, ORG. OF AM. STS., http://www.oas.org/dil/treaties_B-32_American_Convention_on_Human_Rights_sign.htm (last visited Mar. 15, 2016).

communities claimed title in ancestral land occupied by third parties.¹¹⁹ The communities argued that dispossession of their ancestral lands resulted in malnutrition, anemia, widespread parasitism, and high infant mortality.¹²⁰ The Court took an expansive view on the American Convention of Human Rights Article 4's right to life, reasoning that the State must guarantee living conditions that are compatible with a dignified life.¹²¹ Article 4(1) states: "Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life."¹²² In *Yake Axa Indigenous Community v. Paraguay*, the Court determined that the right to life mandates that the State provide medical care, food, clean water, and sanitation.¹²³ In *Sawhoyamaxa Indigenous Community v. Paraguay*, the Court created the test for a right to life violation. The two-part test for a right requires the State: "1) [have] knowledge of a threat to the right to life; and 2) inaction in the state's scope of authority."¹²⁴ The Court found Paraguay did have knowledge that conditions were life-threatening and that the State did have authority to adopt risk-preventing measures.

The most interesting application of this test is *Ximenes-Lopes v. Brazil*.¹²⁵ Although this case does not involve indigenous peoples, it has implications for States that provide medical care under public health programs. In the case, a man checked into a private mental health facility for a mental illness that afflicted him since childhood.¹²⁶ When his mother checked on him three days later, she "found him bleeding, bruised, his clothes torn, dirty and smelling like excrement, with his hands tied backwards, had difficulty breathing, was agonizing, and shouting."¹²⁷ The man eventually died.¹²⁸ The private hospital contracted with the State to provide mental health services under Brazil's health care system.¹²⁹ The Court mentioned the hospital's notorious reputation for patient mistreatment.¹³⁰ Using the *Sawhoyamaxa* two-part test, the court found that (1) the State was aware of the conditions that threatened a right to life; and (2) the State failed to take action.¹³¹ The Court reasoned that States, under the American Convention for Human

¹¹⁹ Keener & Vasquez, *supra* note 117, at 607-08.

¹²⁰ *Id.*

¹²¹ *Id.* at 606. Article 4(1) states: "Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life." O.A.S. Convention, *supra* note 16, at art. 4(1).

¹²² O.A.S. Convention, *supra* note 16, at art. 4(1).

¹²³ Keener & Vasquez, *supra* note 117, at 611.

¹²⁴ *Id.* at 614-15.

¹²⁵ *Id.* at 614-18.

¹²⁶ *Id.*

¹²⁷ *Id.* at 615.

¹²⁸ Keener & Vasquez, *supra* note 117, at 615.

¹²⁹ *Id.*

¹³⁰ *Id.* at 615-16.

¹³¹ *Id.* at 616-17.

Rights, were required to provide and regulate health services necessary to give life to the provisions of the Convention, specifically Article 2.¹³² The *Ximenes* case has serious consequences because it places positive obligations on the State to provide and regulate its healthcare system to promote a dignified existence.

IV. COMPARING THE MODELS

A. Health Policies Arising from the Conceptions of Property

The Marshall Model dictates that Native Americans do not possess the land but are merely “wards” and “caretakers.”¹³³ Their possession of their land is not full ownership and the title to it belongs to the federal government, a concept that defines the rights of Native Americans.¹³⁴ The federal government’s trust responsibility is as close as the government gets to an affirmative obligation to provide health to Native Americans. The trust responsibility is an obligation of Congress to do what it considers to be in the best interests of Native Americans.¹³⁵ It arises from the fact that the federal government is technically the holder of the title to Native American land, and therefore Congress has a duty to care for its inhabitants.¹³⁶ To seek relief, Native American claimants will sue on the ground that the federal government failed to provide adequate medical care or facilities pursuant to the federal-tribal trust relationship.¹³⁷ Congress has not always carried out its trust responsibility in the most informative or practical manner. However, the idea that it is the responsibility of the federal government to be the caretaker of Native Americans has led to significant advances in the field of Native American health, especially in the self-determination era.¹³⁸ The shift in federal government policy has allowed Native Americans to be in positions of power to affect healthcare policies and programs aimed at both reservation Native Americans and urban Native Americans.¹³⁹ For example, the current Director of the Indian Health Service, Robert McSwain, is a member of the North Fork Rancheria of

¹³² *Id.* at 616-17. Article 2 of the American Convention on Human Rights states, “Where the exercise of any of the rights or freedoms referred to in Article 1 is not already ensured by legislative or other provisions, the States Parties undertake to adopt, in accordance with their constitutional processes and the provisions of this Convention, such legislative or other measures as may be necessary to give effect to those rights or freedoms.” O.A.S. Convention, *supra* note 16, at art. 2.

¹³³ COHEN’S HANDBOOK, *supra* note 28, at § 15.06.

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ See *Quechan Tribe of the Fort Yuma Reservation v. United States*, 599 Fed. Appx. 698, 699 (9th Cir. 2015); *Hammitte v. Leavitt*, 2007 U.S. Dist. LEXIS 76051 (E.D. Mich 2007); *White v. Califano*, 437 F. Supp. 543 (D.S.D. 1977).

¹³⁸ COHEN’S HANDBOOK, *supra* note 28, at § 22.04.

¹³⁹ *Id.*

Mono Native Americans of California.¹⁴⁰ In addition, the passages of the ISDEAA, the IHCA, and the ACA have directly contributed to the reduction of health disparities between the dominant population and Native Americans.¹⁴¹

The trust-responsibility, when complemented with the federal policy of self-determination and self-governance, has led to success in reducing health disparities.¹⁴² Native Americans are truly at the forefront of addressing their own health. The United States encourages Native Americans to enter the health field, whether as physicians, nurses, hospital administrators, or within the IHS.¹⁴³ Tribal governments have the flexibility to address the health concerns most prevalent in their local reservations. This comes in the form of the 638 contracts. The reauthorization of the IHCA increases the number of tribal entities who are eligible for these contracts. Also, Native Americans who live in urban areas are able to receive care through Urban Indian Health Programs.¹⁴⁴ The United States Native American healthcare system has often been referred to as an I/T/U system.¹⁴⁵ “I” represents the IHS, the “T” represents tribal 638 programs, and the “U” represents urban health centers.¹⁴⁶

B. Guaranteed Standard of Health Through the Right to Health or the Right to Life

The international approach to solving the disparate health conditions of indigenous peoples embodies health as a right to which all humans are entitled. Simply being human guarantees this right to health. As World War II ended, a

¹⁴⁰ Past Director- Robert McSwain, INDIAN HEALTH SERV., <http://www.ihs.gov/aboutihs/thedirector/pastdirectorrobertmcswain/>. (last visited Mar. 16, 2016).

¹⁴¹ In a 2005 cross-country comparative study between the United States and New Zealand, researchers concluded that healthcare disparities between the Maoris were more pronounced than between American Indians/Alaskan Natives. They found that the Indian Health Service (IHS) is likely to have played a significant role in reducing health disparities. They noted that the disparity in rates of childhood immunization and cervical cancer screening have been nearly eliminated in the United States. Some reasons for this “include[e] comprehensive health services provided through the IHS, integrated primary care services provided in collaboration with tribes (e.g., public health nurse home visits, tracking of immunization status of children, and field clinics head at community centers, schools, and reservations), and free vaccines administered through immunizations programs.” The researchers applauded how coordinated the system of health is in the United States and argued that New Zealand could benefit from studying the U.S. approach. See Dale Bramley et al., *Disparities in Indigenous Health: A Cross-Country Comparison Between New Zealand and the United States*, 95 AM. J. PUB. HEALTH 844, 847 (2005).

¹⁴² See COHEN’S HANDBOOK, *supra* note 28, at § 22.04.

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ Warne & Frizzell, *supra* note 48, at S265.

¹⁴⁶ *Id.*

significant shift in the international community occurred. The focus, which had been on the rights of nations, became centered on the rights of individuals.¹⁴⁷ This shift in policy resulted in documents such as the UNDHR, the UNDRIP, and ILO 169.¹⁴⁸ Countries established international bodies to ensure human rights norms were being respected by national governments.¹⁴⁹ These agencies include regional agencies such as the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights.¹⁵⁰

The right to health involves either a positive or negative duty, on part of the State, to ensure the right is observed and respected. In Judgment T-704/06 (Colombia) and *Ombudsman v. National Government* (Argentina), the courts found a positive duty on part of the government to fulfill the provisions in ILO 169. Extending the right to health to individuals is not a new concept in Latin America. Many Latin American countries have constitutional provisions recognizing a right to health.¹⁵¹ These include Bolivia (Article 7(a)); Brazil (Articles 6 and 196); Ecuador (Article 46); Nicaragua (Article 59); and Venezuela (Article 84).¹⁵² Other countries may not recognize it directly as a constitutional right but may specify the types of protections guaranteed for citizens' health.¹⁵³ Regardless of the form, the constitutions of these countries establish that the State must protect the health of individuals.¹⁵⁴ Thus, judicial litigation is a popular strategy for marginalized populations in Latin America:

The combination of the chronic democratic failure that marks many countries in the region, coupled with favourable opportunity structures in courts (eg, low access barriers, existence of constitutional protection writs, relaxed standing requirements, and speed of resolution) has led to increasing judicialisation of health rights. Thousands, and in some cases hundreds of thousands, of cases focusing on access to health services and essential medicines, but also including other public health issues, have been brought in Colombia, Brazil, Argentina, and Costa Rica in particular.¹⁵⁵

¹⁴⁷ MacIntosh, *supra* note 81, at 78.

¹⁴⁸ See *supra* Part III.A-B.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ ALLAN R. BREWER-CARIAS, CONSTITUTIONAL PROTECTIONS OF HUMAN RIGHTS IN LATIN AMERICA: A COMPARATIVE STUDY OF AMPARO PROCEEDINGS 243 (2009).

¹⁵² *Id.*

¹⁵³ *Id.* These countries are Honduras, Chile, Mexico, Peru, Cuba, and Colombia.

¹⁵⁴ *Id.*

¹⁵⁵ Alicia Ely Yamin & Ariel Frisancho, *Human-Rights-Based Approaches to Health in Latin America*, THE LANCET, Mar. 28–Apr. 4, 2015, at e26, [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(14\)61280-0.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61280-0.pdf).

Judicial accountability has not been the only way to enforce a right to health. Social accountability keeps courts from making disadvantageous decisions and provides for a collaboration of non-governmental organizations and the indigenous community affected by the right.¹⁵⁶ The international community supports this type of accountability by advocating an indigenous presence in developing and maintaining community health services. This is manifested in UNDRIP Article 25.¹⁵⁷ In addition, social accountability allows for the indigenous communities to resolve problems according to respective cultural definitions of health.¹⁵⁸ In Peru, Quecha, and Aymara, women have teamed with regional offices of the Human Rights Ombudsman to monitor women's health, "particularly the right to good quality, appropriate, and culturally respectful material health."¹⁵⁹

C. Borrowing from the Marshall Model

Health is not a distinctive right under the Marshall Model, but it is under the international approach. This difference begs the question as to which model can better close the gap in health services. Resolving health disparities is not as simple. An important consideration is which model the State, where the indigenous group resides, has accepted and used. Ultimately, the Marshall Model appears to be the more advantageous of the two for indigenous peoples, particularly when the federal government advocates policies of self-determination and self-governance. Because most Latin American countries do not adopt the United States' Marshall Model, indigenous peoples in those countries cannot advocate for improving their health system under the Model's framework. Latin American States and indigenous peoples should study and implement healthcare improvements the United States has developed in the last 40 plus years. In addition, indigenous populations of Latin America should advocate for these healthcare improvements through International Human Rights reasoning.

1. Why the Marshall Model is Preferable for Reducing Health Disparities

United States Federal Indian Law places indigenous peoples and tribal organizations in positions that ultimately address health disparities.¹⁶⁰ Powers that were once entirely administered by the federal government have been transferred to tribal organizations closest to the problems.¹⁶¹ The United States federal government has made this a priority in the self-determination era. The I/T/U system is a well-developed, interconnected system that expands access and

¹⁵⁶ *Id.* at e27-28.

¹⁵⁷ UNDRIP, *supra* note 90, at art. 25.

¹⁵⁸ Yamin & Frisancho, *supra* note 155, at e26.

¹⁵⁹ *Id.* at e28.

improves the quality of care. Its biggest advantage is that it has created a fully functioning and effective healthcare system, primarily run by Native Americans. However, the biggest criticism of the American system is that it has been significantly and chronically underfunded.¹⁶² The IHCA and ACA were meant to alleviate those concerns, but the issue is still present.¹⁶³

2. The Problem with the International Human Rights Model

The International Human Rights Model explicitly makes it a policy to reduce health disparities. Article 24(2) of UNDRIP states, “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 to achieving progressively the full realization of this right.” Like the Marshall Model, the International Human Rights Model attempts to make indigenous peoples more involved in their own health.¹⁶⁴ Article 25 of the ILO 169 deals exclusively with making health services a community-based activity.¹⁶⁵ These community-based health services should be coordinated with other social, financial, and cultural measures in the State.¹⁶⁶ The model even places positive obligations upon the states to ensure either the right to health or the right to life is met.¹⁶⁷ However, the problem with the International Human Rights Model is that it only requires the State to reach a minimum standard to meet the right.

The International Human Rights Model does not explicitly demand that States create community-based health services. It only suggests them. Article 25 (1) of the ILO 169 says that “[g]overnments shall ensure that adequate health services are made available to the peoples concerned or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control. . . .”¹⁶⁸ In Judgment T-704/06 and *Ombudsman v. National Government*, the domestic courts, in applying the ILO 169, determined that the States must only provide enough to ensure that the right to health is adequately achieved.¹⁶⁹ One way of achieving the right to health is through the creation of community-based health services, as the United States has done. However, creating community-based health services is not the only possible route.

¹⁶⁰ See *supra* Part II.B.

¹⁶¹ *Id.*

¹⁶² Warne & Frizzell, *supra* note 48, at S264.

¹⁶³ See NAT'L CONGRESS OF AM. INDIANS, HEALTH CARE: IMPLEMENTING OUR VALUES IN THE FEDERAL HEALTH CARE BUDGET 1 (2012).

¹⁶⁴ ILO 169, *supra* note 99, at art. 25(2).

¹⁶⁵ *Id.*

¹⁶⁶ *Id.* at art. 25(4).

¹⁶⁷ See *supra*, Part III.A-B.

¹⁶⁸ ILO 169, *supra* note 99, at art. 25(1).

¹⁶⁹ See APPLICATION OF CONVENTION NO. 169 BY DOMESTIC AND INTERNATIONAL COURTS IN LATIN AMERICA, *supra* note 114.

The emphasis is not so much on self-determination and self-governance, but rather on ensuring that the human right is observed and fulfilled.

The analysis is the same for seeking adequate health standards through the right to life. In *Yake Axa*, the Inter-American Court of Human Rights interpreted the American Conventions on Human Rights' right to life provision as including medical care, food, clean water, and sanitation.¹⁷⁰ These are all resources necessary not only to reduce health disparities but to achieve a dignified life. The two-part test created by the court only tells the State what they are required to do to meet the right to life. In *Sawhoyamaxa*, the Inter-American Court found that Paraguay knew the conditions were life-threatening and did nothing to respond, although they had a duty to act.¹⁷¹ The Inter-American Court places an obligation on those Latin American countries that have adopted the ACHR to ensure that the conditions needed to meet a dignified life are being enforced by the State. If not, they will hold the State liable.

The International Human Rights Model focuses on guaranteeing a set of rights to every individual. However, in Latin America nations, these rights are achieved through placing a positive obligation on the State.¹⁷² So long as the State meets the minimum threshold, there is no need to hold it liable. The International Human Rights Model has not gone all-in on the self-determination and self-governance approach. On the other hand, the Marshall Model has done so because Congress determined that involving Native Americans in their own healthcare is in the best interest of that population. Thus, Congress has supplied Native Americans with the tools and funding to make Native American healthcare more "Native American." The International Human Rights Model is so centered on achieving minimum standards that international governing bodies placed an obligation on States to do whatever is possible to achieve that right.

3. Achieving Self-Determination and Self-Governance in Latin America

This Note suggests that indigenous peoples in Latin America should emphasize the self-determination and self-governance route the United States has undertaken. Unfortunately, Latin American States would likely be reluctant to fund community-based health services and adequate healthcare facilities. In many of these countries, indigenous populations are marginalized and suffer from discrimination.¹⁷³ As demonstrated in Colombia's Judgment T-704/06,

¹⁷⁰ See Keener & Vasquez, *supra* note 117, at 611.

¹⁷¹ *Id.* at 612-13.

¹⁷² See *supra* Part III.A-B.

¹⁷³ See Yamin & Frisancho, *supra* note 155, at e27 ("Peru is a country marked by steep social and economic inequality, and disproportionate marginalisation of indigenous populations, including with respect to their health."); UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER—SOUTH AMERICA REGIONAL OFFICE, *Defending the Rights of Indigenous People in South America* (Feb. 6, 2016), <http://acnudh.org/en/2010/>

indigenous individuals may be the last to receive supplies or may not even receive them at all.¹⁷⁴ So, spending state money on populations who are not well regarded might be considered wasteful spending.

However, one advantage that the International Human Rights Model has over the Marshall Model is the court system. For example, the U.S. Supreme Court, under the Rehnquist and Roberts courts has not been favorable to Native American tribes trying to expand their rights as sovereign entities.¹⁷⁵ Judicial accountability in Latin American countries has been an avenue of success for marginalized populations. As we have seen, both domestic courts and the Inter-American Court of Human Rights have been favorable in the interpretation of health rights to indigenous peoples.¹⁷⁶ Rather than hoping the State undertakes a policy of self-determination and self-governance, it might be necessary for the courts to mandate the State to do so. Indigenous claimants should attempt to change the discourse of the International Human Rights Model in the courts. Instead of placing a positive obligation on the State to do what it can to ensure indigenous health rights are met, they can try to convince the Court that to achieve the “minimum” standard of health, the State must create programs to include indigenous peoples in the management of their own health. Claimants would have to point out that the only way indigenous peoples could ever reach the human rights standards set out in the ILO 169 and State constitutions is for the State to fund programs that put indigenous peoples in positions to influence health outcomes directly. Formulating the argument in this manner captures the self-determination and self-governance agenda while remaining within the framework of the International Human Rights Model that has developed in Latin America. If the courts of Latin America or the Inter-American Court adopt this approach, it would become binding law.

Even if the indigenous claimants lose in court, they would still create awareness that having their own health system and infrastructure is desirable among the indigenous communities. If the State still refuses to fund an indigenous health system, community-based health systems still might be possible. A greater awareness for the need of self-determination could increase the efforts of social accountability. Non-governmental organizations, whether domestic or international, could work with indigenous communities to help make sustainable health systems that address the most pressing health concerns of the community. For indigenous peoples of Latin American countries, reversing the problems that caused health disparities is a difficult proposition. However,

12/defending-the-rights-of-indigenous-peoples-in-south-america/; Alberto Chong & Hugo Ñopo, *Discrimination in Latin America: An Elephant in the Room?*, INTER-AMERICAN DEVELOPMENT BANK (2007), <http://www.iadb.org/res/publications/pubfiles/pubwp-614.pdf>.

¹⁷⁴ APPLICATION OF CONVENTION NO. 169 BY DOMESTIC AND INTERNATIONAL COURTS IN LATIN AMERICA, *supra* note 108, at 110.

¹⁷⁵ See Steven Paul McSloy, *The “Miner’s Canary:” A Bird’s Eye View of American Indian Law and Its Future*, 37 NEW ENG. L. REV. 733 (2002).

¹⁷⁶ See Part IIIA-B.

creating a community-based health system, preferably through State funding, would at least be a step in the right direction to achieving health parity.

V. CONCLUSION

Indigenous people are in a poorer state of health than the dominant populations of the countries in which they live. The Americas contain countries with significant populations of indigenous peoples. These countries are also part of regional organizations that attempt to address existing health disparities. However, there are two different models that address governance of indigenous peoples in the Americas. The first derives from the common law, the Marshall Model. The other derives from the international stage and promises a group of rights to every living individual, the International Human Rights Model. The Marshall Model has been relatively successful in addressing health disparities. Although it still has a ways to go to create health parity, the infrastructure for a successful Native American healthcare system has been put in place. The I/T/U system that has arisen under it addresses health disparities for Native Americans living on both reservations and urban cities. Through the federal government policy of self-determination and self-governance, Native Americans can address the health concerns that directly affect them. On the other hand, the International Human Rights Model emphasizes the full realization of human rights. Humans are entitled to a minimum standard of health through the right to health and the right to life. To accomplish this, both domestic and regional courts place positive obligations on the State to address these concerns. However, the International Human Rights Model does not guarantee that health disparities are addressed. It just guarantees a “minimum” standard of health that can be achieved in any way. There is no complex system in Latin America that addresses health for indigenous peoples on par with the United States. Latin American indigenous peoples can “get the ball rolling” through litigation by persuading the courts that the State meet a “minimum” standard of health by creating and funding community-based health systems. This will not fully address healthcare disparities, but is at least a step in the right direction.

