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THE HEALTHCARE LEGACY OF THE *MISSION CIVILISATRICE* IN UNINCORPORATED U.S. TERRITORIES

Sam F. Halabi^{1*}

ABSTRACT—Individual and population health in unincorporated U.S. territories – American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands – lag terribly behind those in the 50 U.S. states and D.C. The populations in the territories – with drastically higher rates of poverty – suffer and die from chronic conditions like cancer, diabetes, and heart disease at far higher rates; must find facilities and doctors thousands of miles away for even moderately complex cases; and perpetually struggle to make access to basic services available. While scholars have long pointed to the disparate treatment of these populations by Congress – especially with respect to Medicaid reimbursement – this Essay argues that the disadvantages and health disparities experienced by territorial populations run far deeper. In fact, the entire structure of healthcare access and financing in unincorporated U.S. territories is fundamentally shaped by how the U.S. federal government occupied those territories, restructured healthcare practice and facilities to sustain the U.S. presence, and as those territories were transferred to the Department of the Interior, imposed financing and programming constraints that made dependency perpetual. This Essay argues for two immediate measures: parity in Congressional commitment to healthcare financing as between U.S. states and U.S. territories, and establishment of investigatory committees to identify and restore indigenous health practices destroyed by U.S. occupation modeled on the Native Hawaiian Healthcare Improvement Act.

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INTRODUCTION

In nearly all U.S. territorial islands, residents generally have access to a single hospital and patients with even moderately complex needs must seek care thousands of miles away.² Although the poverty rate in each of the U.S. territories is at least two or three times that of the 50 states and D.C. (and in some cases greater than 50% of the territory’s population), Congress provides significantly less Medicaid reimbursement to the territories.³ While Congress limits the reimbursement for territory Medicaid services at 55%, poor U.S. states, like Mississippi, receive 77.6%, and those states which expanded Medicaid under the Affordable Care Act receive even more.⁴ With no meaningful representation in Congress, the

² *Medicaid and CHIP Payment and Access Commission Before the Health Subcommittee Committee on Energy and Commerce U.S. House of Representatives*, 117th Leg., 1st Sess. 19-20 (2021), (statement of Anne L. Schwartz, PhD Executive Director), <https://www.macpac.gov/wp-content/uploads/2021/03/Testimony-Medicaid-and-CHIP-in-the-U.S.-Territories.pdf>.

³ Lina Stolyar & Robin Rudowitz, *Implications of the Medicaid Fiscal Cliff for the U.S. Territories*, KAISER FAM. FOUND. (Sept. 14, 2021), <https://www.kff.org/medicaid/issue-brief/implications-of-the-medicaid-fiscal-cliff-for-the-u-s-territories>.

⁴ Robin Rudowitz et al., *New Incentive for States to Adopt the ACA Medicaid Expansion: Implications for State Spending*, KAISER FAM. FOUND., (Mar. 17, 2021), <https://www.kff.org/medicaid/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending>.

territories rely upon sporadic and one-time commitments – like relief for COVID-19 – from an otherwise occupied legislature far removed from the reality of territorial life.⁵ This Essay argues that the healthcare disadvantages experienced in unincorporated U.S. territories are neither recent nor coincidental. They are the predictable result of healthcare systems leveled then reorganized to accommodate a permanent U.S. military presence; their reorganization has worked to the long-term detriment of territorial populations; and their situation is sustained by current U.S. territorial health policy. Healthcare in the territories, in short, is reflective of, and sustained by, neocolonial policies that limit the capacity of territorial governments to improve the health of their citizens. Those same healthcare policies also subtly suppress self-determination alternatives that would be feasible were those governments not so constrained. The Essay advocates that Congress take two immediate measures – made more urgent by the climate change emergency – to address historical and present inequities, increase territorial healthcare access and implement meaningful territorial control: 1) a Congressional commitment to parity in the funding of healthcare for U.S. territories relative to U.S. states; and 2) a plan to restore evidence-based and effective health practices based in indigenous culture.

Although the United States Government has traditionally contested any characterization of its history as “colonial,” its actual territorial acquisitions and treatment of populations in those territories largely tracks those of European powers more traditionally associated with colonialism.⁶ The main distinction is that the U.S. conquered territories in contiguous North America for decades before its acquisitions overseas; and the peoples over which it exerted colonial authority were Native American tribes rather than indigenous peoples in Africa, Asia, Central and South America (even in that context, the Monroe doctrine made the U.S. a quasi-colonial power in countries like Granada, Guatemala and Nicaragua).⁷

⁵ Abraham Holtzman, *Empire and Representation: The U.S. Congress*, 11 LEGIS. STUD. Q. 249, 253 (1986).

⁶ Edward Said, *CULTURE AND IMPERIALISM* xxviii (Chatto & Windus, 1993).

⁷ Ward Churchill, *Indigenous Peoples of the United States: A Struggle Against Internal Colonialism*, 16 BLACK SCHOLAR 29 (1984).

[O]ne of the major problems which has confronted us in attempting to articulate the status of the indigenous nations of this hemisphere has to do with the specific form of colonialism imposed upon us, “internal colonialism” . . . The conventional spectrum of analysis of the phenomenon of colonization ranges from that adopted by the United Nations (which requires definitionally that an ocean separate the colonizer from the colonized in order for a “true” condition of colonization to exist) . . . Internal colonialism does not occur, however, with the more typical forms of exploitation evident under imperialism. Rather, it is the result of a peculiarly virulent form of socio-economic penetration wherein the colonizing country literally exports a sufficient

This historiography of U.S. behavior is thoroughly researched and well-supported in the secondary literature, even if there is significant resistance to the narrative by those envisioning the United States as a City upon the Hill that was and is to emblemize civil rights, democracy, due process, and justice for others worldwide to follow.⁸ What is less acknowledged is the role of human health as part of the colonial legacy generally, and the U.S. legacy specifically.

Hygiene, medicine, medical education, and healthcare facilities represented a primary justification for the imposition of violent, military control over “inferior” populations in all conquered territories. The ensuing restructuring of cultural, economic, and social spaces in the name of health entrenched colonial control. For the current unincorporated territories – American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands – the legacy of that control is reflected in healthcare access and financing that effectively ensure a continuing limbo: neither meaningful independence nor full incorporation are feasible options in a world where Congress arbitrarily conditions access to health services and healthcare. This is doubly true for those territories acquired at the turn of the twentieth century when hygienic theories of racial superiority were at their apex: American Samoa, Guam, and Puerto Rico. In this sense, the histories of those territories have as much in common with Cuba (before the 1959 revolution), Hawaii (before statehood) and the Panama Canal Zone as with American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands. To be sure, there are important differences between the experience of Cubans, Native Hawaiians and territorial populations, but there are important analogies between the position of, especially, Native Hawaiians, Samoans, Carolinians,

proportion of its population to supplant (rather than enslave) the indigenous population of the colony. Such a method has been termed elsewhere as “settler colonialism.”

⁸ For a comprehensive analysis of existing secondary literature as a colonial power, see DANIEL IMMERWAHR, *HOW TO HIDE AN EMPIRE: A HISTORY OF THE GREATER UNITED STATES* (Farrar, Straus and Giroux, 2019); for a representative essay regarding the saccharine perspective on U.S. colonial history, see William Henderson, *United States Policy and Colonialism*, 26 *PROCS. ACAD. POL. SCI.*, 53, 53 (1957) (“Opposition to colonial rule, and sympathy for the oppressed and downtrodden of all nations, have been among our proudest traditions.”). See also Abram Van Engen, *How America Became a “City Upon a Hill”*, 41 *HUMANS*. (2020), <https://www.neh.gov/article/how-america-became-city-upon-hill>.

That 1630 sermon by John Winthrop is now famous mainly for its proclamation that “we shall be as a city upon a hill.” Beginning in the 1970s, Ronald Reagan placed that line, from that sermon, at the center of his political career. Tracing the story of America from John Winthrop forward, Reagan built a powerful articulation of American exceptionalism—the idea, as he explained, “that there was some divine plan that placed this great continent between two oceans to be sought out by those who were possessed of an abiding love of freedom and a special kind of courage.”

Chamorros, and the practices in Puerto Rico and the U.S. Virgin Islands that predated U.S. occupation. For example, and of significant importance, Native Hawaiians were able to press for programming and funding after they had a Congressional delegation that could advance their interests.⁹ Residents of territories, even U.S. citizens, are unable to do so. Because of some of these territorial idiosyncrasies, this Article is organized according to unincorporated territory, with integrated references to those territories that were eventually incorporated, like Hawaii, and those that gained independence, like the Philippines.

“Modern” forms of medicine and treatment (however scientifically specious in retrospect) served as key assertions of superiority by largely white populations from North America and Europe over indigenous peoples in Africa, Asia, Central, North, and South America.¹⁰ Hygiene was important in the colonial context for its link to the notion of *mission civilisatrice* or “civilizing mission,” an aspect of medical ideology originating in France but quickly mimicked by other European powers and the United States.¹¹

The central argument of this Essay is that the discourse around U.S. territorial possessions has unfolded with inadequate focus on one of the most important sources of assertion of U.S. superiority and justification for control: public health.

The U.S. uses its influence over medicine and medical knowledge to sustain its permanent control of the territories, with neither sovereignty nor equality meaningful aspirations. Though episodic, rhetorical acknowledgments that the U.S. territories should consider, accept, reject, or

⁹ Donna Salcedo, *Hawaiian Land Disputes*, 14 CARDOZO J. DISP. RES. 557, 570-72 (2013) (detailing how representation in Congress has allowed Native Hawaiians to advance a number of initiatives).

¹⁰ Patricia Lorcín, *Imperialism, Colonial Identity, and Race in Algeria, 1830-1870: The Role of the French Medical Corps*, 90 ISIS 653, 654 (1999) (“Was the local population immune to certain diseases? Or, more important, did their lifestyle, culture, and morality influence the transmission of diseases and epidemics? Customs and mores thus became relevant subjects of inquiry.”); Mary Nash, *Social Eugenics and Nationalist Race Hygiene in Early Twentieth Century Spain*, 15 HISTORY OF EUROPEAN IDEAS 741-48. (1992); Rosa Medina-Doménech, *Scientific Technologies of National Identity as Colonial Legacies: Extracting the Spanish Nation from Equatorial Guinea*, 39 SOC. STUD. OF SCI. 81, 84 (2009) (“Importantly, the Spanish racial science that Najera espoused was grounded not only in scientific discourse but also in the newly developed medical technologies.”); see generally Alison Bashford, *IMPERIAL HYGIENE: A CRITICAL HISTORY OF COLONIALISM, NATIONALISM AND PUBLIC HEALTH* (2004).

¹¹ Lorcín, *supra* note 10, at 655 (“By the time the Scientific Commission for the Exploration of Algeria was under way, the medical persona as civilizer as well as a healer had been created”); Leonardo Viniestra-Velázquez, *Colonialism, science, and health*, 77(4) BOL. MED. HOSP. INFANT MEX. 166-177 (2020); Helen Tilley, *Medicine, Ethics, and Empires in Colonial Africa*, 18 AMA J. ETHICS, (2016), <https://journalofethics.ama-assn.org/article/medicine-empires-and-ethics-colonial-africa/2016-07>.

otherwise condition independence from the United States have generally proceeded from abstract principles like self-determination, anti-colonialism, or geopolitical spheres of influence.¹² The reality is that not only was public health and the spread of medical knowledge an essential pretext for U.S. acquisition and control of these territories, but it has structured access to medicine and healthcare – now through Medicare and Medicaid more than direct intervention – such that discourse about independence or alternative forms of autonomy within the U.S. sphere of influence is effectively an empty distraction.

Exposing this aspect of U.S. territorial control does not facilitate easy answers to the problematic relationship between the U.S. and its territories. Given the extent to which territorial independence and constitutional equality have been shackled by the structure of U.S. financing and support for healthcare infrastructure, conversations about independence or alternative forms of autonomy are meaningless unless they place those structures at the center of the debate.

The underlying reality of American occupation and expansion within these territories (the Northern Mariana Islands and U.S. Virgin Islands represent only slightly different cases, more thoroughly analyzed below) means that they are, for now, suspended between equality as sovereigns or as federal units within a constitutional system. Congressional commitment to a level playing field, a special obligation imposed by the climate emergency (for which the United States bears significant responsibility), and an acknowledgement of the value of indigenous health practices suppressed by occupation are only starting points.

This Essay concludes with special focus upon the climate emergency as it has accelerated over the course of the late twentieth and early twenty-first centuries. The United States has been the major contributor of carbon dioxide into the atmosphere; it has emitted around 400 billion tons since

¹² See Timothy Maga, *The Citizenship Movement in Guam 1946-50*, 53 PACIFIC HIST. REV. 59 (1984); Ruben Berrios Martinez, *Independence for Puerto Rico: the Only Solution*, 55 FOREIGN AFFAIRS 561 (1977); *Fitisemanu v. United States*, 1 F.4th 862, 865 (10th Cir. 2021).

We instead recognize that Congress plays the preeminent role in the determination of citizenship in unincorporated territorial lands, and that the courts play but a subordinate role in the process. We further understand text, precedent, and historical practice as instructing that the prevailing circumstances in the territory be considered in determining the reach of the Citizenship Clause. It is evident that the wishes of the territory's democratically elected representatives, who remind us that their people have not formed a consensus in favor of American citizenship and urge us not to impose citizenship on an unwilling people from a courthouse thousands of miles away, have not been taken into adequate consideration. Such consideration properly falls under the purview of Congress, a point on which we fully agree with the concurrence. These circumstances advise against the extension of birthright citizenship to American Samoa.

1751 and it is responsible for 25% of historical emissions.¹³ Much of this emission occurred at the same time that the United States acquired territories that are now among the most at risk for disaster, disease, and public health emergency as a result of climate change.¹⁴ U.S. policy has correspondingly limited the ability of territories to prepare for these circumstances and hobbled their ability to respond when they inevitably occur.

Part I of this Essay outlines the broader relationship between racialized conceptions of hygiene, healthcare, and disease prevention that characterized European exploration and colonization era contemporaneously with U.S. internal expansion on the North American continent. Part II analyzes the U.S. government's adoption of those conceptions as it made its major acquisitions in the Caribbean and Pacific at the turn of the 20th century, including in Cuba, Hawaii, and the Philippines. Part III analyzes the destruction of indigenous health practices by the U.S. Army and U.S. Navy during periods of occupation, the reorganization of healthcare systems to sustain U.S. presence, and the pernicious effects of those reorganizations now sustained by the structure of Congressional entitlement policies. Part IV argues for the adoption of two discrete and feasible measures to address the adverse effects of U.S. territorial healthcare policy: 1) parity in funding and eligibility for healthcare entitlements as between U.S. states and unincorporated territories; and 2) establishment of research committees, based on the Native Hawaiian Healthcare Improvement Act, to resurrect culturally relevant indigenous practices and enhance local control over the structure, location, and content of territorial healthcare.

I. THE U.S. CONSTITUTION'S TERRITORIAL CLAUSE AND U.S. EXPANSION 1787-1903

The Territorial Clause of the United States Constitution gives Congress the power “to dispose of and make all needful Rules and Regulations respecting the Territory or other Property belonging to the United States.”¹⁵ The clause was, from its origin, part of expansionist and colonial expectations of the U.S. federal constitution.¹⁶ Through this clause,

¹³ Hannah Ritchie, *Who Has Contributed Most to Global CO2 Emissions?*, OUR WORLD IN DATA (Oct. 1, 2019), <https://ourworldindata.org/contributed-most-global-co2>.

¹⁴ Gabriele Hegerl, *The Early 20th Century Warming: Anomalies, Causes, and Consequences*, 9 WIREs CLIM. CHANGE. 4 (2018).

¹⁵ Susan K. Serrano, *Elevating the Perspectives of the U.S. Territorial Peoples: Why The Insular Cases Should Be Taught in Law School*, 21 J. GENDER RACE & JUST. 395, 402 (2018).

¹⁶ Henry Wolf Bickl e, *The Constitutional Power of Congress over the Territory of the United States*, 49 U. PA. L. REV. 11, 13 (1901).

the United States accomplished most of its late-nineteenth century colonial conquests.¹⁷ The United States territories of Guam, Puerto Rico, American Samoa, North Mariana Islands, and the United States Virgin Islands are governed through the Territorial Clause, and the U.S. Supreme Court has given Congress virtually unfettered discretion in territories.¹⁸ These five unincorporated territories “exercise self-governance, while still sitting subject to the U.S. Congress’s plenary power.”¹⁹

The 1783 Treaty of Paris establishing the terms of peace between the new United States and the United Kingdom also transferred authority over the Northwest Territory to the new government.²⁰ The Northwest Ordinance, one of the first acts of Congress under the Articles of Confederation, laid the groundwork for expropriation of lands controlled by Native American tribes, as well as their forceful expulsion.²¹ Over the first part of the 19th century, the slowly building confrontation over slavery and, relatedly, white supremacy, spilled over into territorial acquisitions.²²

Ending the regime of joint U.K.-U.S. administration over the Oregon Territory, the United States obtained exclusive control over what are now

However, the absence from the Constitution of an express grant of so important a power as this by no means shows that the framers of the Constitution imagined it did not exist. This part of the Constitution “was introduced into the Constitution on the motion of Mr. Gouverneur Morris. In 1803 he was appealed to for information in regard to its meaning. He answered: ‘I am very certain I had it not in contemplation to insert a decree *de coerendo imperio* in the Constitution of America . . . I knew then, as well as I do now, that all North America must at length be annexed to us.’”

¹⁷ *Id.*

¹⁸ Juan Torruella, *The Insular Cases: The Establishment of a Regime of Political Apartheid*, 29 U. PA. J. INT’L L. 283, 291-96, 314-15 (2007).

¹⁹ Developments in the Law—U.S. Territories, *Introduction*, 130 HARV. L. REV. 1617, 1617 (2017).

²⁰ Treaty of Paris, U.K.-U.S., Sept. 3, 1783; Jay’s Treaty, U.K.-U.S., Nov. 19, 1794; Monroe-Pinkney Treaty, U.K.-U.S., 1806 (rejected by Thomas Jefferson); Treaty of Ghent, U.K.-U.S., Dec. 24, 1814; Carlyle Buley, *Pioneer Health and Medical Practices in the Old Northwest Prior to 1840*, 20 MISS. VALLEY HIST. REV. 497, 497-520 (1934).

²¹ James Huston, *THE NORTHWEST ORDINANCE OF 1787* (1987); Reginald Horsman, *American Indian Policy in the Old Northwest 1873-1812*, 18 WM. & MARY Q. V 35 (1961). For the text of the Northwest Ordinance, see An Ordinance for the Governance of the Territory Northwest of the River Ohio § 8 (July 13, 1787).

For the prevention of crimes and injuries, the laws to be adopted or made shall have force in all parts of the district, and for the execution of process, criminal and civil, the governor shall make proper divisions thereof; and he shall proceed from time to time as circumstances may require, to lay out the parts of the district in which the Indian titles shall have been extinguished, into counties and townships, subject, however, to such alterations as may thereafter be made by the legislature.

²² John Craig Hammond, *“They Are Very Much Interested in Obtaining an Unlimited Slavery”*: *Rethinking the Expansion of Slavery in the Louisiana Purchase Territories, 1803-05*, 23 J. EARLY REPUBLIC 353, 353 (2003).

the states of Washington and Oregon.²³ Seeking to promote white settlement of the territory, Congress adopted pursuant to the Territorial Clause the Oregon Donation Land Act, which provided that white settlers and “half-breed” Indians could obtain 160 acres for settling the Oregon Territory.²⁴ The Donation Land Act, the law authorizing Marcus Neff to purchase the land eventually at issue in *Pennoyer v. Neff*, explicitly excluded Blacks, and validated white settler claims in the Willamette Valley and spurred a rush of settlers to the Umpqua and Rogue valleys.²⁵ White settlers “ruthlessly drove Natives from their traditional hunting and gathering grounds.”²⁶ Regular U.S. Army troops eventually removed most of the surviving bands to the newly established Coast Reservation.²⁷ Before lawmakers voted for the Donation Land Law, they passed legislation authorizing commissioners to negotiate treaties to extinguish Indian title and to remove tribes “and leave the whole of the most desirable portion open to white settlers.”²⁸

“White” resilience to disease, especially smallpox and tuberculosis, served as a justification for expropriation of Indian title.²⁹ Because the “white” population believed that they, by natural immune resistance and by their public health interventions, resisted disease that otherwise devastated Native American communities, it was seen as “natural” that they take over Native American land.³⁰ As Leslie Scott opined in a particularly odious essay celebrating the white settlement of Oregon, “Always it will be a source of thanksgiving that the destruction of the Indians of the Pacific Northwest by diseases spared the pioneer settlers the horrors of a strong and malignant foe.”³¹

²³ Henry Commager, *England and the Oregon Treaty of 1846*, 28 ORE. HIST. Q. 18, 18 (1927); R.L. Schuyler, *Polk and the Oregon Compromise of 1846*, 26 POL. SCI. Q. 443, 443 (1911).

²⁴ Oregon Donation Land Act, 9 Stat. 496-500 (1850).

²⁵ Quintard Taylor, *Slaves and Free Men: Blacks in the Oregon Country 1840-1860*, 83 ORE. HIST. Q. 153 (1982).

During the 20-year period between 1840 and 1860 the Afro-American population of the Pacific Northwest (Oregon and Washington territories) never exceeded one per cent of the total population. Yet the status of slavery, slaves, and free blacks greatly occupied, and in many instances dominated, the political debates of the region during this period. To be sure, the slavery question loomed ominously over the national political scene during these years and culminated in a bloody civil war.

²⁶ William G. Robbins, *The Oregon Donation Land Law*, ORE. ENCYCLOPEDIA, https://www.oregonencyclopedia.org/articles/oregon_donation_land_act/#.YNT7_GhKjIU.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ Leslie Scott, *Indian Diseases as Aids to Pacific Northwest Settlement*, 29 ORE. HIST. Q. 144, 161 (1928).

The vast majority of U.S. territorial acquisitions followed a general trend of colonialism and expulsion of indigenous peoples, in part based on notions of medical superiority.³² During this period, the role of access to medicine and healthcare generally was key to some treaties: U.S. and later Canadian officials promised “white man’s” medicine in exchange for transfer of title.³³

In 1898, the Treaty of Paris ended the Spanish American war, which defeated the Spanish Empire and relinquished the Philippines, Puerto Rico and Guam to the United States.³⁴ The Treaty of Paris left the fate of these territories up to Congress, and Congress was to decide the civil rights and political status of the native inhabitants, instead of directing these territories towards eventual statehood or independence.³⁵ “Puerto Rico became the unincorporated territory of the Union: The Commonwealth of Puerto Rico.”³⁶ Guam was subject to military rule until 1950, when control of the territory was transferred to the Department of the Interior.³⁷

In 1900, a treaty between the United States, Great Britain and Germany gave the United States American Samoa.³⁸ Leaders of Samoa “formally ceded sovereignty to the United States in 1900 and 1904” and the U.S. Navy ran the territory until 1951, and at that time “administrative authority was transferred to the Secretary of the Interior.”³⁹ American

³² J. Diane Pearson, *The Politics of Disease: Imperial Medicine and the American Indian, 1797-1871* (2001) (Ph.D. dissertation, University of Arizona) (Proquest).

Western medicine was utilized as an instrument of empire in colonies established by conquest, occupation, and settlement and was practiced on American Indians between 1797 and 1871. This was medicine in the agents, knowledge and processes of western physicians, western medical “advances” and western medical practices that became part and parcel of the disease experiences of Native Americans and developing federal health care policies. Western medicine, in the form of imperial medicine, was political, economical, military and racial in nature and served to legitimize a federal presence in north American Indian communities.

³³ Sam Halabi, *The Role of Provinces, States, and Territories in Shaping Federal Policy Toward Indigenous Peoples’ Health*, 18 AM. REV. OF CAN. STUD. 231, 232 (2019).

³⁴ Sonia Colon & Elizabeth A. Greene, et. al., *Puerto Rico’s Financial Crisis Impacts the Health Care Industry: When Health Care Goes on Life Support*, 020416 ABI-CLE 645 (2016). The Philippines was also ceded to the United States. *Id.* See also John Offner, *The United States and France: Ending the Spanish-American War*, 7 DIPLO. HIST. 1, 12-13 (detailing the contents of the Treaty of Paris).

³⁵ Serrano, *supra* note 15, at 402.

³⁶ Colon & Green et al., *supra* note 34, at 5.

³⁷ Timothy Maga, *The Citizenship Movement in Guam 1946-50*, 53 PACIFIC HIST. REV. 59, 75-77 (1984).

³⁸ KEES VAN DIJK, *The Partition of Samoa in PACIFIC STRIFE: THE GREAT POWERS AND THEIR POLITICAL AND ECONOMIC RIVALRIES IN ASIA AND THE WESTERN PACIFIC, 1870-1914*, 401, 413 (Taking Ngo ed., 2015).

³⁹ *Id.* at 416.

Samoans are considered “U.S. nationals,” not U.S. citizens like the other four territories.⁴⁰

Despite initial promises of liberation and de-occupation, the U.S. military presence lingered in nearly all territories acquired at the turn of the 20th century. Both routine and exceptional situations arose that called into question the constitutional relationship between the U.S. federal government and the populations of the territories under its control, which were not citizens of states protected by the Fourteenth Amendment to the U.S. Constitution. Indeed, by 1900, nearly all citizens in the contiguous United States enjoyed the protection of the Fourteenth Amendment, with notable exceptions of populations in unique territories, such as what is now the State of Oklahoma, where treaties with Native American tribes nominally regulated relations.⁴¹

In a series of decisions issued in the first two decades of the twentieth century, known as the Insular Cases, the Supreme Court established the constitutional doctrine of “unincorporated territories.”⁴² The initial disputes revolved around the obligation to collect duties on goods shipped from the territories, as the statutory framework at the time distinguished the imposition of tariffs on “foreign” versus “domestic” goods.⁴³ Later disputes, including the right to trial by jury, involved aspects of the U.S. Constitution that bore a far more significant relationship to individual civil and human rights. In 1922, the Supreme Court, in *Balzac v. Porto Rico*, declared that the conferral of citizenship on Puerto Ricans by the Jones Act in 1917 was unrelated to Puerto Rico’s political status.⁴⁴

The language and rhetoric of the opinions were at many points nakedly racist. One Justice warned that “Races, habits, laws, and customs” would portend “extremely serious” consequences if “savages” became entitled to “all rights, privileges, and immunities of citizens.”⁴⁵ Cobbling

⁴⁰ *Id.*

⁴¹ Susan Work, *The “Terminated” Five Tribes of Oklahoma: The Effect of Federal Legislation and Administrative Treatment on the Government of the Seminole Nation*, 6 AM. INDIAN L. REV. 81, 81 (1978).

⁴² Efiren Rivera Ramos, THE LEGAL CONSTRUCTION OF IDENTITY: THE JUDICIAL AND SOCIAL LEGACY OF AMERICAN COLONIALISM IN PUERTO RICO 74-81 (2001).

⁴³ *Id.* at 77, 96.

⁴⁴ *Balzac v. Porto Rico*, 258 U.S. 298, 313 (1922).

⁴⁵ *Downes v. Bidwell*, 182 U.S. 244, 279-282 (1901).

We are also of opinion that the power to acquire territory by treaty implies, not only the power to govern such territory, but to prescribe upon what terms the United States will receive its inhabitants, and what their status shall be in what Chief Justice Marshall termed the “American empire.” There seems to be no middle ground between this position and the doctrine that if their inhabitants do not become, immediately upon annexation, citizens of the United States, their children thereafter born, whether savages or civilized, are such, and entitled to all the rights,

together principles of then-applicable international law of conquest and the Territorial Clause, Justice White developed the doctrine of the unincorporated territory, over which Congress had virtually unfettered authority. Congress could, for example, extend U.S. citizenship, inferior status to citizenship, or no status at all, subject to vaguely defined “fundamental” rights.⁴⁶ Similarly, the disposition of laws applicable to the territories may be arbitrarily extended or retracted. This remains true today: Puerto Ricans are U.S. citizens, but American Samoans are not.⁴⁷ Congress may extend certain parts of Medicare to U.S. citizens, but take those benefits away should one move to the U.S. Virgin Islands.⁴⁸ This plenary authority of Congress, with no voting voice from territorial representatives to condition it, has resulted in the perpetuation of incoherent and injurious healthcare access across all five unincorporated territories.

In 1916, the United States Virgin Islands became a “possession” of the U.S. through a purchase from Denmark.⁴⁹ The U.S. Virgin Islands were controlled by the U.S. Navy, prior to being handed over to the Department of the Interior.⁵⁰

The relationship between the United States and the Northern Mariana Islands began after World War II, “when the United States signed a

privileges and immunities of citizens. If such be their status, the consequences will be extremely serious. Indeed, it is doubtful if Congress would ever assent to the annexation of territory upon the condition that its inhabitants, however foreign they may be to our habits, traditions, and modes of life, shall become at once citizens of the United States. In all its treaties hitherto the treaty-making power has made special provision for this subject; in the cases of Louisiana and Florida, by stipulating that “the inhabitants shall be incorporated into the Union of the United States and admitted as soon as possible . . . to the enjoyment of all the rights, advantages, and immunities of citizens of the United States;” in the case of Mexico, that they should “be incorporated into the Union, and be admitted at the proper time (to be judged of by the Congress of the United States) to the enjoyment of all the rights of citizens of the United States;” in the case of Alaska, that the inhabitants who remained three years, “with the exception of uncivilized native tribes, shall be admitted to the enjoyment of all the rights,” etc.; and in the case of Porto Rico and the Philippines, “that the civil rights and political status of the native inhabitants . . . shall be determined by Congress.” In all these cases there is an implied denial of the right of the inhabitants to American citizenship until Congress by further action shall signify its assent thereto.

⁴⁶ *Id.* at 290-91 (1901).

⁴⁷ *Fitisemanu v. U.S.*, 1 F.4th 862, 864-865 (10th Cir. 2021) (“Congress plays the preeminent role in the determination of citizenship in unincorporated territorial lands, and . . . the courts play but a subordinate role in the process . . . These circumstances advise against the extension of birthright citizenship to American Samoa.”).

⁴⁸ WILLIAM R. MORTON, CONG. RSCH. SERV., IF10484, SUPPLEMENTAL SECURITY INCOME (SSI) 2 (2021), <https://crsreports.congress.gov/product/pdf/IF/IF10482>.

⁴⁹ Jon M. Van Dyke, *The Evolving Legal Relationships Between the United States and Its Affiliated U.S.-Flag Islands*, 14 U. HAW. L. REV., 445, 494-95 (1992).

⁵⁰ *Id.*

trusteeship agreement with the United Nations.”⁵¹ The U.S. government and the Northern Mariana Islands entered into a covenant in 1976, and the Northern Mariana Islands adopted a constitution in 1977 with formal commonwealth status conferred in 1986.⁵²

The U.S. claims that it sought to support freedom-seeking rebels in Spanish colonies, likening the effort to emancipation in the United States.⁵³ However, once independence from Spain was achieved for Cuba, Guam, the Philippines, and Puerto Rico, the narrative justifying U.S. occupation and control could no longer sound in naked conquest or racial superiority, as those had been precisely the reasons the U.S. asserted that those under Spanish control should be freed.⁵⁴ The discourse of hygiene, public health, and civilization provided necessary rationale for U.S. action in the former Spanish possessions, as well as, for that matter, Hawaii, just as it had informed the *mission civilisatrice* for French control over its African, Asian, and South American possessions.⁵⁵

Thus, the U.S. Constitution was always structured for territorial control and even after the adoption of the Fourteenth Amendment, the Federal Government’s right to acquire territory, even by conquest, prevailed over the rights of those who happened to reside in conquered territories. In the Insular Cases, the U.S. Supreme Court decisively subordinated those in conquered and acquired territories. Eventually, when conquest became disfavored (and later banned by the U.N. Charter), other rationales were required to justify U.S. occupation of overseas territories.

⁵¹ Nicole Manglona Torres, Comment, *Self-Determination Challenges to Voter Classifications in the Marianas After Rice v. Cayetano: A Call for a Congressional Declaration of Territorial Principles*, 14 ASIAN-PAC. L. & POL’Y J., 152, 160 (2012).

⁵² *Id.*

⁵³ Jay Sexton, *The United States, the Cuban Rebellion, and the Multilateral Initiative of 1875*, 30 DIPLOMATIC HIST. 335, 340 (2006).

⁵⁴ See Michael Onorato, *Leonard Wood: His First Year as Governor General 1921-1922*, 4 ASIAN STUD. 353 (1966), <https://www.asj.upd.edu.ph/mediabox/archive/ASJ-04-02-1966/onorato-wood-first-year-governor-general.pdf>; see also Pedro A. Cabán, *Puerto Rico: State Formation in a Colonial Context*, 30 CARIBBEAN STUD. 170, 174 (2002).

⁵⁵ Alice Conklin, *Colonialism and Human Rights, a Contradiction in Terms? The Case of France and West Africa, 1895-1914*, 103 AM. HIST. REV. 419, 419-24 (1998).

It is, of course, well known that policymakers under the Third Republic justified the forcible acquisition of French colonies as part of a universal mission—what they referred to as their *mission civilisatrice*—to uplift the ‘inferior races.’ Although hardly a new idea in the *fin-de-siecle*, the civilizing mission acquired greater currency in the age of democratic empire; ruling elites in France sought to reconcile themselves and the recently enfranchised masses to intensified overseas conquest by claiming that the newly restored republic, unlike the more conservative European monarchies, would liberate Africans from moral and material want.

II. HYGIENE, PUBLIC HEALTH, AND THE U.S. COLONIAL PRESENCE

At the turn of the 20th century, when most of these acquisitions occurred, the field of tropical medicine was new. Describing diseases as “tropical” reflected the experience of Europeans as they explored and settled the places where those diseases afflicted the native population.⁵⁶ The London School of Hygiene and Tropical Medicine was established in 1899 precisely to aid in the colonial enterprise.⁵⁷ Sir Patrick Manson, its founder, served as Medical Advisor to the Colonial Office.⁵⁸ In Manson’s view, reflective of the medical profession in the UK generally, physicians should be trained in tropical medicine to treat British colonial administrators and others working throughout Britain’s tropical empire.⁵⁹ The French *Institut Pasteur* accomplished similar objectives by opening overseas *instituts* dedicated to the study of diseases that adversely affected colonial administrators and soldiers.⁶⁰

Indeed, the participation of physicians as colonial administrators was robust over the entire era of colonization. “[G]enerally, they were not physicians or surgeons first: rather, they were administrators, soldiers, explorers, missionaries, businessmen—the familiar roles of European colonists.”⁶¹ Doctors played an important administrative role in colonialism for both the French and the British. Even when cast as important for indigenous populations, access to physicians, medicine, and clinical care

⁵⁶ The definition of “tropics” as being warmer, distant, and exotic reflected colonial administrators and travelers from colder, northern temperate latitudes. Michael Worboys, *Manson, Ross and Colonial Medical Policy: Tropical Medicine in London and Liverpool, 1899-1914*, in *DISEASE, MEDICINE, AND EMPIRE: PERSPECTIVES ON WESTERN MEDICINE AND THE EXPERIENCE OF EUROPEAN EXPERIENCE* 21, 22 (Roy MacLeod & Milton Lewis eds., 1988).

⁵⁷ Gregory Kennedy, *The “Golden Rule” of Tropical Medicine: Brian Maegraith and the Early Emergence of Community-Based Medicine in Thailand* (2011) http://www.princeton.edu/~pphr/gregory_kennedy_11.pdf.

Manson and Chamberlain’s lobbying efforts, coupled with the financial backing of prominent British merchants, led to the establishment of the Liverpool School of Tropical Medicine on April 22, 1899. Bureaucratic hurdles slowed the development of the London School of Tropical Medicine, which was eventually founded six months later in October of 1899. The stated mission of the schools was explicitly tied to the colonial enterprise.

See also Michael Worboys, *The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940*, 15 *OSIRIS* 207, 207-18 (2001).

⁵⁸ Worboys, *Manson*, *supra* note 56, at 21.

⁵⁹ JOHN FARLEY, *BILHARZIA: A HISTORY OF IMPERIAL TROPICAL MEDICINE* 116 (1991).

⁶⁰ Anne Marie Moulin, *Patriarchal Science: the Network of the Overseas Pasteur Institutes*, in *SCIENCE AND EMPIRES: HISTORICAL STUDIES ABOUT SCIENTIFIC DEVELOPMENT AND EUROPEAN EXPANSION* 307, 307-19 (Patrick Petitjean, Catherine Jami & Anne Moulin eds., 1992).

⁶¹ Bob Z. Sun, *MEDICINE AS COLONIAL ENTERPRISE* 10 (2014) (thesis on file with author).

was provided for purposes of ensuring their health for agricultural and other forced labor.⁶²

The reason for the existence of tropical medicine as a discipline was the protection of European colonial presence and the exploitation of indigenous labor. This perspective was comprehensively adopted by the U.S. government as it became a de facto colonial power in 1898 with the acquisition of Cuba, Guam, Hawaii, Puerto Rico, and the Philippines and, shortly thereafter, American Samoa and the Panama Canal Zone. Administration by the U.S. Navy, in nearly every territory, was accompanied by the restructuring of labor and the economy for purposes of revenue—copra, sugar, rum, and other commodities supported Naval operations.⁶³

Although American Samoa, Guam and Puerto Rico are the focus of this Article, it is worth noting the similarities between U.S. justifications for occupation and control in those territories on the one hand, and Cuba and Hawaii on the other. The U.S. initially occupied Cuba from 1899 to 1902, when the Platt Amendment guaranteed perpetual U.S. naval presence (ultimately, control of Guantanamo Bay) and broad authorization for U.S. intervention.⁶⁴ General Leonard Wood, the most important administrator in the first occupation, described the role of the United States with respect to the Cuban people it controlled as:

[T]o prepare the people of Cuba for self-government and to establish conditions which would render the establishment of a Cuban republic possible and its orderly and successful maintenance probable . . . Conditions in Santiago at the time of occupancy were as unfavorable as can be imagined. Yellow fever, pernicious malaria and intestinal fevers were all prevalent to an alarming extent. The city and surrounding country was full of sick Spanish

⁶² David Arnold, *Cholera and Colonialism in British India*, 113 *PAST & PRESENT* 119 (Nov. 1986); William A. Cohen, *Malaria and French Imperialism*, 24 *J. AFRICAN HIST.* 23 (1983); Maryinez Lyons, *THE COLONIAL DISEASE: A SOCIAL HISTORY OF SLEEPING SICKNESS IN NORTHERN ZAIRE, 1900-1940* (1992).

⁶³ I.C. Campbell, *Resistance and Colonial Government: A Comparative Study of Samoa*, 40 *J. PAC. HIST.* 45, 49 (2005).

The government sold this copra in bulk, deducted the amount of tax, plus expenses, and returned any surplus to the chiefs ostensibly to distribute to their villages. Tilley's was an ad hoc system that became permanent: the governor (initially commandant) had no instructions on government, or on the scope and limits of his authority, and did not know what actions might be approved or disapproved. Even the question of whether the naval commandant was entitled to exercise any authority over the Samoans was unclear.

⁶⁴ Lejeune Cummins, *The Formulation of the "Platt" Amendment*, 23 *THE AMERICAS* 370 (1967); Cosme de la Torre, *The Platt Amendment*, 8 *FOREIGN AFFAIRS* 364, 367-78 (1930); *The Origin and Purpose of the Platt Amendment*, 8 *AJIL* 585-91 (1914).

soldiers, starving Cubans and the sick of our own army. The sanitary conditions were indescribably bad.⁶⁵

In other words, the state of hygiene on the Cuban island was a threat to the U.S. military presence there.

While the Wood Administration was committed to building hospitals and facilitating the shipments of medicine to Cuba, it was clear that the primary reason for doing so was the health of the occupying forces:

The death rate among our own troops was heavy and the percentage of sick appalling. The regulars and volunteers engaged in the siege and capture of the city were withdrawn late in August and their places filled with one regiment of regulars and a number of regiments of volunteers. The arrival of these green troops in the height of the unhealthy season was a cause for grave anxiety and their care required unusual precautions.⁶⁶

Similarly, Wood conveyed that a rapid smallpox vaccination campaign was relevant because of its impact on the safety and health of the occupying U.S. forces.⁶⁷

The pattern of military occupiers using tropical medicine to justify their occupation was repeated in American Samoa, Guam, Hawaii, the Panama Canal Zone, Puerto Rico, and the Philippines. In American Samoa, the U.S. Navy administered the territory after German and British accession to U.S. ownership, and continued U.S. presence was justified by the discovery of hookworm and the necessity of the U.S. presence to contain it for the natives' benefit.⁶⁸

In Guam, the U.S. Navy was given control of the island and immediately justified both military control and restructuring of healthcare as part of "tropical medicine" policies: deporting and marooning those afflicted with leprosy (Hansen's disease) to a Philippines island, directing care of pregnancy, birth, and delivery to male naval physicians instead of indigenous midwives, and centralizing healthcare access in facilities built and staffed by U.S. naval forces.⁶⁹ As the navy surgeon-general expressed

⁶⁵ Leonard Wood, *The Military Government of Cuba*, 21 ANNALS OF THE AM. ACAD. OF POL. & SOC. SCIS. 1, 1 (1903).

⁶⁶ *Id.*

⁶⁷ *Id.* at 3. ("Indeed, as an illustration of the efficiency of vaccination, it can be stated that there was not a case of smallpox among troops sent into the district.")

⁶⁸ Campbell, *supra* note 63, at 53.

⁶⁹ Anne Perez Hattori, *Re-membering the Past: Photography, Leprosy and the Chamorros of Guam, 1898–1924*, 46 J. PAC. HIST. 293, 297-99 (2011) (reciting deportation policy for those suffering from leprosy); Anne Perez Hattori, 'The Cry of the Little People of Guam': *American Colonialism, Medical Philanthropy, and the Susana Hospital for Chamorro Women, 1898-1941* 8 HEALTH & HIST. 4, 12-16 (2006) (chronicling the history of the Susana Hospital and its role in reshaping care during pregnancy as well as the process of centralizing healthcare away from villages).

in 1907, “The natives . . . are entirely dependent for medical and surgical relief upon the navy. This service, however, is not a mere charity, but constitutes a legitimate charge in the health interests of the naval community.”⁷⁰ Similarly, Rear Admiral E.R. Stitt advocated “introducing modern ideas of medicine” to the native Chamorros, the indigenous people of Guam, so that “they would no longer be a menace to those [U.S. navy personnel and their dependents] who would be forced to come in contact with them.”⁷¹

In 1904, a year before he established Guam’s Department of Health and Charities, Governor Dyer commented:

It is . . . incumbent on us for our self-protection and efficiency to give the natives such care as they are unable to get for themselves, [and] to see that they are kept healthy and free from contagion. These people must be taught, at once, to help themselves in ways to make themselves useful to us . . .⁷²

Hawaii’s experience was similar.⁷³ The existence of leprosy in Hawaii proved the “savage and barbaric” character of Hawaiian inhabitants:

[H]ence, the control of diseases, particularly diseases which are endemic to the colony but not present in the home country, becomes a manner by which to establish and strengthen imperial domination. American colonial policy towards leprosy therefore can be seen through the prism of both racial and civic imperialism. In the former conceptualization, the pursuit of empire in general and the control of leprosy in Hawaii in particular emerges as a moral mandate combining Biblical adjurations to care for lepers while segregating them as an example of the impact of the sinful life with racist theories arguing for the fundamental barbarity and inferiority of ‘savage races’ permanently afflicted by diseases which were indicative of their lesser moral status.⁷⁴

The primary intervention of U.S. forces post-occupation was to make its relatively advanced healthcare infrastructure available to occupying forces, with disregard for the health of native Hawaiians.⁷⁵

⁷⁰ Hattori, *The Cry of the Little People of Guam*, *supra* note 69, at 8.

⁷¹ *Id.*

⁷² *Id.*

⁷³ Emily Kern, *Sugarcane and Lepers: Health Policy and the Colonization of Hawaii (1860-1900)*, 17 PA. HIST. REV. 78, 78-79 (2010), <https://repository.upenn.edu/cgi/viewcontent.cgi?article=1038&context=phr>.

⁷⁴ *Id.*; *see also* Prince Morrow, *Leprosy and Hawaiian Annexation*, 165 N. AM. REV. 582-590 (1897).

⁷⁵ Keanu Sai, NEA News, *The Impact of the U.S. Occupation on the Hawaiian People* (2018), <https://www.nea.org/advocating-for-change/new-from-nea/impact-us-occupation-hawaiian-people> (analyzing centralization of healthcare under U.S. occupation and the process of excluding Native Hawaiians from their historically universal access).

In the Philippines, it was the U.S. Army rather than the Navy that controlled the islands in the aftermath of Spain's cession of the territory. Armed resistance to U.S. presence was immediate.⁷⁶ The effort against the guerilla war that followed U.S. occupation of the Philippines united the missions of medical directors responsible for addressing sanitation and troops fighting the guerillas.⁷⁷ Manila, for example, was divided into ten districts for the inspection of diseases, and the physician in charge of surveying for disease outbreaks reported to the U.S. Army, not to the newly established civilian health board.⁷⁸ The control of cholera served as the basis for the U.S. administration to control the buying and selling of food, closing off Manila, and inspecting individual households day and night.⁷⁹ According to Warwick Anderson, "hygiene reform in this particular fallen world was intrinsic to a 'civilizing process' which was also a shallow and uneven process of Americanization."⁸⁰ While some efforts, like smallpox immunization, were based upon sound medical evidence, others were clearly specious. The Philippines Health Board, for example, claimed that the introduction of American sports had decreased the incidence of tuberculosis.⁸¹ To address cholera, American public health officials "hosed off the 'China' boys and Filipinos with disinfectants."⁸²

The same pattern surfaced in Puerto Rico, where U.S. officials viewed their presence in the territories as "analogous to that articulated by European colonial officials, as a form of "trusteeship." One medical official described the small-pox campaign there as "the share of the white man's burden that has fallen to the medical departments of the Public Services in Puerto Rico."⁸³

Thus the concept of racialized, hygienic superiority occupied a critical role in sustaining the U.S. presence in territories that it otherwise declared it had arrived to emancipate. As part of that conceptualization, the U.S. occupying forces both restructured the nature and infrastructure of

⁷⁶ Glenn May, *Filipino Resistance to American Occupation: Batangas 1899-1902*, 48 PAC. HIST. REV. 531, 541 (1979).

⁷⁷ Mary Gillett, *U.S. Army Medical Officers and Public Health in the Philippines in the Wake of the Spanish-American War, 1898-1905*, 64 BULL. HIST. MED., 567, 572 (1990).

⁷⁸ *Id.* at 577.

⁷⁹ *Id.* at 578.

⁸⁰ Warwick Andersen, COLONIAL PATHOLOGIES: TROPICAL MEDICINE, HYGIENE, AND RACE IN THE PHILIPPINES 2 (2006); David Chappell, *The Forgotten Maui: Anti-Navy Protest in American Samoa, 1920-1935*, 69 PAC. HIST. REV. 217-60 (2000).

⁸¹ Gerald Gems, *Sports, Colonialism, and U.S. Imperialism*, 33 J. SPORT HISTORY 3, 12 (2006).

⁸² Warwick Anderson, *Excremental Colonialism: Public Health and the Poetics of Pollution*, 21 CULTURAL INQUIRY 640, 648 (1995).

⁸³ Janita de Barros & Sean Stilwell, *Public Health and the Imperial Project*, 49 CARIBBEAN Q. 1, 4 (2003).

healthcare provision in territories. They centralized healthcare access and emphasized acute treatment over prevention and indigenous practices. The other legacies of these interventions are more fully described in the next section.

III. THE LEGACY OF U.S. HEALTH POLICIES ON THE STRUCTURE OF TERRITORIALITY

The leadership of the United States, a country founded upon principles of liberty and equality, felt an immediate anxiety about the inconsistency with its written constitutional principles and its dominion over territories and peoples it had no intention of making either free or equal. According to Gervasio Luis Garcia:

[T]he new legal terms devised after 1870 to control the Native Americans and take away many of their rights were simply transferred to Cuban, Philippine and Puerto Rican affairs after 1898. The post-1870 Indian Wars were a key link between the whites' landed expansion to 1860 and their new overseas empire taken in 1898 and after.⁸⁴

On the one hand, the President, Secretary of State, and many members of Congress acknowledged that the U.S. was behind European powers in the scramble for overseas territories.⁸⁵ On the other hand, "it became increasingly obvious that the preservation of such democratic principles as liberty and equality was incongruous with the capture of territories and the subjugation of their inhabitants."⁸⁶ How could President McKinley and those responsible for U.S. foreign policy state that diplomatic decisions were consistent with constitutional principles of liberty and equality when they now possessed overseas territories the populations, neither of which were free (as in independent from a foreign power) nor equal (as in having equal rights to those in the contiguous United States)?⁸⁷

The McKinley Administration tasked O.P. Austin, an official at the U.S. Treasury Department, with identifying how the U.S. could maintain these possessions as a matter of geopolitical interest, but justify that

⁸⁴ Gervasio Luis Garcia, *I am the Other: Puerto Rico in the Eyes of North Americans*, 87 J. AM. HIST., 39, 44 (2000); see also THE WAR OF 1898 AND U.S. INTERVENTIONS, 1898-1934: AN ENCYCLOPEDIA 454 (Benjamin R. Beede, ed., 1994); WALTER LA FEBER, AMERICAN AGE: UNITED STATES FOREIGN POLICY AT HOME AND ABROAD SINCE 1750 158-61 (1989).

⁸⁵ Garcia, *supra* note 84, at 43.

⁸⁶ *Id.* at 45.

⁸⁷ *Id.*

possession in ways consistent with its constitutional commitments.⁸⁸ The answer was that the U.S. would state that its presence was only necessary at such time as the peoples under its control obtained “benefits of civilization,” such as better healthcare, housing, education, newspapers, schools, and greater powers of home rule.⁸⁹ Public health was fundamental to this civilizing mission. As noted in the quote above by Leonard Wood as it pertained to Cuba, and mimicked by naval officers in the context of American Samoa, Guam, the U.S. Virgin Islands, and Puerto Rico, the people of the territories were seen as needing the U.S. for purposes of reaching their potential, most immediately by stamping out infectious and vector-borne disease.⁹⁰

Because public health infrastructure was essential to justify the U.S. presence in newly acquired territories – and because that infrastructure was central to the status of occupation – access, financing, and facilities were structured around occupation and control rather than the asserted justifications of sovereignty, independence or, in the case of Hawaii, incorporation into the U.S. federal republic. This Part analyzes the lasting effects of U.S.-imposed or U.S.-influenced reorganizations of territorial healthcare systems and how those reorganizations created a situation in which continuing U.S. control was inevitable, with neither statehood nor sovereignty likely. The histories of Hawaii, the Philippines, and Cuba veered, respectively, at integration into and independence from the United States. The structure of healthcare access and financing in American Samoa, Guam, and Puerto Rico, however, reflect the initial construction of healthcare infrastructure that consolidated U.S. presence, facilitated centralized control, and extinguished indigenous practices. Because of this, and their sources of history which enable this analysis, this Article will focus its discussion on American Samoa, Guam and Puerto Rico.

Broadly speaking, the populations in unincorporated territories have high rates of poverty, in some measure because of U.S. policies implemented there.⁹¹ Were they states, they would be entitled to the full benefits of the Medicaid program. One out of every six dollars spent on healthcare in the U.S. is spent by Medicaid, and Medicaid is the major source of financing for states to provide coverage of health and long-term

⁸⁸ U.S. DEP’T OF TREASURY, COLONIAL ADMINISTRATION, 1800-1900: METHODS OF GOVERNMENT AND DEVELOPMENT ADOPTED BY THE PRINCIPAL COLONIZING NATIONS IN THEIR CONTROL OF TROPICAL AND OTHER COLONIES AND DEPENDENCIES (1903).

⁸⁹ Garcia, *supra* note 84, at 48.

⁹⁰ See discussion *infra* p. 73-74; Wood, *supra* note 65, at 45.

⁹¹ See Hector Hernandez-Delgado, *COVID-19 Highlights Unequal Treatment of People of Color in U.S. Territories*, HEALTH LAW (July 31, 2020), <https://healthlaw.org/covid-19-highlights-unequal-treatment-of-people-of-color-in-u-s-territories/>.

care for low-income residents.⁹² Medicaid is administered by states within general federal requirements. It is jointly funded by states and the federal government.⁹³

Under the law, Medicaid provides a guarantee to individuals eligible for services and to states for federal matching payments with no pre-set cap.⁹⁴ Even though it is equally an entitlement to those in the states and the territories, the populations are treated differently.⁹⁵ The federal government matches state spending for eligible beneficiaries and qualifying services without a limit.⁹⁶ The federal part for Medicaid (including children, parents and non-ACA expansion adults, elderly, and people with disabilities) is set by a formula in statute that is based on a state's per capita income relative to other states.⁹⁷ The formula is applied so that the federal government pays a larger share of program costs in poorer states. Under the formula, the federal share (FMAP) varies by state from a floor of 50 percent to a high of 78 percent for fiscal year (FY) 2022.⁹⁸ States may receive higher FMAPs for certain services or populations: “[i]n 2019, the federal government paid 64 percent of total Medicaid costs with the states paying 36 percent.”⁹⁹

The Patient Protection and Affordable Care Act made significant changes that benefited states, although it made only minor improvements for territories. The ACA provided 100 percent federal financing for those made newly eligible for Medicaid by the ACA from 2014 to 2016 (with that match phasing down to 90 percent by 2020).¹⁰⁰ The ACA originally required all states to implement the expansion of Medicaid to all people with incomes up to 138 percent of the poverty level,¹⁰¹ but a decision by the Supreme Court effectively made it optional.¹⁰²

⁹² Robin Rudowitz et al., *Medicaid Financing: The Basics*, KAISER FAM. FOUND. (May 7, 2021), <https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief>; *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>.

⁹³ *Financial Management: 2015 National Health Expenditure Accounts*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/financial-management/index.html>.

⁹⁴ Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92.

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92. See also Sam Halabi, *The Patient Protection and Affordable Care Act of 2010: Rulemaking the Shadow of Incentive-Based Regulation*, 38 RUTGERS L. REV. 141 (2011) (detailing the changes made by the Affordable Care Act).

¹⁰¹ Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92.

¹⁰² See *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2011).

“Medicaid also provides ‘disproportionate share hospital’ (DSH) payments to hospitals that serve a large number of Medicaid and low-income uninsured patients,” but only to patients in U.S. states, not territories.¹⁰³ DSH payments to the states totaled \$17.7 billion in FFY 2019.¹⁰⁴

The United States uses the Federal Poverty Level to determine which states qualify for Medicaid, but uses different, non-uniform, poverty standards when defining healthcare access in the territories,¹⁰⁵ “The unique needs of each territory are not weighed to determine the applicable FMAP and, hence, the statutory cap fails to reflect important distinctions with respect to economic conditions and special health needs.”¹⁰⁶ Some of these distinctions include the distance to major tertiary care centers, access to nutrition, and certain behavioral interventions like smoking cessation. The FMAP establishes the threshold at which the federal government will match all Medicaid expenditures.¹⁰⁷ “Unlike in the 50 states and D.C., annual federal funding for Medicaid in the U.S. territories of American Samoa, Guam, Northern Mariana Islands, and U.S. Virgin Islands is subject to a statutory cap and fixed matching rate.”¹⁰⁸

Once a territory reaches its capped federal funds, it no longer receives Medicaid support, unless Congress passes one-off support.¹⁰⁹ This pressures territorial resources when Medicaid spending continues beyond the federal limit – making the effective match rate lower than what is set in statute. Over time, Congress has provided increases in federal funds for the territories broadly and in specific emergency events, like COVID-19.¹¹⁰ “In addition to increased federal funding, the traditional territory FMAP of 55

¹⁰³ Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92.

¹⁰⁴ *Id.*

¹⁰⁵ *What is the Federal Poverty Level?*, HEALTHINSURANCE.ORG, [https://www.healthinsurance.org/glossary/federal-poverty-level/#:~:text=The%20federal%20poverty%20level%20is,Medicare%20Savings%20Programs%20\(MSPs\)](https://www.healthinsurance.org/glossary/federal-poverty-level/#:~:text=The%20federal%20poverty%20level%20is,Medicare%20Savings%20Programs%20(MSPs)) (“The federal poverty level is used to determine eligibility for Medicaid and CHIP (the Children’s Health Insurance Program); to determine eligibility for ACA premium tax credits and cost-sharing reductions (subsidies); and eligibility for Medicare Savings Programs (MSPs”). Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92.

¹⁰⁶ See Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92 (detailing specific health needs that cannot be addressed in specific territories).

¹⁰⁷ CONG. RSCH. SERV., R43847, MEDICAID’S FEDERAL MEDICAL ASSISTANCE PERCENTAGE, 1 (2020), <https://sgp.fas.org/crs/misc/R43847.pdf> (“The FMAP rate is used to reimburse states for the federal share of most Medicaid expenditures.”).

¹⁰⁸ Stolyar & Rudowitz, *supra* note 3.

¹⁰⁹ *Id.*

¹¹⁰ Rachel Roubein, *The Curious Case of Puerto Rico’s Medicaid funding*, WASH. POST (Sept. 28, 2021), <https://www.washingtonpost.com/politics/2021/09/28/curious-case-puerto-rico-medicaid-funding>.

percent was increased to 82 percent for Puerto Rico and 89 percent for the other territories through FY 2021. Unless Congress acts, there will be a major financing cliff at the end of FY 2021 for the territories,” such that they will all of a sudden have large COVID-19 related illness, but no money to pay for it.¹¹¹

A. American Samoa

After having been, for the latter part of the nineteenth century, the object of an intense international rivalry between Great Britain, Germany and the United States, the Treaty of Berlin in 1889 established a three-power condominium government over the entire Samoan archipelago.¹¹² After a decade, the islands were divided between Germany and the U.S., with the UK accepting territorial concessions elsewhere.¹¹³ The division was bitterly resented by the Samoan population, who viewed itself as a single community.¹¹⁴ The United States acquired all of Samoa east of 171 west longitude, and Germany assumed control of Samoan land west of that line. The United States Senate approved this arrangement on February 16, 1900, and three days later President McKinley ordered the Secretary of the Navy to “take such steps as might be necessary to establish the authority of the United States in the new colony.”¹¹⁵ Today, American Samoa consists of a handful of islands, 2,200 miles southwest of Hawaii, comprising only 76 square miles of territory and supporting a total population of approximately 60,000.¹¹⁶

The organization of American Samoan life after occupation, including healthcare, revolved around the needs of the Navy, for which the harbor at Pago Pago was the most important asset.¹¹⁷ To raise revenues for Naval operations, Benjamin Franklin Tilley, the first acting governor of American Samoa, levied a customs duty on imports, which was paid almost entirely

¹¹¹ Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92.

¹¹² Stuart Anderson, “Pacific Destiny” and American Policy in Samoa, 1872 - 1899, 12 HAW. J. HIST. 45, 56 (1978).

¹¹³ Edward Beauchamp, *Educational Policy in Eastern Samoa: An American Colonial Outpost*, 11 COMP. EDU. 23, 24 (1975).

¹¹⁴ *Malietao Enters a Protest. Declares a Partition of Samoa a Crime Against Law of Nations—Says Natives Are Not Benefited*, N.Y. TIMES, (Jan. 13, 1900), <https://www.nytimes.com/1900/01/13/archives/malietao-enters-a-protest-declares-partition-of-samoa-a-crime.html>.

¹¹⁵ Am. Samoa Bar Ass’n, *Executive Order Placing American Samoa Under the U.S. Navy: Exec. Order No. 125-A*, (Feb. 19, 1900), <https://new.asbar.org/executive-order-placing-samoa-under-the-u-s-navy>.

¹¹⁶ *American Samoa*, National Marine Sanctuary of American Samoa, <https://americansamoa.noaa.gov/learn/american-samoa.html>.

¹¹⁷ See generally Chappell, *supra* note 80, at 217-60 (2000) (detailing restructuring of Samoan life around Naval needs at Pago Pago).

by Samoans shopping in local stores, and he charged local traders license fees.¹¹⁸ The courts supported themselves through fines, and missionaries built and ran the schools.¹¹⁹ The Navy also hired a Samoan police force, the Fitafta Guard or “Fita,” who brokered procurement from the Navy to indigenous Samoans.¹²⁰ The Fita, along with dock and boat work in the harbor, became a new source of cash income.¹²¹ In 1902 some chiefs proposed an additional tax to pay the salaries of native officials, so the Navy government marketed local copra, a dried coconut crop with significant demand in Europe and North America.¹²² The Navy retained 60 percent of the profits for administrative salaries and returned the rest to the growers—an arrangement not dissimilar to European colonial practices in Africa and Asia.¹²³

Hookworm, an intestinal parasite, was discovered in 1909, and posed a threat to the Navy’s copra production and its personnel.¹²⁴ In response, the Navy established a Board of Health and constructed a hospital for Samoans in 1912, and established a two-year training course for Samoan nurses in 1914.¹²⁵ From the beginning of the Naval presence in 1900 to the transfer of Samoan administration to the Department of the Interior in 1951, physicians recruited to American Samoa were all from Europe and the U.S., while Samoan medical practitioners were relegated to taking patient histories and undertaking administrative tasks that require little skill.¹²⁶ A review of the healthcare system in 1955 confirmed the same essential structure, with difficult-to-recruit U.S. and European physicians at the

¹¹⁸ Diana Ahmad, *Two Captains, Two Regimes: Benjamin Franklin Tilley and Richard Phillips Leary, America’s Pacific Island Commanders, 1899-1901*, INT’L J. NAV. HIST. (Oct. 10, 2013), <https://www.ijnhonline.org/two-captains-two-regimes-benjamin-franklin-tilley-and-richard-phillips-leary-americas-pacific-island-commanders-1899-1901>.

Needing a way to finance his government and believing that the traders mistreated the Samoans in their dealings over the coconut meat, Tilley took over the copra export business. The Navy commander more than doubled the price given to the Samoans, allotting them three cents per pound, but charging them one dollar per Samoan as a “handling tax” for selling the copra. Between 1901 and 1902, approximately \$10,000 came from the copra fees.

¹¹⁹ I.C. Campbell, *Resistance and Colonial Government: A Comparative Study of Samoa*, 40 J. PAC. HIST. 45, 53 (2005).

¹²⁰ Tuala Sevaetasi, *The Fitafta Guard and Samoan Experience*, in REMEMBERING THE PACIFIC WAR (Geoffrey M. White ed., 1991).

¹²¹ *Id.*

¹²² Campbell, *supra* note 119, at 49.

¹²³ *Id.* See also J.A.C. Gray, AMERIKA SAMOA: A HISTORY OF AMERICAN SAMOA AND ITS UNITED STATES NAVAL ADMINISTRATION (1960).

¹²⁴ Campbell, *supra* note 119, at 53.

¹²⁵ *Id.*

¹²⁶ Edward Kupka, *Notes on Public Health in American Samoa*, 70 PUB. HEALTH REPS., 362, 362-63 (1955).

center of a healthcare system that operated primarily for naval personnel and other expatriates, and only marginally for indigenous Samoans.¹²⁷

The structure of healthcare financing in the territory reveals the resilience of a system initially established for the benefit of naval personnel. In 1968, the Department of the Interior built the LBJ Tropical Medical Center in Pago Pago, where “almost all health services are actually provided” for American Samoans.¹²⁸ Medicaid was extended to American Samoa in 1983 as a “100% fee-for-service delivery system” with only one hospital for the entire territory.¹²⁹ American Samoa’s Medicaid program is operated under Section 1901(j) of the Social Security Act, which allows the Secretary of Health and Human Services to “waive or modify any requirement of Title XIX” with the following exceptions:

[T]he territory must adhere to the cap set under Section 1108 of the Act; the territory must adhere to the statutory Federal Medical Assistance Percentage (FMAP); and Federal medical assistance payments may only be made for amounts expended for care and services described in a numbered paragraph of section 1905(a).¹³⁰

Nearly 70% of American Samoans rely on Medicaid for health care.¹³¹ From 1983 to 2010, Congress reimbursed American Samoa 50% for Medicaid costs it incurred in providing for its majority-poor population.¹³² The Affordable Care Act increased the reimbursement to 55% in 2010.¹³³ The FMAP for Alabama, by contrast, reimburses 71.88%, and for Mississippi 76.39%.¹³⁴ Just as crippling, Congress imposed an annual cap on all reimbursement, which American Samoa may not exceed.¹³⁵ U.S. states do not face such caps. The FMAP applies “until the Medicaid ceiling funds and the Affordable Care Act available funds are exhausted.”¹³⁶ These

¹²⁷ *Id.* at 363.

¹²⁸ PACIFIC PARTNERSHIPS FOR HEALTH: CHARTING A COURSE FOR THE 21ST CENTURY App. D (Feasley JC & Lawrence RS eds., 1998).

¹²⁹ Medicaid.gov, *American Samoa—Medicaid Overview*, <https://www.medicaid.gov/state-overviews/american-samoa.html>.

¹³⁰ *Id.*

¹³¹ Sarah Mar, “US Territory” – A Consequential Label, PUB. HEALTH POST (May 25, 2021), <https://www.publichealthpost.org/research/american-samoa-health/>.

¹³² 160 CONG. REC. E1729 (2014).

¹³³ *Id.*

¹³⁴ *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier> (2022).

¹³⁵ Cornelia Hall, Robin Rudowitz & Kathleen Gifford, *Medicaid in the Territories*, KAISER FAM. FOUND. (Jan. 25, 2019), <https://www.kff.org/report-section/medicaid-in-the-territories-program-features-challenges-and-changes-issue-brief>.

¹³⁶ American Samoa, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/state-overviews/american-samoa.html>.

two policies cause chronic underfunding of healthcare in the territories, “requiring Congress to step in at multiple points to provide additional resources.”¹³⁷

In 2019, American Samoa’s Medicaid director testified before Congress: “Our block grant can only afford to cover services for our only hospital and this is the priority of our government, to keep the hospital open.”¹³⁸ According to public health scholar Sara Mar “[t]his limited funding inhibits Samoans’ ability to center community health initiatives that would meet the needs of the local population.”¹³⁹ By contrast, Congress authorized the Native Hawaiian Healthcare Act in 1988 to address precisely such needs in Hawaii.

The separation between Samoa (or Independent Samoa) and American Samoa provides a relatively unique opportunity to analyze convergence and divergence between the health of the populations at independence (Samoa was under German then New Zealand authority until 1961). Victoria Fan and Ruth Le’au at the University of Hawaii undertook precisely such an analysis. According to their study, chronic diseases such as diabetes and cancer are the principal causes of death in both nations.¹⁴⁰ However, American Samoa maintains significantly higher rates of death from these diseases.¹⁴¹ In 2007, American Samoa had 1.7 and 3.6 times higher rates of death from diabetes and heart disease, respectively.¹⁴² Relevantly, poverty is a strong predictor of death from heart disease.¹⁴³ In American Samoa, 57% of people live in poverty compared to only 18.8% in Independent Samoa.¹⁴⁴

Fan and Le’au argue that territorial status itself may cause American Samoa’s higher rates of morbidity and mortality.¹⁴⁵ Samoa’s government has invested in community-based assessments of healthcare needs and tailored investments to those needs, broadly labeled the Fa’a Samoa initiative.¹⁴⁶ The program focuses on village outreach and deploying Komiti

¹³⁷ Statement of Anne L. Schwartz, *supra* note 2.

¹³⁸ Sara Mar, “US Territory” – *A Consequential Label*, PUB. HEALTH POST, (May 25, 2021), <https://www.publichealthpost.org/research/american-samoa-health/>.

¹³⁹ *Id.*

¹⁴⁰ Victoria Y. Fan & Ruth Faioso Le’au, *A Tale of Two Polities: Health in Independent and American Samoa*, 74 HAW. J. MED. & PUB. HEALTH, 179, 180 (2015).

¹⁴¹ *Id.*

¹⁴² *Id.* at 180–81.

¹⁴³ Wei-Ching Chang, et. al. *Effects of Socioeconomic Status on Mortality After Acute Myocardial Infarction*, 120 AM. J. MED. 33, 36 (2007); *see also* Fan & Le’au, *supra* note 140.

¹⁴⁴ Mar, *supra* note 138.

¹⁴⁵ Chang, *supra* note 143, at 183; Fan & Le’au, *supra* note 140, at 183.

¹⁴⁶ Caroline Bollars et. al., *Adapting the WHO package of Essential Noncommunicable Disease Interventions, Samoa*

Tumama – local women’s groups – to detect and manage chronic diseases.¹⁴⁷ American Samoa, by contrast, is entirely dependent upon, and limited by, Congressional discretion.

In summary, after the arrival of the U.S. Navy, approaches to healthcare in American Samoa were centralized around the hospital provision of care which was essential for the naval presence. In contrast to independent Samoa, indigenous health practices in American Samoa were largely discouraged, and the indigenous healthcare workforce was put into the service of colonial installations. Congress later exacerbated these changes by limiting and capping reimbursements to the system that had been established.

B. Guam

In Guam, there is evidence of the same pattern of U.S. Navy presence and its continuing influence on healthcare financing.¹⁴⁸ As with Hawaii, treatment of leprosy was both a justification for the continued U.S. presence in Guam and an instrument used to consolidate authority; the sight of afflicted persons adversely affected naval morale, “the paramount concern, as expressed by Guam’s early-20th-century governors . . . was to enact a plan ‘for the protection of the white population’.”¹⁴⁹ Navy Surgeon General P.S. Rossiter stated that, following the Spanish-American War, “Naval medical officers [in Guam] were faced with the problem of dealing with numerous tropical diseases, their prevention and treatment, and the prevention of their introduction into the United States.”¹⁵⁰

As public health scholar Sara Mar states, “[t]he fear that Americans would become infected with leprosy certainly informed the implementation of health policies on Guam in the early 1900s.”¹⁵¹ Where those affected with Hansen’s disease were traditionally cared for by extended networks of family and villagers, the U.S. Navy established a leper colony to which native Guam people, overwhelmingly Chamorros, were deported.¹⁵²

96 BULL. WORLD HEALTH ORG. 578–79 (2018).

¹⁴⁷ Rasul Baghirov, John Ah-Ching & Caroline Bollars, *Achieving UHC in Samoa through Revitalizing PHC and Reinvigorating the Role of Village Women Groups*, 5 HEALTH SYS. & REFORM 78, 79–80 (2018).

¹⁴⁸ ANNE PEREZ HATTORI, *COLONIAL DIS-EASE: US NAVY HEALTH POLICIES AND THE CHAMORROS OF GUAM, 1898-1941* (2006).

¹⁴⁹ Anne Perez Hattori, *Re-membering the Past: Photography, Leprosy and the Chamorros of Guam, 1898— 1924*, 46 J. PAC. HIST. 293, 297 (2011); Kern, *supra* note 73, at 78-79 (establishing the similar pattern for Hawaii).

¹⁵⁰ Hattori, *Re-membering the Past*, *supra* note 149, at 297.

¹⁵¹ *Id.*

¹⁵² *Id.*

Over the next decade, the segregation and deportation policy effectively criminalized leprosy in Guam.

From the hunt for those afflicted, to their capture, confinement and permanent segregation from society, and to their designation by their assigned number or as ‘inmates’, the issues surrounding their segregation focused primarily on the terms of their confinement, rather than on the forms of treatment that would be extended to them.¹⁵³

This demonstrates one example of how the U.S. removed the indigenous healthcare structure, replacing it with a harmful U.S. model.

Where those afflicted with infectious disease were criminalized and banished, other aspects of indigenous society were restructured altogether. Pregnancy, birth, and delivery were transitioned from aspects of communal or village care to the more “civilized” institution of the hospital.¹⁵⁴ The U.S. Navy, supported by the spouses of Naval administrators, erected the Susana Hospital for women and children in order to “modernize” Chamorro conceptions of childbearing and rearing.¹⁵⁵ According to Anne Perez Hattori, Susana Hospital was an intervention intended to subject indigenous women and children who had traditionally been cared for by midwives (*pattera*) to the surveillance of male doctors who provided private, individualized and paternalistic care.¹⁵⁶

“The U.S. Organic Act of 1950 established a civilian government in Guam, and shortly thereafter, a public health system and an acute hospital

¹⁵³ *Id.* at 299.

In 1907, for example, before conducting bacteriological tests, Navy doctors confined 185 patients at the Colony. Over the course of the next three years, laboratory tests would reveal that 159 had been misdiagnosed, and those patients were slowly released from the Colony, the majority of them having spent at least two years in confinement. Furthermore, beginning in 1909, the Navy also began housing patients classified as ‘insane’ at the Leper Colony, suggesting that the Tumon facility was used by the Navy as a prison.

¹⁵⁴ Hattori, ‘*The Cry of the Little People of Guam*’, *supra* note 69, at 15 (recording how home births and midwives were propagandized against).

¹⁵⁵ *Id.* at 9.

¹⁵⁶ Kyle Schlafer, *Schlafer on Hattori, ‘Colonial Dis-Ease: U.S. Navy Health Policies and the Chamorros of Guam, 1898-1941’*, H-NET: HUMANS. & SOC. SCI. ONLINE (Mar. 1, 2005) (book review) <https://networks.h-net.org/node/12840/reviews/13223/schlafer-hattori-colonial-dis-ease-us-navy-health-policies-and>.

In an attempt to bolster the population of the island, the naval government created strict regulations and instruction for midwifery at the newly created nursing school. This process mirrored attempts in the western countries to move the care of mothers and children away from midwives to male medical professionals. The new policies mostly met with resistance as midwives using traditional methods continued to dominate well into the 1950s.

based on the model of the Susannah Hospital.”¹⁵⁷ Following its passage, “almost all care for the civilian population was received at the government-run 250-bed Guam Memorial Hospital.”¹⁵⁸ It is estimated that 21% of Guam’s population is uninsured or underinsured, meaning their private insurance does not adequately cover necessary treatments.¹⁵⁹ Furthermore, many individuals who have health insurance cannot afford the copays for treatments or medications.

In 1975, Congress authorized the extension of Medicaid to Guam.¹⁶⁰ As with American Samoa, Congress set a low cap on fee-for-service reimbursement to services provided at a single facility: Guam Memorial Hospital.¹⁶¹ The federal government matching Medicaid expenditures is capped at 55% and does not follow the federal matching assistance percentage in the states.¹⁶² The FMAP for Guam does not recognize its capacity to pay for Medicaid expenses; instead, the FMAP is set at the lowest rate.¹⁶³ Federal Medicaid statute¹⁶⁴ and the codified Medicaid cap also affects the ability of Guam (and other U.S. territories) to access certain sources of Medicaid funding. For example, as noted above, the Medicaid disproportionate share hospital (DSH) program provides supplementary payments to hospitals that serve a large number of Medicaid and low-income uninsured patients, as Guam Memorial Hospital does.¹⁶⁵ However, the DSH program is available only to hospitals in the states and does not apply to the territories.¹⁶⁶ Given the role of the U.S. in ensuring that a single critical hospital is the major provider of care in Guam, it is inequitable that it not be eligible for reimbursements allocated to hospitals serving indigent populations.

As with American Samoa, the system established in Guam suppressed local practices and consolidated healthcare in centralized, acute facilities. Subsequently, the federal reimbursement systems imposed have shackled

¹⁵⁷ Larry J. Pett, *Utilization of Hospital Services in the Individual Practice Association on Guam: A Comparative Analysis*, 17 MED. CARE, 420, 421 (1979).

¹⁵⁸ *Id.*

¹⁵⁹ Hall et al., *Medicaid in the Territories: Program Features, Challenges, and Changes*, *supra* note 135.

¹⁶⁰ *Guam*, MEDICAID.GOV, <https://www.medicaid.gov/state-overviews/guam.html> (last visited Mar. 17, 2022).

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GOVERNMENT ACCOUNTING OFFICE (Oct. 14, 2005), <https://www.govinfo.gov/content/pkg/GAOREPORTS-GAO-06-75/html/GAOREPORTS-GAO-06-75.htm>.

¹⁶⁴ 42 U.S.C. § 1396.

¹⁶⁵ *Id.*

¹⁶⁶ Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92.

the ability of the island's residents to effectively plan for and implement accessible care.

C. Puerto Rico

Puerto Rico is by far the largest of the U.S. unincorporated territories in terms of both population and area.¹⁶⁷ It is also the territory where the adverse effects of U.S. interventions are clearest, not only related to the initial occupation, but subsequent interventions through Medicare and Medicaid. Unlike the other territories, Puerto Rico undertook an autonomous experiment which provided broadly available, affordable care as part of a constitutional commitment to the human right to health.¹⁶⁸ This was accomplished by establishing a publicly funded regional care system, which Medicare and Medicaid later undermined.

1. From Occupation to 1948

Before the U.S. occupation and reorganization of the healthcare system in Puerto Rico, there was a significant degree of local control and physicians were required to care for the poor, free of charge.¹⁶⁹ The Spanish colonial system placed municipalities at the center of healthcare access and emphasized an explicit obligation on the part of municipalities to provide healthcare for the sick and poor.¹⁷⁰

From the point of U.S. occupation in 1898 forward, public health in Puerto Rico was indivisible from the welfare of occupying U.S. soldiers and the “civilizing” colonial project.¹⁷¹ U.S. military health officials

¹⁶⁷ Michael Gonzalez-Cruz, *The U.S. Invasion of Puerto Rico: Occupation and Resistance to the Colonial State, 1898 to the Present*, 25 *LATIN AM. PERSPECTIVES* 7, 8 (Sep. 1, 1998); Luis Martínez-Fernández, *Puerto Rico in the Whirlwind of 1898: Conflict, Continuity, and Change*, 12 *OAH MAGAZINE OF HISTORY*, 24, 24, 27 (Mar. 1, 1998).

¹⁶⁸ Nylca Sosa, Marinilda Diaz, & Juan Luna, *The Right to Health in the Oldest Colony in the World*, 14 *REVISTA DE ESTUDIOS CRITICOS DEL DERECHO*, 120, 120 (2018).

In 1952, the US Congress rejected Article 2, Section 20 of Puerto Rico's Constitution. Section 20 recognized the right to health as it was conceived in the Universal Declaration of Human Rights. Sixty-two years after the Constitution's approval, this right has not been expressly recognized in Puerto Rico as it has been internationally, but the struggle for its recognition remains. The case of Puerto Rico is presented, first for its colonial condition and its implications for the recognition of the right to health and second to present an example of the emergence of counter-hegemonic forces that use human rights discourse and framework towards a “globalization from below.”

¹⁶⁹ JESSICA M. MULLIGAN, *UNMANAGEABLE CARE: AN ETHNOGRAPHY OF HEALTH CARE PRIVATIZATION IN PUERTO RICO* 32 (New York Univ. Press, 2014).

¹⁷⁰ *Id.* at 33.

¹⁷¹ KEVIN SANTIAGO-VALLES, “SUBJECT PEOPLE” AND COLONIAL DISCOURSES: ECONOMIC TRANSFORMATION AND SOCIAL DISORDER IN PUERTO RICO, 1898-1947, at 184 (State Univ. New York Press, 1994); Jose Flores Ramos, *Virgins, Whores, and Martyrs: Prostitution in the Colony, 1898-1919* in *PUERTO RICAN WOMEN'S HISTORY*, 83, (Félix V. Matos Rodríguez and Linda C. Delgado eds., M.E.

prioritized measures against hookworm, smallpox, tuberculosis, dysentery, and malaria by imposing compulsory sanitation measures.¹⁷² The U.S. colonial government created the Superior Board of Health, whose responsibilities included creating “regulations concerning the practice of medicine [and] maintaining registers of vital statistics, street cleaning, vaccinating, imposing quarantines, supervising travel and traffic, and licensing plumbers.”¹⁷³

The large-scale building of clinics and hospitals island-wide was part of an effort to make the island safer for the expansion of U.S. forces. As with Guam, the U.S. administration encouraged hospital births at a moment when hospitals were sparse, unsanitary, and located far from the homes of many poor people.¹⁷⁴ Prior to the U.S. invasion, Puerto Ricans relied on developed birthing practices which included experienced midwives, a common if not formally codified curriculum, and extensive transmission of knowledge from one generation to the next.¹⁷⁵ Yet “when Puerto Ricans did not flock to the hospitals to give birth, U.S. administrators attributed this to their ‘lack of intelligence.’”¹⁷⁶

The health system was reorganized with the creation of the Public Health Service in 1911 and the Institute for Tropical Medicine in 1912, which played a similar role for the U.S. Administration as the London School of Hygiene and Tropical Medicine played for the UK.¹⁷⁷ In 1917, Congress adopted the Jones Act, which made Puerto Ricans U.S. citizens (and therefore eligible for conscription into the U.S. Army during World War I).¹⁷⁸ The Jones Act also created a Department of Health to be led by a Commissioner of Health.¹⁷⁹ The establishment of the Health Department marked an orchestrated transition away from locally-driven healthcare access and financing decisions to centralized administration, in furtherance of the already present “civilizing” colonial project.

District hospitals were planned and built with a primary purpose of facilitating disease eradication to surrounding municipalities in a hub-and-

Sharpe, 1998); Nicole Trujillo-Pagán, *Health Beyond Prescription: A Post-Colonial History of Puerto Rican Medicine at the Turn of the Twentieth Century* (2003) (Ph.D. dissertation, University of Michigan) (ProQuest).

¹⁷² MULLIGAN, *supra* note 169, at 31.

¹⁷³ *Id.* at 34.

¹⁷⁴ *Id.* at 35.

¹⁷⁵ ARANA SOTO, *HISTORIA DE LA MEDICINA PUERTORRIQUEÑA HASTA 1898*, at 615-17 (1974).

¹⁷⁶ MULLIGAN, *supra* note 169, at 35-36.

¹⁷⁷ GUILLERMO ARBONA & ANNETTE B. RAMÍREZ DE ARELLANO, *REGIONALIZATION OF HEALTH SERVICES: THE PUERTO RICAN EXPERIENCE* 10 (1978).

¹⁷⁸ REXFORD G. TUGWELL, *THE ARTS OF POLITICS AS PRACTICED BY THREE GREAT AMERICANS: FRANKLIN DELANO ROOSEVELT, LUIS MUÑOZ MARÍN AND FIORELLO H. LA GUARDIA* 35-36 (1958).

¹⁷⁹ Puerto Rican Federal Relations (Jones-Shafroth) Act of 1917, Pub. L. 64-368, 39 Stat. 951.

spoke model emanating from the centralized health administration.¹⁸⁰ From 1898 until the late 1940s, U.S. disruptions of life on the island were characterized by concerns about sanitation, quarantine, and large-scale disease eradication measures.¹⁸¹ These disruptions were based on the essential premise that Puerto Ricans were inherently sick and in need of tutelage.¹⁸² Physicians and patients resisted these U.S. efforts to reorganize their lives.¹⁸³

As with American Samoa and Guam, physicians were imported from the United States to oversee the “civilizing” restructuring of healthcare. In one particularly egregious episode, Dr. Cornelius “Dusty” Packard Rhoads penned a letter while visiting one hospital:

And I’m tempted to take [the opportunity for permanent position]. It would be ideal except for the Puerto Ricans. They are beyond doubt the dirtiest, laziest, most degenerate and feverish race of men ever inhabiting this sphere. It makes you sick to inhabit the same island with them. They are even lower than Italians. What this island needs is not public health work but a tidal wave or something to totally exterminate the population. It might then be livable. I’ve done my best to further the process of extermination by killing off eight and transplanting cancer into several more. The latter has not resulted in any fatalities so far. The matter of consideration for the patients’ welfare plays no role here. In fact, all physicians take delight in the abuse and torture of the unfortunate subjects. Do let me know if you hear any more news. Sincerely, Dusty.¹⁸⁴

The letter was discovered by Puerto Rican staff, published in newspapers, and Rhoads quickly returned to New York (where he became the director of Sloan Kettering Hospital).¹⁸⁵

The effect of the reorganization of healthcare was profound. The placement of medicines and access to healthcare away from the villages facilitated the migration of Puerto Ricans from rural areas to more populated ones, with corresponding effects on housing construction and economic structure. “With . . . rural-to-urban migration . . . the health system became more concerned with creating a healthy workforce, limiting family sizes, and providing basic, primary care for the population.”¹⁸⁶ Thus

¹⁸⁰ ARBONA & RAMÍREZ DE ARELLANO, *supra* note 177, at 12.

¹⁸¹ MULLIGAN, *supra* note 169, at 32.

¹⁸² *Id.* at 37.

¹⁸³ *Id.*

¹⁸⁴ IMMERWAHR, *supra* note 8, at 111.

¹⁸⁵ *Id.*

¹⁸⁶ MULLIGAN, *supra* note 169, at 37.

the “civilization” of Puerto Rican healthcare really meant its transformation as an economic and political matter.

2. *Puerto Rican Autonomy and the Regional System*

The 1945 establishment of the United Nations and the associated movement toward decolonization affected relations between the U.S. and Puerto Rico. The United States adopted the Elective Governor Act, which allowed Puerto Ricans to directly elect their governor, although Congress retained plenary authority over the island.¹⁸⁷ Indeed, as Puerto Rico drafted its own constitution over the course of the early 1950s (with Congressional approval), it included an explicit right to health that Congress rejected, which was eliminated from the constitution.¹⁸⁸

Notwithstanding the invalidation of a constitutional right to health, in the aftermath of the autonomy-promoting statutes of the post-U.N. establishment period, Puerto Rico embarked on a restructuring of the healthcare system based on two general themes: 1) regional planning and access; and 2) availability of care regardless of ability to pay.

In the regional organization, local health centers bore responsibility for delivering primary and preventive care as well as public health services and response.¹⁸⁹ There was at least one local health center in each municipality where residents could receive free care.¹⁹⁰ Tertiary care was provided at the regional level by a base hospital.¹⁹¹ The central administration was responsible for creating and enforcing policies and procedures.¹⁹² The system was designed to “destroy the barriers which separated medical from social services, prevention from therapy, and

¹⁸⁷ Elective Governor Act (Crawford-Butler) Act, ch. 490, Pub. L. No. 80-362, 61 Stat. 770-71 (1947).

¹⁸⁸ The provision read:

The right of every person to a standard of living adequate for the health and wellbeing of himself and of his family and especially the food and clothing, housing, *medical care* and necessary social service; the right of every person to social protection in the event of unemployment, sickness, old age, or disability.

P.R. CONST. art. II, § 20. (emphasis added). Rene Pinto-Lugo, *Puerto Ricans: The Inequality of Equals through Time*, 50 REV. JURIDICA U. INTER. P.R. 153, 154 (2015).

Accordingly, President Truman confirmed that the territorial constitution created a republican form of government and urged Congress to approve it. Congress, however, unilaterally made some important changes, such as removing Section 20 of Article II, which had established a right to work, right to adequate standard of living, and social protection in old age or sickness; and adding a provision requiring that any amendment be consistent with the federal Constitution, the Puerto Rican Federal Relations Act, and Public Law 600.

¹⁸⁹ MULLIGAN, *supra* note 169, at 39.

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.*

personal from environmental services.”¹⁹³ The system focused on improving communication between and among the different levels of care. The system also invested heavily in education, “especially in training physicians and nurses to be generalists and focus on primary care in resource-poor settings.”¹⁹⁴

“The regional system was celebrated as a model to be emulated because it boasted an integrated approach to health based on epidemiological principles and rooted in the larger development goals” of the newly directed leadership of the island.¹⁹⁵ The regional system accomplished reduced general mortality rates, especially infant and maternal mortality rates, and increased overall life expectancy.¹⁹⁶

3. *The Crippling Effect of Congressional Interventions*

As with American Samoa and Guam, however, U.S. medical entitlements otherwise available to populations in the U.S. states undermined the publicly supported regional health system developed in Puerto Rico.¹⁹⁷ In 1965, Medicare, the payroll-tax funded public health insurance program for the elderly and other special populations, was established in Puerto Rico as a competitor to the regional systems with respect to physicians.

To understand how Congress crippled Puerto Rico’s regional health system, it is necessary to understand the structure of Medicare entitlements. At its origin, Medicare extended insurance to those aged 65 or older for hospital stays, known as Medicare Part A. This entitlement is funded through a payroll tax. The patient stays at a Medicare-covered hospital, or receives related services, and the hospital is reimbursed by Medicare (the patient also has some financial responsibility). Although Puerto Ricans pay no federal income tax, they pay exactly the same Medicare tax as all U.S. workers.¹⁹⁸ But Congress established reimbursement rates for Puerto Rican hospitals at 25% of federal levels elsewhere in the U.S. (it was raised to 50% in 1997, after a significant amount of financial damage to Puerto Rico’s hospitals).¹⁹⁹ The result was effectively the redirection of Puerto

¹⁹³ *Id.* at 39-40.

¹⁹⁴ *Id.* at 40.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ Colon & Greene et al., *supra* note 34.

¹⁹⁸ Samuel Otterstrom and Benjamin Tillman, *Income Change and Circular Migration: The Curious Case of Mobile Puerto Ricans, 1995-2010*, 12 J. LATIN AM. GEOGRAPHY 33, 38 (2013).

¹⁹⁹ ANNIE MACH, CONG. RSCH. SERV., R44275, *Puerto Rico and Healthcare Finance* 9 (2016); Roberto Pando et al., *Addressing Puerto Rico’s Medicare Crisis and Implementing an Urgent Path to Recovery*, (U.S. Sen. Comm. Fin., Working Paper 2018), <https://www.finance.senate.gov/download/puerto-rico-healthcare-community>.

Rican Medicare dollars from its regional system to the Medicare trust, for the benefit of mainland U.S. citizens.²⁰⁰

Medicare Part B is an insurance benefit for physician services, just as Part A is for hospital services.²⁰¹ Physicians established their own practices outside the regional system and received Medicare's fee-for-service reimbursements, which were higher than the regional system's. So Medicare money went to private physicians, not to the public regional system. The result was that the private sector became more enriched at the expense of the public system.²⁰²

The ultimate result of these policies was *La Reforma* in 1993, which attempted to address the disparities caused by Medicare and Medicaid reimbursement by pushing Puerto Ricans into privately managed care businesses that, theoretically, made Puerto Ricans covered by the regional health system eligible for the system of care available to higher income Puerto Ricans. The result was disastrous. Private managers were under no obligation to accept the insurance extended by *La Reforma*, so they didn't.²⁰³ The result has been increased cost of care and decreased access for poor Puerto Ricans.²⁰⁴

Medicaid and CHIP (the federal-state matching program for low-income children), on the other hand, cover half of all Puerto Ricans.²⁰⁵ Sixty percent of the population of Puerto Rico depends on government-funded health insurance coverage, including Medicare, because of high poverty and unemployment rates.²⁰⁶ On the mainland, by contrast, 60% of health care coverage is privately funded (i.e. employer-sponsored insurance or directly purchased) and 20% of the population is insured by Medicaid.²⁰⁷ So while poor Puerto Ricans, including children, are in greater need of the support Medicaid provides, Congress allocates far less resources to do so.

²⁰⁰ After the establishment of Medicare, physicians established their own Medicare-subsidized practices which drew resources away from the regional health system until it ended in 1993. Krista Perreira et al., *Puerto Rico Health Care Infrastructure Assessment: Site Visit Report*, URB. INST. 8, (Jan. 2017), https://www.urban.org/sites/default/files/publication/87011/2001050-puerto-rico-health-care-infrastructure-assessment-site-visit-report_1.pdf.

²⁰¹ Cole Werble, *Health Policy Briefs: Prescription Drug Pricing, Medicare Part B*, HEALTHAFFAIRS.ORG, (Aug. 10, 2017), <https://www.healthaffairs.org/doi/10.1377/hpb20171008.000171/full>.

²⁰² MULLIGAN, *supra* note 169, at 43.

²⁰³ MULLIGAN, *supra* note 169, at 54.

²⁰⁴ Perreira et al., *supra* note 200.

²⁰⁵ Ximena Benavides, *Disparate Healthcare in Puerto Rico: A Battle Beyond Statehood*, 23 U. PA. J.L. & SOC. CHANGE 164, 173 (2020).

²⁰⁶ *Id.* at 174; *Puerto Rico: Fast Facts*, KAISER FAM. FOUND. (Oct. 2, 2017), <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/puerto-rico-fast-facts>.

²⁰⁷ Benavides, *supra* note 205.

As with all territories, Medicaid in Puerto Rico is capped at 55%.²⁰⁸ If a U.S. state's, e.g. Alabama's or Mississippi's, poverty formula were applied to Puerto Rico, the rate would be 82%.²⁰⁹ Similarly, Puerto Rico reimbursements are capped so that even the full 55% is rarely realized, outside of one-time interventions by Congress.²¹⁰ The federal funding cap in Puerto Rico was set at \$357.8 million in the fiscal year 2018, even though 2017 Hurricanes Irma and Maria made the necessity of increased aid substantial.²¹¹ As noted below, the cap is even more punishing for Puerto Rico in light of its vulnerability to natural disasters, the frequency and severity of which are now fueled by anthropogenic climate change.

On paper, any budget shortfall in the healthcare system must be covered by other sources of revenue, typically the municipal tax base.²¹² But in reality, Puerto Rico has borrowed heavily to make up the shortfall and to ensure continued access to healthcare for its mostly indigent population.²¹³ This borrowing was undertaken primarily through sales of bonds to investors, whom the Puerto Rican government could not continue to afford to pay as their revenues failed to keep pace with the services they needed to fund and the payments they owed investors.²¹⁴ In 2016, Puerto Rico suspended all payments to bondholders.²¹⁵ Prohibited from declaring bankruptcy under U.S. federal law, Puerto Rico's only alternative was an appeal to Congress, which then adopted the Puerto Rico Oversight, Management, and Economic Stability Act (PROMESA).²¹⁶ PROMESA established a Financial Oversight Management Board to administer the law

²⁰⁸ Rudowitz et al., *Medicaid Financing: The Basics*, *supra* note 92.

²⁰⁹ Anna Maria Berry-Jester, *If Puerto Rico Were A State, Its Health Care System Would Recover Faster From Maria*, FIVETHIRTYEIGHT (Oct. 9, 2017, 1:36 PM), <https://fivethirtyeight.com/features/if-puerto-rico-were-a-state-its-health-care-system-would-recover-faster-from-maria>.

²¹⁰ Selena Simmons-Duffin, *America's 'Shame': Medicaid Funding Slashed in U.S. Territories*, NPR (Nov. 20, 2019, 5:00 AM), <https://www.npr.org/sections/health-shots/2019/11/20/780452645/americas-shame-medicaid-funding-slashed-in-u-s-territories>.

²¹¹ Complaint at 9 n.7, Consejo de Salud de Puerto Rico et. al. v. United States et al., 450 F. Supp. 3d 103 (D.P.R. 2018) (Civ. No. 18-1045).

²¹² Pereira, *supra* note 200.

²¹³ Benavides, *supra* note 205, at 164-65, 189.

²¹⁴ Mary Williams Walsh & Liz Moyer, *How Puerto Rico Debt Is Grappling With a Debt Crisis*, N.Y. TIMES (July 1, 2016), <https://www.nytimes.com/interactive/2016/business/dealbook/puerto-rico-debt-crisis-explained.html>.

²¹⁵ Greg Allen, *Puerto Rico Passes Law That Freezes The Island's Debt Payments*, NPR (Apr. 6, 2016, 12:17 PM), <https://www.npr.org/sections/thetwo-way/2016/04/06/473239932/puerto-rico-passes-bill-to-freeze-the-islands-debt-payments>.

²¹⁶ Puerto Rico Oversight, Management, and Economic Stability Act, Pub. L. No. 114-187, 130 Stat. 549, 550-610 (2016); *See also* Benavides, *supra* note 205, at 164-65.

(the provisions of PROMESA) and deal with the financial crisis.²¹⁷ Through PROMESA, Congress effectively reoccupied Puerto Rico, taking over the administration of the island and slashing its health budget by 30%.²¹⁸ In the aftermath of the island's financial crisis, its doctors have left in droves.²¹⁹

The system in Puerto Rico was more extensive than in other territories and correspondingly undermined. In Puerto Rico, there were relatively well-defined norms for access to care and, after 1948, an effective system to broaden access consistent with human rights principles. Uniquely to Puerto Rico, the deployment of Medicare and Medicaid subverted the regional system and through the Medicare tax and reimbursement levels, undermined that human rights approach to care.

D. The Northern Mariana Islands and the U.S. Virgin Islands

While hygienic superiority justified the U.S. occupation and continuing presence in American Samoa, Guam, and Puerto Rico, the histories of the Northern Mariana Islands and the U.S. Virgin Islands are somewhat different and these territories experienced far shorter periods of U.S. military control and restructuring. That is not to say that the “civilizing mission” did not manifest. The purpose of U.S. acquisition of the U.S. Virgin Islands (for \$25,000,000 in 1917, and under threat of military intervention) was to protect U.S. interests in Puerto Rico and the Panama Canal Zone.²²⁰ Unlike acquisitions following the Spanish-American War or the annexation of Hawaii, the population of the Virgin Islands was overwhelmingly Black and, at the peak of the Jim Crow era in the United States, the primary problem with the islands, according to many

²¹⁷ Benavides, *supra* note 205, at 164-65 (citing to 48 U.S.C. § 2121(c)(I), § 2121(e)(3) and § 2123 (2016)).

²¹⁸ *Id.* at 165; see also Robin Rudowitz, Cornelia Hall, & Barbara Lyons, *Medicaid Funding Cliff: Implications for the Healthcare Systems in Puerto Rico and USVI*, KAISER FAM. FOUND. (May 21, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-cliff-implications-for-the-health-care-systems-in-puerto-rico-and-usvi>.

Some territory officials and providers described the potential effects of the funding expiration as “devastating,” catastrophic,” and ‘scary.’ Assuming a return to federal funding limited to the statutory cap and a 55% FMAP after remaining ACA funds expire, Puerto Rico could experience a shortfall of \$1 billion in FY 2020 and \$1.5 billion in FY 2021 (representing 36% and 52% of projected total spending, respectively). Estimates prepared by the Medicaid and CHIP Payment and Access Commission (MACPAC) show that such funding shortfalls could trigger coverage losses of one-third to one-half of current enrollment levels in Puerto Rico of about 1.2 million people.

²¹⁹ Mariela Patron, *Puerto Rico's Exodus of Doctors Adds Health Care Strain to Dire Financial Crisis*, NBC NEWS (Aug. 8, 2017, 2:42 PM), <https://www.nbcnews.com/news/latino/puerto-rico-s-exodus-doctors-adds-health-care-strain-dire-n783776>.

²²⁰ Donald D. Hoover, *The Virgin Islands under American Rule*, 4 FOREIGN AFFS. 503, 503-06 (1926).

in Congress and U.S. Navy officials, was “miscegenation,” a practice the U.S. Navy sought to stamp out.²²¹

Prior to the United States gaining control, the Danes had control of the islands. Like other colonial powers, the Danes had extensively relied upon slave labor to produce mainly sugar-related exports,²²² and the United States structured the inherited hospital system to support that system. Under the Danes, the healthcare system was comprised of “garrison” hospitals, “plantation” hospitals, and “leper” hospitals.²²³ Although slave laborers staffed the three kinds of hospitals, only rarely were slaves tended to as patients. Upon gaining control of the islands, the U.S. Navy adapted the existing healthcare infrastructure rather than entirely reorganizing it, though those adaptations largely retained the benefit for naval personnel and for the few higher-income islanders.²²⁴ According to U.S. Naval administrators, sanitation was “primitive” and the conditions of hospitals, water treatment, and infant mortality were “particularly disgraceful to a civilized community.”²²⁵ The Navy converted the garrison, plantation, and leper hospitals into “municipal” hospitals and undertook a comprehensive smallpox vaccination campaign.²²⁶

The U.S. presence in the Northern Mariana Islands was justified through actions at the U.N. Security Council which left it in U.S. trusteeship until the island residents could determine their own political status.²²⁷ Repeated initiatives to integrate with Guam failed, and the U.S. entered into complicated negotiations with the Northern Marianas; the Marshalls; Palau; and the Federated States of Micronesia.²²⁸ The Northern Mariana Islands became a commonwealth of the U.S. (CNMI) only in 1986.²²⁹

²²¹ Eric D. Walrond, *Autocracy in the Virgin Islands*, 19 CURRENT HISTORY 121, 121 (1923).

²²² Jeannette Allis Bastian, *The Question of Custody: The Colonial Archives of the U.S. Virgin Islands*, 64 AM. ARCHIVIST 96, 104 (2001).

²²³ Enrique Comeiro, THE DANISH WEST INDIES IN BLACK AND WHITE 105 (2011).

²²⁴ Norwell Harrigan & Pearl I. Varlack, *The U.S. Virgin Islands and the Black Experience*, 7 J. BLACK STUDS. 387, 395-96 (1977).

²²⁵ *Id.* at 394.

The United States had become a colonial power several decades earlier (the Philippines, Puerto Rico, and Guam were ceded by Spain in 1898; Hawaii became a territory in 1900), but the traditional “white man’s burden” had assumed another dimension with the purchase of the Virgin Islands - a black colony.

²²⁶ Etienne A. Gibbs, *The Danish West Indies, Denmark, US Virgin Islands & Transfer Day*, WHATSUP UNIV., <https://whatsupuniversity.com/u-s-virgin-islands-and-transfer-day> (last visited Mar. 17, 2022).

²²⁷ S.C. Res. 21 ¶ 2 (April 2, 1947).

²²⁸ William Alkire, *The Carolinians of Saipan and the Commonwealth of the Northern Mariana Islands*, 57 PAC. AFFS., 270, 271 (1983).

²²⁹ Torres, *supra* note 51.

Both territories share the disadvantages imposed by Congress elsewhere: rates of poverty in Guam and the Northern Mariana Islands justify Medicaid eligibility far beyond what Congress allows.²³⁰ Their FMAP is limited to 55% of expenditures and they face an annual limit that further constrains what they do with respect to the health of their populations.²³¹ Hurricanes Irma and Maria also impacted the U.S. Virgin Islands, demonstrating that climate change heavily impacts their economic standing and public health.²³²

IV. MEASURES TO ADDRESS THE RELATIONSHIP BETWEEN HEALTH AND COLONIAL CONTROL

As the foregoing analysis has shown, the structure and financing of healthcare access in unincorporated territories is deeply anchored in “civilizing” conceptions of hygiene and healthcare prevailing at the turn of the 20th century, especially as those conceptions were adapted to justify and support the U.S. military presence.

With the U.S. Supreme Court unwilling to interpret the Constitution as constraining plenary Congressional authority in the territories, there is little left to do besides make reasoned appeals to Congressional leaders.²³³ Part IV provides such an appeal based on two discrete, feasible interventions: 1) parity with U.S. states in health funding; and 2) support for indigenous practices based on the Native Hawaiian Healthcare Improvement Act.

A. *Healthcare Parity between States and Territories and the Climate Change Emergency*

The most obvious measure that should be taken immediately is the commitment of Congress to parity and equity between states and territories in the reimbursements paid by federal programs. The United States uses the Federal Poverty Level to determine which states qualify for Medicaid, but uses different, non-uniform, poverty standards when defining healthcare access in the territories.²³⁴ “The unique needs of each territory are not weighed to determine the applicable FMAP and, hence, the statutory cap fails to reflect important distinctions with respect to economic conditions

²³⁰ *United States Virgin Islands*, MEDICAID, <https://www.medicaid.gov/state-overviews/usvi.html> (last visited Mar. 17, 2022).

²³¹ *Northern Mariana Islands*, MEDICAID, <https://www.medicaid.gov/state-overviews/cnmi.html> (last visited Mar. 17, 2022).

²³² Greg Allen, *In the U.S. Virgin Islands, Health Care Remains in a Critical State*, NPR, (Feb. 18, 2018, 8:09 AM), <https://www.npr.org/2018/02/04/582256476/in-the-u-s-virgin-islands-health-care-remains-in-a-critical-state>.

²³³ Benavides, *supra* note 205.

²³⁴ *Id.*

and special health needs.”²³⁵ In 2019, Senator Elizabeth Warren cosponsored legislation to achieve such parity in the Senate, but has attracted little support.²³⁶ Under this parity scheme, territories would be treated just like states for Medicaid purposes – they would receive high reimbursements based on the number of people living in poverty, and the reimbursements from the federal government would not be capped. The argument for healthcare financing parity between states and territories is intricately tied to the debate about the nature of U.S. control and the dignity of populations under its authority. It is an ethical and moral imperative, albeit not a constitutional one.

The U.S. Supreme Court and federal appellate courts have remained committed to the *Insular Cases* and the racial and ethnic subjugation those precedents necessarily engender.²³⁷ As this Essay has demonstrated, U.S. colonial power utterly reshaped conditions in the unincorporated territories in the name of health and hygiene and destroyed, when they became threatening, indigenous approaches to care and wellness. The legacy of this colonial power has been an access and financing regime that permanently focuses territorial attention and imagination on preserving access to health, rather than the question of sovereignty as it might be presented on a level playing field.

The moral and ethical imperative is made all the more urgent by climate change. All five unincorporated territories are at high risk of adverse changes attributable to climate change. A recent report by the EastWest Center concluded that all infrastructure, sources of potable water, and disease prevention capabilities of American Samoa, Guam, and the Northern Mariana Islands are threatened by rising global temperatures and more severe weather events, which accompany climate change.²³⁸ In 2017, hurricanes Irma and Maria devastated Puerto Rico’s energy and freshwater infrastructure and killed 3,000 people.²³⁹ In the U.S. Virgin Islands, only 5

²³⁵ *Id.*

²³⁶ For a summary of Sen. Warren’s legislation, see *The Territories Health Equity Act of 2019: Section-by-Section Summary*, ELIZABETH WARREN: U.S. SEN. FOR MASS., <https://www.warren.senate.gov/imo/media/doc/Territories%20Health%20Equity%20Act%20of%202019%20-%20Section-by-Section%20Summary.pdf> (last visited Mar. 17, 2022).

²³⁷ See, e.g., *Fitisemanu v. United States*, 1 F.4th 862, 881 (10th Cir. 2021) (upholding *Insular Cases* and refusing to acknowledge American Samoan right to U.S. citizenship).

²³⁸ VICTORIA KEENER, ZENA GRECNI, KELLEY ANDERSON TAGARINO, CHRISTOPHER SHULER & WENDY MILES, *CLIMATE CHANGE IN AMERICAN SAMOA: INDICATORS AND CONSIDERATIONS FOR KEY SECTORS*, at 3 (2021) (ebook); ZENA GRECI, WENDY MILES, ROMINA KING, ABBY FRAZIER & VICTORIA KEENER, *CLIMATE CHANGE IN GUAM: INDICATORS AND CONSIDERATIONS FOR KEY SECTORS*, at 27 (2020) (ebook).

²³⁹ GEO. WASH. U. & U. P.R. GRADUATE SCH. PUB. HEALTH, *ASCERTAINMENT OF THE ESTIMATED EXCESS MORTALITY FROM HURRICANE MARIA IN PUERTO RICO* (2018) 9, <https://publichealth.gwu.edu/>

deaths were directly attributed to the hurricanes, but the major hospitals on St. John, St. Thomas, and St. Croix experienced loss of power, collapse of a floor, destruction of a building housing its cancer center, and flooding of the emergency rooms.²⁴⁰ The islands are still years from recovery.

Moreover, climate change will permanently increase the territories' demand for public health care coverage.²⁴¹ The U.S. EPA estimates that not only will warmer temperatures exacerbate health conditions for children and the elderly in the USVI, but that malaria, dengue, and yellow fever may become more common, along with food-borne diseases attributable to the favorable conditions for bacterial growth in fish environments.²⁴² In 2018, the fourth U.S. climate assessment concluded that in Puerto Rico, the annual number of days with temperatures above 90°F has increased over the last four and a half decades.²⁴³ During that period, stroke and cardiovascular disease, which are influenced by elevated temperatures, became the primary causes of death on the island.²⁴⁴ The effects on agricultural, infectious disease prevalence, fire, and flood will be severe.²⁴⁵

sites/default/files/downloads/projects/PRstudy/Acertainment%20of%20the%20Estimated%20Excess%20Mortality%20from%20Hurricane%20Maria%20in%20Puerto%20Rico.pdf.

²⁴⁰ Muhammad Abdul Baker Chowdhury, Andrew J. Fiore, Scott A. Cohen, Clayton Wheatley, Barnard Wheatley, Meenakshi Puthucode Balakrishnan, Michael Chami, Laura Scieszka, Matthew Drabin, Kelsey A. Roberts, Alexandra C. Toben, J. Adrian Tyndall, Lynn M. Grattan, and J. Glenn Morris Jr., *Health Impact of Hurricanes Irma and Maria on St Thomas and St John, US Virgin Islands, 2017–2018*, 109 AM. J. PUB. HEALTH, 1725, 1732, (Dec. 2019).

²⁴¹ Benavides, *supra* note 205, at 176.

²⁴² U.S. EPA, *What Climate Change Means for the U.S. Virgin Islands* (Nov. 2016), <https://19january2017snapshot.epa.gov/sites/production/files/2016-11/documents/climate-change-usvi.pdf>.

Certain people are especially vulnerable, including children, the elderly, the sick, and the poor. Rising temperatures will increase the frequency of hot days and warm nights. High air temperatures can cause heat stroke and dehydration and affect people's cardiovascular and nervous systems . . . The U.S. Virgin Islands' climate is suitable for mosquito species that carry diseases such as malaria, yellow fever, and dengue fever. While the transmission of disease depends on a variety of conditions, higher air temperatures are likely to accelerate the mosquito life cycle and the rate at which viruses replicate in mosquitoes. The warm marine environment of the Virgin Islands helps promote some water-related illnesses: Vibriosis is a bacterial infection that can come from direct contact with contaminated water or eating infected shellfish. Ciguatera poisoning comes from eating fish that contain a toxic substance produced by a type of algae found in this area. Higher water temperatures can increase the growth of these bacteria and algae, which may increase the risk of these associated illnesses.

²⁴³ WILLIAM A. GOULD ET AL., *FOURTH NATIONAL CLIMATE ASSESSMENT: U.S. CARIBBEAN*, (2018), <https://nca2018.globalchange.gov/chapter/20>.

²⁴⁴ *Id.*

²⁴⁵ *Id.*

B. Local Control over Healthcare Access Determinations

This Essay has also demonstrated the importance of revisiting and restoring indigenous healthcare practices that may better promote health at a lower cost than the interventionist and acute models of healthcare resulting from U.S. occupation. Such indigenous practices include Fa'a Samoa, *pattera* birthing practices in Guam, and local decision-making in Puerto Rico. There is precedent for Congress to invest in the research and reintroduction of these practices, certainly to the extent that such research may result in approaches to health that are not only culturally sensitive but supported by evidence.

In 1980, the U.S. Congress took this kind of approach with respect to federal health policy for Native Hawaiians. That Congress did so shows that meaningful representation in Congress matters. In that year, Congress authorized An Act to Establish the Kalaupapa National Park, which included the provision for a nine-member commission (including three Hawaii residents) to “conduct a study of the culture, needs and concerns of the Native Hawaiians.”²⁴⁶ The resulting report identified disparities in infant mortality, life expectancy, cancer rates, and affliction with chronic diseases, which were much higher for Native Hawaiians than other groups.²⁴⁷ The Commission relied upon the participation of the Hawaii State Department of Health and private organizations formed to address some aspects of the Commission’s mandate, such as Aku Like, to support initial findings and confirm data obtained from other sources.²⁴⁸ The chair of the Commission was Kina’u Boyd Kamali’i, who represented the Ala Moana-Waikiki district before and after chairing the Commission, and served as trustee of the Office of Hawaiian Affairs in 1978.²⁴⁹ The Commission gathered data not only from official and state sources, but also from long hearings during which Native Hawaiians could express their views.²⁵⁰ It therefore also served as a kind of truth gathering exercise about the history of U.S. federal presence in Hawai’i.

The result was an extraordinarily comprehensive assessment of the history and profile of health and wellness among Native Hawaiians:

²⁴⁶ An Act To establish the Kalaupapa National Historical Park in the State of Hawaii, Pub. L. No. 96-565, 94 Stat. 3321 (codified as amended at 16 U.S.C. §§ 410jj-410jj-9).

²⁴⁷ DEPARTMENT OF THE INTERIOR, NATIVE HAWAIIANS STUDY COMMISSION: REP. ON THE CULTURE, NEEDS AND CONCERNS OF NATIVE HAWAIIANS (1983), <https://files.eric.ed.gov/fulltext/ED254608.pdf>.

²⁴⁸ *Id.*

²⁴⁹ Helen Altonn, *GOP Maverick Advanced Hawaiian Interests*, STAR BULL., (Nov. 2, 2005); Manu Boyd, HE HALI’A NO KINA’U BOYD KMALI’I (2005) <https://kaiwakiloumoku.ksbe.edu/article/mele-he-halia-no-kinau-boyd-kamalii>.

²⁵⁰ DEPARTMENT OF THE INTERIOR, *supra* note 247, at 4-5.

sources of traditional medicine and healing, the effects of cholera, influenza, typhoid, and leprosy, the rise of heart disease beginning in 1930, and the corresponding development of a wide range of medical and health associations.²⁵¹ The Commission's report was also extensive as to its study of diet, food, and related changes over time, emphasizing the cultural, health, and medical implications.²⁵² There was also a comprehensive assessment of mental health services infrastructure (including culturally sensitive treatment programs) and drug and alcohol abuse treatment centers.²⁵³

The Commission's findings led to the undertaking of the Native Hawaiian Health Needs Study (E Ola Mau) in 1985,²⁵⁴ which in turn informed a tailored federal law aimed at improving the health of Native Hawaiians: the Native Hawaiian Healthcare Improvement Act, originally passed in 1988 to address the results of health studies conducted by the Native Hawaiian Health Research Consortium. The Native Hawaiian Healthcare Improvement Act established the Papa Ola Lokahi, an organization comprised of and led by indigenous members, to implement the law.²⁵⁵ In 1992 the Act was reauthorized with the additional inclusion of the Native Hawaiian Health Scholarship Program (previously authorized under separate legislation), and the identification of Native Hawaiian Health Care Systems to be recognized and certified by Papa Ola Lokahi.²⁵⁶ Since 1990, life expectancy for Native Hawaiians has increased, infant mortality has edged downward, and the rate of preventative screenings has increased.²⁵⁷

As noted in the beginning of this Essay, there are important differences between the experience of Native Hawaiians and territorial populations, but there are important analogies between the position of Native Hawaiians, Samoans, Carolinians, Chamorros, and the practices in Puerto Rico and the U.S. Virgin Islands that predated U.S. occupation. Hawaii was also well ahead of all other U.S. states in terms of expanding

²⁵¹ *See generally id.*

²⁵² *See generally id.*

²⁵³ *See id.* at 109-12.

²⁵⁴ *See* NATIVE HAWAIIAN HEALTH RESEARCH CONSORTIUM, E OLA MAU - THE NATIVE HAWAIIAN HEALTH NEEDS STUDY (1985), <http://www.papaolalokahi.org/images/pdf-files/NATIVE-HAWAIIAN-HEALTH-NEEDS-STUDY-Prelim-Plan-1985.pdf>.

²⁵⁵ 42 U.S. Code § 11704 (1988).

²⁵⁶ Department of Defense Appropriations Act Pub. L. No. 102-396, §§ 4-16, 106 Stat 1876 (codified at 42 U.S.C.A. §§ 11703-11714); *see also* Davianna Pomaikai McGregor, NA KUA'AINA: LIVING HAWAIIAN CULTURE (2007).

²⁵⁷ *Infant Mortality Rate*, HAWAII HEALTH MATTERS, 2016, <http://www.hawaiihealthmatters.org/index.php?module=indicators&controller=index&action=view&indicatorId=1259&localeId=598> (last visited Mar. 10, 2022).

access to healthcare for all residents.²⁵⁸ However, the basic model applied to Hawaii by the federal government – well-funded initial fact-finding, broad stakeholder inclusion, and tailored federal law, could work in other U.S. territories.

V. CONCLUSION

The legacy of racialized hygienic and medical supremacy is replete with long-standing and enduring disruptions to the health systems in U.S. territories. Congressional interventions in those systems now perpetuate a dependency that nevertheless falls short of treating all populations under its control equally. This limbo is unsustainable and ethically bankrupt, especially in light of accelerating climate change threats. This Essay has analyzed how U.S. intervention and occupation altered and organized health systems for its own benefit, notwithstanding pretextual assertions that health restructuring was for the benefit of territorial populations. While the question of justice embedded within U.S. control of populations who do not enjoy the same constitutional protections as U.S. citizens in the 50 states and D.C. remains unsatisfied, this Essay has argued for two measures that may partially address these inequities. First, Congress should commit to parity funding for health for unincorporated territories and their relatively impoverished and climate-change vulnerable populations. Second, Congress should commission indigenous population-led studies and incorporation of health practices tailored to the needs and cultural sensitivity of territorial communities. As part of a broader effort to enact just policies in U.S. territories, these measures are the least Congress should adopt, until the time that the territories are independent or fully incorporated into the U.S. Constitutional system.

²⁵⁸ Noam Levey, *Hawaii's Trailblazing Healthcare Underscores Disparity*, L.A. TIMES, (Apr. 5, 2014), <https://www.latimes.com/nation/la-na-healthcare-coverage-20140406-dto-htm1story.html>.