Despite Veto, All IHS Programs Will Continue in ’85, Says DHHS

WASHINGTON, D.C. — Seeking to allay fears among Indian health beneficiaries, officials with the Department of Health and Human Services (DHHS) are steadfastly maintaining that there will be no reduction in existing health care services to Indians as a result of President Reagan’s veto of the Indian Health Care Amendments of 1984 (S. 2166) October 19.

The bill, the most significant piece of Indian legislation considered during the 98th Congress, would have amended and extended for four years the Indian Health Care Improvement Act (P.L. 94-437), which expired September 30. The original act was passed in 1976 for the purpose of raising the health status of Indian people to the highest possible level over a seven-year period.

Numerous Indian officials have expressed concern in recent weeks that the Administration will move to impound funding for Indian health programs specifically authorized by the bill. There have also been suggestions that the Administration has prepared a "hit list" of programs targeted for such action, including urban Indian health projects, health scholarships, the Community Health Representative (CHR) program, and health facilities construction. The Administration has sought to eliminate or reduce all these programs in each of its budget requests for the past three years.

Dr. Robert Graham, administrator for the Health Resources and Services Administration (HRSA), which

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overssees the Indian Health Service, says such concern is unfounded, and points to the President's Memorandum of Disapproval as evidence of the Administration's intent to carry out the full scope of the Indian health program in 1985. (The President's message included the statement that, "My disapproval of the bill will in no way affect the continued delivery of health care services to our country's Indian population." For article related to the President's veto, see page 12.)

"We will spend every dollar, every cent that has been appropriated for Indian health in fiscal year 1985. The urban health program will continue; the Indian health scholarship program will continue; and the Community Health Representative program will continue. That's the law." — Robert Graham, HRSA Administrator.

Graham stressed that the Snyder Act of 1921 provides authority for existing IHS programs, and the Continuing Resolution Appropriations Act includes funding for all IHS activities for the remainder of the fiscal year. "We will spend every dollar, every cent that has been appropriated for Indian health in fiscal year 1985," Graham stated emphatically.

"The urban health program will continue; the Indian health scholarship program will continue; and the Community Health Representative program will continue. That's the law," Graham asserted.

Similar assurances have been made by the leadership within IHS. In a memorandum issued to IHS area directors November 4, IHS Director Dr. Everett Rhoades stated, "The President's decision not to sign the reauthorization of the Indian Health Care Improvement Act will have no effect on programs for which Congress has appropriated funds for Fiscal Year 1985. Indian Health Service will insure the continuity of care as provided in appropriations." Rhoades' memorandum also instructed area directors to notify tribes in their respective areas that "there will be no disruption of existing programs."

Despite such statements, some Indian health officials remain uneasy about potential repercussions from the President's veto, especially in light of the Administration's opposition to several Indian health programs, as exemplified in its budget requests and its reluctance to spend funds for certain IHS construction projects approved by Congress.

In addition, many Indian officials realize that any decision to impound IHS funding would be made not by DHHS but by the President's Office of Management and Budget. Ed Dale, spokesperson for OMB, refused to comment on the possibility of an impoundment of IHS funds, and would neither confirm nor deny statements by DHHS that existing Indian programs will continue unabated in FY 1985.

Any request to rescind or defer IHS funds, if such a decision were made, would be announced next February with the FY 1986 budget request and would be subject to congressional review, Dale said. In the case of a rescission request, which seeks cancellation of budget authority previously granted by Congress, both the House and Senate have 45 working days to approve the action. Without such approval within the specified timeframe, the rescission request is disallowed and the monies must be spent, Dale said. Most rescissions are not approved because Congress fails to act on them, he added.

A deferral, on the other hand, does not require specific approval from Congress. However, either the House or the Senate may disapprove a deferral through the passage of an impoundment resolution, which has the effect of overturning the deferral and requires that the affected program funds be spent. Dale stated that about 90 percent of all deferrals are "non-controversial" and therefore are not acted upon by Congress.

Central to the impoundment issue is the question of legal authority under which Congress appropriates funds for Indian health care. The law governing federal expenditures for most Indian services is the Snyder Act, which among other things authorizes funds "for relief of distress and conservation of health." Prior to the act's passage in 1921, appropriations requests for Indian programs were frequently killed on the House floor by point-of-order objections, since there was no legal authority for obligating such funds. Concerned Indian health officials are fearful that the Administration may attempt to withhold IHS funds on similar grounds, by contending that the President's veto effectively ended authority for P.L. 94-437 programs.

"... there will be no disruption of existing programs." — Everett Rhoades, IHS Director.

However, supporters of the Indian health program argue that the Snyder Act's authority is so comprehensive that it covers all current IHS activities, including those specified in P.L. 94-437. According to former IHS director Dr. Emery Johnson, the Indian Health Care Improvement Act provided much-needed direction for the Indian Health Service, building on existing programs and authority without diminishing the broad scope of the Snyder Act. "There's really no justifiable rationale for an impoundment, because the Snyder Act provides authority for all these programs," Johnson said. "There should be no question about the Administration's obligation to continue all (IHS) activities in 1985 as intended by Congress."

New Initiatives Lost

While there is at least some commitment to maintain existing Indian health programs in fiscal year 1985, there is no question that the new Indian health initiatives contained in S. 2166 are lost as a result of the President's veto. In addition to extending existing P.L. 94-437 programs for Indian health scholarships, clinical and outreach services, facilities construction and renovation, and urban Indian health care, the Indian Health Care Amendments of 1984 would have established the following new programs:

- Creation of an Indian Health Care Improvement Fund that would have been used to raise all IHS service units with health resources deficiencies below Level II (defined as 21-40 percent deficient) to at least that level. This section required IHS to work closely with tribes to identify their health resources deficiencies and develop a report to Congress on additional Indian health resource requirements. In addition, health services responsibilities under this section would have been expanded to include emergency medical services, accident preven-

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tion programs, and Community Health Representative programs.

- Establishment of a Catastrophic Health Emergency Fund designed to meet extraordinary costs associated with the treatment of victims of disasters or catastrophic illnesses.

- A section providing for waiver of DHHS competitive bidding requirements when, in the judgment of a service unit’s Chief Medical Officer, such requirements would be detrimental to the delivery of health services.

- Establishment of a controversial demonstration project within the state of Montana that would have prohibited IHS from considering an indigent Indian’s eligibility for state and local health care programs funded by property taxes. (This program was cited as one of two major objections in the President’s veto message.)

- Establishment of a systematic approach for determining the planning, design, construction, and renovation needs of the ten top priority inpatient and ambulatory care facilities required to serve Indian communities; and prohibiting the closure of any IHS hospital or clinic without notification to Congress at least one year prior to the planned closure.

- A declaration that the provision of safe water and sanitary waste disposal facilities is primarily a health consideration, and a requirement for the development and implementation of a new 10-year effort to provide water and sanitation facilities to all new and existing Indian homes and to Indian communities. Other provisions in this section were designed to improve the administration and operation of the IHS sanitation program.

- A provision permitting tribes to expend non-IHS funds for the renovation or modernization of IHS facilities.

- A provision extending the current authority for participation of IHS facilities in the Medicare program to all IHS hospitals, skilled nursing facilities, home health agencies, and rural health clinics that meet applicable Medicare conditions and requirements for payment. IHS would have also been required to return to each service unit at least 50 percent of the Medicare and Medicaid reimbursements collected by those service units.

- A provision requiring IHS to develop an automated management information system (including systems for cost accounting and patient care information) and a privacy component to protect the privacy of patient medical and financial information held by IHS.

- A provision removing IHS as a bureau of the Health Resources and Services Administration and making it an agency within the Public Health Service; the elevation would have been delayed one year in order to permit a seven-member commission to evaluate whether such a move would enhance IHS’ ability to deliver health care services. As specified in this section, if the commission found that the change would benefit IHS operations, the elevation would have taken place immediately. If the commission found otherwise, the elevation would have been delayed an additional six months to allow Congress sufficient time to repeal the provision. (The Justice Department determined that the commission’s authority was unconstitutionally delegated, and the President cited this opinion as one of his reasons for opposing the bill.)

- A provision permitting IHS to enter into leases and contracts with tribes for tribal facilities used in the administration and delivery of health services.

- A section requiring DHHS, the Department of Interior, and the Department of Education to enter into an interagency agreement in order to coordinate available resources and programs to combat Indian juvenile alcohol and drug abuse. The section also required IHS to develop an alcohol prevention training program for elementary and secondary teachers in BIA schools.

- A provision calling for a study of health hazards to Indian miners and Indians living on or near reservations.

**President Also Vetoes NHSC, Health Services Bill**

WASHINGTON, D.C. — The Indian health reauthorization bill wasn’t the only major health legislation that failed to win White House approval following the adjournment of the 98th Congress.

President Reagan also vetoed the Health Professions and Services Amendments (S. 2574), a bill that would have reauthorized most programs of the Health Resources and Services Administration (HRSA). Among the key items in the bill was a provision to reauthorize the National Health Service Corps (NHSC) scholarship and field programs, which provide health professional support to certain geographic regions designated as “health manpower shortage areas.” NHSC personnel have frequently been employed to help meet health manpower needs in Indian communities.

Reagan objected to the bill because he claimed it was too expensive, changed regulations unnecessarily, or involved the federal government in matters best left to the private sector. He also noted that the $2.9 billion health services bill was “seriously flawed,” and he specifically objected to the NHSC programs.

Senator Orrin Hatch (R-Utah), chairman of the Senate Labor and Human Resources Committee, stated in a letter to the President that the programs included in S. 2574 are “truly a safety net . . . to help those who cannot help themselves.” Senator Edward Kennedy (D-Mass.), the committee’s ranking minority member, said, “This veto delivers a severe blow to millions of the low-income and poor America families who rely upon these programs for primary care.”

In addition to the NHSC programs, the bill would have reauthorized HRSA programs for health professions training assistance, nurse training, Health Maintenance Organizations, Community Health Centers, and Migrant Health. The bill also would have established a new program of grants to states for primary care research, demonstration, and services (replacing the existing Primary Care Block Grants), and authorized a three-year program of grants to states for the control of plague.

According to Department officials, existing HRSA programs covered by S. 2574 will be continued under the FY 1985 Labor/HHS appropriations act. A new bill is likely to be reintroduced next year.
New Elderly Law Expands Eligibility for Tribal Grants; Hearings Planned

WASHINGTON, D.C. — A larger number of Indian tribes will now be eligible for social and nutrition service grants under Older Americans Act (P.L. 98-459) legislation signed into law October 9. Having noted that "many tribes have a small on-reservation population, and of that population, the Indian elderly constitute a small percentage," Congress amended Title VI of the law to lower minimum participation of a tribal organization requesting assistance from 75 to 60 older persons.

This and other changes affecting tribes are included as part of a three year extension of the Older Americans Act. First enacted in 1965, the law's goals are aimed at improving the lives of older Americans in the areas of income, health, housing, employment, retirement, and community services. Amendments made in 1978 added a new Title VI authorizing grants for social and nutrition services to Indian tribal organizations.

The legislation also increases authorization levels for Title VI in the amount of $7.9 million in Fiscal Year 1985, $8.3 million in FY 1986, and $8.6 million in FY 1987. The title is currently authorized at $7.5 million; however, appropriations total just $5.5 million.

In response to complaints from Indian country, the conference report accompanying the legislation expresses concern "that the Administration on Aging has failed to respond to the legitimate concerns for the Indian elderly in establishing a focal position" within AOA. AOA is directed to establish a Coordinator of Indian Programs who would report directly to the Commissioner on Aging. The Commissioner is to seek the recommendations of tribal representatives in filling such a position with an individual "knowledgeable about and sensitive to the unique aspects of the Indian elderly and who can effectively advocate their concerns."

All current tribal grantees under Title VI submitted an application during the 1980 funding cycle. Since that time, no new applications have been considered. The Congress commended an announcement in the Federal Register of a few months ago which opened the application process to previously unfunded tribal organizations in anticipation of increased appropriations.

Aside from those tribes fortunate enough to receive the limited funds available under Title VI, others must look to the act's other titles to receive services for their elderly. Chief among these is Title III, through which a nationwide network of "state" and "area agencies on aging" administer state and community aging programs including nutrition and social services.

The law currently requires state agencies on aging and area agency plans to assure that preference in providing services will be given to older persons with the greatest economic or social need. Further, the plans are required to include proposed methods for carrying out this preference. The reauthorizing legislation amends these provisions to specify that in serving those persons with the greatest economic or social need, state and area agencies are to give particular attention to the needs of low income minority older persons.

Congress expressed its concern about the findings of the U.S. Commission on Civil Rights contained in a 1982 report on minority participation in Older Americans Act programs. The commission cited a number of barriers to minority participation in services sponsored under the act, such as location of programs outside areas where minority older persons live, lack of transportation, inadequate knowledge of minority language and cultural differences on the part of staff serving minority groups, and limited outreach to minority groups.

1981 amendments to the act added a provision allowing each state to transfer up to 20 percent of its funds for supportive and nutrition services between these separate allotments. During the past two years states have in-
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creasingly transferred funds between these separate programs, with a notable shift of funds from the congregate nutrition program to other components of Title III. The reauthorizing legislation increases the allowable percentage transfer to 27 percent in FY 1985, 29 percent in FY 1986, and 30 percent in FY 1987.

Earlier this year, the Senate Labor and Human Resources Committee called for a joint oversight hearing next year between itself and the Special Committee on Aging to gather information on Title VI programs and whether such programs are meeting the needs of the Indian elderly. The participation of the Senate Select Committee on Indian Affairs can also be expected. According to the Senate Subcommittee on Aging staff, the hearings are likely to be scheduled for early in the next congressional session.

It appears that there will be plenty to discuss. Certain tribal groups welcome the changes in Title VI but regard them as just a beginning. For the past several years, tribal aging advocates have called for creation of an “Indian desk” within AOA as the conference report directs. “We are now looking forward to seeing what can be accomplished through that position,” says Curtis Cook, program specialist for the National Indian Council on Aging (NICOA).

Creation of an Indian desk was just one of several recommendations made by 48 of the 83 Title VI grantees who met in 1983 regarding reauthorization of Title VI. Larry Curley, who directs the Laguna Pueblo’s elderly program explains, “The person in this position would report directly to the Commissioner in contrast to the staff position for Title VI which is now three layers below the Commissioner.” “But,” he adds, “to make the position effective, the department must be willing to provide sufficient staff in order to monitor programs and provide training and technical assistance.”

Both NICOA and the group of Title VI grantees also favor a further decrease in the minimum participation requirement. Says Cook, “There are still a large number of tribes unable to qualify.” He notes that although AOA allows tribes to band together to form a consortium with the adequate number of elderly participants, “tribes are not always geographically or politically situated to do so.” Curley calls the change from 75 to 60 participants “a step in the right direction” but the Title VI grantees recommend expansion to include all federally-recognized tribes.

Another issue on which NICOA and the Title VI grantees agree is the inadequacy of appropriations. For example, on the vast Navajo reservation, Title VI provides enough money to fund a program for only one of 38 communities served by the tribe, according to aging director Donna Ciccati.

Noting that of all tribes nationwide, only 83 have been able to receive Title VI funding, she maintains, “the majority of need is left unmet.” The Federal Register announcement commended by the Congress for expanding eligibility to additional tribes applies only to increases in appropriations above the current level. Thus, if Title VI appropriations are increased by $2 million, eligibility for that $2 million will be expanded to all tribes with at least 60 elders but only the existing grantees will be eligible to apply for the original larger amount.

Title V of the act provides for an older American community service employment program. The Title VI grantees group recommended that Indian services under this title be consolidated with other components under Title VI at an increased level of funding.

Finally, another issue likely to surface at the oversight hearings is the status of a national policy on Indian aging. AOA has been assigned the responsibility for its development and the Indian elderly community appears eager to see its completion. A number of tribal groups are looking at formulating recommendations for inclusion and NICOA staff report that that organization is preparing a final statement on the issue for presentation to AOA. Tribal recommendations are still welcome, however, adds Cook.
Effort Underway to Set Up Tribal ADP-Oriented Users Group

The following letter was submitted by Mr. Robert Rich, Assistant Director for the Seneca Nation Health Department in Salamanca, New York. Mr. Rich has worked extensively in the area of patient information systems, and served as a co-facilitator for the “Health Care Systems Automation” workshop at the NIHB health conference in Reno, Nevada last summer. As noted in his letter, health programs are making increasing use of computers in the operation of their health programs, and it has been suggested that the formation of a “Tribal Users Group” would be beneficial to ongoing efforts to improve Indian health information systems. Mr. Rich has volunteered to attempt to coordinate such a group, provided there is sufficient interest among tribal programs. In addition to improving existing tribal capabilities, the Tribal Users Group would be an excellent vehicle for working with the Indian Health Service in the development and refinement of its data processing programs. Mr. Rich emphasizes that there is no requirement that a tribe must be utilizing computers in order to participate in the Tribal Users Group.

Persons interested in participating with the group, or who wish to obtain additional information, should write: Mr. Robert Rich, Assistant Director; Seneca Nation Health Department; Box 231, Salamanca, New York 14777.

As I am sure you are already aware, the use of computers in tribal operations is expanding rapidly. Responsive information systems have become a pure necessity in managing the diverse programs and enterprises that tribes are developing and implementing. This letter concerns the need for and potential of sharing our increasing levels of expertise and resources in this area for the betterment of all of Indian country.

Although every tribe and its circumstances are unique, there is a good deal of commonality of need for systems automation. For instance, financial reporting systems must be able to handle business operations, yet satisfy Federal requirements for grants and contracts. Tribal roll systems are essentially the same no matter their location. Many other applications have enough similarity to warrant an exploration of ways to share ideas, experiences and systems that have already been developed.

Some recent developments, in particular within the Indian Health Service, have opened up an opportunity to begin this sharing process. IHS has, in recent months, initiated a wide-scale effort to improve its information systems capabilities. The approach being taken is a dramatic departure from the top-down, centralized design and control methodologies that are typical of Federal agencies (in the past, including IHS). This new, and what I consider to be a much more enlightened, approach is field oriented and will distribute systems development throughout IHS. Naturally, a high degree of cooperation and coordination will be required to achieve success in this endeavor, but the commitment seems to be in place and hopes are high.

As a result of the work that has been done over the past several years by the Seneca Nation in the area of

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Alcoholism/Drug Abuse Bill Stresses Prevention Among Indian Youth

WASHINGTON, D.C. — Although alcoholism is recognized as the number one health and social problem among Indian people, past federal efforts at preventing and treating alcohol and drug abuse in Indian communities have been scattered and largely uncoordinated. Legislation designed to improve federal programs in this area was introduced September 6 in the U.S. House of Representatives. Realizing that there was too little time remaining in the congressional session to move the bill through the House, its sponsors Congressmen Doug Bereuter (R.-Neb.) and Tom Daschle (D.-S.D.) nonetheless wanted to present a proposal that could be refined and enacted during the next Congress. They are seeking the views of Indian people nationwide so that when Congress convenes in January a revised bill can be introduced.

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health systems automation, we have been asked to work with the IHS in this development project to provide tribal input. We have accepted this assignment, at least until a computer-oriented tribal organization is developed to duly select such representation. As a result of our initial involvement, we have taken the responsibility to help such an organization get started — which is what prompts this letter.

At the NIHB conference in Reno I participated in a workshop on health systems automation that was attended by tribal health representatives from around the country. At the conclusion of the workshop, the possibility was raised that a Tribal Users Group might be advantageous to tribes and provide a vehicle for input into systems development activities within the Federal agencies, particularly IHS with its new emphasis. I have since presented this idea to the IHS and received a very favorable response. In fact, the Director of IHS Management Information Systems, Dr. Walt Wolford, has indicated that IHS Headquarters would explore making resources available to help set up an organizational meeting.

If a sufficient response is received to make a national meeting feasible, I will make arrangements with Dr. Wolford and recontact the interested parties with particulars. Please note that there is no requirement for a tribe to be already using computers to participate in the Tribal Users Group. The group will be devoted to information systems (which we all are already involved with, computerized or not) and the key to involvement is an interest in improving the capabilities and responsiveness of these systems.

I believe it is important to all of us to begin to share among ourselves and to have a greater influence on the data processing activities of the agencies we do business with. We can all do it alone, but logic seems to argue for a more collective and cooperative effort. I really hope that we can develop some leadership in this area that will benefit all of the American Indian/Alaska Native people.

The Juvenile Indian Alcohol and Drug Abuse Prevention Act (H.R. 6196) would expand upon an alcoholism initiative contained in the Indian Health Care Improvement Act reauthorization bill (S. 2166, which was vetoed by President Reagan October 19) requiring cooperation between the Departments of Interior and Health and Human Services. Under the S. 2166 provision, which was opposed by the Administration, the two departments were to join in a Memorandum of Agreement to share resources and coordinate programs dealing with the prevention, identification, treatment and follow-up care of alcohol and drug abuse. A role at least equal to that of the federal agencies in this cooperative venture was to be played by tribes. At a tribe's request, the local IHS service unit director and BIA superintendents would enter into an agreement with the tribe to share resources and coordinate programs dealing with alcohol and drug abuse within a community.

In his introduction of the H.R. 6196, Congressman Daschle stated, "It is important for us to be cognizant of the fact that the Indian population is very young. Indian people have the highest birth rate in the nation. They also die the youngest... These statistics point to the importance of focusing efforts on the prevention of alcohol and drug abuse at an early age, not just sporadic treatment after the fact."

The legislation aims its focus on youth. All BIA and contract schools are required to put alcohol/drug education curricula in place at all grade levels. Dr. Dennis Fox, an assistant director in the BIA Office of Indian Education, believes that preventive efforts are most effective among children in the very early grades. "They must be taught how to handle peer pressure and that it's o.k. to say no," he says. "Trying to put fear in the older students only challenges some of them," adds Fox.

The bill would also require that some BIA schools be kept open during the summer as recreation and counseling centers for Indian youth.

In addition, the Indian Education Act (Title IV) would be expanded in order for these efforts to reach urban Indian adolescents. Part A provides money for counselors at schools with large numbers of Indian students. Part B authorizes a 10 percent setaside for graduate fellowships to people training as alcohol/drug counselors. Part C makes money available to urban Indian centers for trained alcohol/drug counselors.

The bill's sponsors also hope to bring a more sensitive and learned reaction to alcohol and drug problems by requiring that a wide range of government employees on reservations whose jobs bring them into contact with substance abuse receive training in this area. IHS would be required to provide alcohol and drug abuse training to BIA education superintendents, BIA agency superintendents, IHS service unit directors, BIA social workers, IHS doctors, nurses, nurses' aides and paramedics. The same training would also be offered to school board and child protection committee members among others. Regular training for tribal Community Health Representa-

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tives would be expanded to contain a week of training on the problems of alcohol and drug abuse including instruction in crisis intervention and family relations.

While IHS presently funds nearly 200 tribal alcohol programs, they are, by and large, programs to deal with people in the late stages of alcoholism and do not focus on prevention. According to the bill's sponsors only two of these programs are equipped to deal with the special problems of the juvenile victims of alcoholism. The legislation requires IHS, within two years, to integrate treatment and followup care of alcoholism into its health services. IHS is to report to Congress on the size of the juvenile Indian population in need of residential alcohol or drug treatment, where such facilities should be located, and the cost of providing such treatment within six months of the legislation's enactment.

Earlier this year, Congressman Bereuter told a number of his fellow congressmen that in researching the Indian bill he and Congressman Daschle "discovered that the majority of children apprehended during the commission of a crime are intoxicated. But the true horror of the situation is that most of these children are then incarcerated in jails with adult offenders, and their chances of receiving appropriate care and services are minimal."

He added, "Without special treatment resources for them, and without a system of referral among Indian Health Service personnel, BIA Education and Social Services staff, juvenile authorities and tribal officials,..."\n
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Heckler Promotes Indian Safety Campaign

WASHINGTON, D.C. — A nationwide campaign to bring attention to the devastating impact of injuries and accidents in Indian communities recently received an unexpected boost from the country's top federal health administrator.

Margaret M. Heckler, Secretary of the Department of Health and Human Services (DHHS), announced here October 29 that the month of November has been designated as the first annual "Indian Safety Month." She also called on the Indian Health Service (IHS) to "redouble its efforts for the prevention and control of accidents among American Indians and Alaska Natives."

Accidents are the number one cause of death among the Indian population, with the accidental death rate for Indians more than three times higher than the national rate for all races, according to Public Health Service data. Treatment of injury victims accounts for the greatest number of hospital days spent in IHS facilities, and outpatient care for treatment of injuries represents approximately 10 percent of all visits to IHS clinics and health centers.

"Each year, more than 3,000 American Indians and Alaska Natives are killed in accidents in and around their homes, on roads and highways, and at work," Secretary Heckler said. "The great majority of these victims are young people who represent the future of Indian peoples. We must focus more effort and more energy on preventing these tragedies." In addition to the fatalities, another 14,000 Native Americans are injured in accidents, including many who are left permanently disabled, she said.

In recognition of the severity of this problem in Indian communities, Congress included specific authority for accident prevention programs and emergency medical services in a bill to reauthorize the Indian Health Care Improvement Act (S. 2166). However, the President vetoed the bill October 19.

The Indian Health Service is presently conducting the Second Annual American Indian/Alaska Native Safety Campaign in order "to emphasize the importance of injuries as a public health threat and to encourage participation of a wide variety of individuals, agencies, and organizations in a concerted injury prevention endeavor."

As part of the campaign, Indian children at schools on or near reservations are being encouraged to take part in a national safety poster contest. Winner of last year's poster competition was Darel Ridley, 13, a student at the Lummi Tribal School in Marietta, Washington.

Winners of the 1984 safety poster competition will be presented with awards by DHHS officials in Washington, D.C. next January.
One Year Later, Santee Sioux Burn Victims are on the Road to Recovery

As noted in the article on page 15, one of the major initiatives of the recently- vetoed Indian health reauthorization bill (S. 2166) was a provision establishing a Catastrophic Health Emergency Fund. The provision, which was originally proposed by the House Interior and Insular Affairs Committee, was designed to protect IHS service units against unexpectedly high costs associated with the treatment of catastrophic illnesses or medical disasters.

A tragic example of such a disaster occurred last year when eight Santee Sioux Indian children were severely burned in an explosion. As described by Mike Gors of The Sioux City Journal, the eight children are now on the road to recovery, although they will require additional treatment and surgery. The story illustrates the tremendous amount of specialized care that can be required to treat victims of medical disasters.

Santee, NEBR. — The bandages they wear and the scars they bear serve as constant reminders of a day eight Santee children would like to forget.

Slightly more than a year after an explosion and fire engulfed them in flames on a hot August afternoon, however, the Santee Sioux Indian kids are finding life on their reservation returning to some form of normalcy.

They were able this year to start school with the rest of their classmates. They are back to doing most of the things they enjoyed doing before the accident. Their hospital visits are fewer and farther between. Their physical recuperation is right on schedule.

They are, in short, adjusting.

It was on August 26, 1983, when the eight children — John Crane, Earl Crane, Lisa Crane, Bobby Hawk, Travis Gilpin, Chris Campbell, Angela Henry and Lonnie Campbell, ages 4 to 15 — began playing in a cool, gaseous cloud in order to beat the summer heat.

The clouds developed when a gas leak formed while fuel was being transferred from a truck to a storage tank across the street from the Santee school building. The truck driver frantically attempted to shoo the kids away but, before he could, the leaking gas ignited and engulfed the children in flames.

That night, staffers in the burn unit at St. Luke's Regional Medical Center in Sioux City were faced with a crisis the proportions of which they had never encountered before. And, that same night, the eight children set out on a long, painful and difficult road to recovery. Some would spend the next 3½ months hospitalized, undergoing intensive treatment and therapy.

The past 13 months have been easier on some than others. One girl was burned on less than 20 percent of her body while another youth was burned on nearly 70 percent of his. The burns all were second- and third-degree, with injuries mostly to hands, upper torsos and faces.

The most badly burned of the eight — John, 10, Earl, 14 and Bobby, 14 — still wear protective garments on their hands, arms, and faces. The bandages, called Jobst custom pressure gradient burn garments, are designed to prevent contractures and to provide pressure to soften healing skin and grafted or scarred areas.

The garments are worn 24 hours a day, seven days a week, except when the patient is bathing. Wearing the bandages also represents one in a series of steps the boys will have to take to fully recover.

Belinda Eacret, a burn unit nurse and outreach coordinator for the unit's burn prevention program, says the treatment of the Santee kids is at the point it should be.

"They are all making very, very good progress," Eacret says. "They all are progressing the way they should be. They honestly have tried to do everything we have asked them to do."

All but one of the children still come to Sioux City for periodic checkups. Eacret says burn unit care is very individualized and each patient develops and recovers in his/her own way, depending on a number of variables.

The most badly burned of the children make trips to Sioux City every couple of months. During each of their checkups, the Santee children are evaluated by physical therapists, the treating physician, social workers and burn nurses, Eacret says.

I da Crane, the mother of John, Earl and Lisa, and Ardith Hawk, Bobby's mother, say life for their children in Santee is as normal today as can be expected. They say the community and the reservation have been supportive and have accepted the children back into the fold with open arms.

I da and Ardith, discussing the past year in Ardith's home one block away from where the accident occurred, credit the burn unit and its educational programs area for making the transition easier for their boys.

The unit sent staffers to the reservation before the children were released from the hospital to speak with tribal and school leaders, as well as classmates of the accident victims. The staffers explained what the victims had gone through in the hospital and what they would look like when they returned, counseled the people of Santee on how to react to and treat the children and answered their questions.

There have been problems, yes. I da and Ardith say it takes a great deal of work to care for John, Earl and Bobby.

I da and Ardith say the boys haven't encountered much teasing, finger pointing and name calling on the reservation. However, when they leave the reservation, the insensitivity of others is telling, they say.

It has gotten to the point where the boys now refuse to accompany their mothers into grocery or department stores in communities outside the reservation preferring, instead, to wait in the car. It is frustrating, their mothers say.

"They can't help the fact they were burned," says I da.

John and Bobby say they had no real problems adjusting to the school routine or to being accepted by classmates after 3½ months in the hospital. John was held back and will complete the fifth grade this year, but tutors helped Earl and Bobby finish the sixth grade and both are enrolled in the seventh grade this year.

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Alcoholism/Drug Abuse . . .

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these children may languish in jail instead of receiving treatment for their illness."

The proposed legislation provides that Indian juveniles arrested by a tribal, federal or BIA law enforcement officer would, whenever possible, be detailed in a temporary emergency shelter, foster home, or community-based treatment facility rather than being placed in jail. In those states which exercise criminal jurisdiction in Indian country, law enforcement personnel would be encouraged to follow suit.

With the tribes' involvement, the BIA would be directed to establish a program under which Indian households would be compensated to serve as temporary emergency shelters for such youths.

A small amount of money, some $5 million, is authorized to carry out the purposes of the bill. The idea behind the legislation, its supporters explain, is that there are existing resources that can be brought to bear which now lack coordination.

Additional comments and recommendations are being sought regarding H.R. 6196: the Juvenile Indian Alcohol and Drug Abuse Prevention Act. These can be directed to: Congressman Tom Daschle, Attn: Karen Funk, 439 Cannon HOB, Washington, D.C. 20515; or to Congressman Doug Bereuter, Attn: Wrexie Agan, 1314 Longworth HOB, Washington, D.C. 20515.
NIHB Honors 51 Persons for Their Efforts in Indian Health

WASHINGTON, D.C. — Three U.S. congressmen whose work and dedication have helped improve health care conditions for Indian people are among 51 persons honored by the National Indian Health Board for their contributions in the area of Indian health.

Senator Mark Andrews (R-N.D.) and Representative Morris K. Udall, who together led the ill-fated effort to reauthorize the Indian Health Care Improvement Act, were presented with special awards at a ceremony hosted by NIHB and the American Indian Health Care Association. "Both Senator Andrews and Representative Udall have committed themselves to addressing the health needs of Indian people," stated NIHB Executive Director Jake Whitecrow during the ceremony.

"Their leadership in the effort to reauthorize the Indian health care act, and particularly their dedication to seeking comments and recommendations from the grassroots Indian community, has earned them the respect and admiration of Indian people throughout the nation," Whitecrow said.

Andrews and Udall first introduced the Indian health reauthorization bills in the Senate and House (S. 2166, H.R. 4567) in November of 1983. The bills were drafted following exhaustive field oversight hearings, conducted by their respective committees, that provided tribal leaders, Indian health officials, and individual Indian health consumers the opportunity to voice their concerns about health conditions in Indian communities.

Another key congressional figure to receive special recognition from NIHB was Representative Sidney Yates (D-Illinois), the 34-year veteran of the U.S. House of Representatives who chairs the House Interior Appropriations Subcommittee. Yates, well known around Capitol Hill for his rigorous questioning of witnesses at budget hearings, has been instrumental in ensuring the continued operation of the Indian Health Service (IHS) in recent years. He has been especially supportive of Indian health programs the Administration has sought to reduce or eliminate, such as the Community Health Representatives program, Indian health scholarships, urban health projects, and the construction and upkeep of Indian hospitals and clinics.

"Sidney Yates understands the federal-Indian relationship as well as any member of Congress," says Whitecrow, who served with Yates on the American Indian Policy Review Commission, and he has worked diligently to see that the United States fulfills its obligation to Indian people. We are all extremely grateful for his longstanding support of Indian health programs."

In another category of awards, NIHB presented its most distinguished honor to former NIHB California representative Timm Williams. A Yurok Indian from Crescent City, California, Williams is one of the original founders of the National Indian Health Board and served several terms as the organization's vice-chairman. Always one of the board's most vocal representatives, Williams is a strong advocate for better management of Indian health services, particularly in the area of IHS contracting under the authority of P.L. 93-638.

Williams has been actively involved over the past 20 years at the local, state and national levels in efforts to improve the health care of Indian people, and he has been the recipient of numerous honors, including being named "Man of the Year" by the National Academy of Pediatrics in 1972. He presently serves as the vice-chairman of the California Rural Indian Health Board and is the California alternate to NIHB.

In addition, 47 individuals were awarded NIHB Certificates of Appreciation for their work in the Indian health field. The awardees, who were selected by area health boards, intertribal councils, and NIHB, were honored for having contributed significantly in one or more of the following areas: furthering the health care benefits and services to American Indians and Alaska Natives as provided under the treaty rights and/or laws of the United States; giving the public a better understanding of matters and problems of health affecting American Indians and Alaska Natives; enhancing and promoting the education and understanding of members of American Indian tribes and Alaska Native villages in health and welfare matters; seeking an equitable adjustment of public health services among participating Indian tribes and Alaska Native villages; and promoting the health and common welfare of American Indian and Alaska Native people.

Certificates of Appreciation were presented to: Alaska state Representative Albert P. Adams; Paul Alexander;

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WASHINGTON, D.C. — In the aftermath of President Reagan's October 19 veto of the Indian Health Care Amendments of 1984 (S. 2166), two major views have emerged as to why the bill was disapproved. One is that top Administration policymakers believed that the bill, as the President's memorandum of disapproval states, was "seriously deficient" and would have adversely affected the delivery of Indian health services. The other is that the rationale offered by the White House is merely a "smokescreen" for a much broader effort by the Administration to restrict the present scope of the Indian Health Service (IHS) and return it to the limited, reservation-based clinical care system that existed 30 years ago. Determining which of these two views most accurately reflects the Administration's true position will be an important part of efforts to secure passage of another Indian health care bill next year.

Proponents of the "smokescreen" theory contend that the President's objections to the bill fail to justify a veto, and that the action instead reflects a sweeping Administration attack on services to Indian people. As stated by Monte Hammit, health director for the Red Lake Chippewa Tribe in Red Lake, Minn., "We've seen nothing over the last four years to protect the rights of Indian people. This (the veto) is just another step toward the termination of the federal government's responsibilities to Indian tribes." Similar sentiments were angrily voiced by a number of Indian leaders and congressional supporters of the bill in reaction to the veto.

Those more sympathetic to the President's position stress that some of the bill's provisions would have indeed been detrimental to the Indian health program. Cherokee Tribal Chief Ross Swimmer, for example, expressed concern that "Congress had added amendments that shouldn't have been there." Swimmer also believes that the veto — which was supported by the Department of Health and Human Services, the Department of Justice, and the Office of Management and Budget — came partially "as a result of an interdepartmental fiasco that led to inadequate and incomplete information getting to the President" and that "the veto should not be viewed as a reflection of the Administration's policy toward Indians." He suggests that a different version of the Indian health reauthorization bill could be adopted next year.

Montana Amendment

According to Swimmer, the most troublesome feature of S. 2166 was a four-year demonstration program in Montana dealing with the eligibility of certain Indians for state and local health services. President Reagan termed the program "totally unacceptable" and claimed that it "would actually reduce access of health services for Indians." He also stated that the provision "would set a precedent for potentially changing the fundamental relationship of the Indian Health Service to State and local entities, as well as depriving eligible Indians of benefits that would be due them by virtue of their citizenship in the State."

Under the provision (Section 204), which was limited to Montana, IHS would have been prohibited from directing indigent reservation Indians to utilize state and local property tax-funded programs (excluding Medicaid) prior to being considered eligible for IHS care. The Montana demonstration program would have worked as follows: When an indigent Indian applied for services from or reimbursed by IHS, their eligibility to receive state or local services would have been examined first. If such a state or local program (excluding Medicaid) were funded by property taxes, and if the Indian person resided on non-taxable Indian land, the local services at that point would have been excluded from consideration in determining the Indian's eligibility for IHS services.

Primarily sponsored by Senator John Melcher (D-Mont.), ranking minority member of the Senate Select Committee on Indian Affairs, the provision came about as a result of complaints from Montana county health officials that their programs are losing thousands of dollars from having to treat reservation Indians who do not pay the property taxes that support those services. They argued that IHS, rather than the local health programs, should be the primary provider of care to indigent Indians in their state. (IHS has a longstanding policy known as the "residual resource rule" in which the agency pays for care in non-IHS facilities with "contract care" funds only after all third-party sources of payment have been exhausted.)

Essentially, according to DHHS officials who opposed it, the Montana provision would have made IHS the primary provider in that state, requiring IHS to assume responsibility for medical costs now paid by state and local programs, which could have amounted to several hundred thousand dollars.

Dr. Robert Graham, administrator of the Health Resources and Services Administration (HRSA), says that in addition to the budgetary considerations, the Administration's opposition to the Montana provision centered on the need to protect the rights of Montana Indians as
state citizens and to maintain their eligibility for state and local health programs. Graham states that the provision, which he dubbed "the Montana Tax Relief Act," would have enabled state and local health agencies to deny services to Montana Indians, and that other states with Indian populations would have eventually sought to duplicate the program. "Anyone fully committed to civil rights would have been opposed to this provision. The President made the right decision on this — he acted to preserve the rights of Indians," says Graham.

But according to Senate committee staff, the provision would not have rendered any Montana Indians ineligible for state or local health programs, nor could Indians have been denied state or local services as a result of the provision. The demonstration program dealt only with IHS' policy of requiring Indians to use state and local services under certain circumstances; it would not have affected an Indian person's right to obtain services on their own, committee staff contend. They note that this matter is specifically addressed in the House-Senate conference report, which states that the Montana provision "does not preclude an Indian, in his capacity as a citizen of the state in which he resides, from receiving state- or county-provided health care services or financial assistance for health care services that are provided to all state citizens."

Prior to Senate passage of S. 2166, a number of tribes and Indian organizations had opposed earlier versions of the provision. "We thought this was discriminatory," said Joe DeLaCruz, president of the National Congress of American Indians, "but it was clear that Congress would not allow this program to continue past the four years" of its authorization period. He added, "It was a bad idea, but not the sort of thing that causes a veto . . ." The provision also drew considerable criticism during a House-Senate conference on the bill.

However, several Montana tribes back the demonstration program and support its inclusion in an Indian health care bill they want to see reintroduced next year. Caleb Shields, a member of the Fort Peck Tribal Council and chairman of the Montana Inter-Tribal Policy Board, asserts that Indian health care is an entitlement based on treaty law and that the federal government should therefore be designated the primary provider of care for Montana Indians.

Franklin Ducheneaux, staff director for the House Interior and Insular Affairs Committee, sympathizes with Shields' argument but nonetheless strongly opposes the Montana provision. "Many Indian people believe that they have a prepaid health insurance program, and that Indian health services should be viewed as an entitlement. I'd like to agree with that. But it's a totally unrealistic way to run the Indian Health Service if you don't have the dollars to make it an entitlement program," he says.

If Congress wants to declare health care an entitlement for Indian people, it should address that issue directly and fund IHS accordingly, Ducheneaux says. "But Congress will not pass it. . . and the President will not sign it. It's a dream, and you can't have legislation based on a dream," he said.

Ducheneaux also denounced DHHS for not adequately informing Congress of its objections to the Montana demonstration program. "If we had received a clear statement from the Administration that the bill would be vetoed because of any provision, we would have dropped that provision. But we never got that signal from the Administration," he said.

HRSA's Graham disagreed. He admits that the department never furnished the committees an official report on the bill, as they had requested. But, he added, DHHS officials testified on various versions of the health care bill and also met with committee staff on several occasions. "They knew exactly where we stood," Graham said.

**Commission on IHS Elevation**

Another key objection raised in the President's veto message concerned the method by which IHS would have been removed from its present placement within HRSA and elevated to an agency level within the Public Health Service. As provided in the bill, the elevation would have been delayed one year to allow a congressionally-appointed commission to study the move. If the commission had approved the elevation, the change would have taken place immediately; if the commission opposed it, there would have been an additional delay of six months to give Congress time to repeal the provision.

Citing a Justice Department opinion, the President said the procedure would have unconstitutionally delegated to the commission the authority to determine when legislation will take affect. House and Senate committee staff respond that the Justice interpretation is wrong and maintain that the commission's function would have been legal. They also point out that such commissions have been similarly employed in the past for programs favored by the Administration.

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The irony of the President's objection is that the three principle committees involved with the bill (House Interior, House Energy and Commerce, and the Senate Select Committee on Indian Affairs) never wanted the commission in the first place. The provision was adopted during a House-Senate conference as a concession to Administration supporters opposed to the IHS elevation, most notably Senator Orrin Hatch (R-Utah), chairman of the Senate Labor and Human Resources Committee, who had earlier blocked Senate consideration of the bill for nearly four months in a dispute over the reorganization. According to the House-Senate conference report, the committees had proposed the elevation, which was widely supported by tribes and Indian organizations, in an effort to promote greater awareness of Indian health needs within the Department; reduce existing bureaucratic overburden that delays critical Indian health-related policy decisions and implementation; and improve IHS' ability to respond to congressional and tribal requests for information. (Earlier versions of the bill called for a higher placement of IHS to an assistant secretary's level within DHHS to achieve these objectives.)

Opposition to the elevation may have contributed more to the veto than has been officially indicated, according to some supporters of the move. Noting that IHS is the largest bureau within HRSA (IHS employs 11,000 of the total 15,000 HRSA workforce), they charge that some Department officials were committed to protecting the existing bureaucratic hierarchy and sought a veto of S. 2166 primarily for that reason.

Graham, who openly criticized the elevation proposal over the past 18 months, counters that the veto was based on recommendations from DHHS opposing the Montana demonstration program and from the Justice Department regarding the unconstitutionality of the commission. He acknowledges that "we weren't ecstatic about the elevation provision," but says the matter was not the principle consideration in the Department's decision on the bill. "My record on this is clear. I believe that, absent the Montana provision, the Department would have supported the bill. That would have been my recommendation to the Secretary," he said.

Graham adds that "people should look at what the President says if they want to understand the veto." In addition to the Montana program and the elevation commission, the President's memorandum of disapproval cites provisions that it claims would have duplicated existing authorities; unnecessarily changed the organization of IHS; placed increased emphasis on services "not oriented toward the primary mission" of IHS; and required "peripheral projects such as unnecessary reports, interagency agreements, and regulations development."

But a number of S. 2166 supporters insist that there is more to the President's veto message than meets the eye. Former IHS Director Dr. Emery Johnson, for example, believes that the White House decision was manipulated by Administration officials and bureaucrats intent on "eliminating everything that is not clinical care" and reducing the Indian health program to the limited system of clinics and hospitals that existed 30 years ago.

Johnson says the reasoning in the President's disapproval message represents a basic misunderstanding of the bill's provisions, and, like Cherokee Tribal Chief Ross Swimmer, he suggests that the veto was largely a result of the White House receiving inaccurate and misleading information. Johnson also says that there might have been a different outcome if S. 2166 had been considered in relation to President Reagan's 1983 Indian policy statement.

"This bill addressed many of the problems identified in the President's Indian message," Johnson said. "It would have forced the bureaucracy to be more responsive to the desires of Indian people, it would have cut the red tape and inefficiency that plagues the program now, and it would have given Indian tribes their best opportunity ever to take part in the system, in keeping with the President's commitment to the policy of Indian Self Determination," he said.

The President's veto message was also criticized for pointing to achievements in Indian health while ignoring existing health problems of the Indian population. As stated by Senator Dennis DeConcini (D-Ariz.), "Indian people endure conditions of poor health which are many times worse than those of Americans dwelling in the poorest city ghettos. Almost twice as many Indian babies die in their first year of life as do other American infants. Life expectancy of Indian people is comparable to that in Africa. The Indian children who survive their first year can expect to live an average of 44 years."

DeConcini adds, "Health care is an extremely critical area for the United States to demonstrate its commitment to the Tribes. Our actions in this area are all-important. The issue is most profound at its simplest point: an Indian child's ability to learn and later contribute to the community begins with healthy parents and proper prenatal care."

Congressional supporters of the bill, like DeConcini, have vowed to renew efforts to reauthorize the Indian Health Care Improvement Act early in the 99th Congress. To what extent next year's legislation resembles S. 2166 will largely depend on how Congress, tribes, and Indian organizations evaluate and deal with the Administration's opposition to this year's Indian health bill.

NIHB Honors

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Lois Armstrong; Linda Big Joe; John Bopp; Jennifer Bouquet; Debbie Brokenrope; Viola Burgess; Dr. James Calvert; Edna Charley, Kenneth B. Charlie; Robert Clark; Norm Delorme; David Dennis; Vernon Dixon; Frank Ducheneaux; Mary Edwardsen; Alaska state Senator Frank Ferguson; Dr. Robert Fortuine; Linda Harrar; Alaska state Representative Adelheid Herrman; Edna Hood; and Pamela E. Iron.

Certificates were also given to: Della Keats; U.S. Congressman Dale Kildees; Julia Knagin; Lillian Lapp; Doreen Lonifight; Dr. Brian J. McMahon; Mary Alice Muncey; Dr. Bhupendra H. Nanavati; Linda Navarro; Alex Nick; Bernadine Ricker; Cecilia Tapio Rohrbuck; Alaska state Senator John Sackett; Carmelita Sketer; Bernice Sipe; Luella Torres; Darryl Trigg; Florence G. Shelunoe Uusitalo; Georgiana Waskey; Luna Wessell; Ethel "Tessie" Williams; Michael Zambalis; and Patricia Zell.
Veto Dashes Hopes for Catastrophic Health Fund in '85

Tony Merrell, a 5-year-old Osage boy from Pawhuska, Okla., suffers from a rare liver disease that threatens his life. Although he desperately needs a liver transplant, the Indian Health Service has indicated it does not have the funds to finance the operation. The Pawhuska community is trying to raise funds to help cover his medical costs.

Throughout the last month of FY 1981, Nevada's Schurz service unit was forced to discontinue payment for all contract care because its budget had been wiped out by earlier emergency costs.

A year ago, a propane vapor cloud ignited while a truck was refueling into an underground storage tank located on the Santee Sioux reservation, seriously burning eight young children who had been playing around the tank. The closest burn center was located over 100 miles away in Sioux City, Iowa. The IHS Aberdeen Area office paid the hospital bills for four of the children, amounting to some $206,000 and representing 22 percent of the total contract health care budget for the Wagner service unit. The high percentage of the budget spent for Santee meant that lower medical priorities for other people could not be funded. Thus, the level of health care for all three tribes within the service unit was seriously jeopardized.

WASHINGTON, D.C. — Catastrophic illness and medical disasters are devastating to Indian communities, both in terms of individual human suffering and in their impact on limited Indian health resources. The recently-vetoed Indian health reauthorization bill (S. 2166) attempted to deal with the economic consequences of such situations by establishing within IHS a "Catastrophic Health Emergency Fund." The provision, one of many new initiatives lost as a result of the President's October 19 veto, would have authorized $12 million for meeting extraordinary costs associated with medical disasters or catastrophic illnesses, with additional monies authorized to restore the fund to the same level in subsequent years.

The fund was designed to protect a service unit's health care budget in events such as those described above. As explained by one of the idea's supporters, Jim Mitchell, acting director of the IHS Division of Health Support Activities, "the IHS contract care program is run based on the availability of funds. This doesn't always coincide with the need for services, especially in catastrophic occurrences."

He believes that a catastrophic fund would enable IHS to level out the administration of contract health services. On this point, he comments, "A local service unit whose total budget may not amount to much more than the cost of one emergency catastrophic occurrence could rest assured that after a certain triggering level they would no longer be responsible for the costs."

Catastrophic medical occurrences are dismayingly common among IHS' service population, according to Mitchell. He states that neonatal care and spinal cord injuries would likely lead a national list of the types of such occurrences. Also being added to the list in increasing numbers are kidney transplants and dialysis.

Mitchell cites some 600 catastrophic cases, each of which cost more than $25,000, encountered by IHS in FY 1982. In Phoenix that year, over $2 million of the area's contract care budget of $12.3 million was spent for renal dialysis alone. Last year, after Arizona put its AHCCCS system (the state's version of Medicaid) in place, 80-90 percent of renal dialysis costs were assumed by the state. Nonetheless, the area was still confronted with expenditures of $2.5 million for catastrophic care from a contract budget of $13.5 million. $700,000 of this amount went for dialysis.

Phoenix's chief medical officer Dr. Ted Retting favors establishment of the catastrophic fund. In agreement with Mitchell, he asserts "it would allow a smoother operation of the contract care budget." Retting makes reference to the manner in which Phoenix and some of the other IHS areas now administer their contract care funds which amounts to holding a large share of the money in reserve until late in the year for fear of being hit with catastrophic occurrences later on.

The Portland IHS area also uses this approach. Sheila Weinmann, director of the Northwest Portland Area Indian Health Board, maintains that although holding back a certain amount of contract care funds for catastrophic cases has worked fairly well in her area, a

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One Year Later

In the next year, a new phase of treatment will begin for some of the kids. John, Earl, Bobby and Travis are scheduled to make a trip to Sioux City toward the end of the month and some of them may, at that time, be admitted for reconstructive surgery to be performed by Dr. Al Jordan.

Typically, Jordan says, treating physicians will wait a year in a burn case to determine what type of scarring will occur and to plot a plan of action to deal with it. Jordan says the types of scars on the Santee children he has seen are not out of the ordinary in cases of severe burns on hands and faces.

Jordan says a person with extremely severe burns may need to undergo between 10 and 15 reconstructive operations over a five-to-seven-year period. Depending on how they develop, the most badly burned of the Santee kids may need two or three operations over the next two or three years, Jordan says.

There is plenty more to be done for some of the kids, but their mothers and their doctors seem to feel things are going well and believe they see light at the end of what has been a long, dark tunnel. Ida and Ardith say their boys are ready for the next step in the process — the surgery.

"They want to do it and get it over with," Ardith says. "They hope one day they won't have to wear the bandages."
Injustice at Rosebud: The Hospital

In past years we have attempted to share with our readers articles and editorials on Indian health issues published in major non-Indian newspapers and magazines. We believe this offers us all an important perspective on how others view Indian country in general, and Indian health in particular. The following article was written by Washington Post staff writer Benjamin Weiser, who spent eight weeks researching life on the Rosebud Sioux Reservation in South Dakota. The article was published last September as one of three installments depicting the economic, social, health, and legal conditions on the Rosebud reservation. Among other things, Weiser's article dealt with problems related to the recruitment and retention of physicians and the medical treatment provided to Indian patients by certain physicians. (IHS officials in the Aberdeen area have responded that many of the problems identified in Weiser's article took place over a several-year period and have since been addressed.)

The Washington Post series was reprinted in its entirety in The Lakota Times in October and drew considerable response from its readers. The installment reprinted below, entitled "Injustice at Rosebud: The Hospital" is part 2 of that series. We invite our readers to respond to the article. Reprinted with the permission of the Washington Post.

ROSEBUD INDIAN RESERVATION, S.D.—One morning in November 1982, John Gobert, director of Rosebud Hospital, was having coffee in the first-floor dining room with a newly hired doctor who introduced himself as Jay Mann, a 47-year-old family practitioner from New York.

At first Gobert was impressed by Mann, a stocky, fast-talking physician who drove a Cadillac, wore a leather-fringed cowboy jacket, and was all hustle and bustle, eager to work. But when Gobert asked Mann where he had been practicing, the doctor seemed evasive and changed the subject. "Something just didn't sit right," said Gobert. He made some calls to determine whether the New York medical license Mann had listed was in fact his.

The answer came two hours later: There was a licensed physician named Mann, but it could not be this one. Dr. Mann had been "dead for four or five years," Gobert was told.

Gobert confronted the impersonator.

"He got very upset," said Gobert. "He said, 'New York is notorious for making mistakes.'"

"I asked to see a driver's license. He said, 'They made a mistake on my driver's license also.'"

The fraudulent Dr. Mann "was asked to vacate Government quarters and would not be allowed to see any more patients," Gobert wrote in a memorandum to his superiors in the Indian Health Service, the federal agency that runs the 29-bed Rosebud Hospital.

For nearly four years Gobert has been writing such memos, alerting federal officials to the large number of unfit, unqualified, unsuitable and, in some cases, unlicensed physicians who have been sent to practice their medicine on the Indians of the Rosebud Sioux Tribe.

There have been alcoholics, drug addicts, an exhibitionist, doctors trying to escape from border officials, a phony doctor, a doctor who fainted at the end of a baby's delivery, doctors incapable of treating cardiac patients, doctors in trouble with the law, and foreign doctors who could not get jobs elsewhere in the United States.

There was even an elderly doctor, known around the hospital as "The Belly Button Packer," who treated patients by stuffing cotton in the navel. After receiving this "therapy," one patient with a bleeding ulcer almost died, according to another doctor who treated him later.

"I think the medical care that is being delivered there is definitely sub-par, and that it is being rationalized by a lot of the people who are responsible for it," said Dr. Robert Hoyt, who practiced at Rosebud Hospital for two years until last May, one of the few permanent physicians on the hospital staff. "The same sort of circumstances to a certain degree exist in a lot of different places in rural America. But I don't think the medical care is necessarily as poor as it is at Rosebud."

"If you view medical care as a right," added Dr. Clark Marquart, another of the reservation's permanent doctors, "then there is no justice here."

Most of the doctors have been sent to Rosebud by Project USA, a federally contracted program run by the American Medical Association that supplies physicians on a temporary basis to Indian reservations and other medically deprived parts of the country. The doctors—known by some as "Rent-a-Docs"—work for salaries of up to $200 a day and are offered free housing, air fare and malpractice insurance. They generally stay for only a few days or weeks.

In the past three years, Rosebud has hired more than 200 temporary doctors to fill as many as five of the seven hospital slots. They come and go with such rapidity, Gobert said, that he sometimes feels less like a hospital administrator than a transit authority chief, dispatching cars and ambulances on two-hour shuttle runs to pick up the latest arrivals at the airport in Pierre.

Doctors are only part of a larger crisis at Rosebud. The hospital operating room has been closed since the last resident surgeon left in 1978. Critical cases must be airlifted to Minneapolis or Rapid City, S.D., several hours away. Infant mortality is twice the national rate. There is widespread alcoholism and much chronic illness. Accidents are a leading killer. So isolated is Rosebud that doctors cannot use radio beepers to keep in contact. So remote are some communities such as Milk's Camp that Lee Six Toes, the night ambulance supervisor, has to drive as far as 100 miles in each direction to take someone to the hospital. No suicide hotline exists because so few families have their own phones.

And death comes here prematurely: in one recent year more than 40 percent of the Indians who died had not reached their 45th birthday.

The medical emergency at Rosebud is permanent; only the treatment of it is transient. The reason, according to John Naughton, director of Project USA in Chicago, is that the reservation is especially unattractive for many doctors because of the isolation and minimal pay. "If it wasn't for Project USA in the Dakotas, many [tribal hospitals] would have to close down for extended

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CLEVELAND KILLS IN SIGHT, right, nearly died after a temporary doctor treated his bleeding ulcer by stuffing cotton in his naval.

Injustice...

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periods," said Naughton. "There are very few people that would go out and perform a service way out in the sticks, work day and night, for that kind of money, whether they be attorneys or bankers. They are sure getting their money's worth."

Naughton said he rarely hears of dissatisfaction with the doctors he sends to the tribes. "I screen them so thoroughly," he said.

But at Rosebud, one hears a different story. As Gobert and others recalled the cast of temporary doctors sent to the reservation, it seemed reminiscent of the chaos depicted in the 1971 Paddy Chayefsky film, "The Hospital."

Gobert said he considered it miraculous that no one has died at the hands of a temporary doctor. "Maybe," he said, "the guy upstairs is smiling on us."

"It's horrible, believe me, I have laughed and cried," said James Sutton, a nurse who worked in the Rosebud Hospital for about four years until 1983.

Consider these cases:

• The Belly Button Packer. Late in the afternoon of October 12, 1981, Cleveland Kills in Sight, 41, entered the Rosebud emergency room complaining of sharp abdominal pains. Kills in Sight, a thin, slightly hunched man, explained to Dr. Charlie Scuderi, a 79-year-old Project USA doctor from Florida, that his ulcer was acting up and that he had a five-year history of internal bleeding, which was documented in his medical chart.

Scuderi, after examining Kills in Sight, stuffed the patient's naval with cotton and sent him home. He wrote in the medical chart: "Navel was packed with cotton and taped. To return next Monday to change packing."

Kills in Sight remained weak and dizzy. He decided to visit the medical clinic in nearby St. Francis. There, a medical assistant took one look and contacted Marquart, who has practiced on the reservation longer than any other physician.

Marquart immediately arranged to have Kills in Sight hospitalized — this time under a different doctor's care. It took four days of blood transfusions and medication to stem the bleeding. "He saved my life," Kills in Sight said of Marquart.

Marquart said Kills in Sight's life was endangered by Scuderi, whose remedy he termed not only "ridiculous but incredibly dangerous."

Six leading gastroenterologists interviewed for this article, including one recommended by the AMA, said they had never heard of such a treatment for bleeding ulcers, which can be life-threatening.

"Anatomically, it's not supportable," said Dr. Joseph Kirsner, the Louis Block Distinguished Service Professor at the University of Chicago medical school, and past president of the American Gastroenterological Association. "I've been at this now for more than fifty years. I've heard all kinds of things. But I must say, I've never heard of this one."

Scuderi, reached at his home in Port Richey, Fla., said that over the years he had employed the "belly button" treatment for hundreds of patients with bleeding ulcers. He said he had been retired for 10 years when he answered the Project USA advertisement, and added: "I told some of the Indians there who were patients that they were getting very, very good service... the best that there is."

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Injustice . . .

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• The Fainter. One semiretired doctor, 66-year-old Artemio Joco, of Liberty, Ind., was sent to Rosebud by Project USA in February 1982. One morning, as he was preparing to deliver a baby, he became queasy, his hands began to shake, and he started to sweat profusely. Moments after the delivery, with the woman still on the table, her legs held up in stirrups, Joco fainted. He was carried out of the room, and the procedure was completed safely by other medical personnel.

Joco, reached at his home, said he had been working a 24-hour shift when the delivery occurred, and added: "I should have rested a little longer."

• The Operators. Some physicians have attempted surgery at Rosebud even though the operating room has been closed and some of the equipment is so antiquated that the rubber fittings are rotting away.

Gobert remembered the day a nurse called him frantically to report on a temporary doctor, saying: "He's all dressed in the gown. He's got a patient ready to operate."

Gobert had to stop the doctor.

A second physician began acting strangely and said he wanted to operate on himself for what he claimed was a hernia. Gobert said the doctor was sent home: "He was going to cut himself."

In a third case, Dr. John A. Dondero, of Mendon, Mass., decided to use the emergency room for surgery and began to operate on 23-year-old Frank Iron Heart, probing inside his chest for hours in an attempt to remove a benign growth, according to nurse Betty Hughes.

"We just didn't have the instruments and we didn't have the setting for any sort of surgical procedures," Hughes recalled. So she summoned Gobert.

"The guy was kind of propped up on the table and didn't have any IV going, no vital signs [were being measured]. There was an exposed rib on the patient," said Gobert. "The patient looked like he was in quite a bit of pain. Dondero had broken the sterile field — whatever he had in there as far as a sterile field — his finger was sticking through the end of his glove."

The wound was closed by another doctor at Gobert's direction. Iron Heart filed a $150,000 malpractice suit against the hospital.

Dondero could not be reached for comment.

• The Oddballs. In the late 1970s, the reservation was served by a doctor who claimed to be hearing mysterious voices, according to hospital clerk Lee Ann Beardt. This doctor muttered "about the world coming to an end." He told some patients they were going to die and one new mother that her baby was going to die, even though none were seriously ill. He eventually left the reservation and hitchhiked back to Oklahoma with a traveling softball team.

Beardt recalled another doctor who responded to her son's severe allergic reaction to a bee sting by taking them outside, picking up some leaves, and telling her to place the leaves on the child's lip to "draw all the poison out." She finally persuaded the doctor that an adrenaline shot would be preferable.

Then there was the physician who had a habit of taking his clothes off and weighing himself in the nude in the same room where embarrased nurses were seeing patients.

‘Potluck’ for Patients

To deal with such doctors, the dedicated nurses, midwives and physicians' assistants at Rosebud Hospital developed what nurse Sutton called a kind of informal underground network to assess which newcomers were unreliable. Marquart recalled that before he would refer
a patient to the hospital, he would call the nurses, asking: "Anybody there you trust now?"

"You were more or less sending the patient to take their potluck chances," Marquart said. "You couldn’t verify for them that nearly all those physicians were competent and trustworthy."

Dr. Loren Petersen, chairman of obstetrics and gynecology at the University of South Dakota School of Medicine, who flies to the reservation once a week to work with pregnant patients, said that in the late 1970s one of the doctors was found to be a narcotics addict. But because of the shortage of physicians, he was kept on for a while, and on nights that he worked, the hospital pharmacy was locked. As a result, Petersen said, pregnant women in labor could not receive painkillers unless the pharmacist was roused at home and dispatched to the hospital.

Dr. Lucy Reifel, the only Rosebud Indian physician on the reservation, recalled that on several occasions she was asked to examine children who had been sent home from the hospital by temporary physicians, only to discover that the children were seriously ill. One child had meningitis; another had appendicitis.

Nurse Nancy Sazama, who supervises the emergency room nursing staff, said that at times this year she has received five or six complaints a week from nurses about temporary physicians who were prescribing the wrong medication, or the wrong dosage. Some were even failing to follow routine medical procedures, such as applying protective padding to a patient’s limb before placing it in cast. Without such padding under a cast, Sazama said, "it rips your leg up when you take it off."

One day in 1981, Sutton said, a temporary doctor "Just dawdled around and didn’t know what to do" when a patient was suffering a heart attack. Sutton said he had to take over the resuscitation effort. "I ordered all the medications, got the individual’s airway established, called the shots the physician would generally call," Sutton said.

The patient was revived for a time, but later died.

Not every temporary doctor has been unsatisfactory. Some have been invited back five and six times and about two dozen out of the hundreds were labeled excellent by Gobert. But the impact of even the best ones has been minimized by their short stays. There is little continuity of care, and for patients with unhappy experiences, the hospital is an object of derision and fear.

Teresa Archambault, a family planning counselor on the reservation, said Cleveland Kills in Sight, the ulcer victim treated by the "Belly Button Packer," is "afraid to go to the hospital now. He doesn’t trust them . . . His whole family is terrified of going to the hospital."

Darlene Kills in Water, a tribal community health worker, said she hears complaints about the hospital from patients who say: "They’re practicing on us. We don’t want to go down there."

Tillie Black Bear, of St. Francis, said that some of her friends are so afraid of the hospital that they "stay away until it becomes a crisis" — then must be admitted in far worse shape.

Marianne Brave Left Hand Bull, 36, also of St. Francis, said: "Now that I’m getting older with health problems coming on, it’s scary. I can imagine how the elderly feel. You don’t know if they know how to diagnose what’s wrong with you."

Often, as doctors change so do treatments. Patients may receive conflicting medication for the same illness on successive visits. One man with dizzy spells and nosebleeds received so many different drugs that they began to interact and his condition did not improve until one doctor ordered all medication stopped.

Gobert, a member of the Blackfeet Tribe in Montana, blamed other tribes for failing to document and share information about unsuitable physicians. He also faulted Project USA’s screening process, which consists of a license check and calls to references. But there were also times, he said, when he had no choice but to accept an unsuitable physician.

"You had to make a decision," Gobert said. "If you didn’t have anybody, what do you do? If somebody’s 35 percent okay, is it better than having no one?"

Naughton said since he learned from Gobert about Scuderì and Dondero, he has not sent them to other reservations.

Some temporary doctors, however, have had a second chance at the Rosebud Hospital. In the fall of 1982, Joco — the physician who had fainted just after the delivery of a baby — returned. "I could not believe they allowed the guy to come back," Sutton recalled. Gobert acknowledged that it had been a mistake to rehire him, saying: "We thought that he wouldn’t harm anybody."

Eleanor Robertson, the federal official who supervises nine tribal hospitals including Rosebud’s, said the glut of doctors in big cities has resulted in some "borderline" physicians seeking jobs in rural areas like the Dakotas. She said her office was trying to weed out the problem doctors, many of whom were in trouble with state licensing boards and who had hoped "to hide out" on reservations and practice medicine undetected. One of Robertson’s assistants said 25 temporary doctors had been rejected in the past three years after routine background checks by the Indian Health Service.

The need for physicians on reservations increased dramatically when the pool of young "draft doctors" dried up after the Vietnam war, and now the reservation must also compete with other communities that can offer large sums of money for new physicians. All Rosebud can offer is a sense of mission.

**Recruiting the Qualified**

On Jan. 11, word reached the reservation that a young physician, 31-year-old Wende Wood, a George Washington University medical school graduate from Bethesda, Md., might be available to work on the reservation to fulfill a three-year government scholarship obligation. She had expressed a desire to be sent to an economically disadvantaged area.

Rosebud officials saw the need to strike quickly. They drove four hours through a blizzard to Pierre, where Wood was attending a recruitment conference. As they waited to meet her, another hospital administrator walked over to chat. "Good luck," he said. "See what you come up with."

Wood was greeted warmly by the Rosebud recruiters, who had decided to be as straightforward as possible
IHS '85 Budget Unlikely to Keep Pace with Medical Cost Inflation

WASHINGTON, D.C. — Despite a slight increase in its fiscal year 1985 budget, the Indian Health Service (IHS) is preparing for a difficult year in which the agency will be hard pressed to maintain the level of health care services delivered in fiscal year 1984.

Under the FY 1985 Continuing Resolutions Appropriations Act (P.L. 98-473), which was passed in the final days of the 98th Congress and signed into law October 12, approximately $793.7 million will be allocated to IHS Health Services and another $61.6 million to the IHS Health Facilities construction program. The figures reflect a 2 percent reduction of the IHS amounts originally agreed to by House and Senate negotiators. The cut, which was applied across-the-board to all Interior appropriations programs (including IHS), was necessary to keep total Interior spending within the limit set by the White House.

The $370-billion continuing resolution was enacted this year because Congress was unable to complete most of the regular appropriations bills needed to fund government agencies during the fiscal year. The measure contains a House-Senate compromise on interior appropriations that specifies IHS funding levels for the remainder of FY 1985.

With an increase of slightly less than 3 percent over 1984 funding, IHS officials are concerned that the 1985 budget may fall short of what is needed to maintain the current level of health care. Assuming, for example, the health care inflation rate of 10-12 percent projected for this year, a $50-$70 million increase in clinical services is necessary for IHS to simply provide an equivalent level of services in 1985. However, in this category, there is an increase of only $18 million, an amount which according to IHS estimates allows only a one percent increase over IHS’ recurring base.

IHS and tribal health officials have stated that funding which fails to realistically take into account the costs of health care inflation could have a severe negative impact on the Indian health care delivery system. Each year from 1979 through 1983, in spite of apparent appropriations increases, IHS per capita expenditures actually declined substantially, according to figures supplied by the Health Services and Resources Administration which take into account health care inflation and adjust dollar amounts to remain in constant 1974 dollars. Progress made toward reversing this trend in 1983 and 1984 with the aid of a congressional “add-on” could be jeopardized, say IHS officials, returning Indian health care to its status of two years ago. At that time, IHS suffered critical staffing shortages, un purchased and/or unavailable equipment, and dangerously low supply levels.

Although it provides for only a limited increase over last year’s budget, the House-Senate compromise is significantly higher than the IHS budget recommended by the Administration earlier this year. Two programs that have been repeated targets for elimination by the Administration — the Community Health Representative (CHR) and Urban Indian health projects — were restored; $25.5 million is appropriated for the CHR program, along with an additional $4 million for Emergency Medical Services that CHR’s provide. Urban Indian Health will receive $9.8 million to fund continuation of some 37 projects that help provide care to about 400,000 urban Indians.

Another program which the Administration has sought repeatedly to reduce, Indian health manpower, will be funded at $6.5 million, with $275,000 of this amount

Ivey Steps in as New IHS Deputy Director

ROCKVILLE, MD. — Gerald H. Ivey, Alaska Area director for the past nine years, assumed the responsibilities of deputy director of the Indian Health Service (IHS) here October 1.

According to IHS Director Dr. Everett Rhoades, “In the course of getting acquainted with Jerry Ivey over the past two years I’ve found him to be an extremely able administrator of a very complex program ... I am extremely pleased that he will be exerting his leadership in the responsibilities for continued effective, efficient, operations of Indian Health Service programs and activities. Coming from his background as an Alaska Native, Mr. Ivey’s knowledge and experience will greatly broaden the IHS headquarters perspective.”

Ivey, 47, says that as deputy he expects to play a significant part in the day-to-day operations of the agency, a role for which he feels well prepared. With over 20 years management experience, the past 15 of which have been spent in Indian health, Ivey claims a thorough knowledge of the “local delivery system.” “I expect to be learning a good deal more about the headquarters level and also look forward to working with the other IHS areas,” says Ivey, who has spent his entire IHS tenure in Alaska.

Ivey is an Athabaskan Indian. He joined the IHS in 1969 as the Alaska Area Native Affairs Officer and was promoted to Area Executive Officer four years later. In 1975 he was selected Area Director and became responsible for overseeing comprehensive health care services to some 71,000 Alaska Natives through seven hospitals, nine health centers and 172 village clinics. The area’s FY 1984 budget is $116.9 million.

A graduate of Mt. Edgecumbe (Alaska) High School, Ivey received a Bachelor of Education degree in 1961 and a Master of Education degree in 1964 from the University of Alaska. He earned a Master of Public Health degree from the University of California in 1972.

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earmarked for continuation of the INMED program at the University of North Dakota and another $200,000 to continue the Indian MPH program.

In the “hospital and clinics” category, the continuing resolution provides for $417 million and specifies that an additional $10 million of carryover balances from the Medicare/Medicaid fund be used to fund mandatory cost increases in hospital and clinic activities. Clinical service programs earmarked for special funding include restoration of a nurse training project ($1 million); continuation of the IHS model diabetes program ($500,000); a village-based clinic program in Alaska ($400,000); a demonstration alcoholism project for the Warm Springs Tribe in Warm Springs, Oregon ($200,000); development of mental health and substance abuse programs at the Sherman and Phoenix Indian boarding schools ($500,000); provision of services to the Poarch Band of Creek Indians in Alabama; and funding for the treatment of hepatitis-B among Alaska Natives residing in the Seattle metropolitan area.

During this year’s appropriation hearings Administration witnesses testified that IHS plans to collect $55.4 million from Medicare and Medicaid in FY 1985 in an effort to increase the portion of services supported by reimbursements. Additional collections were projected from private insurers. Nearly $65 million of the FY 1985 hospital and clinic program counts upon such reimbursements from support in the Administration’s budget. Both the House and Senate committees disapproved the proposed offset against appropriations from collections.

However, at the request of DHHS, the Senate appropriations committee recommended that IHS be granted authority to seek “subrogation” of insurance claims including, but not limited to, the categories of auto accidents, personal injury, disease, disability, and workers’ compensation. As explained by committee staff person Linda Richardson, this will “place IHS first in line with the insurance companies in instances where if it (IHS) hadn’t provided a patient with services, the company would surely have provided reimbursement.”

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Injustice . . .

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about the conditions on their reservation. After all, there were few places more “disadvantaged.”


Marquart said bluntly: “It’s kind of an intense place. The poverty is intense. The violence is intense. The level of illness is intense.”

The next day, Wood traveled to Rosebud. Dressed in blue jeans, suede boots, and a warm sweater, she was given a tour of the reservation, tramping through the snow of St. Francis, visiting the run-down houses outside the hospital where the staff resided. (One trailer house was so dilapidated that a nurse had twice fallen through the bathroom floor while seated on the toilet.)

Dr. Robert Hoyt, a staff physician at Rosebud, then led her through the three-story red brick hospital. A leaky X-ray machine. No major life-support equipment. The inoperative operating room. He pointed it all out. They walked into the medical library — otherwise known as the “rare book room” because all it had was a few outdated texts from libraries in Buffalo and San Francisco that had closed down.

In one room, Hoyt found a bulky tool that had once been used to look down patients’ throats.

“It’s obsolete, shouldn’t be used,” he said. Then, recalling that some of the temporary doctors had actually attempted to use it on patients, Hoyt added: “Occasionally, you get somebody who whips that bugger out and looks around. You do get the opportunity to meet some real characters.”

Several weeks later, Wood decided against going to Rosebud. She chose a non-profit health clinic serving low-income families in Salt Lake City. Rosebud had been too depressing, isolated and confining. “I feel a lot of guilt that I didn’t take the position,” said Wood. “I feel I could have contributed something. I felt sad because I knew if I turned it down they probably wouldn’t have gotten somebody else.”

The search for doctors continues.
This latter phrase refers to exclusionary clauses, commonly contained in insurance policies, which release a company from liability for care rendered in federal facilities if the patient did not become primarily liable. It is unclear whether this provision would actually mandate liability on the part of insurance companies. House-Senate conferees agreed to modify the subrogation provision to “ensure that such action may not be taken if it involves billing of individual beneficiaries.”

In a separate item related to the highly controversial issue of billing Indian patients for services, the Senate appropriations committee recommended, and the conferees approved, continuing the direction provisions to taken if it federal facilities commonly payors nor to charge those lease Congress has agreed upon a specific language establishing positions within Committees Indian Health Service Department that no.

House-Senate conferees also agreed to delete House language establishing a floor for full-time equivalent positions within IHS “... on the assurance of the Department that no ceilings will be imposed on the Indian Health Service which would impede carrying out the IHS program as funded by the Congress. The Committees will monitor this situation closely to determine if additional action is required.”

In the area of Health Facilities construction, the conferees agreed to $19.8 million for new and replacement hospitals, $2.08 million for hospital modernization and repair, $9.7 million for outpatient clinics, $5.49 million for personnel quarters, and $24.5 million for sanitation facilities. Specifically, funds are provided to complete construction of the Crowpoint, N.M. hospital ($9.06 million) and the Kanakanak, Alaska hospital ($5 million); begin first-phase construction at the Sacaton, Arizona hospital ($5 million); start site work at the Rosebud, S.D. hospital ($1 million); and construct outpatient clinics at Kyle, S.D., Wolf Point, Mont., and Fort Thompson, S.D.

As they have done in past years, the conferees criticized the Department for “delays in initiating construction projects once funds have been appropriated,” and directed the Department to “prepare planning information documents annually on the top five construction priority projects and report to the Committees by February 1, 1985 on other steps which can be taken to streamline the facilities planning and design process.”

In a new twist, the conferees approved language allowing tribes to acquire and expend non-IHS funds for renovation and modernization of facilities, including facilities operated under P.L. 93-638 contracts.

A detailed comparison of fiscal year 1984 appropriations, the President’s request, full House recommendations, Senate committee recommendations, and House-Senate conference action is shown below. Neither the FY 1984 nor the FY 1985 figures reflect pay act supplemental appropriations received or required.

<table>
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<tr>
<th>INDIAN HEALTH SERVICE</th>
<th>Enacted FY '84</th>
<th>President's Request FY '85</th>
<th>House Committee FY '85</th>
<th>Senate Committee FY '85</th>
<th>House/Senate Conference (H.J. Res. 648) FY '85</th>
<th>Final Conference Level (2% Reduction) FY '85</th>
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NIHB Elects Five New Executive Officers

SPOKANE, WASH. — Five new officers were elected to the Executive Committee of the National Indian Health Board (NIHB) during the organization's fall meeting here in September.

Comprising NIHB's new executive committee are: Joseph Saulque, California area representative, Chairman; Tony Secatero, Albuquerque area representative, Vice-Chairman; Carolyn Martin, Alaska area representative, Secretary; Maxine Dixon, USET area representative, Treasurer; and Robert Frank, Phoenix area representative, Member-at-Large.

The executive committee plays an integral role in the administration and operation of NIHB, overseeing such matters as planning, personnel, resolutions, budget, meeting reports, and carrying out other duties specified by the entire board. This year the committee was also charged with responsibility for overall planning and preparations for the Seventh National Indian/Alaska Native Health Conference, tentatively set for November, 1985.

Saulque, recently re-elected to a second term as chairman of the California Rural Indian Health Board (CRIHB), has proven himself a strong spokesman on Indian health issues during his relatively short tenure with the board. Through his work with CRIHB, a consortium of 14 tribal health projects that provide direct care services to a large portion of California's Indian population, Saulque has developed special interests in the areas of health management, finance, and P.L. 93-638 contracting. He was also active in CRIHB's efforts to include the so-called "California provisions" in the Indian health reauthorization bill (S. 2166) vetoed by the President October 19.

The new NIHB chairman expressed hope that a stronger working relationship can be forged among tribes, other Indian organizations, and non-Indian medical associations in an effort to improve the health status of Indian people. "We have a tremendous effort ahead of us if we hope to achieve our goals of health parity and greater tribal involvement in the health care system. If our differences keep us from working together, we're going to have a very difficult time in Indian health," he said.

NIHB's new Vice-Chairman, Secatero, voiced similar concern about the need for a more unified approach to addressing health care problems in Indian country. Secatero, NIHB's delegate from the Albuquerque Area Indian Health Board, worked as a health planner and administrator for the Canocito Band of Navajo Indians

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NIHB Elects . . .
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for eight years prior to being elected tribal chairman two years ago. Under his leadership, the Albuquerque board has successfully implemented several excellent health initiatives, including an otitis media project and an alcoholism prevention program. A former NIHB chairman, Secatero has frequently stressed the importance of tribal participation in the preparation of local and area-wide IHS budgets.

Despite having been appointed to NIHB just this past summer, Alaska area representative Carolyn Martin has emerged as one of the board’s more assertive members. She is a strong advocate of tribal contracting for health programs and, as a board director and treasurer with the Southeast Alaska Regional Corporation (SEARC), has been actively involved in that organization’s attempts to contract for the regional IHS program at Mt. Edgecumbe. Martin brings extensive administrative experience to her position with NIHB, having served in several staff capacities with the Alaska state legislature and the Alaska Department of Health and Social Services. She is presently employed as a budget analyst in the Office of the Governor and is completing her first term as chairman of the Alaska Native Health Board, which is composed of elected representatives from each of the 12 Alaska Native regional corporations.

Maxine Dixon, a member of the Mississippi Choctaw Tribe in Philadelphia, Miss. and delegate of the United South and Eastern Tribes (USET), was re-elected to the office of NIHB Treasurer, a post she filled last year. She has served on the Choctaw Tribal Council for the past 10 years and has long played an important role in the development of her tribe’s health programs. Her background includes service as the tribe’s health committee chairman, director of the Choctaw Community Health Representative (CHR) program, and participation in several state health councils. During the past few years Dixon has been especially active in her tribe’s efforts to contract under P.L. 93-638 for the operation of the reservation’s hospital. The Mississippi Choctaw, one of the country’s more economically progressive tribes assumed responsibility for the health facility earlier this year, and Tribal Chief Phillip Martin credited Dixon’s hard work as an important factor in the tribe’s successful takeover of that program.

Bob Frank, NIHB’s Member-at-Large, is chairman of the Washoe Tribe in Reno, Nevada. He serves as NIHB’s Phoenix area representative under a unique “health steering committee” arrangement between the Inter-Tribal Council of Arizona, the Inter-Tribal Council of Nevada, and the Utah tribal councils. Another relative newcomer to NIHB, Frank’s knowledge of tribal politics and administration is frequently demonstrated at NIHB meetings through his questions and comments on such health-related matters as data processing systems, budgeting, legislation, eligibility, and contracting. Frank was instrumental, along with the Inter-Tribal Council of Nevada, in making last summer’s Sixth National Indian/Alaska Native Health Conference the most successful NIHB national convention to date.

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