OMB Proposes Billing Indians For Cost of IHS Services

WASHINGTON, D.C. — In a major policy shift proposed by President Reagan's Office of Management and Budget, individual Indians could be required to pay for the health care services they receive from the Indian Health Service beginning October 1. The recommendation is part of the Administration's austere 1984 budget request for IHS that counts upon an unprecedented $70 million in reimbursements and also calls for the elimination of funds for the Community Health Representative program, urban Indian health projects, and construction of Indian health facilities.

As proposed by OMB Director David Stockman, fees charged to Indian patients for their health services would be one of several resources used to augment the IHS budget in 1984. In a February 23 letter accompanying the 1984 budget recommendations for the Department of Health and Human Services, Stockman stated: "As has been agreed to during the development of the 1984 Budget, Indian Health Service funding is to be supplemented with charges to individuals and third-party reimbursements (e.g., Medicaid/Medicare, Federal employee, liability, and other private health insurance) ... given the agreement to implement the policy by October 1, 1984, HHS needs to expedite its examination of issues involved."

Stockman's recommendation also presupposes the institution of a "financial means test" for Indian patients to determine their ability to pay for health services. According to the OMB director, "the Indian Health Service would operate in the manner of a county hospital — with public funds being the source of health care financing for those without resources."

The OMB proposal represents a marked departure from the existing policy of providing Indians with health care at no charge as part of the federal government's legal and historical obligation to Indian tribes. This policy is generally viewed by the Indian community as a prepaid benefit provided in return for the cession of Indian lands.

Given the gravity of such a change in policy, which in effect would make the Indian Health Service a welfare agency, the Stockman proposal is likely to generate a furor throughout Indian Country, particularly since tribes were not consulted on the recommendation.

"There is little indication that those urging such a course of action fully appreciate that it is the unique Federal-Indian relationship with which they are dealing and that such a significant change in the IHS program would be widely viewed as an abrogation of treaty, legal, and moral obligations to the Indian people..."

Continued on Pg. 3

SENATOR BARRY GOLDWATER (left) of Arizona, Rep. Morris Udall of Arizona, and Rep. Ray Kogovsek (right) of Colorado heard tribal witnesses from Arizona and Nevada testify on the reauthorization of the Indian Health Care Improvement Act and other Indian health issues during a March 31 oversight hearing in Phoenix, Arizona. Additional field oversight hearings on Indian health care are tentatively scheduled for other locations in late May and early June. See pg. 8 for related article.
Possible $57 Million Shortfall Threatens IHS Clinical Operations for FY '83

WASHINGTON, D.C. — Indian hospitals and health clinics may be forced to drastically curtail services — and possibly shut down their operations entirely — in the next six months unless administrative action is taken to avert an estimated $57 million shortfall in the Indian Health Service budget for the current fiscal year.

Under one of several "solutions" proposed in a recent IHS memorandum addressing the agency's budget shortfall, IHS clinical operations would continue at their present levels until FY 1983 funds are exhausted, which is estimated to be late August. Other, less drastic alternatives cited in the memorandum include requesting a supplemental appropriations to cover all or part of the anticipated shortfall; requesting authority to furlough certain IHS employees; seeking authority to "reprogram" existing funds from other IHS budget activities into hospital and clinic operations; and limiting the duration of IHS contracts with tribes and Indian organizations.

According to IHS officials, the FY 1983 budget difficulties are a result of the agency having to "absorb" the high inflationary costs associated with medical care as well as other "mandatory cost increases" over the last three years. In a recent budget analysis utilizing the Consumer Price Index to account for inflation it was determined that an additional $137 million would be required in 1983 to deliver the same level of health services provided in FY 1981.

Through reductions in such areas as travel, training, hiring of new personnel, purchasing of new equipment, and cutting back other program operations, the projected shortfall for FY 1983 has been cut to approximately $57 million, according to IHS officials. However, they contend that "additional savings can only be realized through immediate reduction in current employment levels and, thusly, a reduction in services that can be provided. The situation clearly indicates the need for immediate action."

Authority to reduce IHS employment levels — through furloughs or federal personnel actions known as a Reduction in Force (RIF) or Reduction in Strength (RIS) — must be approved by higher officials within the Department of Health and Human Services, while authority to reprogram funds from one budget activity to another must be granted by Congress.

One area of the IHS budget that has been hit particularly hard by inflation is contract health care, where costs have risen 12-15 percent annually over the past three years. Even though the expenditure of contract health funds is presently limited to emergencies and life-threatening situations, several IHS areas, including Arizona and Oklahoma, will likely exhaust their allocations by the end of July, according to IHS officials.

The problem with contract care funds has been compounded by a month-long IHS hiring freeze that has prevented the agency from filling vacancies for health personnel and support staff, necessitating greater reliance on contract health services. The hiring freeze was mandated by the Justice Department in response to a federal court decision in the case of Preston v. Schweiker, which held that IHS hiring procedures were in violation of Indian preference requirements. Although the hiring freeze was lifted April 19 pending an appeal of the court's decision, IHS officials say that the extra burden already placed on contract care resources will further limit the use of such funds for the duration of the fiscal year.

Of the $57 million needed to maintain existing service and employment levels, approximately $10 million is required for contract care services; $29.3 million for hospital and clinic operations; and $14.2 million is needed to cover pay increases provided by the 1983 Pay Act.

Although it appears the President's Office of Management and Budget will support a supplemental appropriations for the Pay Act, it is unlikely that the Administration will approve a request for the entire $57 million estimated shortfall.

In the absence of a full supplemental appropriations, IHS would likely have to employ other administrative actions in order to maintain direct health care services for the rest of the fiscal year.

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OMB Proposes...

Continued from Pg. 1

Opposition to the proposed change has already been expressed to Congress and top government officials by a number of tribes and Indian organizations. In a recent letter to DHHS Secretary Margaret Heckler, NIHB Director Jake Whitecrow condemned the Stockman proposal, asserting that “health care provided by the Indian Health Service is part of a legal obligation to Indian people that has evolved directly from the treaty and trust relationship that exists between the United States and Indian tribes. The (OMB proposal) clearly represents a fundamental lack of understanding about this relationship... and we deplore such a callous and ill-conceived attempt to alter this relationship and turn the Indian Health Service into a welfare program.”

Further, it appears that even IHS attempts to dissuade such a proposal were ignored by OMB. In a strongly-worded memorandum last year to Assistant Secretary for Health Edward Brandt, IHS Director Dr. Everett Rhoades stated that “any proposal to require an individual Indian, whether economically secure or destitute, to pay for a service already considered to have been paid for, especially a service viewed as stemming from the trust relationship, can be expected to be bitterly resented and vigorously opposed” by Indian people.

Rhoades continued that “there is little indication that those urging such a course of action fully appreciate that it is the unique Federal-Indian relationship with which they are dealing and that such a significant change in the IHS program would be widely viewed as an abrogation of treaty, legal, and moral obligations to the Indian people assumed by the United States at its insistence.”

In response to the OMB proposal, Rhoades recently recommended that the current fiscal year be used to “fully develop a viable approach to obtaining resources from non-Federal sources.” As noted in a March 14 memorandum to his departmental superiors, Rhoades stated that the OMB proposal raises “critical constitutional, political, and administrative issues” that have not been addressed, and that “time is not available to provide a discussion of the proposal on its merits either within the Department, the Congress, or with the Indian community.”

The memorandum also recommends that a cost benefit analysis of the OMB proposal be undertaken to determine what, if any, economic advantages exist in charging Indians for health services. Questioning the fiscal validity of the 1984 budget recommendation, the memorandum states that, “The Indian populations served by IHS have among the highest unemployment rates in the country. Their economic deprivation and high unemployment mitigate against the probability of substantial collections from third parties.”

Such a cost benefit study should also be completed before attempting to initiate a financial means test for Indian patients, according to IHS. “A means test, for example, would require hiring additional service unit personnel to apply the screening criteria for each IHS patient, yet the general poverty level of the Indian population might result in most of the IHS service population satisfying any reasonable means test; in that situation, additional IHS salary expenses might exceed patient revenues.”

In order to allow for such an analysis and to more fully explore the issue of alternative funding, the IHS memorandum recommends that FY 1983 be used to “make the decision on how to best augment the IHS budget with funds from other sources that are not being tapped presently, with the objective of implementing the new procedures by the beginning of Fiscal Year 1984.” The recommendation is one of seven options presently under consideration by DHHS as a response to the OMB proposal. The other options are:

- bill all Indians for services rendered
- bill only Indians that meet a certain means test
- enact federal legislation that would negate the application of the exclusionary clause by third payers for beneficiaries covered by the Indian Health Service
- attempt to work through the States to have them change their statutes in order to negate the exclusionary clause presently contained in their party payer policies
- do not attempt to collect third party payments from additional sources
- prepare and issue a Notice of Intent as soon as possible indicating that the Department intends to make a change in this area that would involve either billing all or some Indians for services rendered, or that we would seek legislative change at either the State or Federal level that would enable us to collect third party payments for eligible Indian beneficiaries.

A decision on which of these options, if any, is to be initiated by DHHS in response to the OMB proposal will be forthcoming within the next few weeks. Meanwhile, the recommendation to bill Indians for their health care is still subject to congressional review and is likely to receive considerable attention in the months ahead when Congress takes up the reauthorization of the Indian Health Care Improvement Act and the IHS appropriations for FY 1984.
The following is a regular feature of the NIHB Health Reporter. In this section we present our readers with short briefs on issues and activities from around the country, including such topics as conference and workshop dates, legislative notices, news on local events, etc. We invite our readers to submit material for publication in this section. Additional information on the items mentioned here can be obtained from the NIHB Public Information Office.

WASHINGTON, D.C. — The Senate Select Committee on Indian Affairs will conduct field oversight hearings on Indian health care in Grand Forks, N.D., May 31 and Billings, Mont., June 1. A third hearing is tentatively set for Washington, D.C., in mid-June, but hearings planned for Seattle, Wash., and Anchorage, Alaska now appear unlikely. The hearings will address the reauthorization of the Indian Health Care Improvement Act and other health-related issues such as eligibility for services; the collection of reimbursements from third party insurers; requiring payment of IHS services; and contract health care. The committee will also accept written comments on these issues until June 6. For additional information contact: Patricia Zell; Senate Select Committee on Indian Affairs; Dirksen Senate Office Building; Washington, D.C. 20510. Phone: 202/224-2251.

WASHINGTON D.C. — Rep. Morris Udall (D-Ariz.), chairman of the House Interior and Insular Affairs Committee, introduced a bill March 3 to establish a new housing program on Indian reservations. The proposed Indian Housing Act of 1983 (H.R. 1928) would place most Indian housing responsibilities within the Bureau of Indian Affairs, but would leave the construction and maintenance of water and sanitation facilities under the control of the Indian Health Service (IHS). The Administration has proposed shifting responsibility for the provision of sanitation facilities to the Department of Housing and Urban Development, which presently administers most Indian housing activities. The Interior Committee is expected to complete action on the bill by May 15.

ROCKVILLE, MD. — A month-long hiring freeze imposed on the Indian Health Service was lifted April 19 pending appeal of a federal court decision that the agency's employment standards are unlawful. The hiring freeze resulted from a January 4 ruling by the U.S. District Court of Alaska in Preston v. Schweiker which held that IHS had not legally adopted employment standards specified in the Indian Preference Act. IHS officials have expressed concern that the court's order could prove detrimental to the effective delivery of health services to Indian people. A decision on the appeal, which was filed March 15, is not expected for several months.

SPOKANE, WASH. — The National Association of Community Health Representatives will hold its annual conference here June 6-8. Among the activities planned for the meeting is a series of workshops on health problems related to alcohol and drug abuse, hypertension, home safety, accident prevention, maternal and child care, and diabetes. Presentations will also be made on the current and future status of the CHR program. Additional information about the conference can be obtained from: Connie Guillory, CHR Coordinator; Nez Perce Community Services; Box 365; Lapwai, Idaho 63540. Phone: (208) 843-2253.

WASHINGTON, D.C. — Margaret M. Heckler was confirmed March 3 as the new Secretary of Health and Human Services, succeeding Richard Schweiker, who resigned the post January 12. Heckler, who served 16 years in Congress, stated that her two broad goals for the Department are to focus on long-range problems and have DHHS programs be a "catalyst for caring in America." In her capacity as DHHS Secretary, Heckler will serve as the chief administrator of the country's health and social services programs, including the Indian Health Service.

TUCSON, ARIZ. — The University of Arizona is recruiting American Indian students for graduate studies in speech pathology and audiology for the 1983-84 school year. Through the University's American Indian Professional Training in Speech Pathology and Audiology project, students can receive special assistance in counseling, tutoring, and financial aid. For additional information, contact: Gail Harris; Department of Speech and Hearing; University of Arizona; Tucson, Ariz. 85721.

1983 Health Conference Postponed

In response to the many requests we have received recently about NIHB's next national health conference, we regret to announce that plans for a Sixth National Indian/Alaska Native Health Conference have been postponed for the immediate future. NIHB had tentatively scheduled the conference for the third week in April in Reno, Nevada. Although it was never officially announced, we have received numerous inquiries from persons interested in participating in the national meeting. We will announce the details of the next conference as soon as a new date is set.

In a related matter, it has been determined that participants of the Fourth National Indian/Alaska Native Health Conference in San Diego are entitled to a two percent reimbursement from their hotel bill because of an excessive sales tax levied by the city. Persons interested in obtaining this refund should send their claim, along with the hotel bill indicating payment of the eight percent city tax during the period of April 1-December 15, 1983, to: City Treasurer, Attn. Alberta Hall; P.O. Box 2289; San Diego, Calif. 92112. Claims must be received no later than July 27, 1983.
Study Reveals Increase in Infant Deaths at Pine Ridge

By Jeanne White, staff writer
Lakota Times
PINE RIDGE, S.D. — The medical staff of the Pine Ridge Hospital recently expressed alarm at the number of infant deaths occurring on the Pine Ridge Reservation attributed to "crib death."

Doctor Edward J. Lammer, pediatrician with the Birth Defects Branch, Center for Environmental Health, Communicable Disease Control Center in Atlanta, Ga., said there has been a marked increase in cases of sudden infant death syndrome (SIDS) diagnosed at the Pine Ridge Hospital in 1982.

Lammer reported the results of a week-long investigative study to a group of local and area health representatives at the Pine Ridge Hospital here January 28. Lammer said he was called in to conduct the study by Doctor Allen Trschendtberg and Janice Morrow, OB nurse at the hospital, when they became concerned after six infants died in the month of December, 1982, and the first two weeks of January.

He said SIDS, or crib death, is defined as "the sudden death of any child, unexpected by history, where a

From the Executive Director

Over the last few months a lot of interested organizations and individuals have worked together in an effort to assist a young Indian baby in New Mexico obtain a liver transplant. I am saddened to report that ten-month-old Leah Addison died recently of complications related to liver failure.

Leah suffered from a liver disorder, biliary artresia, which is a genetic lack of bile ducts. Her condition required constant medical attention, and she spent much of her life in various medical facilities. Despite three major operations Leah's condition failed to improve and it was determined that her only chance for survival was a liver transplant. Those of us that worked with Leah were particularly encouraged when she was accepted as a candidate for a liver transplant at the Pittsburg Children's Medical Center.

In an effort to provide Leah and her parents with financial assistance for transportation and evaluation at the Pittsburg Center, and to offset other medical expenses, NIHB and other organizations joined together in establishing a special fund on her behalf. I wish to personally thank the many individuals who contributed to Leah's cause.

Unfortunately, there are many other children like Leah, who have severe health problems and cannot afford the staggering costs of medical treatment. John and Celina Addison have decided to establish a special foundation in memory of their daughter to help pay for the costs of treating other seriously ill children, both Indian and non-Indian. The NIHB central office will continue to assist the Addison's in coordinating this fund-raising effort. Donations to the foundation can be addressed to: Leah Addison Foundation — NIHB; 1602 S. Parker Rd.; Suite 200; Denver, Colo. 80231.

postmortem examination fails to show adequate cause of death." There are 8,000 to 10,000 such infant deaths a year in the United States. SIDS is the largest single cause of postneonatal infant mortality and accounts for one-third of all infant deaths from one week to one year of age. The peak incidence of crib death is between the second and fourth months of life and it accounts for one-half of all deaths in the third and fourth months.

Lammer said the active case finding approach revealed there were ten deaths suspected to be crib death over the past year. Six autopsies were performed — five cases were diagnosed as SIDS, and other as pneumonia. The four other deaths, where autopsies were not performed, showed symptoms comparable to SIDS and were in the right age group.

He said although there were nine cases of SIDS in the Pine Ridge Service Unit Area, only seven cases are included in the 1982 birth report because the mother of one infant was not a resident of Shannon County and one infant was born in 1981 and died in 1982.

Lammers said the incidence of SIDS in this area has increased three to four times in 1982 from the previous rate in 1977 to 1979. The statistics for the white population nationally is 1.5 deaths per every 1000 births. Lammer stated that the data is not complete, but research done in North Carolina, Alaska, and Washington states indicate the incidence of SIDS is higher in American Indians than other races.

Lammer said further studies of SIDS are planned. To date research has been conducted primarily in states that require postmortem examinations of all deaths. South Dakota does not require an autopsy be performed on every death.

"Crib death" is a specific disease entity and a

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NATIONAL INDIAN HEALTH BOARD
1602 South Parker Road, Suite 200
Denver, Colorado 80231

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Congress, Tribal Groups Assail '84 Budget Request for Indian Health Care

WASHINGTON, D.C. — During the final few weeks of fiscal year 1982 the Indian health care delivery system was nearly shut down as a result of insufficient operating funds. More recently, Indian Health Service officials have been forced to consider several serious administrative measures — including one that would require Indian hospitals and clinics to close in late August — in anticipation of a major shortfall in the agency's appropriations for fiscal year 1983.

Citing these past funding inadequacies, several members of the House Interior and Insular Affairs Committee recently expressed alarm over the possibility of yet another, more severe deficit for the Indian health care program next year. The congressmen's concerns were voiced during the committee's hearing on the Reagan Administration's FY 1984 budget request for the Indian Health Service here March 1.

Committee members, particularly Rep. James McNulty (D-Ariz.) and Rep. John McCain (R-Ariz.), questioned several key elements of the Administration's budget and were especially critical of an initiative to include approximately $70 million in third party collections as part of the IHS base budget for 1984. Of the $720 million recommended for Indian health care in fiscal year 1984, the Administration assumes that some $40 million will be derived from Medicare and Medicaid reimbursements while another $30 million will be collected from individual Indians and third party insurers. The Administration's request for IHS appropriations in 1984 has been reduced to reflect the $70 million in collections.

Addressing the issue of Medicare and Medicaid reimbursements, McNulty noted that the statute authorizing such collections (Title IV of the Indian Health Care Improvement Act) specifies that they be used to maintain accreditation standards of IHS facilities, and he questioned whether this intent would be violated if the funds were used to offset appropriations. McNulty also expressed strong doubts about the Administration's anticipated $40 million target in Medicare and Medicaid collections, pointing out that IHS received only $20 million in fiscal year 1982. Said McNulty to Administration witnesses: "You are projecting a 100 percent increase (in these collections) in 24 months. I would like to know what statistics you have to indicate that this is a valid assumption rather than a mere wish."

Dr. Robert Graham, Administrator for the Health Services and Resources Administration (HRSA), responded that while specific statistics supporting the $40 million target are unavailable, recent evaluations by the General Accounting Office and the Department of Health and Human Services indicate that additional revenues could be collected. Administrative changes are also underway to facilitate additional Medicare and Medicaid collections during the current fiscal year, he said.

Turning to the Administration's proposal to obtain some $30 million from individual Indians and third party insurers, McNulty questioned the legal ability of IHS to collect such funds given the standard clauses in private insurance policies excluding reimbursements to federal facilities. Rep. McCain also criticized the initiative and suggested that IHS' inability to recover this $30 million would contribute to a serious shortfall in the agency's 1984 budget. Continued on Pg. 7

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**Indian Health Service Budget**

Comparison FY 1982 — FY 1984

*(in thousands)*

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<th>HEALTH SERVICES</th>
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<th>FY 1984</th>
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*Assumes supplemental appropriation of $14.2 million for 1983 Pay Act, which Congress has not yet provided.*
In response, Graham admitted that the Administration has had “considerable difficulty in this area” and stated that legislative or regulatory change would probably be required to authorize these collections. With respect to a possible shortfall, Graham said that “if we approach 1984 and have not been able to resolve, by regulation or statute, the issue of recovery from private insurers then...we will have to make some other arrangements” to provide for the estimated $30 million.

Replied McCain: “We need to determine as soon as possible what this shortfall is going to be so we can examine what measures need to be taken. I think this is critical for the health care of Indian people and for the credibility of the entire program.”

Another item in the 1984 IHS budget that drew considerable attention from committee members was the Administration’s recommendation to eliminate the $8 million program for urban Indian health centers. Rep. Morris Udall (D-Ariz.) expressed concern that many urban Indians would lose their only source of health care if these funds were abolished.

When asked about the rationale for such a cut, Graham said that the Administration’s priority is to fund direct health care services on reservations, since it is presumed that Indian beneficiaries residing in other areas, particularly urban locations, have access to alternate health services. He added that the recommendations to eliminate certain IHS programs, including urban Indian health projects, were made despite their many accomplishments in improving the health care of Indian people. “We are simply at a time when we have had to make a series of very difficult decisions on how to use the money available to us,” he said.

Responding to a question from Rep. Dan Marriott (R-Utah) about the possible consequences of such a cutback, IHS Director Dr. Everett Rhoades stated that a few urban Indian health centers would probably be able to maintain their operations by utilizing other resources. However, most projects would have to close down, which would force many urban Indians to return to their reservations for health care, Rhoades said. In other instances urban Indians would receive no health care at all, he added.

The committee also expressed concern over proposed cuts in the IHS preventive health and sanitation facilities programs. Rep. Don Young (R-Alaska) contended that these programs have been especially important in reducing such health problems as tuberculosis among the Alaska Native population and he urged that they be continued.

Also testifying before the committee was Timm Williams, vice-chairman of the National Indian Health Board, who presented comments on behalf of NIHB, the National Congress of American Indians, and the National Tribal Chairmen’s Association.

Williams told committee members that IHS appropriations over the past three years have failed to keep pace with the high inflationary costs related to medical care, resulting in a serious decline in the agency’s capability to deliver quality health services. “Because of the decreased staff, unpurchased and unavailable equipment, and dangerously low supply levels, IHS’ professional staff have indicated that they are no longer able to provide the level and quality of health care which meets basic personal and professional standards,” Williams said.

As a result of this increasing pressure on IHS medical staff, health facilities, and other resources, Indian tribes are now being asked to consider major policy changes in their health programs, such as the institution of new eligibility requirements and the elimination of certain health services, he said. “The health care status of Indian people is the poorest in the United States,” Williams asserted, “and we simply cannot afford the cuts that would occur by reducing the service population or by eliminating specific services.”

Williams urged the committee “to continue its efforts to address the tremendous unmet health care needs of Indian people and to fulfill the intent of the Indian Health Care Improvement Act by providing the resources necessary to deliver quality care to all Native Americans.”

Addressing specific problem areas with the pro-
House, Senate Oversight
Reauthorization of 94-437

In what is likely to be one of this decade’s most important assessments of Indian health care needs, House and Senate congressional committees recently conducted the first of a series of field oversight hearings on the reauthorization of the Indian Health Care Improvement Act (P.L. 94-437). The Act, which was passed in 1976 and amended in 1980, expires at the end of fiscal year 1984.

More than 50 tribal representatives testified during two days of hearings in Albuquerque, N.M., and Phoenix, Ariz., on the reauthorization of the Act and other issues such as health services eligibility, contract health care, tribal contracting, emergency medical services, the establishment of a catastrophic health care fund, and the elevation of the Indian Health Service (IHS) within the Department of Health and Human Services. The Albuquerque hearing was held March 30 by the House Interior and Insular Affairs Committee, while the Phoenix hearing was conducted jointly the following day by the House Interior Committee and the Senate Select Committee on Indian Affairs.

Other field hearings, to be conducted by the Senate Select Committee, are tentatively scheduled in late May and early June for North Dakota, Montana, Alaska and possibly Washington state, with a final hearing planned for Washington, D.C. in mid-June for Administration witnesses.

The purpose of the hearings, according to House Interior Chairman Morris Udall (D-Ariz.), is to solicit comments from the Indian community about P.L. 94-437 programs and other major health concerns that will assist the committees in drafting a reauthorization bill. Udall said he intends to introduce the bill this summer, noting that Congress must take up the legislation this session in order to have the programs authorized in time for deliberations on the fiscal year 1985 budget.

As provided in the Act, Congress established a national goal of raising the health status of Indian people to the highest possible level while also encouraging the maximum participation of Indians in the planning and management of their health services. To this end, Congress enacted programs designed to increase the number of Indians in the health professions (Title I: Indian Health Manpower); eliminate backlogs in Indian health care services (Title II: Health Services); improve or construct Indian health facilities (Title III: Health Facilities); enable IHS to collect Medicare/Medicaid reimbursements (Title IV: Access to Health Services); and develop programs making health services more accessible to urban Indians (Title V: Health Services for Urban Indians).

In his opening remarks at the Phoenix hearing, Senator Barry Goldwater (R-Ariz.) stressed that the Act clearly represents the federal government’s responsibility of providing the best possible health care to Indian people. With the recent cutbacks made in reservation health programs, it appears the federal government is backing away from this responsibility, Goldwater said. He concluded that the reauthorization of the Indian Health Care Improvement Act is a necessary step for reasserting the federal government’s commitment to maintain and improve the health care of Indian people.

Expression of Federal Policy

Similar views on the need to reauthorize the Act were presented by virtually every tribal witness at the Albuquerque and Phoenix hearings. A number of witnesses particularly emphasized the importance of the Act as an expression of the federal government’s commitment to Indian people. Stated Southern Ute Tribal Chairman Leonard Burch: “The reauthorization of the Act will demonstrate to the American people that the national policy of the United States is to fulfill the special relationship, responsibilities, and legal obligations to Native Americans and to meet the national goal of providing the highest possible health status to Indians.”

Wendell Chino, chairman of the Mescalero Apache Tribe, added that “there is no question about the desperate need for the reauthorization of the Indian Health Care Improvement Act. Some progress has been made in meeting the goals of P.L. 94-437, but much work remains to be accomplished if this Nation is to fulfill its special responsibilities and legal obligations to the American Indian people. Only now is the United States beginning to scratch the surface of the huge backlog of unmet health needs of Indian people.”

While overwhelmingly supportive of the purpose and intent of P.L. 94-437, tribal representatives at both hearings repeatedly cited the lack of adequate funding as the major obstacle that has prevented the full implementation of the Act. Reflecting the comments made by many of the witnesses, Delfin Lavato, chairman of the All Indian Pueblo Council, stated that P.L. 94-437 “is the most significant congressional statement ever made about Indian health care. Unfortunately, the law has fallen far short of its intent because of inadequate appropriations. As a result, we are fighting many of the same health care battles we fought ten years ago.”

Funding for P.L. 94-437 programs has never approached the spending levels authorized by the Act. In its fiscal year 1984 budget, for example, the Administration has requested only $4.2 million for Title I programs compared to the $23.9 million authorized by the Act, and recommended eliminating funds for urban projects under Title V, which has an authorization level of $28.5 million. The administration also failed to request funds for the planning, renovation, and construction of Indian health facilities authorized by Title III.

In another budget-related item, a number of tribal witnesses expressed concern about Title IV provisions authorizing IHS to receive Medicare and Medicaid reimbursements for the purpose of maintaining accreditation standards at Indian health facilities. Despite a Title IV requirement that “any payments received for services to beneficiaries hereunder shall not be considered in determining appropriations for health care and
ght Hearings Examine Other Key Health Issues

services to Indians," the Administration has proposed offsetting IHS appropriations in fiscal year 1984 by some $40 million in Medicare/Medicaid collections.

Several tribal representatives criticized the Administration's proposal as "totally unrealistic" and contrary to the law's intent of supplementing IHS resources. Anthony Drennan, chairman of the Colorado River Indian Tribes in Parker, Ariz., urged the committees to include language in the reauthorization bill prohibiting the use of Title IV collections in such a manner. Drennan also presented figures showing that his service unit was able to keep less than half of the revenues it received in 1982 under Title IV, and he recommended that the Act be amended to insure that local facilities be allowed to retain all Medicare/Medicaid collections they receive.

Health Services Eligibility

In addition to testimony related to existing P.L. 94-437 authorities, witnesses at the Albuquerque and Phoenix hearings presented comments on a number of "emerging Indian health issues" that the committees may take up in the reauthorization bill.

A significant amount of attention was given to the issue of health services eligibility and the possibility of establishing new criteria for determining who should be served at Indian health facilities. There was no consensus among tribal representatives on this matter; some witnesses suggested that the existing federal regulations on eligibility were sufficient, while others cited the need for new eligibility standards.

AIPC Chairman Delfin Lavato noted that the question of eligibility is very sensitive to tribes and is sometimes seen as a threat to tribal sovereignty. "We don't like to talk about this. But during a time of limited resources the issue of eligibility must be addressed," he said. Lavato continued that the determination of who among the Indian population should receive federally-funded health services is best decided by tribal governments, and he recommended that tribes be allowed to set their own eligibility criteria.

Other witnesses called for a uniform set of eligibility requirements that would be applied throughout the entire Indian health program. Southern Ute Chairman Leonard Burch recommended that IHS-supported services be made available only to persons of Indian blood who are members of federally-recognized tribes, who live within a clearly defined IHS service area, and who formally enroll for IHS services. Limiting services to enrolled Indians would "assure that IHS services are actually provided to the population for which they were intended, thereby increasing the resources and the number of services available for eligible Indians," he explained.

Another approach to eligibility — requiring a minimum blood quantum — was favored by several tribal representatives. Under a proposal offered by Colorado River Indian Tribes Chairman Anthony Drennan, eligibility would be limited to members of federally-recognized tribes who are at least one-fourth Indian blood. If a tribe wanted to serve individuals with less than one-quarter degree Indian blood, it could charge a sliding fee for those services.

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CHS Task Force Report Receives Mixed Reaction at Hearings

A major federal report calling for sweeping changes in the Indian Health Service (IHS) was given mixed reviews from tribal representatives who testified at two recent congressional field hearings on Indian health care.

The report, prepared by the IHS Contract Health Services Task Force and distributed to tribal chairmen March 14, calls for a number of significant changes in three main areas: the determination of who is eligible for IHS services; the kinds of health care services that will be made available to those persons; and the manner in which those services will be administered.

In a letter accompanying the report to tribal chairmen, IHS Director Dr. Everett Rhoades stated that some of the recommendations "are controversial and would require major program changes." He urged tribal leaders to carefully review the proposed changes, particularly those dealing with health services eligibility and the recovery of charges from third party payers.

Composed of ten federal health administrators and two tribal chairmen, the task force was established last fall by Rhoades to address past criticisms of the IHS contract health services program, which augments the agency's system of direct and tribally-administered hospitals and health clinics. The group's examination of contract care issues eventually expanded to include fundamental issues involving the entire Indian health care delivery system. As a result, the task force report encompasses such issues as eligibility for services, medical priorities, resource allocation, and service delivery areas.

Study Reveals...

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common cause of infant death but its cause is not yet known. SIDS is not hereditary, and despite popular beliefs to the contrary, breast-feeding neither prevents nor reduces the risk of it occurring. Lammer's said epidemiology did not provide evidence indicating environmentally induced causes, nor was the sex of the infant a factor (of the crib death cases in the Pine Ridge area from 1977 to 1982, eight were male and nine were females). However, seasonal variation seemed to be a factor. Of the 17 SIDS cases from 1977 to 1982, 11 occurred in the months between November and April; six between May and October.

Studies show that parents are not at fault in "crib deaths" but are often treated as if they were criminals. In many communities crib death is viewed as suffocation, neglect, or deliberate infanticide. Fact sheets and other printed material are very helpful to parents of SIDS victims. Anyone interested in learning more about SIDS should contact the National SIDS Foundation (310 S. Michigan, Chicago, Ill. 60604, 312-663-0650) or the International Council for Infant Survival, Inc. (1515 Reisterstown Road, Suite 300, Baltimore, Md. 21201, 301-484-0111).

A number of tribal witnesses appearing before congressional committees in Albuquerque, N.M., and Phoenix, Ariz., testified on the task force recommendations. Opinions about the report varied, although there was general agreement about the need for tribal consultation before IHS officially acts on the recommendations.

Several tribes, such as the Papago and Ute Mountain, endorsed the task force report, contending that the proposed changes would strengthen program management and improve the delivery of services. Other witnesses were less supportive. Navajo Tribal Chairman Peterson Zah expressed strong concern about the proposed changes and requested that the report be tabled indefinitely until all tribes have had the opportunity to review it.

The most critical appraisal was offered by Anthony Drennan, chairman of the Colorado River Indian tribes, who called the report "nothing more than a termination plan." He particularly opposed the task force recommendation to establish a medical priorities list, stating that "medical services must be the last function of IHS to be prioritized. If, and when, that need arises tribal governments will decide on the priorities."

Implementation Plan

The task force recommendations are likely to draw additional attention from tribal representatives at upcoming Senate field hearings slated for May and June.

In the meantime, a group of IHS officials are preparing an "implementation plan" on the task force recommendations. According to Charles Erickson, Acting Director of the Office of Research and Development, who is heading up the group, the implementation plan will provide an analysis of the cost and impact of setting each recommendation in place. He added that the proposed implementation dates contained in the task force report, which projects that all recommendations could be in effect by October, 1983, are "totally unrealistic" and that a more reliable timeframe will be worked up by the group.

Briefly, the important recommendations developed by the IHS contract health service task force are:

Eligibility — IHS supported services would be provided only to persons of Indian blood (a) who are members of federally recognized tribes, (b) who live within a clearly defined IHS service area, and (c) who formally enroll for IHS services. These eligibility requirements would be adopted for all clinical services, whether IHS direct care or IHS contract care

Medical Priorities — National priorities would be established for clinical care which group services into five categories according to medical necessity. All IHS enrollees' needs for health services would be satisfied

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House, Senate...

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Drennan contended that without the blood quantum requirement IHS resources will gradually be shifted from reservation-based tribes with a blood quantum requirement for membership to tribes without such a requirement, leading to an inequitable distribution of Indian health resources.

The committees also heard numerous comments regarding a possible elevation of IHS within the Department of Health and Human Services (DHHS). Most of the witnesses supported such a move, claiming it would reduce certain management problems encountered by IHS as a result of having to deal with various levels of the DHHS bureaucracy. As expressed by Mescalero Apache Chairman Wendell Chino: "We have witnessed for many years the inability of the Director of IHS to make his way through the many layers of bureaucracy within DHHS. We strongly believe that the position of IHS Director should be elevated to that of an Assistant Secretary... (so) that he will be better able to comply with the mandates of Congress and carry out the trust responsibility to the tribes in a more efficient manner."

However, some tribal representatives were opposed to such a move, arguing that it would further remove the IHS central administration from the day-to-day operations of Indian hospitals and clinics. As an alternative, Judy Knight, treasurer of the Ute Mountain Tribe, suggested that more authority be provided to IHS service units to promote policy-making at the local level in cooperation with tribal governments.

Tribal witnesses addressed several other key health-related issues during the two days of hearings, including:

— the Administration's proposed transfer of IHS responsibility for sanitation facilities construction to the Department of Housing and Urban Development in FY 1984, which was strongly opposed by several witnesses

— the need for new funding authority for emergency medical services, contract health care, the Community Health Representative program, and tribal management (as well as extending existing authorities for P.L. 94-437 programs)

— the establishment of a centrally-administered catastrophic emergency fund to cover extremely expensive and unforeseen medical cases which presently deplete contract health care funds

— the need for a revised methodology for distributing IHS resources on the basis of need rather than program continuity.

Comments of witnesses at the Phoenix and Albuquerque hearings will be considered by the committees when they begin drafting legislation to reauthorize the Indian Health Care Improvement Act. The bill is expected to be introduced by July 1. Persons interested in obtaining information about specific times and locations for the upcoming Indian health oversight hearings should contact: Patricia Zeil; Senate Select Committee on Indian Affairs; Dirksen Senate Office Building; Washington, D.C. 20510. Phone: 202/224-2251.
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Proposed Indian health care budget, the testimony of the three national Indian organizations strongly criticized the Administration’s reliance on third-party reimbursements, calling the estimated $70 million target “clearly unrealistic.” With over $62 million of this projected amount assumed for use in the IHS budget category for “Hospitals and Clinics,” the national organizations predicted that the failure to recover these funds will result in a huge budget deficit and, consequently, threatens the overall quality of health care extended to Indian people at IHS and tribal facilities.

Also of major concern to the organizations is the Administration’s recommendation, for the second year in a row, to eliminate the Community Health Representative (CHR) program because it is “not central to providing medical services on reservations.” In rebuffing this contention, the organizations’ testimony cited a petition signed by nearly 300 members of the IHS National Council of Clinical Directors that claims “closing of the Community Health Representatives programs would have a severe negative impact on our ability to provide a comprehensive health program for the Indian people.”

According to the clinicians’ petition, the CHR’s play an integral part in the IHS direct care program through such activities as home visitations in remote reservation areas to provide direct care services; emergency medical care; health education; preventive health services; and overall support services at IHS and tribal clinics.

The organizations’ testimony urged the continuation of the CHR program at its current $29 million level ($25 million as a direct line item and an additional $4 million specified for emergency medical services) and recommended that the CHR budget be shifted from the “Preventive Health” category to the “Clinical Services” category, with its separate line-item status maintained.

The groups were further opposed to a recommended $1.5 million cut in the Indian health manpower program, which provides scholarship assistance to aspiring Indian health professionals. Arguing that under current trends “IHS will have virtually no health professional resources to draw upon by 1987,” the organizations stated that “this program is the most reliable source of future Indian health professionals and the best way to protect against manpower shortages in the years to come.” In addition to restoring $1.5 million to allow for new scholarships, the organizations requested that student recruitment programs, particularly the Indians Into Medicine (INMED) and the Master of Public Health programs, be continued at their 1982 levels.

The committee was also asked to reject the Administration’s proposed elimination of the urban Indian program. As noted by the national organizations, the Administration’s request is made “under the assumption that non-reservation Indians will be eligible for services funded with alternative resources, such as block grants...for health services. However, this has not been the case; state and local resources for health and social services have been rapidly diminishing and there is no reason to expect the situation to change in FY 1984.” The organizations recommended that urban Indian health program be funded at $9 million in 1984 to allow the existing 37 projects to continue their present operations.

The national organizations also recommended that:
— the committee oppose the Administration’s request to use $6.7 million in 1983 construction funds for the hospital at Browning, Mont., to partially cover pay increases for IHS employees in 1983
— the committee support the continued planning and construction of IHS hospitals, outpatient facilities, and personnel quarters. The Administration requested no funding for such activities in FY 1984
— the committee support an additional appropriations of $47 million to provide water and sanitation facilities for Indian homes and communities
— adequate funds be made available for indirect costs and employee cost-of-living increases for tribal health programs contracted under the authority of the Indian Self Determination and Education Assistance Act
— the committee continue its efforts to improve the existing IHS management structure to insure that health services are delivered to Indian people in the most cost-effective and beneficial manner possible
— the committee support a special line item for the operation of Indian health advisory boards in order to facilitate increased tribal and consumer involvement in the Indian health care program.

Congress will take further action on the Administration’s 1984 budget request in the months ahead. The House Interior Appropriations Subcommittee, following its review of recommendations from the Administration, tribes, and the House Interior and Insular Affairs Committee, which provides authorization levels for Indian programs, will issue its own budget recommendations in mid-summer. Following similar action by the Senate subcommittee, any differences between the two funding bills will be reconciled and the agreed-upon measure will be sent to the President for his signature.
Urban Indian Health Centers
Again Targeted for Cuts in ’84

For the past two years the Reagan Administration has proposed to cut funding for the urban Indian health program established under Title V of the Indian Health Care Improvement Act. Although Congress has refused to go along with these recommendations, the Administration has again requested the elimination of the urban Indian health program in FY 1984 under the assumption that non-reservation Indians will have access to health services funded with alternative resources, such as block grants to states. But in establishing Title V, Congress recognized that urban Indians — who make up approximately 50 percent of the American Indian population — experience a disproportionate problem of access to health services and that their health needs were not being met by other resources. The $8 million program presently helps support 37 health centers that provide urban Indians with a wide range of ambulatory, outreach, and referral services. In the following article, Eric Scigliano of The Weekly, a Seattle news magazine, examines some of the problems the Administration’s proposals have posed for the Seattle Indian Health Board, which provides health care services to the 14,000 Indians that reside in and around the city of Seattle.

SEATTLE, WASH. — For sheer dollar value, it’s a drop in the federal appropriations bucket. The federal Urban Indian Health Program had a budget last year of only $8.1 million — not enough, its supporters like to say, to run the Defense Department for 20 minutes. But this modest project has been the target of a determined, two-year attack by President Reagan’s Office of Management and Budget. The latest attack sparked a vehement response from urban Indian health supporters, and even drew former U.S. Senator Warren Magnuson from retirement to pitch for a program he helped create.

Urban Indian Health was saved from the obit lists for another year, but its eventual fate is still chancy. The fight over its appropriation resumes this year, and it is only a prelude to the big battle to come in 1984, when the law establishing the program comes up for renewal.

Already, the administration’s attack on Urban Indian Health demonstrates its willingness to make social policy, and to rewrite congressional mandates, through the budget process. The program was authorized by the Indian Health Care Improvement Act of 1976, which was amended and given a four-year extension in 1980. The Act noted that “inadequate, outdated, inefficient, and undermanned facilities” made it impossible for Native Americans, on and off the reservations, to get decent health care. It affirmed that such care was mandated by “the Federal Government’s historical and unique relationship with, and resulting responsibility to, the American Indian people.” The Indian Health Service was to meet this need by providing training and scholarship programs for Indian health professionals, and by upgrading those inadequate facilities. It specifically ordered that health services be made accessible to urban Indian people, with up to $15-million authorized for contracts to clinics and other local agencies in 1980.

The Act arrived at the crest of a wave of renewed federal commitment to assisting the tribes, a wave that had swelled through the Nixon and Ford administrations. And it accorded with what Columbia University historian Hazel W. Herzberg calls the relatively “good Indian record” of the Republican party, dating back to Lincoln and Teddy Roosevelt.

The Urban Indian Health program was also a belated corrective to the federal “relocation policy” of the 1940’s and 1950’s, under which an estimated 160,000 Indian people were moved from the reservations to the cities. The Seattle Indian Health Board estimates that 3,500 were relocated in the Seattle area in the latter phase, from 1965 to 1980, alone. The intent was to integrate Indians into the work force and lessen the reservations’ dependence on the government.

But the policy never achieved that goal. The ills of reservation life followed the relocatees to the cities, and

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Renewed Commitment to Indian Health

Johnson noted that significant progress has been made in reducing infant and maternal mortality rates, infectious disease, and other major health problems that were once common among the Indian population. Their infant-mortality rate is more than double the national average.

Of the estimated 17,000 King County Indians who lack the insurance or cash to pay for conventional medical treatment, over 14,000 are patients of the Seattle Indian Health Board, located next to the Seattle Public Health Hospital. The Health Board began as a shoe-string volunteer clinic, meeting in Public Health's hallways, five years before the Indian Health Care Improvement Act was passed. Today, it is one of the largest and highest rated of over 30 Urban Indian Health centers in the nation. It offers not only general medical, dental and optometric services but also specialized mental-health and alcoholism treatment.

The Reagan Administration argues that these services duplicate those already available to all the poor. Nevada Senator Paul Laxalt, a close Reagan ally, summed up the argument: "Those Indians who are affected by the program will have adequate access to other federally funded health-care services."

But JoAnn Kaufman, executive director of the Seattle Indian Health Board, argues that any apparent savings in cutting this program are illusory, since Reaganomics has already eliminated any excess local capacity in free medical services. "The local facilities are simply not able to take in 14,000 more indigent patients," she explains. "There used to be four community health clinics getting over $2-million from the federal government. Now there are two getting $1-million. The reality is that specialists and physicians are not opening their offices to them."

WASHINGTON, D.C. — Recent improvements in the health care status of American Indians and Alaska Natives are on the verge of being wiped out due to critical problems with the funding and management of Indian health programs, according to former Indian Health Service Director Dr. Emery Johnson.

Appearing as a special witness before the House Interior and Insular Affairs Committee here March 1, Johnson noted that significant progress has been made in reducing infant and maternal mortality rates, infectious disease, and other major health problems that were once common among the Indian population. However, he continued, this progress could be halted and even reversed unless substantial changes are made in the IHS program.

Johnson, who served for 12 years as IHS director before retiring in 1981, addressed two major areas of concern with the Indian health care program. Regarding the first, which involves the extent of the federal government's commitment to Native Americans and their health needs, Johnson said that landmark legislation of the 1970's (the Indian Health Care Improvement Act and the Indian Self Determination Act) firmly established the federal responsibility for providing the necessary resources to deliver quality health care to Indian people and for supporting opportunities for tribes to manage their own health programs.

"Unfortunately," Johnson testified, "the tangible actions of the federal government have not matched the vigor of its words." Administration budget recommendations for IHS in recent years have eroded the federal government's commitment to Indian health care by forcing the agency and tribes to "absorb" numerous costs related to unrealistic assumptions about the medical inflation rate and other aspects of the IHS program.

Pointing to the Administration's 1984 budget request as an example, Johnson told the committee that "the budget you have before you is replete with assumptions that have very little substantive basis." Congress is unlikely to take up new legislation to permit IHS collections from private insurance companies, Johnson contended. "Nevertheless, $30 million of the funds needed to pay for doctors, nurses, support staff, and medical supplies is based on that kind of assumption," he said.

IHS budget inadequacies in recent years have also led to a reluctance among tribes to contract for their own health programs. "The reason is obvious," Johnson stated. "What responsible tribal leader would advocate taking over an underfunded and probably declining health operation?"

Johnson complimented Congress for taking "a more serious view of the federal commitment" to Indian health care by increasing these budgets in the annual appropriations process. However, he added, "we're getting to the point where Congress is being required to correct far too many errors and oversights" in the Administration's budgets.

Addressing his second area of concern, Johnson stated that "complex layers of management in the Department of Health and Human Services and the low status — both of organizational level and of attention — given to IHS" have seriously impaired the agency's ability to effectively manage its health programs. As an example, Johnson told the committee about one IHS document that was reviewed by 38 individuals in the
As evidenced by the FY 1984 budget proposal for the Indian Health Service, Administration budget officials are clearly opposed to the planning and construction of Indian hospitals, clinics, and sanitation facilities for Indian homes. Not only has the Administration refused to recommend funding for hospital construction in FY 1984 — it has requested that $6.7 million appropriated by Congress in 1983 for the hospital in Browning, Mont., be rescinded and used to help cover pay raises for IHS employees. Congress soundly rejected a similar appropriation for a much more responsible approach to the construction of Indian health facilities.

Among the tribes that have been hurt as a result of the Administration's stand on hospital construction is the Rosebud Sioux in South Dakota. Although Congress appropriated planning and design monies for a much-needed new hospital on the Rosebud Reservation last year, a series of Administration delays has set the project far behind schedule. According to Tribal President Carl Wain, "The Rosebud Sioux people are faced with documented, exceptionally poor health, a half-condemned hospital, a very limited access to care anywhere else. The promise of a new IHS hospital has been held out for more than 10 years now with no tangible results." Washington Post columnist Colman McCarthy recently took the following insightful look at the health care plight of the Rosebud Sioux people and, particularly, their need for a new hospital.

Beneath the insults leveled at Indians by James Watt, and his later apologies for his grossness, lies at longer-running, less noticed and more damaging assault. Watt will pass from power soon enough, but the sufferings of Indians were here well before the Reagan administration and promise to persist long after.

Few stories better illustrate the victimization of Indians than that of the Sioux tribe's 20-year effort to get a new hospital on its Rosebud reservation in South Dakota. The story involves the value of several doctors and nurses who refuse to be demoralized, the helplessness of public health officials to convince the Reagan administration that budget cuts are destroying Indian lives and the reality that the health of Indians, already bad, is worsening.

The 8,000 Rosebud Sioux live in a county rated among the nation's 10 poorest. Three other South Dakota counties, all with Sioux, are also in the bottom 10. The tribe's average family income is about $30 a week. Unemployment ranges from 80 to 90 percent.

Medically, the reservation has similarities to a death camp. Mortality rates are more than twice the U.S. average. In a recent two-year period, 11 percent of Rosebud Sioux deaths were of infants. For the rest of the United States, the figure was less than 3 percent. Tuberculosis rates there are the highest in the country.

The fear of death and disease is so great that the tribe lists the absence of health care as its severest problem. The fear is not new. In 1972 the Indian Health Service, now a part of the Department of Health and Human Services, announced plans for a small hospital meant to replace an antiquated facility. One wing, built in 1915, has been condemned as a firetrap.

When announced in 1972, those plans were seen as 10 years late. This year, with construction already a decade behind schedule, the plans remain only plans: No construction money for a new Rosebud hospital is in the 1983 federal budget.

Even if this crisis were somehow miraculously resolved and the hospital immediately built, getting doctors, nurses and health care workers to the reservation would remain the permanent crisis. At times, the low salaries, poor working conditions and lack of support from officialdom in Washington have created turnstile medicine: in 1981 more than 100 doctors worked temporarily in seven physician slots. Indian Health Service nurses begin at $12,000 a year, a third less than the salaries of South Dakota's private nurses.

Without overblowing it, it takes medical heroism and moral courage to be a health care worker at Rosebud. Few better exemplify these virtues than Dr. Clark Marquart, a 35-year-old general practitioner who is the medical director of Indian Health Management, a

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their doors to those who can't afford to pay. The cut would have driven many people back to the reservation and created a big burden on emergency rooms."

Horror stories abound of Indians turned away from hospitals in the bad old days because they were poor or "difficult." Ironically, the growth of the Indian Health Service may have reinforced the assumption in mainstream facilities that Indians can always be treated elsewhere. Gordon Jackson, research director for the Alaska Native Foundation in Anchorage, flew his father down here in a desperate search for treatment for kidney and pancreas failure. The Seattle center was "swamped," says Jackson, but tried to help find a hospital. Seattle and Tacoma hospitals rejected his father, by now "half past dead," because he lacked insurance. Finally, after a day's agonizing search, his father was admitted to Puget Sound Hospital, where he died soon after.

"What's frightening," says Kauffman, "is that you've got direct threats to life from (cuts in) the federal budget." In the short term, those threats have been forestalled. Under pressure from a phalanx of outraged supporters (which included Seattle's mayor and Washington's Republican senator) Senate Interior appropriations subcommittee chairman James McClure and his House counterpart, Sidney Yates, reached a compromise of $6-million. Thanks to a carryover from the 1982 budget, the compromise appropriation will mean full funding for programs like Seattle's in 1983. Four other marginal centers are now slated for closing, which will help Urban Indian Health show the most efficient possible face in 1984, when it comes up for reauthorization. Clearly, it will need all the help it can get.
**Former IHS...**

*Continued from Pg. 14*

bureaucracy between IHS and the Office of the Secretary. “One wonders about the possible contribution that many people can make. One thing is certain — much of the reality of the needs of Indian people is lost in the translation,” Johnson asserted.

To address the problems identified in his testimony, Johnson recommended that Congress first examine the adequacy of funding levels for fiscal years 1983 and 1984, and that legislative language be developed to assure that Administration directives — such as personnel freezes, ceilings, and administrative reviews — do not frustrate the “will of Congress” in providing adequate health care to Indian people.

Moreover, “Congress must come to grips with the size and scope of the federal commitment to Indian health,” Johnson said. He suggested that Congress consider identifying an enrolled population that would be eligible for a defined scope of services, which would help eliminate many of the uncertainties about the IHS program.

As a final recommendation, Johnson asked the committee to consider elevating IHS to the Assistant Secretary level within DHHS, a position similar to the Bureau of Indian Affairs within the Department of Interior. This would “help alleviate many of the management problems of IHS by eliminating much of the bureaucratic layering in DHHS and by permitting the IHS Director access to the decision-making level of the Department,” Johnson concluded.

**Rosebud Tribe...**

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nonprofit group on the reservation. Were he like many doctors, he would have taken a quick look at the near-hopelessness of the enduring misery among the Sioux and headed for a suburban practice that could double or triple his salary for half the work and a 10th of the frustration.

Marquart somehow slipped through medical school with his beliefs and zeal intact. They have sharpened since. Marquart came to Rosebud in 1974 after an internship in Denver. He stayed for 18 months and then left to serve among the Indians in Washington state. He returned to the Sioux in January 1981.

“I still have bruises from beating my head against the wall the last time I was here,” Marquart wrote in a letter to me. “But when I returned to Rosebud two years ago, problems at the IHS hospital were far worse than when I left. The hospital has some excellent doctors and nurses on its staff right now. What the reservation has never seen, however, is a level of medical resources remotely approaching the level of need.”

Severe poverty is found on every Indian reservation. The story of Rosebud differs because in addition to the strains of high rates of death and disease there is the psychological torment: Washington — Congress, public health officials, budget makers — is aware of the misery and has said, through the announced plans for a new hospital, that help is on the way. It just hasn’t said when.

The Sioux dangle.

Indians have always been able to claim, with strong reason, that the white man speaks with a forked tongue. For the Rosebud Sioux, now there is not even double talk. Only silence.

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