Congress Restores FY '84 IHS Funds for CHR's, Urbans, Construction

WASHINGTON, D.C. — For the second straight year Congress has rejected Administration recommendations to eliminate major Indian health programs for Community Health Representatives (CHR's), urban Indian health care, and health facilities construction. On October 20 the Senate gave final approval to the Interior Appropriations Act of 1984, which includes funding for the Indian Health Service (IHS). President Reagan signed the measure into law November 4.

Under terms of a six-week “continuing resolution” that became effective October 1, the beginning of fiscal year 1984, IHS has been operating at the spending levels established in the Interior Appropriations Act. As provided in the law, those figures are $770,408 million for health services and $53,595 million for facilities construction. The total IHS appropriation, $824 million, is $72 million more than the FY 1983 IHS budget and $172 million higher than the Administration's request for FY 1984 (see chart for budget comparison).

Among the important items included in the IHS appropriation are $30 million for the CHR program ($26 million as a direct line item and $4 million provided in clinical services for CHR emergency medical technicians), $9 million for urban Indian health centers, and the $53,595 million for planning and construction of Indian hospitals, outpatient clinics, personnel quarters, and sanitation facilities. The Administration earlier this year asked for the elimination of all these programs.

Congress also decided against the Administration's request to offset the IHS appropriation with a projected $67 million in reimbursements from Medicare, Medicaid, and third-party payors. The appropriations act will enable IHS to use these collections, which will likely be substantially less than the Administration's estimate, as a budget supplement to maintain quality standards at Indian health facilities.

One significant change that may affect some tribes' collection of additional health revenues is a provision to allow non-Indian patients to be treated in all IHS facilities. However, according to a House-Senate conference report, health care to non-Indians “shall be extended only if approved by the affected tribe(s) and such care shall be subject to reasonable charges to be established by the Secretary.”

Continued on Pg. 2

REAUTHORIZATION OF THE Indian Health Care Improvement Act (PL 94-437) was the primary focus of an oversight hearing conducted by the Senate Select Committee on Indian Affairs July 29 in Washington, D.C. Senator Slade Gorton (R-Wash.), second from left, and Committee Chairman Senator Mark Andrews (R-N.D.), third from left, both cited the need for extending the provisions of the Act, which expires in 1984. Also pictured are committee staff person Patricia Zell (far left) and committee staff director Paul Alexander (far right). Reauthorization bills are expected to be introduced shortly in both the House and Senate. See pg. 6 for related story.
Congress Restores...

Continued from Pg. 1

With respect to the Administration's proposal to charge Indian patients for their health services, the appropriations act permits IHS service units which currently bill Indians to continue this practice, but it prohibits any further action by IHS to initiate such a policy.

As in past years, IHS' contract care program drew special attention in the act, which requires IHS to "establish reasonable rates for contract care payments in place of the current system which generally pays 100 percent of billed charges." The Senate Interior Appropriations Subcommittee, citing a General Accounting Office report, earlier this year predicted that IHS could save approximately $20 million by adopting medicare payment rates. The Senate subcommittee also requested IHS to examine the feasibility of using an intermediary, or fiscal agent, to process contract care claims. The IHS report is due next spring.

In the area of health facilities construction, the conference report states that the committees are "extremely concerned with the failure of the Department to release funds for the planning of the Rosebud hospital, which were appropriated in fiscal year 1982. As a result of the Department's failure to proceed with the planning, the managers have had to delete the funds for initial construction, with great reluctance..." The report directs the Department to release the Rosebud planning funds within 45 days of the law's enactment.

Health facilities monies included in the act are for: construction of hospitals at Crownpoint, N.M., Kanakanak, Alaska, and Browning, Mont.; planning for hospitals at Pine Ridge, S.D. and Anchorage, Alaska; modernization and repair of the hospital at Lawton, Okla.; planning for outpatient clinics at Kyle, S.D., Ft. Thompson, S.D., Wolfpoint, Mont., and Wagner, S.D.; and construction of personnel quarters at Browning, Mont.

---

**INDIAN HEALTH SERVICE BUDGET**

($ In Thousands)

<table>
<thead>
<tr>
<th>Health Services</th>
<th>1983 Appropriations¹</th>
<th>President's 1984 Request</th>
<th>House</th>
<th>Senate²</th>
<th>1984 Appropriation²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Services:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals &amp; Clinics</td>
<td>$335,562</td>
<td>$349,093</td>
<td>$411,554</td>
<td>$386,892</td>
<td>$397,700</td>
</tr>
<tr>
<td>Dental</td>
<td>21,054</td>
<td>19,487</td>
<td>21,767</td>
<td>23,190</td>
<td>23,940</td>
</tr>
<tr>
<td>Mental Health</td>
<td>8,721</td>
<td>7,870</td>
<td>11,194</td>
<td>9,391</td>
<td>10,891</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>21,207</td>
<td>19,182</td>
<td>20,182</td>
<td>23,469</td>
<td>23,469</td>
</tr>
<tr>
<td>Maintenance &amp; Repair</td>
<td>8,267</td>
<td>8,267</td>
<td>8,267</td>
<td>18,267</td>
<td>18,267</td>
</tr>
<tr>
<td>Contract Care</td>
<td>139,972</td>
<td>139,223</td>
<td>165,427</td>
<td>150,000</td>
<td>157,927</td>
</tr>
<tr>
<td><strong>Preventive Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanitation</td>
<td>16,530</td>
<td>15,223</td>
<td>20,978</td>
<td>16,502</td>
<td>16,502</td>
</tr>
<tr>
<td>Public Health Nursing</td>
<td>9,009</td>
<td>7,573</td>
<td>10,861</td>
<td>10,002</td>
<td>14,774</td>
</tr>
<tr>
<td>Health Education</td>
<td>2,566</td>
<td>2,106</td>
<td>3,616</td>
<td>2,680</td>
<td>2,680</td>
</tr>
<tr>
<td>CHR's</td>
<td>25,000</td>
<td>-</td>
<td>27,500</td>
<td>25,000</td>
<td>26,000</td>
</tr>
<tr>
<td>Immunization</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Urban Health</td>
<td>6,000</td>
<td>-</td>
<td>9,000</td>
<td>-</td>
<td>9,000</td>
</tr>
<tr>
<td>Indian Health Manpower</td>
<td>5,760</td>
<td>4,232</td>
<td>5,832</td>
<td>6,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Tribal Management</td>
<td>2,634</td>
<td>2,634</td>
<td>3,134</td>
<td>2,634</td>
<td>2,634</td>
</tr>
<tr>
<td>Direct Operations</td>
<td>53,942</td>
<td>54,624</td>
<td>59,624</td>
<td>59,624</td>
<td>59,624</td>
</tr>
<tr>
<td>Equity Health Care Fund</td>
<td>22,492</td>
<td>22,492</td>
<td>27,362</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reduction By Collection</td>
<td>(5,000)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Subtotal, Health Services</strong></td>
<td>679,216</td>
<td>652,506</td>
<td>801,798</td>
<td>734,651</td>
<td>770,408</td>
</tr>
<tr>
<td><strong>Indian Health Facilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals, New &amp; Replacement</td>
<td>6,700</td>
<td>-</td>
<td>36,695</td>
<td>25,004</td>
<td>25,805</td>
</tr>
<tr>
<td>Hospitals, Planning &amp; Design</td>
<td>-</td>
<td>-</td>
<td>1,360</td>
<td>-</td>
<td>3,360</td>
</tr>
<tr>
<td>Outpatient Facilities, Planning &amp; Design</td>
<td>-</td>
<td>-</td>
<td>760</td>
<td>-</td>
<td>760</td>
</tr>
<tr>
<td>Modernization &amp; Repair</td>
<td>3,944</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Sanitation Facilities</td>
<td>49,056</td>
<td>-</td>
<td>30,000</td>
<td>3,715</td>
<td>21,000</td>
</tr>
<tr>
<td>Personnel Quarters</td>
<td>14,000</td>
<td>-</td>
<td>2,470</td>
<td>2,470</td>
<td>2,470</td>
</tr>
<tr>
<td><strong>Subtotal, Health Facilities</strong></td>
<td>73,700</td>
<td>200</td>
<td>69,015</td>
<td>31,389</td>
<td>53,595</td>
</tr>
<tr>
<td><strong>Total, Indian Health</strong></td>
<td>$752,916</td>
<td>$652,706</td>
<td>$870,813</td>
<td>$766,040</td>
<td>$824,003</td>
</tr>
</tbody>
</table>

¹Includes FY '83 Supplemental Appropriation, 1983 Pay Act and 1983 "Jobs Bill" funds.
²Equity Health Care Fund is provided in other "Health Services" line items.

(EDITOR'S NOTE: This chart is based on our analysis of 1984 IHS Appropriation. The figures may differ slightly in other presentations due to different accounting formats.)
Health News Across The Nation

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.

ALBUQUERQUE, N.M. — The Albuquerque Indian Health Board (AIHB) has established a special fund for contributions toward the reconstruction of the Alamo Navajo outpatient clinic, which was destroyed by fire in early July. The tragedy occurred only days before the newly-constructed clinic was scheduled to receive its first patients. Located approximately 100 miles southwest of Albuquerque, the Alamo Navajo Chapter is so remote that its only means of communication to neighboring towns is a single mobile phone. "We came so close to having the clinic that we desperately need, that our people's expectations were already raised," said Chapter President Jesse Apachito. "Now we must meet those expectations." Alamo craftspeople have offered their skills to help reconstruct the building, and chapter officials are seeking funds, materials, and technical assistance for the project. Persons interested in contributing to this effort, or who would like additional information, should contact: Albuquerque Area Indian Health Board; 3939 San Pedro, N.E.; Building F, Suite B; Albuquerque, N.M. 87110. Phone: (505) 881-6900.

PORTLAND, ORE. — Twenty-four Indian students from Northwest Tribes were awarded certificates this summer for successfully completing the 4th Annual Summer Enrichment Program sponsored by the Northwest Portland Area Indian Health Board (NPAIHB). The students, who hope to pursue health careers, took university classes in chemistry, writing, and math, and took part in various health professions programs. For most of the students it was their first time away from home, and offered them a brief look at the rigors of college studies. The NPAIHB Summer Enrichment Program is held each year to help prepare selected Northwest Indian students begin careers in the health professions.

DALLAS, TEXAS — Indian health issues related to diabetes and maternal and child care will be among the many important topics addressed at the 111th Annual Meeting of the American Public Health Association (APHA), to be held here November 13-17. APHA, the country's largest health organization with more than 50,000 members, has selected the theme "Science and Social Action for Health and Peace" for its meeting. The Indian committee of APHA, the American Indian/Alaska Native Caucus, will sponsor three technical meetings: "American Indian/Alaska Native Maternal and Child Health: Issues, Problems, and Progress;" "Diabetes Research, Treatment and Education Among Native Americans;" and "American Indian Health: Contributed Papers." The three Indian health sessions will feature presentations on such topics as parenting, Sudden Infant Death Syndrome, Fetal Alcohol Syndrome, diabetes control and prevention, health education, and major changes facing the Indian Health Service. According to chairperson Margo Kerrigan, the APHA American Indian/Alaska Native Caucus is committed to promoting improved research and

Continued on Pg. 4
The National Indian Health Board was saddened by the sudden and unexpected death of Senator Henry M. Jackson September 1. Senator Jackson was an unusually strong leader and legislator who had the courage and commitment to play a key role in federal-Indian relations. He sponsored several important bills, beginning with a measure that repudiated termination of tribes as a federal policy, Senator Jackson was also instrumental in securing the passage of the Indian Self Determination Act and the Indian Health Care Improvement Act.

Although in recent years Senator Jackson did not serve on major Senate committees dealing with Indian legislation, he maintained his interest in Indian policy issues and Indian health care. Senator Jackson will long be remembered as a giant in the Senate and as a friend of Indian people. We will miss him very much.

Health News...

Continued from Pg. 3
understanding of Indian health issues; affecting national policies to improve health care systems for American Indians and Alaska Natives; and furthering Indian involvement in the planning and delivery of health services to tribes and Indian communities.

***

PARKER, ARIZ. — Under a $440,000 grant from the Department of Housing and Urban Development (HUD), the Colorado River Indian Tribes (CRIT) will soon be able to make much-needed improvements to the Indian Health Service hospital here. The grant, awarded as part of HUD's Community Development Block Grant program, provides building funds that "will make our hospital a lot more functional," says Bob Crawford, CRIT health administrator. Planning and construction of the project will be carried out by the tribes, he said. Crawford added that the local Indian community is excited about the prospect of renovating the facility, especially since it was nearly shut down last year as part of the federal government's "small hospital" initiative. "This represents a 180-degree turnaround for us," Crawford said. "We're very proud about what we've accomplished."

***

ROCKVILLE, MD. — A nationwide search has been initiated by the Indian Health Service (IHS) to identify candidates for the agency’s vacant position of Deputy Director. An IHS search committee, chaired by Aberdeen IHS Director Eleanor Robertson, has been established to coordinate activities for advertising and filling the position. "We encourage as many qualified people as possible to apply," says Robertson. An official announcement will be distributed in mid-December, and Indian preference will be observed in the selection process, she said. The Deputy Director vacancy was created following IHS administrative changes in which former Deputy Director Dr. Joseph Exendine assumed the duties of Director, Division of Indian Community Development, and Dr. John Todd, former Director of Program Operations, was named Acting Deputy Director.

OMB Official Responds to Indian Billing, ‘Means Test’ Issue

Several months ago we published a report (Vol. 3, No. 5, pg. 1) about a proposal by the Office of Management and Budget (OMB) to bill Indians for health services, a proposal that has since been repudiated by Congress and DHHS officials. Because of several concerns raised about our article, we contacted the Office of Management and Budget and invited an official there to further discuss the billing proposal, as well as other issues related to the Administration’s 1984 budget request, in our newsletter. We received the following response from Edwin L. Dale, Jr., Assistant to the Director for Public Affairs for OMB.

Dear Editor:

The President’s FY 1984 Budget requests $720 million to continue funding for the traditional Federal role in delivering health care to the Indian people. The provision of basic inpatient and outpatient medical services will continue as the highest IHS priority.

With regard to the article’s reference to a means test, I can assure you that the President’s Budget does not assume such an approach for receipt of IHS services. Rather, our proposal represents a major initiative and emphasis to increase collections for health services from insurance and other third-party payors. These additional collections will result in increased IHS flexibility to maintain existing health services despite the rising costs of medical care. Such additional support will strengthen efforts to improve the health status of the Indian people, while assuring that third-party payors reimburse for covered health services provided to Indians.

Both HHS and the IHS are working to develop the most efficient and effective ways to implement this policy for FY 1984. At the same time, I wish to emphasize that implementation of efforts to strengthen IHS financing resources will not change current policies for delivering health care. Indians will continue to be served by IHS regardless of their ability to pay.

With regard to the Community Health Representative (CHR) Program, I certainly agree that the program was created as part of a general effort to expand health services to Indian people. As a corollary, the program of course has supported employment for the CHR representatives.

Thank you again for the opportunity to clarify the Administration’s policy for strengthening the IHS.

Sincerely,

Edwin L. Dale, Jr.
Assistant to the Director for Public Affairs, OMB

(EDITOR’S NOTE: The $720 million FY 1984 budget amount identified in Mr. Dale’s response differs from the $652 million cited as the Administration’s request elsewhere in this newsletter. The difference results from the inclusion of nearly $70 million in third-party collections—a fundamental assumption of the Administration’s budget—in Mr. Dale’s figure. The $652 million figure excludes these collections.)
NIHB Urges Impact Analysis of CHS Task Force Report

ALBUQUERQUE, N.M. — The National Indian Health Board (NIHB) recently joined the ranks of tribes and Indian organizations that have expressed concern over a federal report calling for major changes in the Indian health care delivery system.

The report, issued last January by the Indian Health Service (IHS) Task Force on Contract Health Services, contains statements and recommendations on the legal status of IHS, health services eligibility, medical priorities, resource allocation, third party billing, and a number of technical administrative matters. Distributed to tribes and Indian organizations in March, the task force's report has been roundly criticized, particularly during this summer's House and Senate oversight hearings on Indian health care, for being developed and implemented without adequate tribal involvement.

Charging that the report's recommendations "represent a major and basic restructuring of the IHS delivery system," NIHB representatives urged that any further action on the report be delayed "until a responsible and acceptable methodology is developed ... to allow for full tribal consultation and review."

The board adopted its position on the task force's report during a busy meeting here July 19-21 in which NIHB members also developed recommendations for reauthorization of the Indian Health Care Improvement Act; heard several informative presentations from tribal council members, tribal health officials, federal administrators, and nutrition experts; worked on a long-range "program plan" that spells out NIHB's future goals and objectives; and elected new corporate officers for the coming year.

In its review of the CHS task force report, NIHB took strong exception to the task force's position regarding IHS' status as the "last health resource for Indians," which states that "as a matter of departmental policy, IHS services are 'residual' to other health care delivery systems and health care payment mechanisms." The report also cites the Snyder Act of 1921, the basic IHS authorizing legislation, for establishing IHS "as a discretionary program, not a program entitling eligible Indians to specific services."

Asserting that it "strenuously objects" to the task force's statements, NIHB maintained that "it is our position that this is an incorrect interpretation of the intent of the Snyder Act of 1921." Subsequent legislation, such as the Indian Self Determination Act (P.L. 93-638) and the Indian Health Care Improvement Act (P.L. 94-437), and federal court decisions substantiate the congressional intent toward the provision of health services to Indians, the board stated.

NIHB agreed with the task force's view that the availability of IHS services does not preclude the eligibility of Indians for services under other programs. But, the board added, Indian people "should not be required to seek alternate resources before becoming eligible to receive IHS services. We recommend that . . . the Administration recognize (its) responsibility in the provision of comprehensive health care services, and that the IHS be considered the primary provider of health services to Indian people."

Another task force recommendation addressed by the board deals with the sensitive question of eligibility for IHS services. The task force recommended that

Continued on Pg. 8

FORMER NIHB CHAIRMAN Tony Secatero illustrates a point during the Board's Albuquerque meeting July 19-21. Secatero stepped down from the NIHB chairmanship following two busy years at the organization's helm. Secatero was recently elected chairman of the Canoncito Band of Navajos.
Indian Groups Cite Need for IHCIA Reauthorization

WASHINGTON, D.C. — Over the next few months Congress will begin deliberation on one of the most critical legislative initiatives ever introduced affecting the delivery of health services to American Indians and Alaska Natives.

The initiative, a soon-to-be-introduced bill to reauthorize the Indian Health Care Improvement Act (P.L. 94-437), has been the primary focus of a five-month series of House and Senate committee oversight hearings on Indian health care. Recommendations made by tribes, Indian organizations, and other representatives from the Indian community will serve as an important guide to the committees in drafting a reauthorization bill.

At the most recent of the Indian health oversight hearings, the Senate Select Committee on Indian Affairs heard testimony here July 29 from national Indian organizations, including a joint presentation by the National Indian Health Board (NIHB) and the National Congress of American Indians (NCAI), supporting reauthorization of most existing P.L. 94-437 provisions and recommending adoption of several amendments to improve the Act.

Also appearing before the committee were Dr. Robert Graham, administrator of the Health Resources and Services Administration (HRSA), and Dr. Everett Rhoades, director of the Indian Health Service (IHS). Graham told the committee that the Department of Health and Human Services (DHHS) is presently evaluating P.L. 94-437 programs, and a decision on whether or not to support their reauthorization will not be made until the evaluation is completed. The Department's determination might not be reached until after the committee's reauthorization bill is introduced, Graham said.

Although the testimony of Graham and Rhoades failed to shed any light on the Administration's position regarding the reauthorization of P.L. 94-437, their responses to committee questions helped clarify several other Indian health-related issues, including:

- **billing Indians for health services** — The prospect of Indians being billed for their health services was raised earlier this year in a memorandum from Office of Management and Budget Director David Stockman, which stated that IHS funding in FY 1984 "is to be supplemented with charges to individuals" and that IHS "would operate in the manner of a county hospital — with public funds being the source of health care financing for those without resources." Graham stated emphatically that the Department does not support such a policy. He noted that both the House and Senate appropriations bills for FY 1984 "make it very clear that we are not to bill Indians, and it is not our intent to bill Indians." However, Graham added, "we do not feel that we are prohibited from submitting bills to insurance companies" for Indians with private health coverage, and he indicated that such billing would commence in FY 1984.

- **eligibility** — The need for establishing new eligibility requirements for IHS-funded services has been raised frequently over the past year by tribes, IHS officials, and a presidential commission on cost containment. On June 6, HRSA published two notices in the Federal Register soliciting comments on health services eligibility and eligibility verification. Although a July 20 deadline was set for responses to the Federal Register notice, Graham indicated that the comment period would remain open to permit consideration of as many replies as possible. "We are not under any time constraints or administrative constraints to change IHS eligibility requirements by a certain date," he said. "On this particular issue I would say we are a substantial distance down the road from any change."

- **contract health services task force** — Numerous tribes and Indian organizations have expressed concern that HRSA is moving too quickly to implement recommendations made by the IHS Task Force on Contract Health Services, which call for fundamental changes in eligibility, medical priorities, resource allocation, payment policy, and other aspects of the Indian health program. Graham assured the committee that HRSA is seeking tribal comment on the report and any major policy change recommended by the task force, if implemented, would be carried out in consultation with tribes.

- **physician recruitment and retention** — Committee Chairman Sen. Mark Andrews (R-N.D.) said he was disturbed about several "horror stories" regarding the medical treatment received by some Indian patients and questioned whether IHS adequately scrutinizes physicians' training background and skills. "Are we using Indian reservations as a dumping ground for people with M.D. diplomas who are really not doctors?" he asked. Graham responded that questionable medical practices "would be of absolute concern to anyone in the Indian Health Service and anyone in the medical profession." He explained that IHS maintains "an elaborate and very effective process of peer review" to ensure high medical standards. And, according to Rhoades, IHS uses a detailed screening process in recruiting physicians into the Indian health program.

Andrews also voiced concern over the shortage and high turnover rates of IHS physicians, particularly in the Aberdeen area. As a possible solution to such problems, Andrews pointed to the Indians Into Medicine (INMED) program at the University of North Dakota, which recruits and assists Indian students interested in medical school. He called the program "one of the best ways for training doctors who understand Indian people and who have a desire to go back to the reservation to serve." Rhoades agreed, and said he would like to replicate the success of the INMED program in other parts of the country.

Continued on Pg. 7
Indian Groups...

Continued from Pg. 6

- hepatitis B — Sen. Frank Murkowski (R-Alaska) posed a series of questions related to IHS’ three-year program to treat Alaska’s hepatitis B epidemic, which he called “the number one medical concern in Alaska.” Murkowski suggested that changes are needed in the immunization program in order to improve its effectiveness. In response, Rhoades stated that a meeting of scientists specializing in diseases of the liver, planned for Anchorage early next year, will evaluate the hepatitis B immunization effort and recommend whether alterations should be made in the program.

Reauthorization Bill

Testimony presented by other witnesses at the hearing primarily addressed the reauthorization of P.L. 94-437 programs. As provided in the original Act, Congress set a national goal of raising the health status of Indian people to the highest possible level while also encouraging maximum participation of Indians in the planning and management of their health services. The Act provided authority for programs to help correct physical deficiencies and staffing inadequacies in Indian health facilities and eliminate the excessive backlog of unmet Indian health care needs.

One P.L. 94-437 program that may encounter difficulty in the reauthorization process is the provision for urban Indian health projects under Title V, which the Administration has attempted to abolish for the past three years. In his opening statement at the Select Committee hearing, Sen. Slade Gorton (R-Wash.) called the urban health program “necessary, effective, and efficient.” He stated that he was especially impressed with the services and treatment provided by the Seattle Indian Health Board, which serves some 14,000 Indians in the Seattle area. In addition, two of Gorton’s colleagues that testified separately before the committee, Sen. Rudy Boschwitz (R-Minn.) and Sen. Don Nichols (R-Okla.), commended the success of urban Indian projects in Minneapolis and Tulsa, and urged the committee to include Title V in its reauthorization bill.

JoAnn Kaufmann, director of the Seattle Indian Health Board and president of the American Indian Health Care Association, a consortium of urban Indian health centers, told the committee that Title V is an important part of the federal government’s commitment to increase the quality of life for American Indians and Alaska Natives.

Reauthorization Bills Due Soon

GREEN BAY, WISC. — A Senate bill to reauthorize the Indian Health Care Improvement Act (P.L. 94-437) will be distributed to tribal leaders and Indian health officials within the next few weeks, according to Paul Alexander, staff director for the Senate Select Committee on Indian Affairs.

An initial draft of the bill has been completed and should be introduced in the Senate by the end of October, said Alexander during a presentation here October 11 to the 40th Annual Convention of the National Congress of American Indians (NCAI). The present Act, passed by Congress in 1976 to raise the level of Indian health care over a seven-year period, expires in 1984.

According to Alexander, the major elements of the Select committee’s bill include the reauthorization of existing programs for Indian health manpower (Title I), health services (Title II), health facilities (Title III), access to health services (Title IV) and health services for urban Indians (Title V); statutory provision for an Assistant Secretary for Indian Health within the Department of Health and Human Services; legislative authority under Title II for the Community Health Representative (CHR) program and Alaska’s Community Health Aide program; and a provision to limit competitive bidding requirements for Indian health services.

Alexander explained that the committee’s bill was drafted following a number of oversight hearings to solicit comments and recommendations on the new legislation from tribes, Indian organizations, and individuals. The committee will continue to seek tribal views on the reauthorization bill, and the final version could change substantially, depending on responses from the Indian Community, Alexander said. The draft will be circulated to tribes over the next few weeks, and hearings on the bill will be scheduled after it is introduced, he added.

Alexander predicted that the bill will likely encounter resistance from some members of Congress and the Administration. “The participation and support of the tribes is essential to this bill’s passage,” he told NCAI delegates.

On the House side, the Interior and Insular Affairs Committee will complete its version of a reauthorization bill by the end of the year, with hearings likely scheduled for January or February, according to committee staff person Alex Skibine. The House committee “is committed to reauthorizing (P.L. 94-437) and will continue working closely with the Indian community to improve the Act,” Skibine said.

For additional information about the Senate and House bills, or the hearings, write: Chairman, Senate Select Committee on Indian Affairs; Hart 838; Washington, D.C. 20510; and Chairman, House Interior and Insular Affairs; U.S. House of Representatives; Washington, D.C. 20510.
Indian Groups...

Continued from Pg. 7

to Indian people, since past federal policies have been largely responsible for relocating Indian populations from reservations to cities. She added that most urban Indians have little or no access to health care services other than those provided through Title V projects.

Reauthorization of Title V was also endorsed in the joint testimony of NIHB and NCAI, which cited the projects' achievements in delivering a wide range of health services, including primary care, preventive health, screening, health education, and referral. The "positive changes in the health care indices of urban Indian people are a direct result of the formation of these urban Indian health projects," stated the organization's testimony, which was presented by NIHB Executive Director Jake Whitecrow.

"health conditions . . . still exist"

On the overall accomplishments of P.L. 94-437, Whitecrow told the committee that inadequate funding has kept the Act's programs from fulfilling their intent. "Although tremendous strides have been made under the law to improve the quality of life for Indian people," Whitecrow said, "the purpose of the Act has not been realized. Funding for the programs has never approached the authorized levels. As a result, many of the health conditions that led to the passage of the Act in 1976 still exist today."

Adolescent and young adult Indians still have an unusually high mortality rate, with many deaths related to "preventable" causes such as accidents, alcoholism, homocide, and suicide, Whitecrow said. He also pointed out that the incidence of rheumatic fever, infectious hepatitis, mumps and other illnesses is significantly higher in the Indian population.

To address the prevailing Indian health care deficiencies, Whitecrow called for reaffirming the federal policy of "providing the highest possible health status to Indians and to provide existing health services with all the resources needed to effect that policy," as declared in the Indian Health Care Improvement Act of 1976.

In addition to urging reauthorization of existing P.L. 94-437 programs, Whitecrow recommended two major amendments to the present law. To facilitate tribal health planning and greater consumer involvement in the health care system, Whitecrow requested that the committee include new provisions for Tribal Specific Health Planning and Indian health consumer boards. Stated Whitecrow: "Following passage of the Act in 1976, literally hundreds of tribes and urban Indian groups were for the first time given the opportunity to identify and plan for their individual health care needs . . . rather than having to rely solely on the Indian Health Service." He added that Indian health consumer boards, comprised of tribally-elected officials, can assist in the health planning process and provide "a valuable liaison between IHS and Indian communities."

The second NIHB/NCAI recommendation requests the committee to examine the possibility of elevating the Indian Health Service to an Assistant Secretary level within the Department of Health and Services. A number of tribes and Indian organizations have supported such a move, contending that it would strengthen IHS' administrative and policy-making capabilities.

The Senate bill to reauthorize the Indian Health Care Improvement Act is expected to be introduced in late October, with a hearing on the measure tentatively planned for mid-November. A companion bill, now being drafted by the House Interior and Insular Affairs Committee, will be introduced in the House later this year or early next year, with hearings to be scheduled shortly thereafter.

NIHB Urges...

Continued from Pg. 5

eligibility for IHS-supported services be defined only as those persons (1) who are members of a federally-recognized tribe, (2) who live within a clearly defined IHS service area, and (3) who formally enroll for IHS services. In a related action, the Health Resources and Services Administration (HRSA) published notices in the Federal Register June 6 seeking comments on health services eligibility and eligibility verification.

NIHB's position on health services eligibility is based on the importance of the historical government-to-government relationship between tribes and the United States, and stresses that "each individual tribal government is the best judge of who should and who should not be eligible for federally-funded health services." The federal government should "allow each and every tribe and Alaska Native village to make the determination of eligibility for services . . . (and) a full impact analysis should be presented to each tribal governing body" to assist tribal governments in making those determinations, the board recommended.

With respect to acceptance and implementation of the task force's recommendations, NIHB requested that any further action by IHS and HRSA be delayed until full tribal consultation is carried out and a thorough analysis of the report is completed. The board also encouraged IHS to seek active tribal and health board participation in national and area-wide consultation meetings on the report; preparation of a detailed impact analysis of the task force's recommendations, and the development of any future policy recommendations for the delivery of health services to Indian people.

Copies of the NIHB positions on "IHS as the Primary Provider of Health Care," "The Legal Foundation for Health Services Provision," "The Contract Health Services Task Force Report," and "Eligibility and Residency Standards" are available at the NIHB central office. Copies of the "NIHB Program Plan," which describes NIHB's purpose, organizational structure, and long-range goals and objectives, and NIHB's "Recommendations for the Reauthorization of the Indian Health Care Improvement Act" are also available. All of the positions were developed as part of the board's Albuquerque meeting. To obtain copies, please contact: National Indian Health Board, 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231. Phone: (303) 752-0931.
ALBUQUERQUE, N.M. — Tribal leaders, health providers, administrators, and Indian health consumers are all too familiar with the economic turmoil that has surrounded the Indian health care delivery system in recent years. Indian hospitals and clinics remain understaffed; medical supplies are often dangerously low; diagnostic equipment is frequently unavailable, and contract health care is generally limited to emergency and life-threatening situations.

While much of the blame for these conditions has been leveled at policy and budget recommendations made by the Reagan Administration, at least one key federal official believes that the fiscal trouble of the Indian Health Service (IHS) is part of a trend that began in 1977 and "is not merely a phenomenon of the current administration." According to Dr. Robert Graham, administrator of the Health Resources and Services Administration (HRSA), the federal agency that oversees the Indian Health Service, the per capita investment for IHS patients has declined steadily over the past six years from approximately $600 in 1977 to about $360 in 1983.

Using graphs to illustrate IHS spending trends, Graham told representatives of the National Indian Health Board (NIHB) here July 20 that the six-year dropoff in the per capita expenditures for IHS beneficiaries—which translates into decreased health care services—demonstrates how serious the problems of funding and resource management have become for the Indian Health Service. Spiraling medical costs, which have run 3 to 4 times higher than the general inflation rate, and service population increases, which have averaged 18,000 new patients per year, are the two main causes of the agency's monetary dilemma.

Another problem, Graham said, is that the mission of the Indian Health Service has changed dramatically since the mid-1970's, when the agency's primary focus was providing health care to Indian individuals. "Since 1977, as the total effective dollars for buying Indian health services have been declining, there have been additional legitimate priorities placed on IHS that involve not only the health care of individuals but Indian self determination, Indian preference, and community development."

As a result, "IHS has become responsible for accomplishing several missions — and there is no clear number one," Graham said. He also indicated that these priorities can sometimes conflict with one another as, for example, in circumstances involving Indian preference. "There are decisions where we do not manage the Indian Health Service in its medical care mission the way we would without Indian preference," he said.

Relief from the financial constraints that have hampered IHS operations will have to come through changes in the agency's management, since federal appropriations will not cover the increased Indian health care costs, said IHS Director Dr. Everett Rhoades, who addressed NIHB representatives in a separate presentation.

Two major management problems that must be resolved by IHS, Rhoades said, involve the determination of precisely who is to be served and what health services are to be provided to them. To address these issues, IHS will institute a "registry" program to identify all IHS beneficiaries and utilize a cost-accounting system that will promote cost containment and better enable IHS officials to track the cost of services provided at Indian hospitals and clinics, he said.

Rhoades added that there will be a stronger commitment to program accountability through the use of work plans and a performance evaluation process for all IHS employees. "We have to move in this direction... if we are to eliminate the general perception that the Indian Health Service doesn't know what it's doing," he said.

**CHS Task Force Report**

Proposed changes in the Indian health care program have been the subject of considerable debate...
Fiscal Analysis...

Continued from Pg. 9

among tribal officials, federal administrators, and congressional committees during the past year. In particular, a controversial federal report — the IHS Contract Health Services Task Force Report, which was distributed to tribes March 14 — that calls for fundamental changes in Indian health services eligibility, medical priorities, resource allocation, and a number of other areas — has been roundly criticized for being implemented without proper tribal consultation.

In defending the task force report, Graham stressed that both he and Rhoades are committed to consulting with tribes about the recommendations and that no major changes will be made without the official notification required by the Administrative Procedures Act. He said that several letters about the report have been sent to tribal chairmen and that notices have been published in the Federal Register seeking comments on health services eligibility, eligibility verification, and third party billing. Noting that responses thus far have been fewer than anticipated, Graham said that "it is very important that we hear from every tribe and Indian organization about these issues."

While efforts to consult with tribes will continue, Graham also made it clear that neither he nor anyone in his agency should be viewed as advocates for Indian people. "The Indian Health Service has a responsibility to work within the administration," Graham said, "so to

Continued on Pg. 12

Alaska's Charlie Elected as NIHB Chairman

ALBUQUERQUE, N.M. — Four new officers were elected to the Executive Committee of the National Indian Health Board (NIHB) during the board's meeting here in late July.

NIHB's new executive officers are: Kenneth Charlie, Alaska area representative, Chairman; Timm Williams, California area representative, Vice Chairman; Donald LaPointe, Bemidji area representative, Secretary; and Maxine Dixon, USET area representative, Treasurer.

Charlie replaces Tony Secatero, NIHB's chairman for the past two years, who is stepping down from the position to devote more time to other commitments. Secatero's hard work and leadership were instrumental in guiding the organization through some of the most difficult times in its 11-year history. He used the experience gained during his eight years as tribal health administrator for the Canoncito Band of Navajo Indians to effectively address many of the complex budget and administrative issues that have surfaced in the Indian health program. Secatero, who will remain as NIHB's Albuquerque representative, was recently elected chairman of his tribe, and will likely need the additional time to oversee Canoncito's expanding array of programs for health, social services, economic development, and business.

NIHB's new chairman, Charlie, brings a similarly impressive background to his new position. His expertise is in health management, and he has served for the past five years as Chairman of the Alaska Native Health Board; is the Chairman of the Tanana Chiefs Regional Health Board Advisory Committee; is President of the Minto Village Corporation; and is Chairman of the Interior Regional Council with the Alaska State Department.

Charlie told board members that he is committed to improving the involvement of Indian people in the health care delivery system. He stressed that active participation by tribes, health boards, and individuals is especially important in the policymaking process, and he expressed his desire for NIHB to regularly consult with IHS on policy matters.

Williams, NIHB's Vice Chairman, has served as Chairman of the California Rural Indian Health Board (CRIHB) for 11 of the past 14 years. Comprised of 14 tribal health projects, CRIHB contracts with IHS under the authority of P.L. 93-638 (the Indian Self Determination and Education Assistance Act) to provide direct care services to a large portion of California's Indian community.

In addition to his work with CRIHB, Williams, a Yu­rok Indian from Crescent City, CA, has worked at the San Francisco Center for the Blind and at the Crippled Children's Hospital. He was named "Man of the Year" in 1972 by the National Academy of Pediatrics and has received numerous other awards in the health field.

LaPointe was re-elected as NIHB's Secretary and will continue as Chairman of the NIHB Resolutions Committee, a position he has held with distinction for years. LaPointe, a member of the Keweenah Bay Chippewa Tribe in Baraga, Mich., has served on his tribal council for 11 years, including 9 years as vice-chairman. He is the official health representative of the Four State Inter-Tribal Assembly, which is comprised of 29 tribes from Michigan, Wisconsin, Minnesota, and Iowa, and which serves as NIHB's affiliate organization in the Bemidji area. LaPointe has extensive experience in the area of health, having worked for eight years with the Michigan State Mental Health Department in occupational therapy. He has also served on the Keweenah Bay Tribal Alcoholism Board, and is presently involved in the tribe's social and economic development.

Maxine Dixon, the board's new Treasurer, a member of the Mississippi Choctaw Tribe, has been elected to her tribal council for the past nine years and has served as NIHB's representative from the United South and Eastern Tribes (USET) for five years. Her extensive health background includes service as the Public Health Liaison for the Choctaw Health Center; director of the tribe's Community Health Representative (CHR) program; appointment to the state-wide Health Coordinating Council by the Governor of Mississippi, and service on the Mississippi Health Systems Agency board. •
DENVER, COLO. — As part of an overall effort to strengthen the management and accountability of the Community Health Representatives (CHR) program, a group of Indian Health Service (IHS) and tribal health officials are working to devise uniform program guidelines that they hope will be applied to all tribal CHR contracts by October 1, 1984.

An initial draft of the CHR program guidelines was reviewed by CHR administrators and IHS contracting and project officers from five IHS areas here September 13-15. A similar meeting for representatives from other IHS areas was conducted in Albuquerque, N.M., in early September.

For the past two years, the CHR program, which is operated through contracts with tribes to provide a wide range of health-related services to Indian communities, has been targeted for elimination by Administration budget officials. Although Congress has rejected the Administration’s efforts and provided funding for the program, including a total of $30 million for FY 1984, congressional committees have cited the need for better management and reporting of CHR activities.

Ironically, the need for stronger program accountability was pointed out unsuccessfully by CHR’s years ago, stated Ada White, CHR supervisor for the Crow Tribe in Montana and president of the National Association of CHR’s, during a presentation at the Denver meeting.

A key problem that has plagued the CHR program, according to White, has been the absence of program criteria and mandatory reporting requirements. “If less than one-half of the programs are using the reporting system, then all the data becomes invalid. This hurt the CHR program in the eyes of Congress,” she said.

White explained that a special CHR task force, comprised of IHS staff, tribal health personnel, and representatives from national Indian organizations, was established last year to address congressional concerns and examine ways to improve the CHR program. The task force developed 28 recommendations related to program philosophy, administration, funding and training, which were approved by IHS Director Dr. Everett Rhoades this past June.

One task force recommendation in particular that will provide more stability and administrative coordination for the program is the creation of a headquarters-level CHR office, which will be staffed by a director, analyst, and a secretary. The CHR central office, first announced in May, should be operative shortly.

Most of the other issues raised by the CHR task force will be taken up in three separate projects that IHS officials believe will significantly improve CHR program effectiveness. The three projects will: (1) develop standard guidelines for CHR contracts and scopes of work; (2) establish CHR medical and cost effectiveness criteria; and (3) develop a CHR program resource allocation methodology. Project One (standardizing guidelines) was the focus of the Denver and Albuquerque meetings; Projects Two and Three will be undertaken separately.

According to Vonnie Haggins, Albuquerque area CHR coordinator who is also Project One supervisor, the contract guidelines will not restrict tribes’ ability to tailor their CHR activities to the specific health needs of their communities. “It is IHS’ responsibility to see that the (CHR) contract is written to fulfill the desires of the tribe, and that it clearly defines what the program will do.”

While retaining the flexibility to address the many different health concerns of tribes, the contract guidelines will also provide program “boundaries” that will exclude activities which are obviously inappropriate to the provision of health care, Haggins said. Performance of such non-health related activities, such as road construction, is one reason for the program’s past problems, she said.

Haggins indicated that several CHR scopes of work based on the guidelines will be written in fiscal year 1984, and that all CHR contracts will use them in fiscal year 1985. The guidelines will continue to be revised and comments from CHR’s and tribal officials are encouraged, she said. “When we finish, we will have input from all the areas and we will be able to write the guidelines according to what the tribes want. That is what Project One is all about.”

VONNIE HAGGINS, Coordinator for CHR Project One, discusses program guidelines for CHR scopes of work during a Denver meeting September 13-15. The guidelines will provide uniform standards in CHR contracts for program descriptions, resource identification, statement of health needs, objectives, and activities, performance monitoring, training, and evaluation.
expect us to become advocates is unrealistic. They didn’t hire us to do that. They hired us as administrators. If we choose to use our positions to forward interests that are personal rather than the interests with which we are charged in our positions, that is an abuse of office,” he said.

Graham said that his role as HRSA’s administrator requires him to insure that federal health resources are used as effectively as possible. Although some of their management decisions are likely to be unpopular, Graham said that “there will be some changes down the line because of our attempts to better manage the IHS and because of our attempts to maximize the resources available to IHS.”

Elevation of IHS

One administrative change that Graham does not appear to favor is a proposal to raise IHS to the Assistant Secretary level within the Department of Health and Human Services (DHHS). Numerous tribal officials, as well as former IHS Director Dr. Emery Johnson, testified before Congress this summer that IHS is subjected to unnecessary review, policy and reporting delays, and other management problems because it is buried under layers of bureaucracy within DHHS. The proposed elevation of IHS within the department has been widely endorsed by tribes and Indian organizations, including NIHB.

In discussing this issue, Graham noted that “there have been suggestions that the problem with the Indian Health Service is its location within the Department. But the location of IHS has not changed since 1955. I believe the operative variable is not (IHS’) location but other macroeconomic factors, and that’s what has to be addressed.”

As established by last year’s reorganization of several federal health agencies, IHS is one of four bureaus under the HRSA administrative structure, which gives HRSA certain review and oversight authorities over IHS. Of the 16,000 individuals employed by HRSA, approximately 11,000 work for IHS.

Graham contended that elevating IHS within the department would require that the IHS director be a political appointee, rather than a career-oriented administrator as provided by existing personnel procedures. And as a political appointee, the IHS director could be changed by each new administration, with the appointment likely based on the candidates’ political views rather than their familiarity with Indian health care, he said. “For a direct-delivery program of the complexity and scope of the Indian Health Service, that would not be a good thing.”

One of the positive aspects of IHS’ location under HRSA, according to Graham, is the fact that the management positions, including those of IHS director and HRSA administrator, are now career-oriented, which provides the agency with a degree of administrative stability and continuity. “The best bet for the IHS is to keep it within the career management and leadership” provided by the present system, he concluded.

The NIHB Health Reporter is published bi-monthly by the National Indian Health Board. All opinions and views expressed in this publication are those of NIHB. We are pleased to provide this newsletter at no charge to our readers throughout the country and welcome the further distribution of information contained therein. We do kindly request, however, that NIHB receive credit for articles reprinted from the NIHB Health Reporter.

NIHB encourages readers to submit articles and comments for publication. Please send correspondence and mailing requests to John P. O’Connor, National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colorado 80231.

EDITOR: John P. O’Connor

This publication made possible through contract No. 240-83-0033 with the Indian Health Service, Department of Health and Human Services.