WASHINGTON, D.C. — Will the elevation of the Indian Health Service (IHS) to a higher level within the Department of Health and Human Services (DHHS) result in improved management and delivery of health services to Indian people, or will it lead to a "disaster" for the entire Indian health care program?

Although a debate over the bureaucratic position of IHS may seem somewhat removed from the day-to-day operation of hospitals and health clinics on Indian reservations, the final outcome of this matter may have an important long-term effect on the health care of Native Americans. For that reason House and Senate congressional committees will be seeking an answer to this and other questions related to Indian health care as they take up consideration of legislation to reauthorize the Indian Health Care Improvement Act of 1976 (P.L. 94-437) in the coming weeks. The existing Act expires at the end of the current fiscal year.

The proposal to elevate IHS to an Assistant Secretary level within DHHS is a major amendment contained in both the House and Senate reauthorization bills (H.R. 4567; S. 2166), which were introduced November 18.

Hearings on the two bills are slated to begin February 29 and will run through April 12. The bills must be reported out of the committees by May 15 in order to authorize spending for the Act's programs in fiscal year 1985.

No one argues about IHS' present location in the DHHS bureaucracy — it's at the bottom, under four major departmental levels, each with its own array of divisions and offices. The debate centers on whether this lowly position adversely affects the agency's ability to effectively manage its programs.

According to numerous tribal witnesses that testified at Congressional oversight hearings last year, IHS has indeed suffered from excessive review and supervision performed at the higher echelons of the Department. As noted by Wendell Chino, president of the Mescalero Apache Tribe of New Mexico: "We have witnessed for many years the inability of the Director of IHS to make his way through the many layers of bureaucracy within the Department of Health and Human Services. We are not unaware of the intra-departmental battle for funding and positions. We

(Continued on Pg. 2)
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 effective manner."

One individual with extensive experience in dealing with the DHHS hierarchy is Dr. Emery Johnson, who served as IHS Director for 12 years before retiring in 1981. Testifying before the House Interior and Insular Affairs Committee last spring, Johnson contended that the "basic problem" confronting IHS "is the complex layers of management in DHHS and the low status — both of organizational level and attention — given to IHS."

Decisions within DHHS, he said, are based on broad national concerns and generally are made without properly considering the special needs of Indian communities served by IHS. As an example, Johnson pointed to department-wide personnel freezes that can leave local Indian hospitals and clinics unable to hire the nurses, health technicians, and support staff required to provide health care to an Indian community. Another example, he explains, is the Department’s procurement regulations, which fail to fully address IHS’ special contracting needs. "IHS is the only substantial provider (within DHHS) of direct health services to communities and simply cannot be treated as if it were just another 'money-changing' operation," he said.

Johnson added that various reviews performed by DHHS agencies are not only time consuming but frequently result in a distorted view of Indian health

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Hearings Set for FY ’85
IHS Budget, Reauthorization Bills

WASHINGTON, D.C. — As the second session of the 98th Congress swings into full gear in the coming months several House and Senate congressional committees will be taking a close look at a number of important issues affecting Indian health care.

Congressional hearings have been set from February through May to examine the fiscal year 1985 budget for the Indian Health Service (IHS) and the reauthorization of the Indian Health Care Improvement Act (P.L. 94-437). With Congress scheduled to recess for the summer’s political conventions and the elections this fall, House and Senate committees will be under heavy pressure to complete their work in an unusually short session.

The tight schedule has been cited by one committee as the primary reason for not conducting the customary hearing for "outside" witnesses (tribes, Indian organizations, and other non-federal witnesses) on the fiscal year 1985 budget for IHS. The Senate Interior Appropriations Subcommittee will not hear oral testimony from outside witnesses this year, but will accept written statements (maximum 3 typewritten pages, single-spaced). Correspondence may be submitted by April 1 to: Subcommittee on the Interior and Related Agencies; Senate Appropriations Committee; 114 Dirksen Senate Office Building; Washington, D.C. 20510.

On the House side, hearings on the IHS fiscal year 1985 budget will be held for outside witnesses February 21-22, and written testimony (maximum four pages) may be submitted through March 15. Statements should be addressed to: Subcommittee on the Interior and Related Agencies; House Appropriations Committee; 308 B Rayburn House Office Building; Washington, D.C. 20515.

In addition to the FY 1985 budget, the reauthorization of the Indian Health Care Improvement Act will likely draw considerable attention from tribes and Indian organizations. Hearings on the Senate reauthorization bill (S. 2166) will be held by the Senate Select Committee on Indian Affairs February 29 for Administration witnesses and mid-to-late March for tribal witnesses. For additional information about the hearings, contact: Senate Select Committee on Indian Affairs; U.S. Senate; Washington, D.C. Phone: (202) 224-2251.

Four separate dates have been set by the House Interior and Insular Affairs Committee to review the House reauthorization bill (H.R. 4567): March 22 and March 29 for intertribal council witnesses; April 5 for national organizations; and April 12 for Administration witnesses. For more information, contact: House Interior and Insular Affairs Committee; U.S. House of Representatives; Washington, D.C. 20510. Phone: (202) 226-7393.

Listed below is a summary of key hearing dates, which are scheduled for Washington, D.C., unless otherwise noted. Contact the appropriate committee for additional information about time and location. Dates are subject to change without notice.

Hearing Schedule

February 21, IHS FY 1985 budget: Administration, national organizations (House Interior and Insular Affairs Committee)
February 21-22, IHS FY 1985 budget: Outside witnesses, (House Interior Appropriations Subcommittee)
February 23, IHS FY 1985 budget: Administration, national organizations (Senate Select Committee on Indian Affairs)
February 29, 94-437 reauthorization: Administration, national organizations (Senate Select Committee on Indian Affairs)
March 8, IHS FY 1985 budget: Administration (Senate Interior Appropriations Subcommittee)
Mid-March, 94-437 reauthorization: Administration, selected outside witnesses (House Subcommittee on Health and the Environment)
Mid-March, 94-437 reauthorization (Denver, Colorado): Outside witnesses (Senate Select Committee on Indian Affairs)
March 22, 94-437 reauthorization: Intertribal councils (House Interior)
March 29, 94-437 reauthorization: Intertribal councils (House Interior)
April 5, 94-437 reauthorization: National organizations (House Interior)
April 12, 94-437 reauthorization: Administration (House Interior)
May 9, IHS FY 1985 budget: Administration (House Interior Appropriations Subcommittee)
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.

PHILADELPHIA, MISS. — The Mississippi Band of Choctaw Indians has entered into a three-year $11.5 million contract with the Indian Health Service (IHS) to manage and operate the entire health care delivery system for its members. Transfer of the health program to the tribe was completed under the authority of P.L. 93-638, the Indian Self-Determination and Education Assistance Act. Under the contract, which was signed January 3, the Mississippi Choctaw Tribe will operate a modern 35-bed hospital; a four-chair dental clinic; three satellite health stations; environmental health services; health education and public health nursing services; and programs for mental health, alcoholism and social services. Approximately 4,800 tribal members will be served by the program. About 100 IHS employees who previously worked with the federally-administered program will remain as tribal employees under Intergovernmental Personnel Act agreements. The Mississippi Choctaw Tribe is the fifth tribal entity to assume total responsibility for its health care program under P.L. 93-638.

BOSTON, MASS. — Indian health care will be the focus of a one-hour documentary to be broadcast nationally by the Public Broadcasting Service March 27. Produced by the highly-acclaimed NOVA Series, the documentary, “Make My People Live: The Crisis in Indian Health,” examines current issues in the field of Indian health and features interviews with Indian health practitioners, administrators, and consumers. The program will be aired nationally on Tuesday, March 27, at 8:00 p.m. Viewers should consult local listings for the exact time and date the documentary will be shown in their area.

OKLAHOMA CITY, OKLA. — Indian students interested in health careers and who are high school seniors or college freshmen may be eligible for an eight-week, expense-paid program designed to increase their science, math and communications skills. The program, sponsored by the University of Oklahoma Medical School, will be held at the Headlands Conference Center in Mackinaw City, Michigan, June 14-August 11. Students will attend classes and labs, and spend one day a week at a local hospital or on field trips. Application deadline is April 1. For additional information, contact: Headlands Indian Health Careers; College of Medicine; University of Oklahoma; P.O. Box 26901; Oklahoma City, OK 73190. Phone: (405) 271-2250.

ALBUQUERQUE, N.M. — The National Rural Primary Care Association will hold its 7th Annual National Conference on Rural Primary Care here March 18-21. The Albuquerque Area Indian Health Board will cosponsor the event, which features some 70 work-

(Continued on Pg. 4)
THE NEWLY-CONSTRUCTED OUTPATIENT clinic at Anadarko, Okla.—the largest Indian outpatient facility in the country—was officially dedicated during ceremonies in early December. Officials that participated at the clinic’s opening included (l-r): Ace Sahmaunt, Vice-Chairman, Kiowa Tribe; Lawrence Snake, Vice-Chairman, Delaware Tribe; Mary Pat Francis, Chairman, Caddo Tribe; Lonnie Tstoddle, Chairman, Apache Tribe; Capps Tehauno, Vice-Chairman, Comanche Tribe, and Jim Cussen, IHS Liaison Officer.

Health News...

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shops covering a wide range of rural health care topics. For additional information, contact: Judy Harris; New Mexico Health Resources; P.O. Box 8735; Albuquerque, NM 87198. Phone: (505) 262-1828.

ROCKVILLE, MD. — The Indian Health Service (IHS) published a revised list of its Contract Health Service Delivery Areas (CHSDA) in the Federal Register January 10. The areas are the geographic boundaries within which IHS beneficiaries must reside to be eligible for contract health services. Copies of the CHSDA listing may be obtained from the NIH Public Information Office.

BERKELEY, CALIF. — The University of California, Berkeley, is actively seeking Indian students for programs leading to graduate degrees in the fields of public health and social welfare. “These are professions that offer well-paying positions along with a sense of service to Indian communities,” says Elaine Walbroek, Director of the American Indian Graduate Program at the University of California here. Walbroek noted that recent graduates from the two professional schools are currently employed in a dozen or so states in such positions as health planners, executive officers, and health educators with the Indian Health Service, tribal health programs, and urban Indian health centers. Financial assistance may be available for those accepted into the program. Applications for the Fall, 1984 quarter must be submitted by February 1. For more information, contact: Elaine Walbroek; Room 140, Warren Hall; University of California; Berkeley, Calif. 94720. Phone: (415) 642-3228.

TULSA, OKLA. — The National Indian Council on Aging will convene the Fifth National Indian Conference on Aging here March 28-29. The conference, which has as its theme “Let Us Continue in Unity,” will address issues of concern to the Indian elderly, including development of a National Indian Policy on Aging and the reauthorization of the Older Americans Act, which provides funding to tribal projects for the elderly. For additional information about the conference, contact: National Indian Council on Aging; P.O. Box 2088; Albuquerque, NM 87103. Phone: (505) 766-2276.

MINNEAPOLIS, MINN. — Indian Health Service (IHS) model alcoholism programs will be the subject of a 30-week study conducted by the First Phoenix American Corporation and the National Indian Board on Alcoholism and Drug Abuse. The project, entitled “Identification and Assessment of Indian Health Service Alcoholism Projects,” will develop exemplary models for eight types of Indian alcoholism programs (prevention, outreach, detoxification, primary residential treatment, halfway house, outpatient counseling, custodial care, and comprehensive). An expert panel on alcoholism-related problems will be convened to assist with the research methodology, and sixteen site-visits will be made to IHS exemplary alcoholism programs during the course of the study, which is scheduled for completion April 30, 1984. For additional information, contact: Margaret Peake Raymond; 2649 Longfellow Ave.; Minneapolis, MN 55407. Phone: (612) 721-8018.

FLAGSTAFF, ARIZ. — A $1 million, five-year grant has been awarded to Northern Arizona University (NAU) to establish a Native American Rehabilitation Research and Training Center that will address the needs of disabled Indians nationwide. The grant, funded by the National Institute of Handicapped Research, will enable the NAU-based center to examine issues related to “the perception of disability and definition of rehabilitation from the Native American cultural perspective; early identification, screening, and assessment as service delivery barriers in the rehabilitation process; the interagency delivery of rehabilitation services; and cross-cultural service delivery barriers in the rehabilitation process.” The center will also seek to increase Indian participation in the rehabilitation profession and establish an in-service training program for health professionals working with disabled Native Americans. For additional information, contact: Dr. Joanne O’Connell; Institute for Human Development; Northern Arizona University; Flagstaff, AZ 86011.

BEMIDJI, MINN. — Recent vision screenings conducted by the Indian Health Service (IHS) Program Office here revealed that approximately one quarter of the Headstart-aged children and more than 60 percent of high school-aged youth have significant refractive and functional eye problems. More than half of the younger children had astigmatism (which prevents focusing of sharp images), while many in the...
Fort Defiance Attacks Raise Fears Among Hospital Staff

Hospital personnel at the Fort Defiance, Shiprock, and Crownpoint service units on the Navajo Reservation have expressed growing concern for their safety following several violent attacks on the reservation. One nurse has resigned at the Crownpoint facility, saying that she feared for her safety. Much of the concern stems from incidents at the Fort Defiance IHS hospital in which two non-Indian nurses were attacked — one was raped and stabbed, and the other shot. In addition, according to IHS administrators, hospital employees are concerned because of "threats" and a series of recent break-ins and acts of vandalism. Although there have been no injuries reported in the break-ins, the fear that something could happen has been intensified as a result of the Fort Defiance incidents.

The following account of the Fort Defiance attacks, which appeared in the Navajo Times, describes the tension among hospital staff on the reservation. A suspect was recently arrested and charged with both attacks. Meanwhile, security at the Fort Defiance, Shiprock, and Crownpoint hospitals has been increased, and escort services have been established to provide staff members with transportation to and from their homes.

FORT DEFIANCE, ARIZ. — The shooting of an Indian Health Service (IHS) nurse here January 11, just one month after another nurse was raped and almost killed, has heightened concern for the safety of IHS personnel here.

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Continued from Pg. 4

older group exhibited problems with myopia (which causes distant objects to appear blurred). It was also noted that only about one-third of Indian children in need of corrective lenses actually wear them.

SEATTLE, WASH. — A program of the Seattle Indian Health Board that is directed toward preventing pregnancies among Native American teenagers has been funded for the second straight year by the Charles Stewart Mott Foundation. The program has three major goals: prevention of pregnancy among Indian teenagers through the provision of outreach education and medical, social and family planning services; improvement of pregnancy outcomes through medical, social, prenatal and post-partum services; and improvement of the future economic status of teenage mothers. Full family participation in the program is encouraged and discussed with teens at the time of their initial interviews. Community presentations promoting project services are currently being scheduled with school parent groups and Native American youth groups throughout the Seattle area. For more information about the program, contact: Vanessa Carter; Seattle Indian Health Board; P.O. Box 3364; Seattle, WA 98114. Phone: (206) 324-9360.

"There is deep concern here for not only the safety of our personnel but the safety of others within the Fort Defiance community," Vern Harris, director of the hospital, said.

The attacks upon the nurses, both of whom were anglo, and reports by other nurses of incidents ranging from strange phone calls to prowlers at night have made several nurses consider resigning and moving off the reservation. "I just don't think this is a safe place to be right now," one nurse said. Nurses are afraid to comment on the situation publicly for fear that this will focus attention on them and make them the target of a future attack.

Harris and other IHS officials said they can understand why women on the hospital staff are afraid for their own safety. Harris said that so far no nurses have submitted their resignation, although there have been hints that some nurses were considering it.

The first attack occurred in mid-December in the parking lot of the hospital when a nurse was attacked while reporting to duty on the midnight to 8:00 a.m. shift. Hospital officials said she was beaten, raped and then the attacker attempted to cut her throat. She survived and is now recuperating off the reservation, Harris said. She has not told hospital officials yet whether she will be back.

On the same night, Harris said, someone went through the IHS housing compound and broke several car windows with an air pellet gun. He said that hospital officials were not sure whether these two incidents were related.

As a result of this attack, the hospital set up more security, including providing transportation to and from their homes for any staff member who wanted it.

The second attack took place January 11 about 10:30 p.m. Hospital officials said the woman, whose name was not released, was sitting at her dining room table sewing when someone standing just outside her window fired a shot. The bullet struck her in the forehead but did not penetrate the skull. She was released from the hospital early Friday afternoon.

On the day following the attack, hospital officials called together some of the staff who talked about the incidents with officials from various law enforcement agencies and representatives of the chapter. "We stressed at the meeting that we regard the incidents as a threat to the entire community and not just the hospital," Harris said.

Another IHS administrator, who asked not to be identified, said the feeling among some IHS personnel is that the attacks may have been done by someone who has a hatred of women in general. Nurses have been the targets, he said, because their work shifts and irregular hours make them more vulnerable to these kinds of attacks.

Law enforcement officials, while refusing to comment on the investigation of either attack, have indicated that there is no evidence at this time to think the

(Continued on Pg. 12)
On November 18, legislation was introduced in the House by Congressman Morris Udall (D.-Ariz.) and in the Senate by Senator Mark Andrews (R.-N.D.) to reauthorize the Indian Health Care Improvement Act of 1976 (P.L. 94-437). The two bills (H.R. 4567, S. 2166) would extend most of the existing programs established by the original Act. In addition, each bill contains major new amendments designed to improve the delivery of health care services to American Indians and Alaska Natives.

Both the House Interior and Insular Affairs Committee and the Senate Select Committee on Indian Affairs have scheduled hearings to solicit public comment on the legislation. The bills must be reported out by each committee before May 15 in order to assure funding for the Act's programs in fiscal year 1985.

Due to the importance of these two measures we have reprinted the following itemized chart, which includes a description of the existing P.L. 94-437 programs and a comparison of the provisions contained in H.R. 4567 and S. 2166. It should be noted that information in the column marked “Probable Administrative Proposal” identifies provisions taken from several budget and legislative documents, since the Administration has not yet come forth with a reauthorization proposal. The information in this column represents the “best guess” of the Administration’s position on each provision.

For additional information about the two bills or the related hearings, contact: House Interior and Insular Affairs Committee; U.S. House of Representatives; Washington, D.C. 20510. Phone: (202) 226-7939; or the Senate Select Committee on Indian Affairs; U.S. Senate; Washington, D.C. 20515. Phone: (202) 224-2251.

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<tr>
<td>Definitions</td>
<td>Secs. 4(i)(j) &amp; (k) define “rural Indian”, “rural community”, and “rural Indian organization.”</td>
<td>No comparable provision.</td>
<td>Deletes Secs. 4(i)(j) &amp; (k)</td>
<td>No comparable provision.</td>
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<td>Manpower (Title I): Recruitment</td>
<td>Sec. 102 authorizes grants for identification of Indians with potential as health professionals; FY ’84 Auth.: $3,500,000</td>
<td>Authorizations: FY ’85: $500,000; FY ’86: $600,000; FY ’87: $600,000</td>
<td>Authorizations: FY ’85: $500,000; FY ’86: $600,000; FY ’87: $600,000</td>
<td>Authorizations:</td>
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<td>Preparatory Scholarships</td>
<td>Sec. 103 authorizes scholarships for Indians preparing to enter health professions schools</td>
<td>• Adds requirement that recipients be attending school full time</td>
<td>Authorizations: FY ’85: $437,000; FY ’86-89: Such sums as necessary</td>
<td>Authorizations:</td>
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<tr>
<td>Health Professions Scholarships</td>
<td>Sec. 338C of PHS Act authorizes Indian Health Scholarships to health professions students. Priority for Indians. Obligation to serve in IHS or elsewhere serving Indian people.</td>
<td>• Limits scholarships to Indian students. • Eliminates private practice option. • Authorizes site visit travel for spouses prior to assignment.</td>
<td>Authorizations: FY ’85: $3,704,000; FY ’86-89: Such sums as necessary</td>
<td>Authorizations:</td>
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<tr>
<td>- IHS Extern Program</td>
<td>Sec. 105 authorizes temporary employment in IHS of Indian Health Scholarship recipients.</td>
<td>• Prohibits payment of scholarship stipend while serving in extern program.</td>
<td>Authorizations: FY ’85: $291,000; FY ’86-89: Such sums as necessary</td>
<td>Authorizations:</td>
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<td>Health Services (Title II): Patient Care</td>
<td>Sec. 201(c)(i) authorizes $30,500,000 and such additional positions as necessary for FY ’84</td>
<td>Authorizes a consolidated amount for all health services (Title II of P.L. 94-437): FY ’85: $66,400,000; FY ’86-89: Such sums as necessary</td>
<td>Authorizes for FY ’85-87 such sums as necessary to raise all tribes to Level II of IHS priority system. Funds are to be used for: clinical care, preventive health; dental care; mental health; alcoholism; accident prevention; CHR and community health aide programs; and maintenance and repair.</td>
<td>Authorizations:</td>
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<td>Field Health</td>
<td>Sec. 201(c)(ii) authorizes $9,700,000 and such additional positions as necessary for FY ’84</td>
<td>Authorizes development and implementation of a plan to reduce Indian infant mortality.</td>
<td>Requires the Secretary to expend 1% of IHS health service appropriation for research.</td>
<td>Authorizations:</td>
</tr>
<tr>
<td>Dental Care</td>
<td>Sec. 201(c)(iii) authorizes $2,875,000 and such additional positions as necessary for FY ’84</td>
<td>Establishes an Indian Catastrophic Health Emergency Fund to meet extraordinary costs.</td>
<td>Requires development and implementation of a plan to reduce Indian infant mortality.</td>
<td>Authorizations:</td>
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| Patient Care | | | |
| Field Health | | | |
| Dental Care | | | |
## Comparison of H.R. 4567, S. 2166

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<tr>
<td>Health Services (Title II)</td>
<td>Sec. 201(c)(4)(A) authorizes $3,800,000 and such additional positions as necessary for FY '84</td>
<td></td>
<td>Community Mental Health Services Authorizations: FY '85: $4,074,000 FY '86: $4,071,000 FY '87: $4,067,000 FY '88: $4,060,000</td>
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<td>- Inpatient Mental Health Services</td>
<td>Sec. 201(c)(4)(B) authorizes $1,150,000 and such additional positions as necessary for FY '84</td>
<td></td>
<td>Inpatient Mental Health Services Authorizations: FY '85: $1,233,000 FY '86: $1,320,000 FY '87: $1,413,000 FY '88: $1,511,000</td>
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<td>- Model Dormitory Mental Health Services</td>
<td>Sec. 201(c)(4)(C) authorizes $3,600,000 and such additional positions as necessary for FY '84</td>
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<td>Model Dormitory Mental Health Services Authorizations:</td>
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<tr>
<td>- Therapeutic and Residential Treatment Centers (Mental Health)</td>
<td>Sec. 201(c)(4)(D) authorizes $690,000 and such additional positions as necessary for FY '84.</td>
<td></td>
<td>Therapeutic and Residential Treatment Centers Authorizations: FY '85: $740,000 FY '86: $782,000 FY '87: $846,000 FY '88: $907,000</td>
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<tr>
<td>- Training of Traditional Indian Practitioners (Mental Health)</td>
<td>Sec. 201(c)(4)(E) authorizes $375,000 for FY '84</td>
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<td>Training of Traditional Indian Practitioners Authorizations:</td>
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<tr>
<td>- Alcoholism Treatment and Control</td>
<td>Sec. 201(c)(5) authorizes $25,100.00 for FY '84</td>
<td></td>
<td>Alcoholism Treatment and Control Authorizations: FY '85: $25,908,000 FY '86: $28,802,000 FY '87: $30,821,000 FY '88: $32,969,000</td>
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<tr>
<td>- Maintenance and Repair</td>
<td>Sec. 201(c)(6) authorizes $7,600,000 and such positions as necessary for FY '84</td>
<td></td>
<td>Maintenance and Repair Authorizations: FY '85: $8,148,000 FY '86: $8,721,000 FY '97: $9,333,000 FY '98: $9,983,000</td>
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<td>- Community Health Representatives and Community Health Aides</td>
<td>No comparable provision.</td>
<td></td>
<td>CHR/Community Health Aides Authorizations: FY '85: $37,520,000 FY '86: $40,162,000 FY '87: $42,977,000 FY '88: $45,973,000</td>
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<td>- Contract Care Reimbursement Rate</td>
<td>No comparable provision.</td>
<td>Requires contract providers to reimburse IHS at Medicare rates.</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
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<td>Facilities (Title III):</td>
<td>Sec. 305 authorizes such sums as may be necessary for FY '84</td>
<td>Authorization a consolidated amount for construction and renovation of both health services facilities and sanitation facilities: FY '85: $13,000,000 FY '86-99: Such sums as necessary.</td>
<td>Hospital/Health Center construction Authorizations: FY '85-98: Such sums as necessary.</td>
<td>Sanitation facilities construction Authorizations: FY '85-98: Such sums as necessary.</td>
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<td>- Construction and Renovation of IHS Hospitals, Health Centers, etc.</td>
<td>Sec. 305 authorizes such sums as may be necessary for FY '84</td>
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<tr>
<td>- Construction of Sanitation Facilities</td>
<td>Sec. 305 authorizes such sums as may be necessary for FY '84</td>
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<td>Access to Health Services (Title IV): Medicare/ Medicaid enrollment</td>
<td>Sec. 404 authorizes a program of grants and contracts to assist tribes to enroll members in Medicare (Part B) and Medicaid. Authorization level for FY '84: $7,610,000</td>
<td>No extension of this authority is proposed.</td>
<td>No extension of this authority is proposed.</td>
<td>Authorizations: FY '85: $8,158,000 FY '86: $8,732,000 FY '87: $9,345,000 FY '88: $9,996,000</td>
</tr>
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<td>Medicare reimbursement</td>
<td>Sec. 1880 of Social Security Act authorizes Medicare reimbursement for care rendered in IHS &quot;hospitals or skilled nursing facilities.&quot;</td>
<td>No change proposed.</td>
<td>No change proposed.</td>
<td>Expands the authority to allow Medicare reimbursement for care provided by hospitals, ICFs, SNFs, or any other type of facility.</td>
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<tr>
<td>Medicaid reimbursement</td>
<td>Sec. '911 of the Social Security Act authorizes Medicaid reimbursement for care rendered in a &quot;facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility).&quot;</td>
<td>No change proposed.</td>
<td>No change proposed.</td>
<td>Expands the authority to allow Medicaid reimbursement for care provided by hospitals, ICFs, SNFs, or any other type of facility.</td>
</tr>
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<td>Urban Indian Health Care</td>
<td>Title V authorizes contracts with urban Indian organizations to improve access to health services. FY '84 authorization: $28,500,000.</td>
<td>No extension of the authority is proposed.</td>
<td>No extension of this authority is proposed.</td>
<td>Extension proposed: FY '85: $9,900,000 FY '86: $10,690,000 FY '87: $11,975,000</td>
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<tr>
<td>Rural Indian Health Care</td>
<td>Title authorizes contracts with rural (as well as urban) Indian organizations to increase accessibility of health services. FY '84 authorization: $3,000,000</td>
<td>No extension of this authority is proposed.</td>
<td>No extension of this authority is proposed.</td>
<td>No comparable provision. No comparable provision. No comparable provision. Requires the Secretary to complete the current Hepatitis-B screening project in Alaska within one year from date of enactment.</td>
</tr>
<tr>
<td>Nuclear Resource Development Health Hazards</td>
<td>Sec. 707 requires the conduct of various studies and establishment of a Task Force with regard to the hazards to Indians living or working in nuclear resource development areas.</td>
<td>No change proposed.</td>
<td>No change proposed.</td>
<td>Repeals Sec. 707.</td>
</tr>
<tr>
<td>Arizona as a CHSDA</td>
<td>Sec. 708 requires designation of the State of Arizona as a Contract Health Services Delivery Area, and provides an authorization ($2,000,000 in FY '84) for contract health services there.</td>
<td>No extension of this authority is proposed.</td>
<td>Extension is proposed through FY '87 at $2,000,000 per year.</td>
<td>Extension is proposed: FY '85: $2,276,000 FY '86: $2,956,000 FY '87: $3,604,000 FY '88: $3,941,000</td>
</tr>
<tr>
<td>California Indians</td>
<td>Sec. 709 stipulates that Indians in the State of California who are members of formerly Federally-recognized tribes are to be eligible for IHS services through FY '84. This authority is proposed to be made permanent.</td>
<td>No extension of this authority is proposed.</td>
<td>Extension is proposed through FY '87.</td>
<td>Extension is proposed through FY '88.</td>
</tr>
<tr>
<td>Personnel Ceilings Demonstration Project</td>
<td>Sec. 710 authorized a project to demonstrate a more flexible approach to setting IHS personnel ceilings.</td>
<td>No extension of this authority is proposed.</td>
<td>Repeals Sec. 710.</td>
<td>Repeals Sec. 710.</td>
</tr>
<tr>
<td>Service to Non-eligible Persons</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
</tr>
<tr>
<td>Reduction and Control of Hepatitis-B in Alaska</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
<td>Requires the Secretary to complete the current Hepatitis-B screening project in Alaska within one year from date of enactment.</td>
</tr>
<tr>
<td>Clinical Care Priorities</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
<td>• Prohibits any reduction, restriction, or modification of clinical health care services being provided by IHS.</td>
</tr>
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</table>
Reauthorization...  
Continued from Pg. 8

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<tr>
<td>Clinical Care Priorities continued</td>
<td>No comparable provision.</td>
<td>No comparable provision.</td>
<td>• Establishes an Office of Indian Health Affairs directed by an Assistant Secretary of DHHS for Indian Health.</td>
<td>• Requires a report to Congress on clinical care priorities.</td>
</tr>
</tbody>
</table>
| Organizational Location of IHS | No comparable provision. | No comparable provision. | • Transfers the IHS to the new Office of Indian Health Affairs. | • Formally establishes the IHS in DHHS.  
| | | | • IHS to be headed by an Assistant Secretary of Health and Human Services for Indian Health. | • Establishes a National Indian Health Advisory Board. |
| Payment for Services to Indigent Indians by Non-IHS programs | No comparable provision. | No comparable provision. | No comparable provision. | • Establishes a new program under which the costs of medical care rendered to indigent Indians by non-IHS facilities can be reimbursed by the Secretary under a negotiated agreement.  
| | | | • Authorizes "such sums as may be necessary" for this program. | Allows the Secretary to negotiate contracts with non-IHS providers of health care, notwithstanding other laws requiring the advertising for competitive bids for such contracts. |
| Competitive Bidding | No comparable provision. | No comparable provision. | No comparable provision. | |

Congress, Tribes...  
Continued from Pg. 2

care needs, as demonstrated by the Administrations' (both Republican and Democrat) budget requests for IHS. He also cited one IHS document that was reviewed by 38 individuals between IHS and the Office of the Secretary. "One wonders about the possible contribution that many people can make," Johnson said. "One thing is certain — much of the reality of the needs of Indian people is lost in the translation."

Raising IHS to an Assistant Secretary level would strengthen the agency's management, make it more accountable to Congress and Indian tribes, and improve the policy and decision-making process, Johnson said. He has also called the change a "no-cost" option, especially since IHS staff would be freed from excessive reporting and review tasks required in dealing with the various levels of the Department, thus allowing staff time to be more judiciously allocated to running the Indian health program.

"... would be a disaster"

Not unexpectedly, some higher-level DHHS officials take a dim view of the proposal to raise IHS to an Assistant Secretary position, and it appears certain that the Department will officially oppose such a move.

In fact, Dr. Robert Graham, administrator of the Health Resources and Services Administration (HRSA), has stated that establishing the IHS director as an Assistant Secretary "would be a disaster." HRSA is the agency directly above IHS in the DHHS administrative structure, which gives HRSA officials review and oversight authority over the Indian health program. IHS is the largest of the four bureaus within HRSA, employing approximately 11,000 of the agency's 16,000 member workforce.

Graham says that his opposition to the elevation of IHS is not motivated by a desire "to keep his turf intact" but rather by the potential liability of having IHS administered by a political appointee. If IHS were moved to an Assistant Secretary level, Graham maintains, the director of the program would be subject to change with each new administration. The appointees would probably be selected on the basis of their political views and association with the new administration instead of their familiarity with Indian health, he says. Such changeovers would disrupt the program continuity that IHS can experience with a career-oriented manager provided under the existing administrative arrangement, he says.

Structurally, Graham points out that the functions of assistant secretaries within the Department are geared more toward policy-making and carrying out the intent of the President rather than administering operational programs. He contends that IHS' present locus in the department "insulates" the Indian health program from political pressures because "there are protections within the Public Health Service that cushion operational agencies from the comings and goings in the political system."

(Continued on Pg. 10)
Congress, Tribes...

Continued from Pg. 9

Under the current structure, IHS has experienced a degree of program stability that Graham believes would be difficult to maintain with an Assistant Secretary of Indian Health. He also suggests that existing IHS linkages with health manpower programs, such as the National Health Service Corps and the PHS Commissioned Corps, might be harmed by an elevation of IHS.

Despite these potential problems, a number of tribes and Indian organizations, including the National Indian Health Board, have endorsed the change. And while the issue of elevating IHS is certain to receive considerable attention at upcoming congressional hearings, many tribal health officials believe that other provisions within the House and Senate bills may have a greater impact on the health care of Indian people.

The House bill (H.R. 4567), for example, includes several innovative new provisions that, if funded, could significantly improve Indian health services. Under Title II (Health Services), the bill would create an Indian Health Care Improvement Fund that would be used to assist certain tribes that fall below a specified level of health resources. The same title would also establish an Indian Catastrophic Health Emergency Fund to meet extraordinary costs of certain illnesses or medical disasters. In the area of construction, the House bill calls for a new federal policy to provide for safe water supply, sanitary sewage, and solid waste disposal systems for Indian homes and communities.

Important new items in the Senate bill (S. 2166) include a program to control and prevent the incidence of hepatitis B in Alaska; a somewhat controversial “impact aid” type of program that would authorize federal reimbursements to certain county-run non-IHS facilities for treatment rendered to indigenous Indians; and a provision that would, under certain conditions, exempt IHS from departmental competitive bidding regulations for contract health services.

Both the House Interior and Insular Affairs Committee and the Senate Select Committee on Indian Affairs have indicated that their respective bills could be revised substantially, depending on the response received from the Indian community. The National Indian Health Board has prepared a discussion paper that reviews the different provisions of each bill. Copies are available upon request.

Comments on H.R. 4567 and S. 2166 or questions about the hearings should be directed to: House Interior and Insular Affairs Committee; U.S. House of Representatives; Washington, D.C. 20510; or the Senate Select Committee on Indian Affairs; U.S. Senate; Washington, D.C. 20515. ■

New AIPC Program Promotes Prevention of FAS Among Indians

ALBUQUERQUE, N.M.—The All Indian Pueblo Council has been awarded a contract with the Indian Health Service (IHS) to conduct an intensive nationwide Fetal Alcohol Syndrome Prevention Program. As provided under the contract, the program’s staff will offer training on the prevention of Fetal Alcohol Syndrome to selected IHS and tribal health professionals over a 15-month period.

Fetal Alcohol Syndrome (FAS) is a disastrous birth defect caused by maternal alcohol consumption during pregnancy. The prevalence of FAS in the United States is estimated to be approximately one FAS baby born in each 750 live births. Recent research conducted by the Fetal Alcohol Syndrome Project of the Indian Children’s Program shows evidence that the incidence of FAS among American Indians is higher, one in every 633 babies overall, with some tribes as high as one in 100. Further, the prevalence of FAS makes it the most common recognizable birth defect among both Indians and whites.

Because women who do not drink alcohol during pregnancy are at no risk for having an FAS child, the possibility of preventing this birth defect through extensive public education in Indian country is enormously encouraging, according to FAS program director Philip May. Research, he adds, has found that fetal alcohol damaged Indian babies are born to a relatively small number of women, which indicates that identification of these women and intervention efforts hold great promise.

The National Indian FAS Prevention Program plans to train a spectrum of people in FAS, its history, its etiology, and prevention strategies. The major focus is to spread the current state of knowledge to local areas through the training of two types of experts: (1) FAS clinical specialists for each IHS area, and (2) a minimum of ten prevention trainers in each service unit. These trainers will be selected from programs dealing with Indian health, alcoholism, social service, maternal and child health, health education, child welfare, and headstart. The program will also work with local officials and tribal leaders in selecting the people to be trained.

The first phase of the project, in which 35 clinical specialists will receive intensive training in FAS, will be carried out February 22-23. Phase two, in which FAS training sessions will be conducted for selected staff at all 93 IHS service units, will begin in early March, May said.

In addition, the program will serve as an on-going resource center on Indian Fetal Alcohol Syndrome, May said. New health education and resources materials will be developed, including pamphlets, posters, a bibliography, a training outline, news releases, a resource guide, an FAS glossary, and copies of selected articles on Fetal Alcohol Syndrome.

For more information about the program, contact: Philip May, Director; National Indian Fetal Alcohol Syndrome Prevention Program; 2401 12th St., N.W.; Albuquerque, NM 87102; Phone: (505) 766-2873.
FY '84 Issues Crucial to Future of Indian Health Care

By Jake Whitecrow, NIH Executive Director

DENVER, COLO. — Over the past year a number of critical issues have emerged in the area of Indian health, issues that will ultimately have a significant impact on the future health and well-being of American Indians and Alaska Natives.

For example, last year we witnessed an Office of Management and Budget proposal to initiate a policy of billing Indians for health services provided by the Indian Health Service, a proposal that was later rejected by the Department and Congress. Budgetary constraints have eroded the infrastructure of the Indian health program, and although there has been improvement in the budget for fiscal year 1984, limited health resources will continue to be a major problem in the years ahead.

As a result, there has been pressure over the past twelve months to bring about policy and administrative changes to stretch Indian health resources. Serious consideration has been given to major changes related to health services eligibility and the allocation of IHS resources, and IHS is proceeding with plans to implement a national patient registry system and an automated third-party billing process.

In the area of legislation, bills were recently introduced in the House (H.R. 4567) and Senate (S. 2166) to amend and extend the Indian Health Care Improvement Act of 1976. Passage of these bills is absolutely necessary for the continuation of a number of Indian health programs.

In order to provide Indian people, elected officials, health administrators, and other interested persons with a forum to examine these important administrative and legislative matters, the National Indian Health Board will sponsor the Sixth National Indian/Alaska Native Health Conference May 21-24 at the MGM Grand Hotel in Reno, Nevada. On behalf of the Board I wish to extend to each of you an invitation to participate in this conference.

I would also like to request your assistance in the preparation of this event. We are presently accepting recommendations for conference speakers and workshop presenters. If there is a particular subject area that you would like to see addressed at the conference, please write us and we will make every effort to accommodate your request. We are particularly interested in hearing from tribal health programs that would be willing to share their experience and knowledge with other conference participants.

In addition, we are planning on conducting an awards ceremony to honor those special individuals that have made noteworthy contributions in the area of Indian health. This is an excellent opportunity to show those individuals how much we appreciate their work and dedication. If you know of someone — a physician, nurse, Community Health Representative, administrator, elected official, etc. — that deserves special recognition, please contact your area health board, intertribal council, or NIHB representative.

Our theme for the conference, "The Key to Prevention — YOU!", was chosen to emphasize the need for each of us to take more responsibility for our health. Many of the leading health problems in our Indian communities today, such as alcoholism, accidents, and diabetes, could be greatly reduced through preventive health measures. It is our hope that every attendee will be able to come away from the conference with new ideas about how to better promote preventive health in their communities.

In keeping with this theme, which stresses the need for individual responsibility and participation, I have a special request for our readers. As I noted earlier, and as is described in greater detail elsewhere in this newsletter, two important bills have been introduced in the House and Senate that would continue the provisions of the Indian Health Care Improvement Act. I urge each of you to become familiar with the provisions in these bills and to work with your tribal councils, health boards, and health administrators to fully understand how these bills will impact the lives of our people. The House and Senate committees will be holding hearings on these bills in the next few months and it is essential that they hear from Indian Country. We have prepared a discussion paper about the two bills — if you would like to receive a copy, please contact us.

I believe this is a critically important time for our health program — the actions we take now, and the decisions made in the months ahead, will affect the lives of American Indians and Alaska Natives for many years to come. It is my hope that by working together we can insure a healthy, more prosperous future for our people.

I hope to see you in Reno.

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

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Applicants Sought For 3 NIHB Staff Positions

DENVER, COLO. — The National Indian Health Board is seeking qualified applicants for the positions of program analyst/planner, associate editor, and executive secretary at its central office here.

Under the direction of the NIHB executive director, the analyst/planner will perform a number of tasks related to the analysis of budgets, health legislation, statistical data, and other health-related information; preparation of NIHB positions, impact analysis statements, and policy recommendations; and presentation of materials at meetings, workshops, and conferences. The incumbent will also be responsible for providing training and technical assistance to tribes, Indian organizations, and individuals on P.L. 93-638 contracting matters, tribal specific health planning, budgeting, health administration, and other health-related matters as needed.

The associate editor will assist in the dissemination of public information materials for the organization. Specific duties include assisting in the research, writing, layout, production, and distribution of a newsletter, the NIHB Health Reporter; assist in the development, design, and content of other NIHB informational materials; assist in NIHB publicity and press work; maintain a repository of Indian health-related files and respond to public request for information on Indian health care.

The executive secretary will perform a variety of secretarial and clerical duties, including dictation, typing, composition of letters; filing; take notes and prepare minutes of NIHB staff and directors' meeting.

Applicants should possess an appropriate combination of education, work experience and skills to successfully carry out the responsibilities of the position. A detailed job description may be obtained from the NIHB central office. Preference will be given to qualified American Indian and Alaska Native applicants.

To apply, please send resume by March 15 to: National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, CO 80231. Phone: (303) 752-0931.

Fort Defiance...

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attacks were done by the same person or for the same motive. "In a way, this is even worse because it would indicate that there are two persons out there with some kind of grudge they are trying to work off," the IHS administrator said.

As a result of the second attack, security around the hospital and the housing compound have been beefed up. Tribal police officials said they would try and provide more patrols for the area, especially at night. "We realize that the Navajo police and the Bureau of Indian Affairs are short staffed, but we feel that cooperation by everyone in the community will help make the community safer for everyone else," Harris said.

The IHS has already offered a reward of $1,000 for information leading to the arrest of and conviction of the person or persons who are responsible for the attacks. Harris said that he plans on seeing that publicity about the reward is circulated around the community.

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

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