Tribes, Indian Organizations Voice Concern Over IHS Budget for 1985

WASHINGTON, D.C. — Health and Human Services Department witnesses testifying on behalf of a reduced Fiscal Year 1985 Indian Health Service budget found little congressional support during recent budget oversight hearings here. Members of the House Committee on Interior and Insular Affairs and the Senate Select Committee on Indian Affairs closely questioned the Administration witnesses regarding the proposed budget which would end the Community Health Representative, urban, tribal management and facilities construction programs as well as make drastic reductions in the area of Indian health manpower.

Overall, the Administration is asking $741.95 million for Indian Health Services, $28.46 million less than appropriated in Fiscal Year 1984. No money is requested for Indian Health Facilities whereas $53.56 million was allocated for the current fiscal year.

Three of the four committees with jurisdiction over the IHS budget (the House Appropriations Subcommittee on the Interior being the third) held hearings here the week of February 20. The House Interior and Senate Select Committees heard from both Administration and tribal witnesses, while the House Interior Appropriations Committee heard from tribal witnesses only. For the first time in recent memory, the Senate Interior Appropriations Committee chose not to hear from "outside" (non-administration) witnesses regarding the IHS budget. Administration witnesses appeared before the committee on March 8.

Both tribal and national organization testimony complained of the overall decline in the IHS program in recent years and the Administration's repeated failure to request adequate appropriations. "The FY 1985 budget submission proves no exception to this disappointing trend. While health care costs continue to escalate (a health care inflation rate of 10-15 percent is projected for this year), the Administration is suggesting an IHS Health Services budget totalling over $28 million less than in FY 1984," stated Tony Secatero, Chairman of the Conocito Band of Navajos

Continued on Pg. 2

LIKE MANY INDIAN patients, Annie Grey Bull requires expensive renal dialysis treatment in order to live. Proposed reductions in the IHS budget for FY 1985 could be particularly threatening to this kind of specialized treatment. For related article, see pg. 6.
and Albuquerque area representative to the National Indian Health Board (NIHB). Secatero and NIHB Bemedji representative Donald La Pointe appeared before the committees on behalf of NIHB and the National Congress of American Indians.

Congressman Dale Kildee (D-Mich.) who chaired the House Interior hearing, voiced strong sentiments on the role of HHS in the IHS budget process. "I always distinguish between OMB and the agency. I want to remark on your not becoming an advocate for your agency in the manner of Caspar Weinberger (Secretary of Defense) . . . He has done quite well in that," he told Health Services and Resources Administration (HRSA) Administrator Dr. Robert Graham. Later, in parting remarks, he reminded the HHS witnesses, "The trust responsibility which the United States has towards the Indian people resides not just in the executive branch but throughout the entire U.S. government."

Committee members questioned IHS' ability to collect some $55.4 million in projected Medicare/Medicaid payments next year and objected to a segment of the Administration's budget justification which reads, "Of the $55.4 million anticipated to be collected . . . $15.4 million . . . will be diverted to fund continued provisions of current services."

As National Indian Health Board witnesses testified, "as specified in the authorization for these collections, these reimbursements are dedicated to maintaining the quality of IHS facilities and services at accreditable levels."

On the same note, Congressman Kildee told Graham, "Congress wanted to upgrade these hospitals and this money is to be used only for those purposes. You are assuming Congress will permit an offset in violation of the law." Despite lengthy questioning and repeated assurances by Graham that no diversion is intended and that such funds would be used to maintain JCAH accreditation, Kildee admonished, "Unless you can provide this committee with better proof than you offered this morning that Medicare/Medicaid collections will not be diverted then we're going to disallow it."

In defending proposed cuts in the CHR, urban, Indian health manpower and tribal management programs, the HHS witnesses did not once criticize the programs or question their effectiveness. Rather, Graham reasoned that "During these times of fiscal restraint highest priority must be given to provision of inpatient and outpatient medical care services."

Conference Notice

Due to an unexpected conflict in schedules, the dates for the Sixth National Indian/Alaska Native Health Conference in Reno, Nevada have been changed. The conference dates, which had previously been set for May 21-24, 1984, have been changed to June 4-7, 1984.

Conference registration and hotel reservation forms are included in the center insert of this issue and additional information about conference speakers, workshops, etc., will be announced shortly. The National Indian Health Board regrets any inconvenience caused by the change in schedule.

Questions about conference registration, housing, exhibits, awards, or agenda topics should be directed to: Scott Cull; National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231.

Continued from Pg. 1

Continued on Pg. 9
$28 Million Cut Sought for Indian Health Care in FY '85

WASHINGTON, D.C. — In an Indian Health Service budget proposal closely resembling the one it submitted last year, the Reagan Administration is once again urging discontinuation of the Community Health Representative and Urban Health programs as well as substantial decreases in the Indian Health Manpower program. No money is sought for new or replacement facilities. And once again, the budget relies heavily on IHS' ability to collect "third party reimbursements," primarily Medicare and Medicaid.

Overall, the Administration is asking $741.95 million for Indian Health Services, $28.46 million less than appropriated in Fiscal Year 1984. No money is requested for Indian Health Facilities whereas $53.56 million was allocated for the current fiscal year.

The Administration is again seeking elimination of the Community Health Representative (CHR) program "in an effort to focus IHS budgetary resources on maintaining key inpatient and outpatient medical care services." The program has received strong support from the IHS medical community, as evidenced by last year's petition by the IHS National Council of Clinical Directors (comprised of all IHS physicians) urging continuation of the program and citing the CHR's importance to their own medical efforts. The program is currently funded at $30 million, with $26 million in direct appropriations and an additional $4 million designated for Emergency Medical Services provided by CHR's.

For the fourth year in a row, the Administration is proposing elimination of the urban health program on the basis that "non-reservation Indians will be eligible for health care under various alternative programs, supported by Federal health block grants, and other state and local funding agencies." The justification is the same offered last year despite the Administration's failure to gain support for this argument in Congress. In FY 1984 the program (which includes some 37 projects) received an appropriation of $9 million. The funding is supported under Title V of the Indian Health Care Improvement Act which was enacted because existing state and community health facilities were not serving or refused to serve Indian patients.

The IHS budget justification offered by the Administration states that "IHS has suffered shortages of the critical health manpower required to effectively provide health services." It further notes that the four universities supporting Indian Master of Public Health (MPH) programs and one university supporting the INMED (Indians Into Medicine) program "provide a valuable service to the IHS manpower effort by providing assistance with the identification and recruitment of students for the IHS scholarship programs." The FY 1985 request of $4.63 million (a reduction of $1.37 million from the FY 1984 level of $6 million) will provide scholarship funding for 416 continuing students and 50 extern placements. Nonetheless, funding would not be provided for approximately 63 continuing students and support for the INMED and MPH programs would be eliminated. No explanation is offered for elimination of these funds.

The Administration states that IHS plans to collect $55.4 million from Medicare and Medicaid in FY 1985 in an effort to increase the portion of services supported by reimbursements. (Additional collections are projected from private insurers.) The IHS budget justification states that "there is not sufficient data to fully assess" the impact and effect of its new Medicare collections methodology initiated this fiscal year and that "states will be doing as much as possible to reduce the costs of their Medicaid program." Nonetheless, nearly $65 million of the FY 1985 hospital and health clinic program counts upon such reimbursements for support.

Total "clinical services," including programs for hospital and health clinics, dental health, mental health, alcoholism, contract care, and maintenance and repair, were appropriated $637.52 million in FY 1984. $647.21 is proposed for FY 1985, assuming some $65 million in "third party reimbursements.

To cover the IHS cost of maintenance and repair of 47 hospitals, 84 health centers, more than 300 health stations, over 2,000 groups of personnel quarters, and other facilities, the Administration is suggesting a figure of $8.75 million. This total reflects a decrease from 1984, showing almost $10 million less than the $18.27 million of the current year. The cutback also reflects the end of a program to accommodate the backlog of maintenance and repair needs.

A large decrease in the 1985 proposed budget lies in the "preventive health" category that includes sanitation, public health nursing, health education, community health representative and immunization programs. The proposed preventive health budget, reflecting a recommendation that the CHR program be eliminated and three of the other four programs be cut, is $31.62 million, nearly $30 million less than in FY 1984.

The Tribal Management program, a program designed to help promote capacity-building activities for tribal health programs, especially with new tribes with few or no resources for development, would be eliminated in FY 1985 under the proposed budget. The program is currently funded at $2.63 million.

Each year since 1979, in spite of apparent increases in its budget, there has been a decrease in the IHS per capita expenditure for the Indian service population. This information is according to figures supplied by the Health Services and Resources Administration for the FY 1984 budget hearings, taking into account health care cost inflation and adjusting fiscal amounts to remain in constant 1974 dollars. Health Care Finance Administration figures submitted for the same hearing record (reflected in constant 1974 dollars) show that since 1979 the gap between the amount of money spent on each Indian person for health services...
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.

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CHAPEL HILL, N.C. — The School of Public Health at the University of North Carolina at Chapel Hill is actively seeking qualified American Indian students who are interested in a graduate level degree in public health. The school offers 32 graduate degrees in nine academic program areas: biostatistics; environmental sciences and engineering; epidemiology, health policy and administration, health education, maternal and child health, nutrition, parasitology and laboratory practice, and public health nursing. Some of the degree programs are broken down into sub-areas for greater specialization. The American Indian Recruitment Program offers assistance in obtaining financial aid and other support. For additional information contact: The American Indian Recruitment Program; University of North Carolina at Chapel Hill; School of Public Health; Chapel Hill, N.C. 27514. Phone (919) 966-3534 (collect).

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WASHINGTON, D.C. — The National American Indian Court Judges Association (NAICJA) has been awarded the 1983-84 family law/child welfare training contract of the Bureau of Indian Affairs' Division of Social Services. Under the contract, NAICJA will be responsible for providing training to court and social service personnel in each of the BIA's 12 areas. Topics covered at the NAICJA training sessions include Networking; Adoption and American Indian Children; How to Prepare and Make Courtroom Presentations; Grants Management, and other issues related to family law and child welfare. Workshop topics and instructional staff are chosen after consultation with the area's Indian Child Welfare Act grantees and tribal employees. According to NAICJA President Judge Homer Bluehorse, the contract "fits with our concern for upgrading tribal juvenile and family court services and provides us an immediate means for focusing on the problems affecting American Indian children and families." Schedules and agendas for the training sessions are currently being developed. For additional information, contact: Jenny Long; NAICJA; 1000 Connecticut Avenue NW, Washington, D.C. 20036. Phone: (202) 296-0685.

* * * * * * *

POLACCA, ARIZ. — Hopi Indian students at the Polacca Day School succeeded in raising more than $2,000 for cancer research at St. Jude's Children's Research Hospital in Memphis, Tenn. The hospital is a leading research facility concentrating on the alleviation of such childhood diseases as lymphocytic leukemia, Hodgkin's disease, and other types of cancer. Students at the school raised the money during a special "math-a-thon" in which sponsors contributed donations for correct answers to math problems worked out by the students. The students worked on a set of 200 math problems over a ten-day period.

* * * * * * *

ROCKVILLE, MD. — Indian Health Service (IHS) has announced a major reorganization of its headquarters operations here that will consolidate a number of the agency's divisions. As described in the Federal Register January 27, the reorganization establishes four major offices to replace seven previous administrative divisions. The four offices, which will each be administered by an associate director, are: the Office of Administration and Management, which will provide IHS-wide leadership, management, and coordination for a number of administrative, personnel, and fiscal activities; the Office of Planning, Evaluation and Legislation, which will provide long-range program planning and evaluation, inter-agency coordination, legislative analysis and proposals, statistical reporting, policy analysis, and preparation of agency regulations; the Office of Program Operations, which will provide for direct supervision and coordination of all IHS clinical and tribal health delivery systems, monitors quality control and operational planning activities, and provide guidance for the agency's environmental health, occupational health and safety programs; and

Continued on Pg. 5

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$28 Million . . .

Continued from Pg. 3 and that spent on the general U.S. population has grown substantially each year.

A comparison of the Fiscal Year 1985 budget proposed by the Reagan Administration with amounts appropriated last year follows:

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</table>

Indian Health Facilities: $37,700 $53,595 —
Continued from Pg. 4

the Office of Tribal Activities, which will promote tribal and community participation in the delivery of health services, assist tribes in contracting for health programs, develop policy and standards for all tribal contracts, and provide broad guidance on the conduct of tribal contract reviews by IHS Area Offices. Overall direction and leadership of IHS will continue under the Office of the Director, according to the announcement. Copies of the Federal Register notice can be obtained from the NIHB Public Information Office.

ROCKVILLE, MD. — A booklet on Fetal Alcohol Syndrome, entitled "Preventing Fetal Alcohol Effects: A Practical Guide for Ob/Gyn Physicians and Nurses", has been published by the National Clearinghouse for Alcohol Information and is available free of charge upon request. The guide is written for health care professionals and is designed to assist them in identifying patients who are subject to the health hazards associated with alcoholism during pregnancy. The debilitating effect of maternal alcohol consumption during pregnancy, known as Fetal Alcohol Syndrome, is one of the leading causes of birth defects in the U.S., and research has shown that the incidence of FAS is particularly high among the American Indian population. Copies of the guide may be obtained by contacting: The National Clearinghouse for Alcohol Information; 1776 E. Jefferson St.; Rockville, MD 20852. Phone: (301) 468-2600.

MINNEAPOLIS, MINN. — The Third Annual Minnesota Indian Institute on Alcohol and Drug Studies has been scheduled for August 6-17, 1984 at the University of Minnesota West Bank campus. The major thrust of the Institute is in the areas of prevention, treatment, and program management. Questions regarding the submission of papers and the agenda for the Institute should be directed to: Bev Ringsak; Dept. of Conferences; 335 Nolte Center; University of Minnesota; 315 Pillsbury Drive, S.E.; Minneapolis, Minn. 55455. Phone: (612) 373-3843.

BERNALILLO, N.M.—The Pueblo Indian Parent Education Project recently published a guide for health professionals and programs concerned with parent education and prevention of developmental disabilities in Indian children. The Growing Path: Traditional Infant Activities for Indian Children is a large-format 16-page booklet that provides descriptions of traditional infant care practices that have been shared by parents concerned about maintaining and fostering Indian child rearing patterns. Prepared by the Pueblo Infant Parent Education Project, which provides home-based early intervention services to 7 Pueblo Indian communities in New Mexico, The Growing Path addresses the needs of Native American families and provides a model for other programs interested in preparing parent handbooks that build on cultural and community traditions. Copies of The Growing Path may be obtained from the Pueblo Infant Parent Education Project; P.O. Box 788; Bernalillo, NM 87004.

ALBUQUERQUE, N.M. — Technical assistance in developing tribal codes for child welfare and/or state/tribal agreements with an emphasis on encouraging permanency planning is currently being offered by the American Indian Law Center. Tribes interested in having AILC staff work with them on reviewing, revising, or drafting a children's code may request such assistance through October, 1984. Costs for the services are negotiable with 75 percent being paid through funds appropriated to AILC through the Department of Human Development Services. The remaining 25 percent must be picked up by the service recipient. For additional information, contact: Nancy Tuthill or Toby Grossman; American Indian Law Center; PO Box 4456, Station A, Albuquerque, N.M. 87196. Phone: (505) 277-5462.

TSALIE, ARIZ. — The Navajo Community College will coordinate a new program to train Navajo paraprofessionals who serve developmentally disabled persons. The purpose of the program, which is based on a curriculum developed by Meyer Children's Rehabilitations Institute at the University of Nebraska, is to improve a community's ability to care for their handicapped people rather than placing them in institutions. A class of 34 Navajo paraprofessionals from various reservation agencies that serve the handicapped recently completed the program here.
Proposed Budget Cuts Threaten Q

From time to time we reprint articles published in the non-Indian media in order to provide our readers with a perspective of how others view Indian health care. In the following article, excerpted from an eight-part series entitled “The New Indian Wars” that appeared in The Denver Post last fall, reporter John Aloysius Farrell examines the status of the Indian health program and the efforts to reduce or eliminate certain programs of the Indian Health Service. Although most of the FY 1984 Administration recommendations described by Farrell were rejected by Congress last year, the article remains relevant because the Administration has requested virtually the same budget for IHS in FY 1985, as reported elsewhere in this newsletter. Among other matters, the article discusses the proposed reduction of the Indian health scholarship program; the elimination of the Community Health Representative (CHR) program, urban Indian health services, and Indian health facility construction program; and the heavy reliance on projected third-party reimbursements (Medicare/Medicaid, private insurers, etc.) to offset direct funding for IHS.

We appreciate the permission of The Denver Post to reprint the portions of this article. Copies of a 72-page, full color special reprint of “The New Indian Wars” in its entirety can be obtained for $3.00 from The Denver Post; 650 15th St., Denver, Colo. 80202.

The name of his home is Be-Nun-I-Kin — the House on a Hill. It was christened by a delegation of Navajo, and it was the treatment of his Indian constituents that Barry Goldwater had on his mind.

Arizona’s senior senator was shamed and angered by the testimony of Indian witnesses at a congressional hearing in Phoenix. So he did something rare: he took their words back to his living room, with the panoramic view of the city behind him, sat alone at his desk, and began a letter to his friend, Ronald Reagan.

“Dear Mr. President,” Goldwater wrote. “In the over 207 years that we have had a government, in well over a hundred years of our relationship with our Indians, we have never, I repeat, never, lived up to the moral obligations that we owe these people.”

Goldwater listed a few examples: Native Americans are the most “grossly abused” people he knew of in the field of human rights. The Navajo tribe is dogged by the highest unemployment rate in the nation. The Office of Management and Budget has decided that America won’t build any more Indian hospitals. The Indian Health Service has threatened to stop paying for dying dialysis patients.

“I’m just plain fed up, sick and tired of the neglect of these people,” Goldwater concluded. “Please, let’s establish something in our own back yard that we can begin to be proud of. Let’s act toward each other in this country like we really mean what we talk about.”

“Some critics may say that there is already a tremendous amount of money going to the Indian reservations,” Goldwater said later. “And I say those critics should go out to the reservations and see for themselves the unbuilt hospitals, the unclothed and hungry children, the lack of school facilities, and the washed-out dirt roads.”

This was no sappy Eastern liberal writing that letter, no spend-us-into-ruin Democrat, no whisky-faced Boston bleeding heart. This was a man who went by the nickname “Mr. Conservative,” a man whose grandfather had been shot by angry Indians while settling the territory of Arizona—a man quite familiar with the problems that face America’s Indians.

“...and that there can be no more sugar-coating.” — Senator Barry Goldwater

Goldwater’s comments reflect the anger of his Native American constituents and their fears that the Reagan budget cuts are hurting, not helping, the cause of Indian self-sufficiency.

It was only last January that the White House released its formal statement of Indian policy. In seven pages of well-reasoned and sometimes eloquent prose, Ronald Reagan set out his agenda for Native American affairs. The premise was simple: It is time for the United States to get out of the Indian business.

David Lester, a member of the Creek tribe, is the executive director of the Council of Energy Resource Tribes, an organization of thirty-seven tribes whose reservations are blessed with energy resources. Before taking that position, Lester served in the administrations of both Jimmy Carter and Ronald Reagan.

“I was part of the subcabinet team that worked on the President’s message,” he says. “There was one voice in that message coming from the Office of Management and Budget, and that was to get out of the Indian business, to call it self-sufficiency, or self-government, or self-determination, or whatever, but only as sugar-coating on the pill.”

“The other voice in the message realized that there is a link between the government and Indians that cannot be erased. To them, the words aren’t smoke screens or sugar-coating.

“And so it comes down to the apparatus of implementation,” Lester says. “And not only have the budgets been reduced, but those areas which would implement the President’s message—job training, economic development—have been cut the heaviest.

Sen. Barry Goldwater
The Sixth National Indian/Alaska Native Health Conference

June 4-7, 1984 * MGM Grand Hotel * Reno, Nevada

Sponsored By The National Indian Health Board
HOTEL RESERVATION FORM
Sixth National Indian / Alaska Native Health Conference
MGM Grand Hotel
June 4-7, 1984
Reno, Nevada

MAIL TO: MGM Grand Hotel
Attn: Room Reservation Department
2500 East Second Street
Reno, Nevada 89505
1-800-648-5080

IMPORTANT: Please make all reservations through the MGM Grand Hotel. The MGM Grand Hotel will serve as the conference headquarters and we have a block of rooms reserved there. We have secured an excellent room rate of $42.00 (+ 7% tax) per night for both single and double occupancy, and we encourage all conference participants to stay at the MGM Grand Hotel as it is a self-contained facility. In addition the MGM Grand has a free shuttle service to and from the airport, and to and from the Reno downtown area. Please see the picture caption for other hotel facilities.

To ensure availability of hotel rooms, reservations must be made by May 4, 1984. Please forward one night's room deposit of $42.00 with the Hotel Reservation Form, or provide a credit card and credit card number to which the room can be charged. Room Deposit is refundable if reservation is cancelled 24 hours prior to arrival date.

Conference participants who plan to stay at the MGM Grand Hotel are encouraged to register as early as possible. As a special incentive, conference participants who make their hotel reservations at the MGM Grand Hotel prior to May 4, 1984, will be eligible for a random drawing for a free ticket to the renowned stage production "Hello Hollywood." One free ticket will be awarded for every 75 persons registering prior to May 4, 1984.

Please Print or Type All Information Below

Arrival Date ____________________ Time ____________________ Departure Date ____________________

NAME(s) __________________________________________ Telephone # ( )

ADDRESS __________________________________________

Room Required: Single __ Double __ Amount enclosed $ __________

Credit Card Name __________ Expiration Date __________ Credit Card # __________

THE SITE OF the Sixth National Indian / Alaska Native Health Conference will be the MGM Grand Hotel in Reno, Nevada, a 2,001-room resort/hotel located at the base of the High Sierras directly adjacent to the Truckee River. With its extensive facilities the MGM Grand Hotel will serve as the self-contained headquarters for all conference assemblies, workshops, exhibits, and other activities. The hotel contains seven international restaurants, entertainment lounges, 50 bowling lanes, two movie theaters, and recreational facilities. A special conference room rate of $42 (single and double) has been secured for attendees.
REGISTRATION FORM
Sixth National Indian / Alaska Native Health Conference
MGM Grand Hotel
Reno, Nevada
June 4-7, 1984

Sponsored by the National Indian Health Board

“The Key to Prevention -- YOU!”

This form can be used for Pre-Registration or Registration. Each participant should pick up their conference packet at the registration area at the MGM Grand Hotel. Name tags will be included in the conference packet and must be worn to be admitted to the General Assembly and Workshops. The registration fee entitles registrant to receive conference materials, access to the Conference General Assemblies, Workshops, and Exhibit Area, and a conference report.

Registration Fee:
1. Pre-Registration — $50.00 (post marked not later than May 11, 1984.)
   Pre-Registrants will receive the conference poster free of charge.
2. Registration — $50.00 (at the Conference site)
3. Student Registration — $30.00

Make Checks Payable To: National Indian Health Board (N.I.H.B.)

Mail Pre-Registration To: National Indian Health Board
1602 S. Parker Road, Suite 200
Denver, Colorado 80231

NOTE: The National Indian Health Board will acknowledge receipt of all Pre-registration by mail. If you do not receive an acknowledgement within 15 days, please call the NIHB central office at (303) 752-0931. Refund of Pre-registration fee will be made only for written requests that are received at NIHB by May 11, 1984.

Name ___________________________________________ Telephone ( ) _________________________
Address ___________________________________________________________________________________
City, State, Zip Code _______________________________________________________________________
Organization/Tribe _________________________________________________________________________

Do Not Write Below This Line (For Office Use Only)

Amount Received $ ___________ Check # ___________ Money Order # ___________ Cash ___________
Date Received ___________ Received by __________________________________________________________
"How far will the Indian standard shrink? After a lot of dead children and sick adults?" Lester asks. "In the absence of a policy backed by action and money, the message has become a smokescreen."

The Administration's actions have certainly matched its words. The cost-cutters at the Office of Management and Budget attacked the Indian programs with a vengeance from the moment Reagan took office.

The Indian Health Service, for example, had been singled out by Congress in 1976 for its underfunded programs and obsolete facilities. Half the IHS hospitals could not win accreditation; a third could not meet national fire and safety standards; more than fifty new or remodeled health centers or clinics were needed.

The IHS is chronically understaffed. More than 800 doctors and 3,000 nurses would have to be hired to bring Indian health care up to national standards. In the Midwest and northern Great Plains, the average IHS facility has only 45 percent of the doctors and nurses needed to provide even a minimal level of care—and most of those who do serve are fresh out of medical school and are spending time on the reservation only to fulfill the terms of their public health scholarship. Few are Indians.

Despite these handicaps, the IHS has managed to make some dramatic improvements in Indian health.

Yet there are still diseases that specialize in attacking Indian families. Otitis media, a disease of the middle ear, strikes 60,000 Indians each year. The average Native Alaskan baby can expect to have two acute attacks of the disease before his or her first birthday. One-fourth of these children will have chronic problems throughout their early childhood—when speech and language formulation is taking place—and may suffer from learning disabilities. From 10 to 15 percent will lose all hearing. A backlog of several thousand patients awaits the simple surgery that can prevent deafness.

The Standing Rock reservation in North and South Dakota contains the second poorest county in the nation, with a per capita income of only $2,642. For every thousand Sioux Indians born at Standing Rock, 36 die before their first birthday. But for the state of North Dakota, only 11 of every 1,000 babies die in their first year of life. Even some Third World countries have better records: In Cuba, infants die at a rate of 19 per thousand.

The average age of death for American citizens is 65. But on the Navajo reservation, people are dead—on the average—by the age of 42.

Such statistics, however, did not stop David Stockman's budget analysts from dismantling the Indian health budget. The first target was a scholarship program for Indian medical and nursing students. To reach parity with the rest of the American population, about 6,000 more Indian doctors and nurses are needed. But the Reagan administration asked Congress to cut the scholarship program in half in 1982 and to eliminate it completely from the 1983 and 1984 budgets.

Other easy targets were the forty-one urban health centers established to serve 700,000 American Indians—about 50 percent of the total Indian population—who live in or near American cities. Again, Reagan urged Congress to cut funding for the health centers by half in 1982 and to eliminate them entirely in 1983 and 1984.

Despite the dramatic improvements that federally built housing and sanitation projects have made in reducing Indian infant mortality and communicable disease, 90,000 Native American families still live in homes that need either replacement or repair. One-third of all houses on Indian reservations still lack adequate water and sewer systems. About 50,000 Indian families rely on water from ditches, hand wells, and melted snow.

Yet Reagan has urged Congress to eliminate funding for any new Indian houses or sanitation systems in the past three years. And about $2 million worth of new federally built homes sit empty on Indian reservations because IHS has not had the money to build water and sewer systems for them.

One of the biggest problems in providing adequate health services for Indians has been the isolation of many large Western reservations. Thousands of Indians live in sparsely settled rural areas far from clinics and hospitals. Trips to the closest doctor may take all Continued on Pg. 8

ACCIDENTS ARE THE number one cause of death on Indian reservations. Here, Emergency Medical Technicians and tribal CHR's attend to a traffic accident victim.
**Proposed Budget . . .**

Continued from Pg. 7

day, especially in winter, when already bad roads are closed by snow or mud.

To meet this problem, a Community Health Representative program was authorized by Congress. The health reps provide ambulance service and emergency medical care for victims of traffic accidents and heart attacks; they travel to remote areas to immunize children and check for cases of otitis media; they visit the elderly to give physical examinations and supervise medication; and they operate well-baby, nutrition, preventive health care and eye and ear clinics.

"Some critics may say that there is already a tremendous amount of money going to the Indian reservations. And I say those critics should go out to the reservations and see for themselves the unbuilt hospitals, the unclothed and hungry children, the lack of school facilities, and the washed-out dirt roads." — Goldwater

According to the congressional testimony of Indian Health Service officials, the CHR program is even cost efficient. The price tag of medical care for Indians might skyrocket without it—since the health representatives catch ailments like otitis media, valvular heart disease, cataracts, and angina at an early stage, when treatment is relatively cheap. The program is so successful that Canadian and African health officials plan to copy it. But the Reagan administration has urged its elimination.

The IHS currently operates forty-eight hospitals, twenty-one of which were built before World War II. Over 13,000 Pima and Maricopa Indian patients from Arizona's Salt River Indian community, for example, are treated each year in an IHS hospital in an old wooden military surplus building of only 1,400 square feet. The doctor's office is a supply closet. Rain leaks through the ceiling of the patient's waiting room. The floors aren't strong enough to support modern medical equipment.

But the Reagan administration reduced the IHS budget for new hospitals from $25 million in 1981 to $9.5 million in 1982 and planned to eliminate all funding in 1983 and 1984.

When a new $22 million hospital—approved by previous administrations—was constructed at Chinle, Arizona, it remained half-closed for a year because no housing had been built for the medical staff. Instead of hiring new health professionals for Chinle, the IHS wants to "redeploy" doctors and nurses from already understaffed hospitals that serve other Pueblo, Hopi, and Navajo communities, while admitting that "the capabilities of each of the hospitals will be reduced because of the reduced staffing level."

In attempting to cope with inflation and budget cuts, the IHS has had to restrict the availability of expert care from non-IHS hospitals and specialists.

In the Northern Plains states, for example, 685 Indian patients have been waiting—some a year or more—for medical care that the IHS does not have the experts to provide, or the money to pay for. Because they are not life-threatening situations, treatment for these Indians—about half of whom are children—has been postponed indefinitely. There are Indians sick with diabetes, and those who need operations to repair ruptured ear drums, or gallbladders, or cleft palates.

The IHS estimates that 23,000 Indians across the country are awaiting surgery for such serious and painful ailments as otitis media, mastoiditis, cataracts, and hernias. Many face progressive blindness or deafness while they wait.

"I think it is only correct to say that service has suffered as a result of the declining resources," said Dr. Everett Rhoades, the Kiowa Indian who heads the IHS, while testifying before a congressional subcommittee last spring.

"For example," Rhoades said, "a young woman may be permitted to stay in a difficult labor longer than the physician would wish, before being referred to specialized obstetrical care."


"It could be life-threatening, yes," said Rhoades.

"Why would you do it?" asked Yates.

"The only reason one would do it would be because the physician would face a dilemma in trading off dollars for that patient versus some other patient that might be even more urgent the following week," Rhoades said.

Despite the budget cuts, Rhoades is respected among American Indian leaders. So is Ken Smith, his counterpart at the Bureau of Indian Affairs. They are, at least, Indians, and they have fought for the tribes in Washington.

But they do not have the final say—not even a major voice—in the decisions on Indian appropriations. That role is reserved for the Office of Management and Budget, a fact which bitterly galls America's Indians and even Smith and Rhoades.

"They don't understand," says Smith, when asked about David Stockman's staff of budget analysts. "I think they want to understand and some of them have actually been on a reservation. They don't know what life is out there."

In justifying its budget cuts in 1983, for example, OMB decided that $30 million would be recovered by IHS from Indians who are also covered by Medicare and Medicaid. The final amount collected was only $11 million.

Learning nothing from the $19 million shortfall, the OMB analysts decided that $40 million could be collected from Medicare and Medicaid in 1984, in addition to $30 million from the Indian beneficiaries of private insurance plans.

"What is your guess, are you going to get the full amount?" Yates asked Dr. Robert Graham, the administrator of the Health Resources and Services Administration, which includes the IHS.

"Quite honestly I don't know," said Graham. "The $30 million figure was a figure which was developed wholly in the Office of Management and Budget."

"Do they have any idea as to how many private beneficiaries there are?" Yates asked.

"None they were able to share with us," said Graham.

Continued on Pg. 9
Continued from Pg. 2

"So that is just a figure drawn out of the air, isn't it?" Yates asked.

"Yes, as far as I am concerned it is," Graham replied.

The only way to recover $30 million, Rhoades says, is to bill individual Indians for services now paid for by IHS, a concept that would violate the terms of dozens of Indian treaties, strike up a "political firestorm," and ignore the language of several acts of Congress. If the money is not recovered from Medicare, Medicaid, or private insurance firms, IHS will be forced to cut further its preventive health, surgical, and specialized care.

The budget cuts already have started to affect the health of Indians, according to the testimony this summer of witnesses before the Republican-controlled Senate Select Committee on Indian Affairs, in the hearings that spurred Goldwater's letter.

IHS officials from the Northern Plains states told the committee that tuberculosis cases increased 53 percent from 1981 to 1982 and 400 percent in the first five months of 1983. Sudden Infant Death Syndrome cases have also risen sharply at Pine Ridge, the nation's poorest reservation, until the rate of such deaths is now four times the national average.

"I can't prove this, but one of the things that I think that's been really disastrous and may be more of a disaster is a decreased number of outreach workers like the Community Health Representatives," said Eleanor Robertson, who heads the Aberdeen, S.D., office of the Indian Health Service, when testifying before the committee.

"Unless you increase people somewhere—and I know the Administration doesn't like to hear that—then I believe that you're going to see instances of disease that should not be occurring at all," she said. "I think that is one of the tragedies that I see in this kind of budget-cutting climate."

A longstanding problem in Indian health care has been the tendency of private and public hospitals to turn Indian patients away from their emergency rooms. "In addition to the inadequacy of health care and unsafe conditions found to exist on some reservations in Indian Health Service hospitals, non-Indian hospitals have refused to take Indian patients," wrote the U.S. Commission on Civil Rights in a 1982 report.

In Farmington, New Mexico, for example, the San Juan County Hospital was sued by an Indian legal services team and the U.S. Department of Justice after a Navajo woman died on route from the hospital—where she had received rudimentary care and was discharged before her condition stabilized—to an IHS facility.

The hospital agreed in a pre-trial settlement to treat Indians in its emergency room, and Congress thought it had solved such problems by providing millions of dollars for non-IHS contracted care under the terms of the Indian Health Care Improvement Act of 1976.

But with the Reagan budget cuts, IHS officials have had to warn public hospitals and Indian patients that the government will not pay medical bills if the case is not found to be a bona fide emergency, fostering doubt in the minds of Indian patients and the non-IHS doctors who treat them.

At the Fort Berthold Reservation in North Dakota, for example, Indians are hesitant to drive to a public hospital only 50 miles away because the IHS may dispute their interpretation of what is an emergency; instead, they travel to an IHS facility 144 miles distant.

"We have heard some terrible stories about Indian people who have died because of this cumbersome process," said North Dakota Sen. Mark Andrews, the Republican chairman of the Senate Select Committee on Indian Affairs. "The major problem is that the non-IHS doctors are going to suspect they are not going to be paid. The horror stories of Indians having to drive 144 miles to get IHS permission before they can get care that is 25 miles away is idiotic and has no place in this country.

"The problem that we have is that the people in the Office of Management and Budget have never been on a reservation. They don't really know what the need is out there. They look down their own block and their own delightful suburb of Washington and they think everything is fine with the doctor and his Mercedes on every block. That isn't the real world," Andrews said.

Tribes, Indian Organizations . . .

Continued from Pg. 2

In a move of support for the program, Senator Melcher announced plans to request a General Accounting Office study to evaluate the CHR's cost-effectiveness. He stated, "We need a broad study to determine just how important the CHR program is. It's my judgment that we've been short-shifting them." He suggested that such a study could be completed in the next eight to ten months.

Melcher further questioned the Administration's proposal to eliminate IHS tribal management funds which currently support preparatory development for tribes wishing to manage their own health programs. He questioned Graham saying, "Your statement says you plan to assist tribes in achieving Self-Determination. Yet you are zeroing out tribal management funds. This appears to be contradictory." Graham argued that IHS makes available other training and technical assistance to tribes interested in developing contracts for IHS programs.

Asked for an explanation of the proposed cut in Indian health manpower program funding including elimination of the Indians into Medicine (INMED) and Masters of Public Health programs, Graham again cited fiscal constraints and added, "We have no data to suggest that the program has been ineffective."

Speaking on behalf of the four Indian MPH programs, Clara Sue Kidwell of the University of California, Berkeley, requested $240,000 to maintain the current level of services. One hundred and forty one
Four years ago we published a report on the radioactive spill in Church Rock, NM, an accident which deeply affected the lives of the Navajo residents in and around that area. In the following article, Sandy Tolan of the Southwest News and Information Bureau reports on the aftermath of the largest uranium waste spill on record and how Church Rock residents are still frightened over possible adverse health effects from the radioactive waste.

FLAGSTAFF, ARIZ.—Four years after the largest uranium waste spill on record, residents living in the checkerboard region in and around Church Rock, NM, say that their lives are still not back to normal.

On July 6, 1979, 94 million gallons of radioactive water and 1,010 tons of solid uranium waste broke through a hole in a dam at the United Nuclear Corporation’s Mill northeast of Church Rock.

People living near the river reported seeing the quiet summer streambed turned into a rushing yellow river. They watched as New Mexico state environmental officials posted signs warning residents to stay away from the Rio Puerco.

Some of the contamination traveled all the way to Holbrook, Arizona, where it vanished into the Little Colorado River. Much of the rest of the contamination disappeared into the streambed below the river. The remainder was cleaned up in the days following the spill.

Today, there is still much confusion over whether the spill ever caused any damage. Residents of Church Rock say it has. Many report increased deformities from lambs and calves born since the spill. “It’s kind of hard to raise them the way we used to,” said Lena Willie, who lives along the river. “They die on us. They can’t stay away from the river any way. They still go down there.”

However, government officials say there is almost no evidence of long or short-term adverse health effects from the spill. The Federal Center for Disease Control (CDC), after studying eight Church Rock animals and three animals from a nearby community, said the risk of contamination from eating the livestock appeared small.

But the CDC added that it might be a good idea for Church Rock residents to avoid eating the animals’ liver and kidney, because the limited tests showed higher than normal levels of radiation in those animals.

The New Mexico Environmental Improvement Division (EIP) said, “Although the spill was potentially hazardous it’s short-term and long-term impacts on people and the environment were quite limited.” However, the agency said the river may still not be safe for watering livestock.

Meanwhile, representatives of a private environmental group, the Southwest Information Center in Albuquerque, NM, believes it is much too early for anyone to say that the spill did not harm anyone, because some of the possible illnesses may take many years to develop.

These various studies and statements have left some Church Rock residents confused over who to believe and bitter toward United Nuclear for not preventing the spill in the first place.

“I’m confused, yes,” said Ted Silversmith, a health worker at the Church Rock Chapter House. “When they first moved in here, I didn’t really know what the uranium was for, and how it was going to affect us. All we knew was there was mining going on over there. At this point, I’m a little angry, too. After that happened, (United Nuclear) just up and went and now the wastes are there. I don’t really know what to say.”

Officials from United Nuclear say the problem is the result of exaggerated press reports and unnecessary regulatory measures. They say the problem could have been helped greatly if there were more communication and understanding between the Church Rock residents and the nuclear company.

“When we hear things like radiation, we don’t have a good sense of what radiation is,” said Stanley Crout, an attorney for United Nuclear. “It’s not something we see or feel. It’s not part of our common experience, so it scares people,” he said.

“United Nuclear doesn’t know of anyone downstream who was harmed,” he continued. “All the studies conducted by any scientific group—the federal, state and private, have all reached the same conclusion: that there was no adverse effect.” Some studies have also concluded that not only was there no adverse effect, but that there will never be any adverse effects.

So researchers admittedly disagree. “Nobody who knows anything about the situation with low-level radiation could ever make a statement like that, because there are still too many questions,” said Lynda Taylor, director of the Radiation and Health section of Southwest Research.

The organization is urging the state to conduct long-term, 30-year studies of a group of Church Rock residents to determine without any doubt what the effects of the Church Rock accident were. “If any particular health effect is going to show up, it’s not going to show up soon,” said Chris Shuey, an associate of Southwest Research. “The industry, and particularly the United Nuclear, would like you to show that you’ve got dead bodies before they will agree that there has been a health effect. We say you can’t tell, and we need to study the people so that down the road, you can tell,” said Shuey.

So far, neither the Navajo Tribe nor any other government body has authorized or funded such a study. The agencies appear more concerned with radioactive contamination seeping from a uranium waste pile at the United Nuclear Church Rock mill.

Thorium from the tailings pile has leaked into groundwater below the site and has moved into monitoring wells that are located at the edge of BIA allotted lands in the New Mexico checkerboard region. There

Continued on Pg. 11
Expanded Hepatitis B Program Proposed for Alaska

ANCHORAGE, ALASKA — The Indian Health Service (IHS) will increase efforts to control the spread of Hepatitis B in Alaska with a proposed two-year, multi-million dollar plan to immunize all Natives against the disease.

The viral infection, which in some cases can cause liver cancer, has struck a large number of Alaska Natives, particularly in rural western Alaska villages. While the incidence of Hepatitis B among the general population is no higher than one percent, it runs as high as 10 percent in some Alaska communities. In certain Alaska Native villages most adults have been infected at one time or another.

The new Hepatitis B immunization plan is the result of recommendations made by a panel of medical experts that convened here February 7-9 to examine past IHS efforts to control the disease. A Hepatitis B screening and immunization program has been underway in Alaska for the past several years, and $1 million was appropriated for the program in FY 1984.

According to Dr. Brian MacMahon, coordinator of the Alaska Native Health Service’s Hepatitis B control program, about 20,000 Alaska Natives have been tested for Hepatitis B in the last three years, about 5,000 have been found to have had the disease at one time or another. Under the proposed new plan, which could cost $7.2 million over the next two years and must still be approved by Congress, the agency hopes to screen all Alaska Natives — about 60,000 people.

About 90 percent of those who contract Hepatitis B recover and develop resistance to the disease, MacMahon says. The remaining 10 percent may be carriers for years. Up to one percent of the carriers can be expected to eventually develop liver cancer, and about 10 percent of the carriers can be expected to have other liver diseases, he says.

Children appear to be especially susceptible to complications from Hepatitis B, which is one reason that much of the immunization efforts are directed toward infants and school children. MacMahon states that children who contract the illness in infancy or early childhood are less able to tolerate Hepatitis B in later years. They may show no symptoms but may become carriers, infecting other people throughout their lives.

Hepatitis B is generally transmitted by close personal contact, and can be transmitted through blood transfusions or sexual contact. However, the virus can also survive on exterior surfaces for a period of time, and for that reason can frequently be transmitted from child to child. Since there is no cure for chronic carriers of Hepatitis B, the emphasis of the program has been immunization with a vaccine that helps the body develop more resistance to the virus. The vaccine is expensive and difficult to store, which adds to the cost of the program. The three-shot Hepatitis B series costs about $110 per person vaccinated.

IHS officials are hopeful that the expanded control effort can begin this fall. The two year Hepatitis B plan will be reviewed by House and Senate appropriations committees in the coming months.
students have graduated to date from the MPH programs and another 56 Indian and Alaska Native students are currently enrolled.

According to Elizabeth Demaray, assistant director of the INMED program, the need for more Indian health professionals is still "clearly evident." She cited a staffing shortage of 50 percent in the Aberdeen area and chronic understaffing in the Billings area. She requested continuation of INMED as a line-item within the IHS budget and funding of $250,000 to maintain the program's recruitment and retention services. "Since March 1980 we have not had one dropout," pointed out program director Dr. Lois Steele.

The President's budget requests no money for Indian health facilities and would transfer the "Indian Health Facilities" program to the "Health Services" budget. NIHB Secretary Donald LaPointe told the House Appropriations Subcommittee on Interior, "We are deeply concerned about this Administration's continued disregard for the planning, construction and maintenance of Indian health facilities." He added that the proposed program move "would cause the IHS construction program to lose its separate identity, and could make future IHS construction appropriations more vulnerable to the Administration's manipulation — such as unwarranted delays in the release of funds and 'reprogramming' requests — that we have witnessed in recent years."

A number of tribes approached the committees regarding funding for construction for sorely needed new or replacement medical facilities in their areas.

With the legislation under which funding for a number of IHS programs are authorized, P.L. 94-437: The Indian Health Care Improvement Act, set to expire at the end of this year, there were numerous mentions of the necessity of continuing the law. Reauthorization hearings were to begin the week of February 27.

Both the Senate Select and House Interior Committees have until March 15 to submit their recommendations to their respective Budget Committees. The Budget Committees will then have until May 15 to consider committee recommendations and draft the First Concurrent Budget Resolution, the legislation which provides guidelines to the appropriations committees in their own deliberations.

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EDITOR: John P. O'Connor
EDITORIAL CONSULTANT: Linda Bossert
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