Senate Markup Keeps 94-437 Well Below Authorized Level

WASHINGTON, D.C.—Appropriations for the Indian Health Care Improvement Act (P.L. 94-437) continue to lag far behind authorized levels following the second round of congressional markups on President Carter’s IHS budget proposal for the upcoming fiscal year.

Although the 94-437 increase recommended by the Senate Interior Subcommittee on Appropriations is substantially lower than last year’s markup, it restores funding levels to several IHS programs that were drastically cut by the President’s proposed budget.

While the President’s budget would force IHS to eliminate funding for Title I of 437, Indian Health Manpower, the Senate Subcommittee matched the $6.8 million approved earlier this year by the House Interior Subcommittee on Appropriations. These funds will continue current programs of recruitment, preparatory and professional scholarships, externs, and education allowances.

The Senate Subcommittee’s appropriation of $3.2 million for Title V, Health Services for Urban Indians, was $500,000 less than the House Subcommittee markup for the same area, but nevertheless represents a marked increase over the president’s budget. Under the latter proposal, funding for Title V would be deleted, forcing an end to new urban Indian health programs started in FY 1978.

Largest of the Senate Subcommittee’s markups was the $7 million increase in Title III construction funds over the President’s allocation of $70 million. But even with the Senate markup, construction funding for FY 1979 would still be $7 million below the $84 million appropriated for construction during the current fiscal year. The House Subcommittee markup for this area was only $600,000.

Despite the Senate increases for 94-437, funding remains far below the levels authorized for the act. IHS Director Dr. Emery Johnson testified earlier this year that a total of $281 million and 760 staff positions were needed in FY 1979 to adequately fund 94-437 and the backlog of unmet Indian health needs in general. Dr. Johnson’s request is reflective of congressional authorizations for the act, and compares to the $65.5 million proposed by the President’s budget.

In addition to 94-437 appropriations, the Senate Subcommittee restored $3.1 million in implementation funds for the Indian Self-Determination and Education Assistance Act (P.L. 93-638), matching the amount designated by the House Subcommittee. Included in this appropriation are technical assistance funds for Tribal Specific Health Planning.

The two subcommittees reached differing figures for IHS Community Development programs, with the Senate $1 million markup far less than the $3.2 million recommended by the House.

Overall, the Senate Subcommittee increased President Carter’s total IHS budget proposal by $15 million, while the House approved a total increase of $17.8 million.

The total IHS budget recommendation for the Senate comes to $481 million for services and $77 million for facilities, which compares to House figures of $490 million and

Continued on Pg. 3
IHS-GAO Disagreements Continue Freeze on Funds

WASHINGTON, D.C.—Despite a tentative agreement by IHS and GAO officials on the bed planning dispute that has delayed construction of ten IHS hospitals, funds for all but two of those facilities will be withheld until IHS develops an acceptable comprehensive bed planning methodology and a priority list for hospital construction, according to Daniel Press, NIHB General Counsel.

Funding for two of the facilities — $3 million for the first phase of construction for a new hospital in Chinle, Ariz., and $550,000 for the planning of a joint Indian/non-Indian facility in Talequah, Okla. — was recommended by the Senate Interior Appropriations Committee August 2. However, funding is still contingent upon resolving the bed planning issues.

Chances Slim for ‘Early Out’ Bill

WASHINGTON, D.C.—S. 666, a bill to allow certain employees of the Bureau of Indian Affairs and Indian Health Service to retire early, suffered a surprising defeat when it before the full House of Representatives here June 26.

The measure was voted down 204-118 after the House suspended its rules requiring prior debate at the request of Gladys Spellmen (D-Md.), Chairwoman of the Subcommittee on Compensation and Employee Benefits. Subcommittee staff blamed the defeat on “a lot of the members misconstruing it as an effort to expand Indian preference while it’s really nothing of the sort.”

Opposition was lead by Rep. Jack Cunningham of Washington, already (in)famous for his introduction of legislation to abrogate the treaty rights of Native Americans. He said, “once again there is the contention that a U.S. citizen who happens to be a treaty American has a special class of citizenship over another U.S. citizen and that I do not feel is right.”

What the proposed legislation would actually do is make a non-Indian employee of the Bureau or IHS with 25 years service or one 50 years of age with 20 years service eligible to retire. It also sets out some very specific exceptions to the absolute Indian preference policy.

It came about as a result of complaints by non-Indian employees in higher level positions that the Indian preference policy has kept them from further advancement for years.

Adopted by the Senate in January and reported favorably out of the House Committee on Post Office and Civil Service, the bill had the support of both IHS and the administration and had been expected to pass with little trouble.

If the bill is not reconsidered during this congressional session, it would be “dead.” Its sponsors have asked the House Rules Committee to bring it to the floor again subject to normal procedures. But, asked to assess the likelihood of another House vote, a sub-committee staff member, gave the bill only “a 50-50 chance” at this point.

Representatives from the Senate, the Department of Health, Education, and Welfare (HEW), and GAO held an informal meeting here June 22 to discuss the bed methodology controversy that has resulted in a congressional freeze on funds appropriated for the ten hospitals in FY 1978.

IHS offered its latest version of the “IHS Acute Care Bed Need Methodology,” which predicts inpatient care needs of the American and Alaska Native population in specific service areas. Although GAO disagreed with parts of the overall IHS bed methodology, it approved application of the process to several of the facilities in question.

“While we (GAO) still had reservations about IHS bed methodology, we were close enough on bed counts for six of the ten facilities to go along with approval of construction funds for those projects,” Joseph Hobbs, GAO Supervisory Auditor, informed Senate representatives at the meeting.

Those six projects are Sisseton, S.D.; Rosebud, S.D.; Pine Ridge, S.D.; Harlem, Mont.; Browning, Mont., and Sacaton, Ariz. IHS came down substantially from its original estimates for these facilities. The Rosebud hospital, for example, was initially forecasted as needing 65 and 70 beds. Under its new methodology IHS would agree to build a 45-bed facility, which is closer to the GAO estimate of 37 beds.

GAO, with Senate committee support, will not approve a go-ahead to the construction of facilities at Shiprock, N.M. and Winslow, Ariz. IHS has been asked to view Navajo as a single service area and develop a Regional Facilities Master Plan before funding for future health facilities at Navajo will be approved, according to Jim Neifert, P.L. 94-437 Title III Project Manager for IHS.

But in spite of the accord reached by IHS and GAO on six of these facilities, funds will apparently remain frozen until two issues are resolved, Press said. The first is an agreement with GAO on the overall IHS bed methodology, and the second is the IHS submission of a priority list for hospital construction.

GAO does not question the need for the new facilities, but rather the IHS analysis of the need for new beds. GAO contends that IHS bed methodology is based on “questionable” assumptions that fail to reflect “the continued declining trend in the use of inpatient hospital facilities in most IHS areas.”

Press specified three problem areas that are currently preventing a resolution of the bed planning dispute.

(1) While GAO and IHS agree that the appropriate formula is 3.7 beds per 1,000 population, GAO argues that a smaller figure should be used when other data indicate a lesser need in a service area. IHS prefers a more universal application of the formula.

(2) GAO demands a more thorough study of expansion needs for mental health and alcoholism centers. GAO claimed present facilities are underutilized and therefore cannot justify the need for additional beds. The mental health and alcoholism facilities at the new hospital in Chinle will serve as a demonstration project to provide further evaluation of bed planning needs in this respect.

(3) Finally, GAO questions IHS’ analysis of bed needs

Continued on Pg. 3
in the conversion from contract to direct services.

IHS has been requested to submit a uniform bed planning methodology which could be applied within all service areas for approval by the House Interior Appropriations Committee before October 1, Press said.

However, Press added that approval of the bed methodology will not end the freeze on construction funds for the ten facilities. GAO and Senate representatives expressed as much concern over the IHS priority system used to determine where hospitals should be built as they did over the bed methodology.

Continued on Pg. 7

**NHSC Program Offers Extra Health Personnel**

Indian tribes suffering from acute health manpower shortages may be overlooking an important source of aid, Charles Deegan, Public Health Region V representative, told members of the National Indian Health Board at their quarterly meeting in Rhinelander, Wisc., July 26.

Few Indian organizations, Deegan said, apply for funding and manpower available to them through the National Health Service Corps (NHSC), which is designed to improve the “delivery of health services through the assignment of physicians, dentists, nurses, and other health professionals to health manpower shortage areas.”

Specifically, tribes may apply through the Rural and Urban Initiative Program for grants of about $200,000 per year for a three year period. The program primarily provides manpower assistance to critical health manpower shortage areas for short periods allowing tribes time to identify other resources for funding.

Tribes can apply for grants and assignment of health personnel from NHSC, Deegan said, but they must initiate the application process themselves and not rely on IHS to make the application or provisions for them.

“One federal agency cannot apply to another for funds. A tribe must organize a health authority itself and apply for funding directly,” Deegan said.

NHSC has been in operation since 1972 and, with 709 health professionals in its ranks, staffs 396 sites in 48 states and Puerto Rico.

To receive assistance from NHSC, a tribe must be designated as a Health Manpower Shortage Area (HMSA) by the Secretary of Health, Education, and Welfare (HEW) and qualify as a public, non-profit organization. Criteria for HMSA are set forth in the January 10, 1978 Federal Register and can be obtained from DHEW Regional Offices.

Information booklets are available containing “everything applicants need to know to qualify for funding,” Deegan said, and may be obtained from: U.S. Department of Health, Education, and Welfare; Public Health Service; Health Services Administration; Bureau of Community Health Services; Rockville, Md. 20857.

**No Date Yet for Hearings**

WASHINGTON, D.C.—The Senate Select Committee on Indian Affairs has received its largest public response ever to announcement of its intention to hold oversight hearings on the Indian Health Service.

According to the committee’s assistant counsel, at least 75 tribal groups and individuals have already notified the committee of their desire to testify once hearing dates are set.

It remains unclear how soon that will be. Chairman of the committee, Sen. James Abourezk of South Dakota, who plans to chair the hearings is leading a filibuster against the Carter administration’s natural gas bill in the Senate. A similar filibuster of a like bill last year lasted about three weeks, according to committee staff.

The primary purpose of the oversight hearings is to examine the satisfaction of IHS health care recipients and IHS’ fulfillment of its requirements in both delivering services and fulfilling its legislative mandates.

Following the hearings the Select Committee will take action on major complaints or problems identified.

All persons who have notified the committee of their interest in the hearings will be contacted by telephone once dates are scheduled, according to Karl Funke, the committee’s assistant counsel. For those unable to testify in person, written testimony may be submitted to the committee up to 30 days after the hearings and will be taken under consideration by Senator Abourezk.

For further information contact Funke at the Senate Select Committee on Indian Affairs; 5331 Dirksen Senate Office Building; Washington, D.C. 20510; Phone (202) 224-3415.

Senate . . . .

Continued from Pg. 1

$70.5 million, respectively. Both are increases over the president’s budget of $473 million for services and $70 million for facilities, but are substantially lower than last year’s markups.

Sol Ordín, IHS Financial Management Branch Chief, offered several possible reasons for the reduced amounts. There is a feeling among some congressmen that Indian programs in the past have been overfunded. He also cited a tax-wary Congress, in the shadow of California’s Proposition 13, for cutting back on overall government spending. However, he added that while IHS will probably not receive approval for its full budget request in FY 1979, it will probably not face the severe cutbacks slated for other government agencies.

Senate and House appropriations committees will convene soon to compromise on the final IHS budget figure. A decision is expected by August 19, according to Orden, and will be forwarded to the president for his signature.
PHOENIX, ARIZ.—Senate and House health committees have adopted amendments to the National Health Planning and Resources Development Act (P.L. 93-641) which aim to prevent Health Systems Agencies (the health planning bodies created under that law) from infringing on tribal sovereignty in health matters.

But, as recently reported by NIHB General Counsel Daniel Press, assuming their passage by Congress sometime yet this summer, “with the best of all possible worlds,” the amendments would not become law until early October. And this being an election year, Congress will likely recess early and a final version may not be out until around Christmas.

Meanwhile, “641 creates more questions than it answers; it causes more problems than it solves.” Perhaps this quote from Intertribal Council of Arizona (ITCA) attorney Joe Sparks most aptly describes the implications of “641” as understood by most tribes at this point.

With the amendments still under congressional consideration and a project to inform and assist tribes in this state with the law approximately two-thirds complete, the advantages and disadvantages of involvement continue to be weighed by tribal groups.

Some persons, including Press, view participation with HSA’s as unavoidable. “There’s no such thing as opting out completely since reservations are included within HSA areas,” he contends. Yet, frustratingly enough, Irene Wallace of the Papago Tribe (forerunners in 641 involvement), said at a May ITCA symposium here that her tribe has received no direct benefit from its efforts.

In the course of its one year project under the Health Resources Administration — due for completion in December — ITCA is holding five symposia to educate Arizona tribes about 641. In the three held to date, each of the several duties of HSA’s and their possible implications for tribes have been reviewed and tribal representatives have discussed alternatives for forming HSA relationships.

“You cannot allow it to . . . dominate you.”

Early on, Sparks warned them, “You cannot allow it (641) to become obstructive nor to dominate you. I think you can afford to participate but if you do so, cautiously.” What Spaks’ remark can be taken to mean is that while many of the possibilities for tribal involvement with HSA’s have positive aspects, they also have the potential to prove detrimental, especially within the conservative political climate in this state.

Tribal Funding Requests Subject to HSA Comment

Of great concern to tribal groups is the authority these bodies (HSA’s) possess to review and comment on tribal applications for certain federal funds. These include applications for programs such as drug abuse, mental health, alcoholism, family planning, EMS, health education, etc. covered under the Public Health Service Act, the Community Mental Health Centers Act, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

IHS funds are not subject to HSA review.

Each HSA establishes its own set of review procedures which conform to federal regulations and guidelines implementing 641 and to other applicable federal and state regulations.

After a project is reviewed, the governing body of the HSA usually forwards its comments to a higher authority (e.g., the state agency or the Secretary of HEW) where a final decision is made.

Positively speaking, Sparks suggests that a tribe can learn from such reviews and remodel a proposed service or facility to be more reflective of needs.

HSA’s are to offer advice and guidance to organizations in their area wishing to establish service “in compliance with the area’s plan.” Specifically with Indian tribes, they are also required to provide information about federal funding sources.

Project consultant William Mack suggests this as a possible source of assistance for tribes in their health planning, although he adds, “HSA’s are obviously not as familiar with Indian health concerns as IHS.”

And unfortunately, the ability to get assistance will likely depend a great deal on a particular tribe’s influence.

If Congress decides to appropriate a proposed Health Services Development Fund approximately 40 cents per person would be available for development of projects and services to carry out the area plan. Such funds would be another potential resource to tribes, says Mack, who also predicts “a good bit of competition among area groups.”

At this point, no exact definition of review and comment as it applies to tribes has been made. Sparks points out that such authority has had very substantial impact with other governmental agencies, citing Environmental Impact Statements as a comparable example.

And it remains to be seen whether review and comment might not have the same practical effect as review and approval, as 641 state and federal entities might be expected to rely heavily on the comments of an HSA (since one of the major intents of the law is to place health planning at a local level).

A fundamental purpose of HSA review is to rationally balance scarce resources (health care funds, manpower, services, etc.) in relation to the established goals and priorities set out in plans developed by the HSA of the community.

Project reviews fall into two broad categories: (1) those relating to applications for grants or contracts for certain federal health funds and (2) those of existing or proposed new health services or facilities.

IHS or other federal facilities are not subject to review of “new institutional health services.” It is not clear whether tribally-owned facilities would be subject to review although there is nothing in the law or regulations which excludes them.

And, it remains unsettled, according to Sparks, whether non-Indians wishing to operate facilities on Indian reservations are subject to state review and approval.

Tribes here are also pondering the fact that many federal fund applications in which they have an interest are subject to HSA approval. Off-reservation community programs serving tribal members and programs used for contract health services are prime examples.
Involvement but Issues are Universal

Reservation and other Indian population totals are counted in figures used to justify designated HSA areas. Ironically, as pointed out by Mike Everett, Health Director for the White Mountain Apaches, although that tribe wants to build a nursing home itself, if the off-reservation group which has expressed the same desire seeks funding from the same federal source, the off-reservation group is entitled to use the reservation population figures in its request.

A Tribal Role in the Area Health Plan?

Matching review and comment in importance to tribes is the role each must choose to play (or not to play) in HSA development of overall health plans for the area. The HSA's statement of desired achievements for improvement in the health status of area residents and in the health systems serving that population is contained in its Health Systems Plan (HSP). The long-range goals and objectives it sets forth provide the foundation for the development of the short-range priority objectives of an Annual Implementation Plan (AIP). Both plans are annually reviewed and revised as necessary.

One of the duties of an HSA is to coordinate with other health planning entities in its area. Applied to plan development, this requirement gives a tribe an opportunity, if it chooses, to present tribal needs, concerns, problems, goals, objectives, etc. for inclusion into the plan. This may be especially important where the reservation and/or tribal population make up a substantial part of the area total.

One practical reason for tribal input into the HSP and AIP relates to project review. When certain proposed uses of federal funds for projects on or near the reservation are subject to review and comment or approval by the agency, they will receive more favorable consideration if the HSP and AIP make provisions for such projects. Projects not conforming with the HSP and AIP usually are not approved or will receive unfavorable comment.

A Connection with TSHP's

Attention should also be paid to how the development of Tribal Specific Health Plans (TSHP's) by tribes under P.L. 94-437 relates to HSP's and AIP's, advises Sparks. In general, the laws provide for parallel and unrelated health planning systems. They both cover about the same subject matter and planning processes and are designed to produce similar results.

At one extreme, says Sparks, there is no necessary connection at all between the two processes. A tribe could proceed entirely on an independent basis to develop its health plan using IHS and other supporting assistance and not coordinate the activity with the HSA at all.

The disadvantage of this approach, he stresses, is that it might be unwise to ignore the possible relationships which could arise later between the implementation of such a tribal plan and the activities of the HSA such as in project review.

Even if a TSHP has been developed independent of the HSA, the tribe could still request that its contents be used in development of the HSP and AIP.

It is also possible that exchange of planning information might be useful during the plan development process, especially if there could be common or mutually supportive goals and objectives between the two entities.

"Unfortunately . . . the free flow of information has hurt Indian people."

But, warns Sparks, "mindful of aggressive political elements tribes must be cautious as to what information is exchanged." He elaborates by saying, "Some Arizona tribes don't wish to share information publicly because of the possible negative aspects of its use. Unfortunately in the past the free flow of information has hurt Indian people. They must now be aware of the political motivations of HSA members."

Continued on Pg. 6

SOME of those who participated in the small group discussions on tribal options for HSA participation following ITCA's initial 641 symposium, held in May: photo on left (I-r): Diane Porter, Southwest Indian Development; Thornton Coochyouma, Indian Health Service, Keams Canyon Agency and Michael Everett, Director, White Mountain Apache Tribal Health Authority, photo on right (I-r): Gevene Savafa, Kaibab-Paiute Tribal Health Department; Marilyn Hunter, Phoenix Service Unit Indian Health Advisory Board and John R. Lewis, Executive Director, ITCA.
Urban Center Seeks Health Personnel

NEW YORK, N.Y.—The American Indian Community House, a mid-town Manhattan Indian center, is looking for two people to help expand its health program. The job openings are as follows:

Job Title: Health Administrator
General Description: Position consists of administering health project, management of staff, coordination of multiple service network and planning.
Salary: $15,000-$17,000
Knowledge, Skills and Ability Required: High motivation and initiative; effective communication skills, written and oral; strong management and supervisory ability; sound judgmental ability.
Training and Experience Required: BS/BA degree, preferably in a health or social service area; two years management and supervisory experience; awareness of Indian values and unique problems.

Job Title: Registered Nurse
General Description: The nurse will be responsible for pre-screening of clients, home visits to the sick and elderly and examination area. Will be responsible to the Health Administrator.
Salary: Up to $14,000
Training and Experience Required: Strong background in medical procedures on the general health level; R.N. degree.

To apply for either position, submit resume reflecting personal history, education, work experience, qualifications and references to: Michael A. Bush; AICH; 10 East 38th St.; New York, N.Y. 10016; Phone (212) 532-4897.

HSA's are to call attention to these issues via the local media. Such an opportunity might also be made use of to help tribes eliminate some of the discrimination against Indians among non-Indian health care providers.

541 agencies are also charged with data management and analysis for use in development of area health plans. Some of this information may cover or include reservation areas. Tribes might find helpful in their own health planning data not adequately covered by the IHS data system. Possibilities might include analyses of motor vehicle accidents and deaths and socio-demographic indicators affecting mental health conditions such as social services and welfare data, divorce and marriage statistics, mental hospital admissions and crime statistics.

Having gained some familiarity with the many pros and cons which must be weighed when considering, or for some reconsidering, HSA involvement, says project director Albert Tippeconnic, "the tribes here now realize that it is important to be aware of HSA activities and that they will be affected by them."

Several are still raising strong questions. Based on "serious questions regarding tribal sovereignty," says Everett, the White Mountain Apaches discontinued participation with their HSA in May.

Wallace says that of the Papagos' two year involvement, they have received no direct benefit, although they have gained "knowledge and a voice over what's happening in the nearby urban area and awareness of what's going on."

Problems with HSA involvement may outweigh the benefits for small tribes, such as the Hopis, claimed Eugene Kaye, Hopi Health Director, at the second ITCA symposium held in May. Supporting his assertion when asked if she belonged to a smaller tribe whether she would consider HSA participation worthwhile, Wallace replied, "very candidly, no."

"What you don't know might hurt you."

On the other hand, speaking as a member of the largest tribal group in the nation, Ron Wood of the Navajo Division of Health Improvement Services, advised the other participants that "the knowledge gained in the 641 process is important and what you don't know might hurt you."

Smaller tribes especially, have a greater chance for making the non-Indian health system accessible through HSA involvement, suggested Press in a small group discussion. This is so, he explained, because contact with the non-Indian health system is substantial among smaller tribes considering contract care, emergency care, and referrals.

Perhaps one of the strongest reasons for tribes to involve themselves is for protection from the often naive attitude of HSA members and staff (who are at least indirectly empowered to plan for their areas). Speaking at the most recent ITCA symposium July 13, William Griffor of the Central Arizona Health Systems Agency told tribal representatives, "You must look at possible gains from cooperative planning. Doing things in isolation is not to the benefit of the community."

"You cannot always look at the greatest good for the greatest number."

In reply, one audience member retorted "you cannot always look at the greatest good for the greatest number
because this outlook often considers residents of rural and reservation areas expendable."

And Everett told Griffor, "With their low health status Indian people cannot be expected to compete for health services and facilities on the same basis as the non-Indian population."

Several options for tribal participation have been discussed throughout the course of the ITCA project. Indeed, Arizona seems to be the ideal place for such a study because of the multiplicity of tribes and relationships already in place. One reservation, the Navajo, is designated exclusively as a separate health service area.

Other tribes which have been involved stress that a written coordination agreement can be extremely important. In addition to developing a health plan for their own area, as a sub-area advisory council the Papagos have representatives on their HSA governing board and governing body.

Whether tribes wish to participate or not, according to the law, says Sparks, an HSA must represent all of its area population segments. If it fails to do so, he contends, a strong case could be made for a separate tribal HSA or an independent relationship with HEW. A tribe might also seek to change the boundaries of its area HSA if it is not being represented and yet comprises a substantial portion of that HSA's land base, he advises.

In addition, tribes may opt not to participate or to participate through HSA committee membership, general committee participation, or formation of an Indian advisory committee.

The primary benefit of tribal involvement as seen by Press is that tribes will be included in health planning "and the need for tribal health planning is critical," he adds.

"IHS ... is losing credibility."

"IHS has been doing an inadequate job and is losing credibility before Congress as a result of the GAO investigations," he maintains. He told those present here in May, "tribes need to do their own health planning."

Although IHS has been a strong proponent of tribal specific health planning mandated at the adoption of 94-437, several representatives here viewed the IHS role in 641 as somewhat shaky. "It's unclear whether IHS will actually support tribal specific health planning priorities when they are considered by HSA's and Congress or whether they will push for their own different priorities," said Dr. Jack Lewin, Director of the Navajo Division of Health Improvement Services.

Everett accused the IHS of "fence-sitting." "We have tried and tried to get something definitive regarding 641 from IHS. What has become of IHS as the advocate for Indian health? They seem to have developed a new phrase that 'this is a tribal matter.' "

(Given a chance to respond to such charges, Tim Shea, Chief of the IHS Health Services Planning Branch, comments that the tribal specific health planning idea originated with the director of IHS and that it would be "nonsensical for us to develop and promote the idea and not follow through with it." IHS will very definitely use the TSHP process to prepare its report to the Secretary of HEW, he affirmed.

He says that IHS has also sent out information dealing with 641 to each of its area offices with instructions to disseminate it to their respective tribes.)

Tribal fears regarding HSA infringement on their sovereignty and problems encountered through involvement with HSA's to date could be alleviated through adoption of the 641 amendments proposed by NIHB now under congressional consideration. "The opportunity for constructive relationships now exists. The real work remains with procuring regulations," says Press.

Representatives of NIHB and ITCA met August 2 with Dr. Robert Graham, Deputy Director of the Health Resources Administration and top representatives from the Bureau of Health Planning (BHP). Press said following the meeting that the HRA and BHP "are fully aware of their failure to act on Indian issues in the past and are open to any form of Indian involvement."

The group plans to meet again in September along with senior BHP staff to sensitize them to Indian concerns and to submit recommendations for 641 regulations policy and overall policies within BHP on Indians.

IHS-GAO . . .

Continued from Pg. 3

"One of the biggest needs we (GAO) foresee, and the senate committee agrees, is for an area-wide planning system to determine what populations need to be served, what services are necessary, and how they will be provided," Hobbs said.

Such a priority list, according to Press, generally accompanies IHS budget requests but often fails to reach Congress. As a result, committees have little guidance on hospital construction and are subjected to tremendous political pressure from tribes to have hospitals built in their areas.

IHS was also asked about the process for developing the priority list. GAO showed that the list often changes. For example, in 1977 a facility proposed for the Blackfeet reservation was number two on the list and in 1978 it was number eleven. GAO questioned whether these changes were due to political factors rather than professional judgments based on the need for new facilities.

Consequently, the Senate requested that IHS submit a priority list and the criteria used for developing that list. Senate representatives indicated that the priority list will "lead to a more rational construction policy within IHS" as well as reduce the influence of political pressure on IHS hospital construction.

Press said funding for the approved facilities would probably be released after IHS complied with congressional requests and received approval for a bed methodology from the House and submitted an adequate priority list to the Senate. No date was determined as to when these agreements might be reached, and when planning and construction of these facilities would begin.

He added that these problems were not the result of analysis by GAO, which is "just a technical arm of the Congress," but rather due to pressure from Senate and House committees that reflects a changing and more responsible role on the part of Congress in overseeing IHS hospital construction.
NIHB Ponders Policy Role and

director remains “categorically opposed” to policy-making by the board.

While the Navajo Area Indian Health Board also serves only as an advisory board, the tribe’s Health and Welfare Committee, on the other hand, has some policy-making power, according to the chairman of both, Elwood Sagane. "Yet," he complained, "IHS doesn’t seem to want to listen to either."

If area boards and NIHB decide to assert themselves in the sphere of policy-making, claim those in favor, such an attitude on the part of IHS would no longer be possible.

Several board members expressed the opinion along with Gonzales, that at the very least, the intent of 638 and additional recent federal legislation entitles Indian health boards to a policy-making role.

“I don’t see it as biting the hand that feeds us.”

NIHB Vice-Chairperson Ada White of the Billings area, maintained that “At this time, federal law mandates that if we want to develop in certain areas, that we be allowed to develop. I don’t see it as biting the hand that feeds us and feel that a strong policy-making stand is needed and will only serve to strengthen the area boards.”

(White perceives “much room” in her own area for both a greater advisory capacity as well as policy-making on the part of her board.)

The Portland Area Indian Health Board has already established itself in some areas of policy-making. When the IHS processes for allocation of CHR positions and contracts under 638 were creating area dissension, the Indian health board itself developed alternate methods deemed equitable to all tribes and eventually adopted by IHS.

But, contends Portland area representative Mel Sampson, “We are not dictating direct policy to IHS.” And he cautioned other NIHB members, “I’m not sure at this time that any board could handle policy-making 100 per cent nor would I advise it. I don’t really feel anybody’s ready for it.”

“That’s not to say the situation wouldn’t be different in three to four years,” he added quickly.

Nonetheless, Gonzales implored NIHB to give priority to increased status for area boards. It (NIHB) has already adopted a resolution supporting the right of service unit health boards in the Portland area to prioritize their own needs in contract health services and “supporting policy-making decisions at the local level.”

And NIHB General Counsel Daniel Press has promised to reexamine P.L. 93-638 and draw up a memorandum on that law’s implications for policy-making by boards by the end of the month.

Such was the tone of the spring quarterly meeting of NIHB as its members focused their efforts primarily on internal affairs and most particularly, strengthening and improving the board.

Solving the representation dilemma

For some time, NIHB has been beset with complaints
Organizational Restructure

from groups in several areas that the board members from their areas are not representative of their needs and concerns. Two of them, the Eastern Oklahoma Indian Health Advisory Board (composed of the Five Civilized Tribes) and the California Tribal Chairmen’s Association (which renewed its request at this meeting), are still seeking to gain their own seats on the board. In the Albuquerque area, the Pueblos, now organized into the New Mexico Intertribal Health Authority, have stated their dissatisfaction with the representative from their area but have withdrawn their request for participation in NIHB.

A reorganization committee composed of three NIHB members was established several months ago and issued its recommendations to the board here July 27. Board chairman Howard Tommie expressed the hope that if the committee’s suggestions are adopted “We will bury one of the biggest items plaguing the board for a long time.” At least by dealing with the problem, he continued, “we will feel we have made a significant effort to answer the requests of those factions which have been asking to be seated.”

NIHB composition could change drastically

Specifically, the committee proposed that the board increase its membership from 12 to 24, with two representatives from each IHS area (and eliminating alternate positions).

“This may not solve the problems in the dispute areas but it does offer an opportunity for solution,” asserted Mel Sampson, reorganization committee member.

Action on the recommendations will be taken at the next meeting of NIHB, allowing time for members to confer with their own boards.

Continued on Pg. 10
a number of other health matters, according to the report given by Al Elgin, Executive Director of the Albuquerque Area Indian Health Board.

**Alaska**

Based on the astronomical rates of pay in the State of Alaska and the current Resource Allocation Document used by IHS, Alaska Native people are finding it “very difficult to come up with a health plan that IHS and Congress can live with,” reported alternate Darryl Trigg.

He illustrated the situation by saying, “I can understand the feelings of IHS doctors in Norton Sound and Nome who, looking down the road 500 miles, see private doctors making $100-$125,000 a year when they’re only making $40-$45,000.”

**Navajo**

Meanwhile in the Navajo area, representative Elwood Saganey informed the group, all three recent laws affecting the health of Native Americans, are aiding in development of a Navajo area health plan.

The tribe’s Division of Health Improvement Services which coordinates all 437 and 638 health activities on the reservation is working in cooperation with the Navajo Health Systems Agency (established under P.L. 93-641, the sole tribal HSA in the country) to revise the HSA’s plan to fit tribal specific health planning needs. Funds for the tribe’s activities come through P.L. 93-638 and boasts Saganey, “although some tribes have problems with their HSA’s, the Navajos are making good use of theirs.”

Included in plans of the Division of Health Improvement Services (DHIS) is a reservation-wide transportation system to bring needy Navajos throughout the vast Navajo area to health-related agencies. The tribally-sponsored system will begin operations next January. (Although the funding arrangements for the Navajo project are unique, as later explained by Dr. Jack Lewin, DHIS Director, other tribes wishing to adopt such an idea are eligible to apply for transport vehicles for this purpose under Sec. 16B2 of the Urban Mass Transit Act of 1964.)

**Tucson**

Tribal health planning under 437 in the Tucson area is “total mass confusion” as described by NIHB representative Irene Wallace. “We don’t know what we’re doing and they (IHS) don’t know what they’re doing and nobody has any answers,” she continued. Wallace added that as of the week before the meeting here, the Papago Tribal Council decided that a TSHP would be prepared and delineated priority areas around which it should focus.

Until now, the Papagos have been the lone tribe within the Tucson service area but as explained by Wallace, that may soon change with federal recognition of the Yaqui Tribe in the offering (a bill for their recognition is now in conference between the U.S. House and Senate). Yet, while the tribe would be eligible for IHS services no additional money has been appropriated for their care. The Papago facilities may, therefore, end up providing services to the Yaquis, which said Wallace, “poses a problem when contract health funds are already inadequate.”

**Billings**

In addition to its joint sponsorship of the TSHP workshop, the Billings Area Indian Health Board also recently sponsored health career workshops for Indian high school seniors, reported representative Ada White.

She also informed fellow NIHB members of the opening of a facility at Poplar, Mt. and the withdrawal of the Wind River, Wyo. contingent from her area board.

**Bemidji**

Optimism for the reorganization of a board for this area continues, according to Donald LaPointe, chairman of the tri-state board health board which disbanded in 1974.

In the meantime, those involved in tribal health planning and operations in the area are concerned over the establishment of a clinic instead of a full-scale hospital, as hoped, at Kincheloe Air Base in Michigan.

**Oklahoma**

Joe Pedro, Chairman of the Cheyenne-Arapaho tribe and of the Oklahoma City Area Indian Advisory Board stated here that he accepts the internal problems of his area as a challenge.

Speaking in a hopeful manner, he said he would like his board to establish a “new working relationship with IHS and all of the tribes.”

He reported that the board is preparing testimony to present at the Senate oversight hearings on IHS.

Continued on Pg. 11
Phoenix

The Phoenix Area Indian Health Board has been concerned of late with the possibility of BIA discontinuing its funding of intermediate elderly nursing home care due to lack of funds. "IHS doesn't want to get in the business of nursing home care and the Bureau wants out," said Sundust of the dilemma. He added that his board has asked that both agencies take steps to resolve the problem.

Portland

In an effort aimed to help accomplish the goals of Indian self-determination under P.L. 93-638, the Northwest Portland Area Indian Health Board is providing training to tribes and smaller tribal health boards, reported Mel Sampson, NIHB representative.

He also pointed out that the Northwest remains the only IHS area without an Indian referral hospital. Each year IHS contracts for a specific number of beds in the PHS hospital in Seattle, Wash. Sampson further explained that a patient representative has been working to increase acceptance of Indian patients by the hospital staff in what the board hopes will result in increased utilization of that hospital by the area's Indian people.

USET

Plans for construction of an Indian hospital, this one in the area represented by Howard Tommie, were recently jeopardized when the state of North Carolina objected to construction of a hospital on the Cherokee reservation without its consent. Tommie informed board members that the controversy has now been resolved and that an additional appropriation for equipment was being sought from Congress.

Also in his report, Tommie expressed his regret at the decision of Rep. Paul Rogers, Chairman of the House Interstate and Foreign Commerce Subcommittee on Health, not to seek reelection this fall. "He has a real feeling for Indian people and was of great assistance with the 437 appropriations," said Tommie of the congressman from his home state of Florida.

Local Health Reports

The board also heard from local area health organizations during an afternoon panel discussion. Representatives from the Michigan Inter-Tribal Council, the Michigan Indian Health Board, the Great Lakes Inter-Tribal Council and the Minnesota Chippewa Tribe presented health status reports for their respective areas.

Concerns expressed by these representatives included the lack of adequate facilities in the tri-state (Michigan, Minnesota and Wisconsin) area, the unavailability of funding for improved health services and the difficulty in receiving current information from IHS about tribal specific health planning for their areas.

14 Resolutions Adopted

In other business, the board adopted 14 resolutions ranging from an indictment of IHS for "taking lightly" requests for participation in NIHB meetings to support of a second national CHR conference planned for next April. The other resolutions are as follows:

- support for an Alaska area member of the IHS P.L. 94-437 consultants group
- support for reservation-based dental service for the Keweenaw Bay Indian Community of Michigan
- support for area Indian health boards in their requests to IHS for full funding under 94-437 for recruitment, counseling and summer training of Indian students in all health fields
- support for the efforts of the Northwest Portland Area Indian Health Board's analysis of the implications of P.L. 93-641 for Northwest tribes

ABERDEEN representative Clare St. Arnaud tells of the continuing shortage of medical personnel to serve the Indian people of North and South Dakota, Iowa and Nebraska. Also shown are board chairman Howard Tommie (left) and Donald LaPointe, Bemidji representative at right.
A Look at the President's NHI Principles

by Howard P. Bad Hand, NIHB Program Analyst

On July 29, President Carter, through HEW Secretary Joseph E. Califano, released his long-awaited and overdue principles on a National Health Insurance Plan.

Potentially, depending upon the nature and extent of an actual National Health Plan based on President Carter's principles, certain groups of Indian people could be affected. Certainly, the principles warrant consideration in light of the Indian position on NHI.

In a directive to the Secretary, Carter stated that he has always supported "...the goal of a universal, comprehensive National Health Plan to contain skyrocketing health costs and to provide all Americans with coverage for basic health services and with protection from catastrophic expenses." Such a plan, he stated "...would be the cornerstone of a broader National Health Policy designed to improve the health of Americans."

Pointing out several defects in the present health care system, Carter further stated that before he would submit any National Health Insurance legislation to Congress, the plan must be consistent with the Administration's efforts to control inflation not only in the health sector, but in the general economy as well. Therefore, the plan must be based on an indepth analysis of cost control and health system reform. In his own words, Carter stated, "...I will not propose any health care plan which is inflationary."

The principles around which a National Health Plan is to be constructed are extremely general and open to broad interpretation. The principles call for a plan that assures that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses, and that it make quality health care available to all Americans.

- The plan should further assure that all Americans have freedom of choice in their selection of physicians, hospitals and health delivery systems.

- The plan should be phased into existence beginning in 1983 to make certain that no additional current federal spending is involved, and that with careful planning and implementation, it should be financed through multiple sources.

- With proper government regulation, a significant role for the private insurance industry should be included and the plan, while assuring consumer representation throughout its operation, should provide resources and develop payment methods to promote major health system reform.

Earlier this year, NIHB's National Health Insurance Core Group met with staff members of Secretary Califano's NHI team. At that time, the NIHB Core Group discussed the Indian consensus position on NHI and how various groups within the Indian population could fit into a National Health Plan.

The core group was told that the president's principles would determine the nature and extent of a National Health Plan and that Indian people would have an opportunity to respond to the principles and projected plan.

The consensus Indian position on NHI states that Indians should not be included in the basic NHI program, so that they can continue to build their own unique health programs. Yet, in the event that a NHI program does come into existence, a section of the NHI legislation must specifically address Indian concerns by (1) reaffirming Indian people's right to their special Indian program; (2) defining the relationship between NHI and Indian health programs; and (3) strengthening IHS by incorporating several of the basic elements of NHI into the IHS system. This means that Indian people, though not included in the basic NHI program, could utilize some of its positive aspects. For example, elements of a National Health Plan such as Carter's that guarantees a benefit health package could be incorporated into IHS. Thus, IHS would offer a guaranteed benefit health package to all Indians, a provision vitally needed and presently lacking.

In the discussion summarizing the president's NHI principles, it was stated that they could be broadly interpreted. The principle stating that the NHI plan be comprehensive for all Americans is in opposition to the Indian position excluding Indian people from the basic NHI program.

However, another of the presidential principles expressing freedom of choice in the selection, by Americans, of physicians, hospitals and health delivery systems, and that quality health care be made available to all Americans, enhances the solidity of the Indian position expressing that a section of the NHI program must specifically address their concerns.

NHI core group discussions with HEW and congressional

Continued on Pg. 15
NIHB Supports Mental Health Care Improvement

RHINELANDER, WISC.—If mental health treatment for Indian patients is to improve, a national effort is needed to insure that all Indians have access to programs that are highly individualized and, to the greatest extent possible, carried out by local Indian communities.

So Manny Moran, administrative officer for the IHS Mental Health Program, told National Indian Health Board members at their quarterly meeting here July 25.

The IHS Mental Health Program is headquartered in Albuquerque, N.M., with a staff of more than 300 serving Indians on and off reservations in mental health programs across the country.

Moran's presentation on Indian mental health was part of a request that the board establish a Mental Health Standing Committee to help identify funding sources for Indian mental health programs and emphasize the need for a national commitment to Indian mental health service.

"We must make sure that mental health treatment will be a national effort, so that all Indians will have adequate services available to them," Moran said.

The Indian Mental Health Program has improved tremendously over the past 12 years, Moran said. Much of that success has been due to programs that offer highly individualized treatment and local community involvement.

Individualized treatment allows mental health programs to be flexible in complying with the needs, wishes, and conditions of different Indian communities. One of the keys to this kind of process is the Indian paraprofessional, Moran said.

"There aren't many professional mental health workers that are Indian. We are encouraging as many young Indians as we can to pursue this field, but for the present we must rely on the work of non-Indian professionals and Indian paraprofessionals," he stated.

These paraprofessionals — Indians experienced in mental health work, but lacking formal degrees — help overcome cultural and language barriers that arise between non-Indian professionals and Indian patients.

"By careful selection we have been able to hire paraprofessionals who have been capable of teaching non-Indian staff members about the customs and feelings of Indian people. This has allowed us to provide unusual forms of mental health services to the people we serve," Moran said.

Moran cited an example of Indian health workers helping to conduct group psychotherapy in languages such as Lakota and Navajo, as well as English.

Indian mental health paraprofessionals also play an important role in direct services given to psychotic and other severely disturbed patients. Their work is particularly important where state hospitals are inappropriate for Indian mental health patients, Moran said.

As an illustration of the latter, Moran pointed to one state hospital whose staff had to rely on an emotionally disturbed young boy as their only interpreter in dealing with 20 other non-English speaking Indian patients.

The availability of mental health services and competent Indian paraprofessionals have allowed many Indian patients to remain on reservations for treatment, Moran said.

Because of the vast differences in the Indian populations they serve, Indian mental health programs work closely with local communities to determine specific needs of the area, Moran said. He added that they often work with tribal councils, a number of which have formed special mental health committees.

IHS mental health program concerns range from alcohol and drug rehabilitation and suicide prevention to treatment for psychosis. Moran said he is particularly worried about the growing number of young people in need of mental health treatment.

In reply to Moran's request for a NIHB health committee, the board voted July 27 to form and support such a group.

NIHB . . .

Continued from Pg. 11

- support of the Northwest Portland area board's efforts to conduct an evaluation study of the IHS contract health service system in its area
- support for an IHS deputy director for the Northwest Portland area
- support of an IHS training session for the Northwest Portland board
- support of efforts by the Phoenix Area Indian Health Board to obtain adequate funding for nursing home care for the Indian elderly
- support of a request for funds to construct a health care facility on the Fort Hall Indian reservation
- urging HEW Secretary Califano to advise Congress of his recommendations based on the feasibility study of an Indian school of medicine and that he recommend funding for the school
- appointment of an NIHB working committee on mental health to advise the IHS mental health component; and
- retention of staff positions at the Acoma-Canoncito-Laguna hospital in New Mexico

Continued on Pg. 16
The Bakke Decision: No Threat for an Indian School of Medicine

(As mandated by Title VI of the Indian Health Care Improvement Act, A Study to Determine the Need for and Feasibility of Establishing an American Indian/Alaska Native Medical School was completed last August. A supplemental study undertaken by the Bureau of Health Manpower (BHM) has also been completed. Both studies found that an American Indian School of Medicine is needed and feasible. Title VI requires that “Within one year of the date of the enactment of this Act, the Secretary shall complete such study and shall report to the Congress findings and recommendations based on such study.”

P.L. 94-437 was enacted on September 30, 1976 so the deadline for the Secretary’s report has long since come and gone. Despite the positive findings of the studies and despite the fact that they were submitted to the Secretary of HEW in August 1977, the report still awaits his action.

Meanwhile, a recent Supreme Court decision has raised questions in Indian circles regarding the legal validity of a separate Indian school of medicine.

New Deputy Adds to NIHB Legal Expertise

DENVER, COLO.—Since the end of June, NIHB has had a new deputy director in the person of John Powless, an Oneida from the State of Wisconsin.

Upon his arrival, he acquainted himself with the workings of the NIHB central office and became quickly absorbed with review of past NIHB budgets and drafting the organization’s fiscal plan for FY 1979.

Powless is a three-time graduate of Brigham Young University, having received his B.A. degree in History in 1971, a Master’s of Public Administration degree in 1976 and a J.D. from the J. Reuben Clark School of Law last August.

He brings to the position a varied background of legal experience with some emphasis on health issues. While employed as a law clerk for the Oneida Tribe of Wisconsin last year, he helped secure a license for the Oneida Nursing Home. (With such a license patients who receive services at the nursing home became eligible for federal funds administered by the state.)

Prior to that, as a legal researcher for his tribe, he studied treaties, statutes, and law cases dealing with the legal status of Indian lands within the boundaries of the Oneida reservation.

Powless is responsible for assisting with NIHB administrative matters.

Meanwhile, his legal training is reflected in the interests he brings with him to NIHB. If and when the Indian Child Welfare Act becomes law, he intends to analyze its implications for Indian tribes and both state and private adoption agencies. He has a particular interest in complaints lodged by consumers against the Indian Health Service.

As deputy director, he is also working closely with NIHB’s program analysts in keeping abreast of any legislative issues affecting Indian health.

Powless, 30, is married with four children.

The following analysis prepared by NIHB Deputy Director John Powless and Program Analyst Rick Nordwall of the “Bakke decision” should provide relief to such a school’s proponents.)

The Indian Health Care Improvement Act of 1976 mandated a feasibility study of an American Indian School of Medicine. If such a school is finally established, the board of regents will have to address the implications of the Bakke decision as applied to the exclusive admission of Indian students.

Basically, the Bakke decision stated that affirmative action programs could not establish quotas, where a certain number of minorities would be admitted to medical school, and that quotas were unconstitutional when based upon race. In the past, Davis Medical School (the school in Davis, Ca. where Bakke applied for admission) had reserved 16 slots for minorities, who would be admitted even if other non-minority applicants were more qualified.

The Supreme Court ruled that the school could not reserve 16 slots on the basis of race. However, it did say that race can be used as a factor in determining who should be admitted to medical schools.

So, what are the implications of Bakke in establishing an admissions policy for an Indian school of medicine? Can an Indian school of medicine excluding non-Indians be established?

The Bakke decision has an impact on any proposal for an Indian school of medicine. The first positive implication of the Bakke case is that race can be considered a factor in admissions, for the first time, has established, the board of regents has the concept of Affirmative Action.

Because of the endorsement by the Supreme Court, an Indian medical school need not worry about a court challenge to the racial make-up of its student population.

However, Bakke has imposed limitations on the mechanics of admissions. First of all there cannot be a rigid, fixed racial quota which reserves a specific number of slots for members of a particular race. There must be open competition for all available slots.

But, the school can determine which qualities it deems desirable in its students. These can include race, character, cultural awareness and sensitivity, home geographical location; any qualities which will advance the purposes of the school. The only limitation is that race cannot be the single factor, but rather one of a number of considerations.

The problem in the Bakke case was that the admissions policy completely excluded Bakke from any consideration for the slots which were reserved for minority applications. So the Davis Medical School erred in not considering Bakke for one of the 16 reserved slots.

The Supreme Court straddled the fence on minority admissions by saying yes to race and no to strict quotas. Who really won in Bakke will be determined by the interpretation given by future cases of the concepts advanced by the Supreme Court opinion in Bakke. Other than funding,

Continued on Pg. 15
Child Welfare Act: Time Running Out

WASHINGTON, D.C.—Proponents of the Indian Child Welfare Act of 1978 continue to anxiously await a vote by the House of Representatives on the bill. As of the week of August 7, the proposed legislation was pending before the House Rules Committee.

The act would establish standards for the placement of Indian children in foster and adoptive homes in order to prevent the breakup of Indian families and would provide additional measures for the strengthening of Indian families. It received Senate approval last November and was adopted by the House Interior and Insular Affairs Committee two months ago.

Copies of the House committee report on H.R. 12533 numbered 951386 are available from the Subcommittee on Indian Affairs and Public Lands; 1324 Longworth House Office Building; U.S. House of Representatives; Washington, D.C. 20515.

As Congress is expected to recess from the middle of August until after Labor Day and to adjourn by early October, time for passage of the bill grows exceedingly short.

Therefore, tribal members, groups and organizations are urged to write or call their congressmen requesting their support of H.R. 12533.

NIHB . . . .

Continued from Pg. 13

Executive Director's Report

In other business, NIHB Executive Director John Belindo presented board members with a preliminary model to evaluate alcohol programs, as part of the NIAAA/IHS alcohol transfer agreement.

Belindo also reported on the National TSHP Workshop held in Tucson, May 23-25, and attended by representatives from the 12 service areas. Results of regional TSHP workshops should be reported back to the board, said Belindo, as part of an effort to make NIHB a communications focal point for TSHP efforts.

Board members heard a presentation on health board training to be conducted by NIHB and designed to educate boards about pertinent legislation and additional concerns regarding Indian health. The board voted unanimously to approve an initial area board training session in Alaska sometime late this year.

In addition, the board heard reports on NIHB contract goals for FY 1979 and a financial report of the 1978 budget.

National conference to be in Spokane

Finally, the board chose Spokane, Wash., as the site for the Third National Indian/Alaska Native Health Conference to be held July 22-26 of next year.

The NIHB Health Reporter is published monthly by the National Indian Health Board. NIHB is pleased to provide this newsletter to our readers throughout the country and welcomes the further distribution of the information contained therein. We do kindly request, however, that NIHB receive credit for articles reprinted from the NIHB Health Reporter.

Please submit all articles, correspondence and mailing requests to L. Joy Bossert; National Indian Health Board; 1020 15th St., Rm. 4E; Denver, Colo. 80202.

EDITOR: L. Joy Bossert
EDIToRIAL ASSISTANT: John P. O'Connor

This publication made possible through Contract No. HSA-244-77-0070 with the Department of Health, Education and Welfare, Health Services Administration.

NIHB
1020 - 15th St., Rm. 4-E
Denver, Colo. 80202

Non-profit Organization
U.S. Postage
PAID
Permit No. 1903
Denver, Colo.
Bakke cannot hurt Indian schools. Unfortunately, for Indians wishing to attend other institutions of higher learning, Bakke does make it easier for a school to cut down on minority admissions and harder for a school administrator to step up minority admissions.

The worst implication Bakke could possibly have for an Indian medical school would be to contribute to Congressional hesitancy to provide federal start-up monies. There is no legal obstacle to federal funding of a medical school whose students will be predominantly Indian.

The reason Congress may be hesitant is the current political climate in Washington. The Bakke decision alone is not cause for concern. The problem arises when you place Bakke on top of the white backlash to Indian rights and the spending limitations suggested by Proposition 13.

This is not to say there will be no federal start-up monies for an Indian school of medicine, but rather to point out the obstacles we have to overcome in order to make it a reality. Knowing the political realities in Congress we Indian people now have to work harder, which will just make our victory just that much sweeter.

Health Professions Scholarships for Fall Still Available

ROCKVILLE, MD.—September 8 is the deadline for applications for two health professions scholarship programs operated by Indian Health Service. The Health Professions Preparatory Scholarship Program for Indians provides scholarship support for up to two academic years of compensatory preprofessional education to enable a student to be eligible to enroll or reenroll in a school of health professions.

Such funding is not available to students simply wishing to pursue a “pre-med” curriculum but is limited to those already enrolled in a medical professions school with a need to strengthen specific skills or for persons assured of acceptance into school on the contingency that they strengthen certain skills.

The Indian Health Scholarship Program provides scholarship support for students enrolled in or accepted for enrollment in health professions school.

This award cycle, the third since November 1977, is an attempt to provide a maximum opportunity for all persons wishing to be considered for health professions scholarship support in the Fall Term 1978.

Completed applications must be received in the nearest Indian Health Service Area/Program Office, ATTN: Grants Management Officer, on or before September 8. Applicants will be informed of any action taken by the last week of September. Awards will be made retroactive to the beginning of the Fall Term.

For additional information or a Scholarship Application Kit contact the scholarship coordinator in your IHS area office.

A Look . . .

Continued from Pg. 12

staff indicate that the present Indian health delivery system will not be adversely affected by any National Health Plan developed by the Administration for two reasons: (1) the Indian Health Service is well entrenched politically on Capitol Hill and (2) the two pieces of legislation — P.L. 93-638, The Indian Self-Determination Act and P.L. 94-437 — The Indian Health Care Improvement Act — that define Indian tribe's rights to self-determination and self-governing efforts, and define the legal scope of the U.S. Government's role and responsibility in health to Indians, insure that a National Health Plan would have minimal effect on tribal health roles.

Urban Indians and urban Indian health projects could be beneficially affected by a NHI plan such as that suggested by Carter's principles. One, urban Indians would be provided access to a health delivery source beyond those now available to them. Two, with proper development of payment methods, a National Health Plan as an alternative health financing system could prove financially beneficial to the urban Indian health projects.

Politically, the release of the president's principles polarized some of the support for the Administration's NHI efforts. Senator Kennedy, notably, accused President Carter of a "failure of leadership" and withdrew his support for the Administration's projected NHI plan. Labor, in support of Kennedy, voiced strong objections. Carter's approach on NHI is that of conditioning the implementation of a universal and comprehensive NHI program on various economic indicators, and both Kennedy and labor consider this a fundamental flaw. They feel, according to Kennedy, that a NHI program "... should (not) condition the guarantee to the American people of health care as a right of the state of the economy."

The other apparent disagreement is that Kennedy and labor favor an entitlement approach to NHI which would guarantee Americans certain coverage within a certain timeframe. Within this timeframe, certain mid-term correction and authority mechanisms would be granted the Administration over the NHI program. Kennedy and labor feel that Carter's approach does not contain such checks and balances, and implicitly does not guarantee health coverage as an entitlement.

Analytically, the lack of support for the Administration's NHI plans, and the divisiveness of congressional support for a National Health Plan have killed the possibility of a strong NHI Plan being enacted within this Administration. In fact, the possibility exists that NHI efforts will take a back seat in Congress for a number of years.

Yet, President Carter insists that his NHI Plan is to be phased into existence beginning in 1983. The language in the principles does not clarify whether the plan will be introduced as one piece of legislation or several pieces extended over a period of time. Most monitors of NHI activities generally agree that the latter is more likely. This being the case, there is no guarantee that Congress will accept the whole of Carter's plan. It is thought that by "piece-mealing" his plan he has considerably weakened his position in Congress. Likely, Congress would adopt Carter's phases of NHI legislation that would be non-controversial and reject those controversial parts of the program. Judging by the country's mood and developments such as "Proposition 13", Carter's plan will not be accepted in toto.