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Budget Constraints Prompt Officials To Consider New IHS Eligibility Criteria

BISMARCK, N.D. — Faced with the prospect of continued economic hardship, Indian Health Service (IHS) and tribal health officials are under mounting pressure to consider several major cost-cutting initiatives that, if enacted, could substantially alter the health care delivery system of American Indians and Alaska Natives.

One such initiative that strikes at the very heart of the Indian health program concerns the issue of eligibility, and the possibility of establishing new criteria for determining who should receive health care services paid for with IHS resources. Such a change could sharply reduce the number of beneficiaries that presently depend on IHS as their primary source of health care.

Under existing regulations, "persons of Indian descent belonging to the Indian community" are considered eligible for "direct care" services provided at IHS clinics and hospitals. IHS policy also permits non-Indian spouses and other non-Indian members of an Indian's immediate family to be treated at IHS facilities. Eligibility for "contract care" — health services purchased by IHS from the private sector — is governed by

a separate, more restrictive set of regulations that require the individual to be "eligible for direct care, live in a designated geographic area adjacent to a reservation and either belong to or maintain close ties with tribes living on the nearby reservation." Approximately 883,000 persons are now eligible for IHS direct and contract health care under these guidelines.

Over the past year, the question of who should or who should not receive IHS services has drawn considerable attention not only from tribal officials but from members of Congress, the media, and officials within the Reagan Administration.

For example, during Senate appropriations hearings earlier this year, Senator Ted Stevens, a longtime supporter of Indian health programs, openly criticized the existing IHS eligibility policy as too lax and cited it as the primary reason for a rapidly expanding IHS service population. He urged tribal leaders to take the lead in reassessing this policy.

In several reports by local and national media — including *The Washington Post* and *NBC Nightly News*

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CHILDREN IN A Laguna Pueblo classroom in Laguna, N.M., listen attentively to a health care presentation by Elsie Cheresposy, a dental aide with the Laguna Pueblo Community Health Representative (CHR) program. Similar community health education and preventive health services are provided by CHR's on reservations throughout the country. Congress recently approved FY 1983 funding for the CHR program, which the Reagan Administration had earlier proposed to abolish. See related story pg. 10.

Congress Passes IHS Budget; Cuts Care for Non-Indians

WASHINGTON, D.C.—Amid round-the-clock legislative activity to push several appropriations bills through Congress, House and Senate conferees hammered out an agreement that would provide Indian Health Service (IHS) with a \$680 million budget for FY 1983.

Of particular importance in the bill (Interior Appropriations Bill; H.R. 7356) are provisions to restore \$25 million to the Community Health Representative Program, \$6 million for urban Indian health projects, and \$34 million for IHS construction activities. All three programs were targeted for elimination under President Reagan's budget request last spring.

Another important item in the bill is a provision that would virtually eliminate IHS services to non-Indians. Under existing policy, non-Indian spouses and other non-Indian members of an eligible Indian's household may receive treatment at IHS facilities. The provision in H.R. 7356 would prohibit such services to non-Indians except in the case of a pregnant non-Indian spouse, and cases of public health emergencies.

President Reagan is expected to approve H.R. 7356. Until the bill is signed, however, IHS and many other federal agencies will operate under the Second Continuing Resolution of FY 1983. Since October 1, the agency has been operating on 1982 budget levels under the first continuing resolution. ■

Indian Health Service Budget

Fiscal Year 1983
Congressional Action to Date
(in thousands)

	1982 Budget	House/Senate Conference
Clinical Services		
Hospitals/Clinics	\$ 297,628	\$ 328,055
Dental	17,884	20,156
Mental Health	7,488	8,158
Alcoholism	16,290	21,207
Maintenance/Repair	8,267	8,267
Contract Care	122,938	130,547
Total Clinical	\$ 470,495	\$ 516,390
Preventive Services		
Sanitation	\$ 14,090	\$ 15,349
Public Health Nursing	7,969	8,902
Health Education	2,194	2,333
CHR	28,800	25,000
Total, Preventive	\$ 53,053	\$ 51,584
Urban Health	\$ 8,160	6,000
Indian Health Manpower	5,760	5,760
Tribal Management	2,634	2,634
Program Management	48,851	50,721
Equity Fund	15,492	17,492
1982 Pay Act	18,160	0
Reduction,	4,800	5,000
Offset M/M Collections	(4,800)	(5,000)
Total, Services	\$ 617,805	\$ 645,583
Total, Construction	\$ 58,352	\$ 34,700
TOTAL, IHS BUDGET	\$ 676,157	\$ 680,283

Budget Constraints...

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— it has been suggested that part of IHS's financial trouble in 1982 was due to a large number of patients treated at IHS facilities that are either non-Indian or of questionable Indian heritage.

And IHS officials, from agency Director Dr. Everett Rhoades to physicians practicing at reservation clinics, have frequently cited the need to re-examine the issue of eligibility, particularly as it applies to non-Indians, because of the overcrowded conditions at many IHS hospitals and clinics. In fact, a "notice of intent" to change existing regulations has been drafted and is awaiting approval for publication in the *Federal Register* (see related article pg. 5)

Although tribal views on proposed changes in the IHS eligibility regulations have not been formally soli-

"What would happen if in another year or so they cut the budget again. Do we come back . . . and say that eligibility should be cut back to those with one-half degree Indian blood?"

cited, an indication of Indian and Alaska Native sentiments on this issue was revealed during the final general assembly of the National Congress of American Indians' (NCAI) 39th annual convention here October 1.

Following a lengthy and sometimes emotional floor debate before the general assembly, NCAI delegates voted to table a resolution calling for a three-phased approach to eligibility that recommended: limiting services funded by IHS to persons with at least one-quarter degree Indian blood who are members of federally-recognized tribes; allowing service units, with tribal concurrence, to establish a sliding fee for service based on income for those less than one-quarter Indian blood but eligible under current regulations; and requiring IHS to adopt a consistent definition of "service area".

As explained by Bob Crawford, health director for the Colorado River Indian Tribes in Parker, Ariz., who introduced the eligibility resolution at the NCAI convention, a dramatic increase in the IHS service population coupled with recent cuts in the IHS budget has created a dangerously excessive demand for available health services.

"We're going to be in real serious trouble if we don't do something," asserted Crawford. "Indian people are already being deprived access to medical care because of (services provided to) non-Indians and those less than one-quarter blood. I think that's a crime," he said.

Crawford, an outspoken proponent of stricter IHS eligibility criteria, said that the Colorado River Indian Tribes have adopted the one-quarter Indian blood requirement, and noted that the majority of Arizona Indian tribes testifying before the Senate Select Committee on Indian Affairs last spring favored the concept.

Although precise statistics are unavailable, Crawford estimates that "a minimum 20-30 percent of IHS services nationwide are being provided to individuals

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Health News Across The Nation

The following is a regular feature of the NIH 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 items mentioned here can be obtained from the NIH Public Information Office.

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WASHINGTON, D.C.—Secretary of Health and Human Services Richard Schweiker has given tentative approval to an arrangement that would permit all area residents of Bethel, Alaska—including non-Natives—to utilize the services of non-federal physicians who may use the facilities at the Bethel Indian Health Hospital. Under this unique agreement, which has been endorsed by the Alaska Native Health Board, the Bethel clinic could serve as “a model for IHS facilities in other rural areas of Alaska and the rest of the country,” according to Senator Ted Stevens (R-Alaska), who has pushed for the arrangement. Stevens said the arrangement could “enable the IHS rural facilities to fulfill more of a community role” and would “test the concept of joint federal and state funding” at a time when federal funding is uncertain. The Bethel health board has applied to the state for \$90,000 in supplementary funds to implement the “model health clinic” in Bethel.

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FORT COLLINS, COLO.—Researchers at the center for Western Behavioral Studies at Colorado State University here have published a comprehensive report on the drug problems of Indian youth. Entitled “Drug Abuse Among Native American Youth: Summary of Findings (1975-1981),” the report describes in detail the researchers’ work in investigating drug abuse among young people residing on reservations. Among the key findings reported in the publication are indications that: inhalents are tried more often by Indian young people than by non-Indian youth; one in 20 Indian adolescents is exposed to heroin compared with one in 200 for non-Indian adolescents; drug use has increased steadily among Indian youth since 1975, with much of this increase occurring in recent years; and identification with Indian culture provides some protection against the more serious types of drug involvement. Copies of the report are limited. For additional information, write: Fred Beauvais; Western Behavioral Studies; Department of Psychology; Colorado State University; Fort Collins, Colorado 80523.

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ROCKVILLE, MD.—The Indian Health Service (IHS) recently attempted to clarify its procedure for establishing FY 1983 funding levels for tribal contracts negotiated under the Indian Self-Determination and Education Assistance Act (P.L. 93-638). As amended by a November 26 directive from IHS Director Dr. Everett Rhoades, Indian Self-Determination Memorandum No. 82-4 requires that proposed negotiated FY 1983

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AFTER MORE THAN ten years of planning and preparation, construction of the new Anadarko Indian Health Clinic in Anadarko, Okla., officially commenced with ground-breaking ceremonies October 25. Pictured (l-r) here are representatives from the seven Oklahoma tribes that will be served by the clinic: Neil Wooster, Caddo Tribe; Edgar French, Chairman, Delaware Tribe; Mildred Cleghorn, Chairman, Ft. Sell Apache Tribe; Lonnie Tsoataddle, Chairman, Apache Tribe; Glenn Hamilton, Kiowa Tribe; George Watchetaker, Comanche Tribe; and Newton Lamar, Chairman, Wichita Tribe. NIH Oklahoma City Representative Lawrence Snake presided over the ceremonies. (Photo Courtesy Jim Cussen, IHS Liaison Officer)

Health News...

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contract amounts shall be no greater than the total estimated FY 1982 amount, which shall be the total of the FY 1982 base funding level and provisional indirect costs funded by IHS.

Additional information about Indian Self-Determination Memorandum No. 82-4 (as amended) can be obtained from IHS area offices or from Dr. Robert Birch; Indian Resource Liaison Staff; Indian Health Service; Room 6A-19; 5600 Fishers Lane; Rockville, Maryland 20857. Phone: (301) 443-1044.

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Danielson

BILLINGS, MONT.—James Danielson, associate director for administration for the Indian Health Service (IHS), has been appointed director of the IHS Billings area office, effective January 3. A member of the Oklahoma Cherokee Tribe, Danielson began his IHS career in 1967 as the tribal affairs officer in Portland, Oregon. He was transferred to IHS headquarters in 1974, and was

assigned the position of IHS associate director for administration in 1977. As the Billings area director, Danielson succeeds J. R. Smith, who will serve as IHS Director Everett Rhoades' special assistant for inter-governmental relations.

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RAPID CITY, S.D.—The Nutrition and Dietetics Training Program of the Indian Health Service announced two workshops to be held here at the Black Hills Training Center. The first workshop, "Nutrition and Alcohol," will be held January 26-28 and is open to personnel employed in substance abuse programs, Community Health Representatives (CHR's), and community nutrition workers. The second workshop, "Diet and Diabetics," is set for January 31-February 2 and is open to personnel working with diabetics, including CHR's and community nutrition workers. There is no registration fee, and food and lodging is provided by the Center. Participants are responsible for their own transportation. For additional information, contact: M. Yvonne Jackson; Nutrition and Dietetics Training Program; P.O. Box 5558; Sante Fe, N.M. 87502.

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FORT COLLINS, COLO.—The National Indian Health Board Science Center is once again accepting applications for its popular series of health education materials on infant feeding, diabetes, and traditional Indian foods. The materials—which are valued at \$50 per set—are available to tribes and Indian organizations through a special grant from Chevron U.S.A., Inc. There is no charge for the materials. A similar grant earlier this year resulted in an overwhelming response for the materials; consequently, preference for the education "packages" will be given to previous appli-

cants whose requests could not be filled. Approximately 300 sets of the materials, which include tape recordings and illustrated booklets designed especially for American Indian audiences, will be distributed under the grant. For information about application procedures, write: Alan Ackerman; NIHB Science Center; Department of Food Science; Colorado State University; Fort Collins, Colo. 80523.

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NEW YORK, N.Y.—Two American Indian women that have actively worked to improve the health care status of Indian people were among 18 nationally-acclaimed recipients of "Wonder Woman" awards announced here recently. Ada Deer (Menominee) and Phyllis Old Dog Cross (Mandan-Hidatsa) were given the award following a year long review of more than 1,400 nominations from around the country. Deer, a former Washington lobbyist and analyst for the Native American Rights Fund, is a longtime supporter of Indian social and community health work. Cross, a psychiatric nurse for the Indian Health Service in Rapid City, S.D., was cited for her "holistic approach to the field of mental health. She combines Indian healing traditions with modern medicine."

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GRAND FORKS, N.D.—The Indians Into Medicine (INMED) program at the University of North Dakota here is recruiting Indian medical school applicants for the fall semester of 1983. "There is a desperate need for Indian physicians to help upgrade the health care provided at Indian communities," says INMED Director Dr. Lois Steele. The INMED program provides counseling, tutoring, financial aid, and other support for Indian college and medical students. For additional information about the program contact: Dr. Lois Steele; INMED; Box 173—University Station; Grand Forks, N.D. 58202. ■

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IHS to Seek Comments on Proposal for New Eligibility Regs

ROCKVILLE, MD—Tribes, Indian organizations, and individuals interested in formally commenting on the eligibility criteria of the Indian Health Service (IHS) should keep a watchful eye on the *Federal Register* for the next few weeks.

IHS has prepared a draft notice to solicit information and ideas for developing a proposal to amend its eligibility regulations. If approved, this "Notice of Intent" will be published in the *Federal Register* in the coming weeks. Any specific proposal developed subsequently would also be published as a notice providing an opportunity for additional input and comment.

The draft document briefly reviews existing regulations governing eligibility for direct care, which basically require that a person be of Indian descent and belong to the Indian community served. Although these regulations sufficed for many years, a number of factors have made it "increasingly difficult and time consuming to determine who is eligible for services and who is not," according to the IHS notice. These factors include shifts in populations away from reservations, increasing inter-marriage, greater urbanization of traditionally rural areas (with a resulting increase in the Indian/non-Indian mix of population) and the expansion of services to new areas through contract health care.

The proposed notice also states that "more people with a claim of Indian descent are using IHS services than ever before even though alternate medical care is available. This situation has arisen from greater awareness of possible eligibility, the availability of improved care, greater acceptance of the program by Indian people, and increased costs of medical care outside of IHS."

In discussing possible changes in the eligibility criteria for IHS services, the draft notice identifies four frequently suggested recommendations: (1) adopt the definition of the term "Indian" as used by Congress in the Indian Self Determination and Education Assistance Act (PL. 93-638), which would mean that to be eligible a person would have to be a member of a federally-recognized tribe; (2) adopt a minimum blood quantum as a requirement; (3) include a residency requirement and, (4) some combination of the above.

Some advantages and disadvantages for each of these alternatives, as presented in the IHS notice, are:

- Eligibility based on membership would strengthen the role and position of the tribes and presumably would be relatively simple to administer. It might, however, disqualify many California Indians because of their unique history and the past termination policies of the federal government. Should such a proposal be given consideration it might be appropriate to consider an exception such as the temporary measure dealing with California terminated Indians contained in the Indian Health Care Improvement Act Amendments of 1980. There may be other special circumstances (such as closed membership rolls) that should be reflected in any proposal based on tribal membership.

- Eligibility requiring a specified minimum blood quantum could be based on either the degree of Indian blood or the degree of tribal blood. An Indian blood quantum requirement could cover Indians who had sufficient Indian blood quantum but who lacked the necessary tribal blood quantum to qualify for tribal membership. However, members of tribes which do not have a blood quantum requirement or which had a blood quantum requirement that was lower than any established by IHS might not be eligible for services. Either type of blood quantum requirement could exclude some people currently receiving service as well as some family members.
- A residency requirement could be similar to the contract health services regulations which require that an eligible person reside on a reservation or in a county which includes or adjoins the reservation. This approach would bring the requirements for direct and contract health service more closely in line with each other, would make it easier to determine the eligible population and help restrict services to those belonging to the local Indian communities. It would, however, change the current policy of not having any residency requirement for direct services. It might also require modification in the current contract health service regulation (42 CFR Part C) in order to assure that residency requirements would be uniform.

According to IHS officials, the "Notice of Intent" will probably be published in the *Federal Register* within the next two months. Approximately 60 days will be allowed for written comments and suggestions. ■

Where to Send Comments

Any change in the regulations governing eligibility for health services provided by the Indian Health Service (IHS) will potentially affect thousands of individuals that presently depend on IHS for their health care. Due to the importance and complexity of this issue, it is imperative that tribes, Indian organizations, and individuals be given every opportunity to review and comment on any proposed change in these regulations.

To facilitate Indian involvement in this process, we recommend that copies of comments, ideas, or proposals related to eligibility for IHS services be sent to the National Congress of American Indians; Health Committee; 202 E St., N.E., Washington, D.C. 20002. (Phone: 202/546-1168). NCAI is presently preparing a concept paper on eligibility for IHS services and plans to address this issue at its executive council meeting in Washington, D.C. January 26-29.

Although an official "Notice of Intent" to change IHS eligibility regulations will not be published in the *Federal Register* for several weeks, ideas and suggestions should nonetheless be sent to IHS. Address such comments to: Richard J. McCloskey; Indian Health Service; Room 6A-14; 5600 Fishers Lane; Rockville, MD 20857. (Phone: 301/443-1116).

Long-Dead Uranium Mines Still Haunt Navajo Miners, Families

During the late 1940's the federal government initiated a program to produce uranium ore for the nation's nuclear defense program. Much of the mining and processing operations were carried out by Indian workers at uranium sites on reservation lands. Working conditions in these uranium mines and mills were generally deplorable; inadequate radiation detection, poorly ventilated mines, inferior equipment, and the lack of proper inspection and worker safety procedures exposed many Indian miners and millworkers to dangerously high levels of radiation.

What has become clear in recent years is that these working conditions have had a devastating impact on the health and well-being of the Indian uranium workers and their families. Although research on Indians employed in uranium mines and mills is limited, existing evidence indicates that the workers suffer from abnormally high rates of chronic lung disease, cancer, and other sickness. Several studies have also reported unusually high levels of birth defects, spontaneous abortions and stillbirths among mining families, particularly in areas where uranium mining and processing have been rife, as in the Four Corners Area (the juncture of the states of Colorado, Utah, Arizona, and New Mexico).

Two years ago we published a report on the effects of radiation exposure on the lives of Indian millworkers and on their efforts to obtain compensation for the suffering they have endured as a result of that exposure. One lawsuit brought by Indian workers against several companies involved in the uranium operations has since been dismissed for jurisdictional reasons. However, according to an attorney for the workers, another suit has been filed under the Federal Torts Claims Act and is expected to go to trial early next year.

In the following article, Jane Kay reports on the uranium mining and how it has affected the lives of Navajo miners and their families. Ms. Kay, a reporter for the Tucson Daily Star, is a past recipient of the Scripps-Howard Foundation's Edward J. Meeman Award for environmental writing. We wish to thank her and the Tucson Daily Star for permission to reprint the article. (Note: One of the Navajo miners interviewed for this story, Dirty Bedonie, died shortly after the article was published last year).

MEXICAN WATER, ARIZ.— "My neighbors and relatives are dying from cancer."

"They're just now getting it."

"The miners leave widows who can't do anything for themselves."

"Some people say the uranium doesn't affect us, but it affects our newborns. It continues through generations."

The voice of Navajo Robert James, a former miner, rang out angrily as he stood at the back of the community's chapter house in the Four Corners area, blaming uranium for death and suffering.

"It seems the companies can get into our land quicker than we can get anyone to test our water and our air.

"The people don't understand how dangerous it is. Especially the elderly. It's not fair to treat them this way.

The bad water and air is closing in on them.

"We were taught to hold our land sacred. This is going to ruin us and kill us.

"These companies have no respect for us, and the reason why it's happened is that we're afraid of white people. They tell us one thing, then another, and we back off.

"VCA has hurt us very bad, and we are dying."

Across the road and up the hill, beneath a ramada shaded by sweet-scented leaves, Dirty (Dirly) Bedonie, his friend from the old Vanadium Corp. of America mine in Monument Valley, was dying of lung cancer.

Thoughts of him, lungs shriveled, wasting away, were with the 25 or so Navajo uranium miners who had come from Red Rock, Cove, Teec Nos Pos, Red Mesa, Sweetwater, Tes Nez lah, Dinneshotso, Chilchinbito, Kayenta and Monument Valley to talk about the dead and the dying.

Sunday morning meetings have become a regular event in the Four Corners Area, where, federal officials say, residents have had more long-term exposure to radiation than any other group in the nation.

Up on the platform sat Frank Tsoosie, silent and drawn, diagnosed as having lung cancer, and Jess White, dignified and frail, whose X-rays have begun to show telltale spots.

They are survivors of a radiation epidemic that is seizing the Navajo Indian Reservation, as the medical community turns its attention to elevated rates of birth defects and cancers in all the Four Corners states, particularly in areas of intense uranium mining and milling.

The miners, who worked in unventilated tunnels, drinking natural water that pooled on the floors and eating lunches underground, are the obvious uranium victims.

They wore no masks, had no change of clothes, had no clean water to wash off dust. They took no more precautions than if they had been working on any construction job.

But health surveys are showing other victims of radiation damage — families of miners and those merely living near uranium residue from mines and mills.

With disturbing frequency, wives get uterine cancer, babies are born with missing feet or spinal malformations, and children have leukemia or holes in their hearts.

Yet the fear is most intense among the Navajo miners, who at one time numbered 700. Fifty have died of mining-related ailments, and two or three die each year.

The men gather now to find out anything they can about pursuing benefits or a class-action lawsuit, or the possibility of establishing special clinics conducted by medical people from Albuquerque.

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INDIAN WORKERS, such as these Navajo miners, employed in the mining and processing of uranium in the 1950's and 1960's are now experiencing unusually high rates of cancer and chronic lung disease. To seek compensation for these damages, a lawsuit has been filed on behalf of the miners and their families and is expected to go to trial early next year.

Long Dead...

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When a weak feeling comes on, they wonder if it is what their friends have described — the beginning of the sickness that cannot be healed by the Navajo doctors.

It starts with shortness of breath, as the microscopic radioactive particles inhaled over months and years, and lodged deep in the bronchi, first form scars or produce malignant cells, then perforate the tissue.

The "radon daughter" — offspring particles released by radon gas, derived from radium, a natural decay product of uranium — is carried in the blood to the bones, the liver, the spleen and the lymph nodes, where it continues to irradiate throughout the victims' lives.

Scientists say it takes an average of 21 years and longer for the most durable non-smoker to develop lung cancer or other respiratory disease after inhaling radon gas from decaying uranium for a few thousand hours.

The toll goes up every year around Mexican Water.

Frank Bigboy died a few years ago, after putting in 15 years in VCA No. 2. His widow has no money, and no one to help her get food or haul water.

Frank Jackson, a former miner, was found dead in the snow, after three years of coughing and vomiting blood.

Jean Yellowman's husband died of lung cancer years after collapsing underground. It was a common occurrence among the men to faint, get severe headaches, then return to work the next day without ever seeing a doctor.

Jess White didn't believe it when they told him six years ago what could be happening to him. He says seven of the 50 men he worked with died of lung cancer, a disease virtually unheard of among these Indians before the mining.

Now, at 53, White has six children. "But I stay here every day, every year. Even with a little bit of work, I get sick and go to bed."

Deaths from lung cancer are so widespread in the northeastern corner of Arizona that concerned Navajos have begun a clothing and food drive to help the hungry and destitute widows and children of uranium miners get through the severe winters in Red Rock and Cove.

The Navajo Uranium Miners and Widows Fund has been started to help pay legal costs of a suit filed by Stewart Udall, former secretary of the Interior, and William P. Mahoney, a Phoenix lawyer. On behalf of 50 widows and 100 miners who have lung problems, the suit asks for compensation from the U.S. government under the Federal Torts Claims Act.

Udall says that not one of his clients has received a penny of compensation from state worker insurance plans or from the government. The case is expected to go to trial in early 1983, says Mahoney.

At least 6 million tons of uranium ore was hauled to mills on the Navajo reservation from the mid-1940's to the mid-1960's, when the mining and milling moved primarily to northwestern New Mexico.

All but one of the uranium mines in Arizona were on Indian lands, where the health and safety of the workers were the responsibility of the U.S. Bureau of Mines.

"A nightmare" is how a U.S. Public Health Service official who spent his career in and out of uranium

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Cameron Fears An Enemy It Can't See

by Jane Kay

CAMERON, ARIZONA— The town dump is an abandoned uranium mine along the Little Colorado River.

Children swim in pools of water that fill old pit mines.

Sheep and cattle stumble into shafts where Indian miners once loaded ore into buckets.

Gouged, rutted, scraped land, worked over by mining companies seeking payloads of uranium ore, remains as it was 15 years ago when the bottom fell out of the international uranium market.

In this part of the Navajo reservation 50 miles north of Flagstaff, 25 abandoned mines lie on the east side of the Little Colorado and more than twice that many on the other side.

That the companies have been able to mine and run is a tribute either to the grace of the Navajos, who silently bore the despoiling of their land, or the government's generosity to the military contractors, who never were required to clean up.

Now the people fear and resent the invisible radioactivity. They want to find out if their environment is hazardous and, if it is, they want the poisons out.

Most young men from Cameron worked in these mines, like Don Cancino's older brother, who now lives in Salt Lake City. The brother called home about reopening a mine on family grazing land, Cancino said.

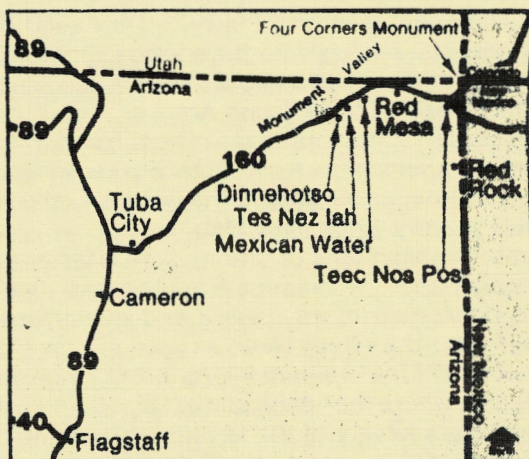
"We don't believe in that now," the family told him.

That's how it stands in Cameron and many other parts of the Navajo lands, says Virgil Bigsinger.

Last year, Bigsinger turned over a map naming the abandoned mines to tribal officials in Window Rock.

His interest stems from his founding of Cameron's community farm, one of four recently developed to mine abundant water instead of uranium on the reservation.

He has worked with Cancino and other young people to grow food on the fertile, moist banks of the river.



Abandoned Uranium Mill Tailings

Along the Little Colorado, water can gush at 250 gallons a minute from four wells to the 64 acres under cultivation by families who have plots of fruit trees and vegetables.

But, the people wonder, how clean is the farmland?

Water and soil tests are infrequent, even though wind blows and water erodes these colorful leftovers of uranium exploration.

Bigsinger was bulldozing to build a reservoir. A man came up and told him it was uranium tailings he was pushing around.

The people at Cameron had considered growing sugarbeets to produce gasohol. But again, they were afraid the land might be contaminated with uranium.

Not far from the farm, in a hogan yards from an old mine, Amelia Horse is relieved when the highway department takes water out of the deep pits on her grazing land to spray on the road. Then her sheep, which go to the unfenced area to drink, get the fresh underground water that refills the pond instead of standing water, she says.

She swam there as a child, as did Bigsinger and many others. And now they wonder if the water is radioactive.

She and Bigsinger both want ongoing testing of animals and the environment.

Looking over the discarded pit that is now the town dump bothers Bigsinger because of the potential health hazard of dust stirred up whenever someone takes out the garbage.

"I know this radiation sometimes handicaps a person," he said. "Not now, but in the future or to a child. Maybe you're healthy one day. The next day you don't know what's wrong with you. The doctor says, 'He's getting old.'"

"Or you have a child with a limp arm. They don't ask what you've been doing in the past. No studies or research on why the child is like that...Sometimes the people lose hope. They just take the children home and take care of them.

"To a medicine man, he doesn't know what radiation is. Radiation is something he cannot see or feel.

"There is no money to get the land back the way it was. They never paid for the land damage. They didn't even push the dirt back into the holes.

"People used to live along the river. There was sometimes livestock all along here. Harold Tso (director of the Navajo Environmental Protection Commission) came around and said the radiation has an effect.

"People said to themselves, 'Maybe we're doing something wrong by using the land and water.' They asked the tribe and the BIA (Bureau of Indian Affairs) to actually check to see if there was radiation. But they didn't have any instruments." ■

Budget Constraints . . .

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who are non-Indian or less than one-fourth degree Indian blood."

He cited one IHS facility in Oklahoma where 40 percent of all inpatient and outpatient services in 1981 were provided to persons with less than one-quarter degree Indian blood. In a strongly worded letter con-

"Maybe it would be nice if we were built like thermometers so they could just look at us to see if we were one-quarter, one-eighth, or whatever."

demning this situation, IHS medical staff at the facility complained that "our population is too large for the resources. The physicians cannot and will not accept the continued decline in the quality of services as the result of a larger and larger patient population."

Crawford also emphasized that the proposed resolution on eligibility would not affect a tribe's right to decide on its membership. "This (resolution) does not say that a tribe cannot determine its own members. All it says is who gets their health care paid for by IHS."

Mixed Reaction

Reaction to the eligibility resolution was mixed, with a number of NCAI delegates voicing emotional appeals both in support and in opposition to the quarter-blood quantum requirement. Gilbert Roberts of the Sisseton-Wahpeton Sioux Tribe in South Dakota said his tribal council has passed a blood quantum requirement but federal regulations prevent its enforcement. "We realize that a lot of people are using our medical services that we don't feel are entitled. Sometimes our old people are waiting to see a doctor, and these other people come in, they are pushy, and say 'Wait a minute, take me first!' They push our old people out," Roberts said.

"Indian people are already being deprived access to medical care because of (services provided to) non-Indians and those less than one-quarter blood. I think that's a crime."

Lance Grey, of Salt River, Ariz., told the NCAI general assembly that his tribe's constitution requires at least one-quarter Indian blood for tribal membership. However, the IHS clinic on his reservation is required to serve all Indians regardless of their blood quantum, and frequently services must be provided to non-tribal patients that travel as far as 100 miles to use the clinic. "We don't have enough medical services for our own people, yet we must serve these others. All we are trying to do take care of our own people in the community," he said.

Other NCAI delegates spoke out strongly against the proposed recommendation on eligibility. Mel Tonasket, vice-chairman of the Colville Confederated Tribes of Washington, expressed concern that "We're falling in line with the BIA (Bureau of Indian Affairs) or any other government agency. It was the BIA that first set up the quarter-blood policy, and we're backing it up here."

Tonasket contended that acceptance of the proposed eligibility guidelines would allow the federal government to dictate to tribes who they can serve rather than permitting tribes to make their own decisions. "If we are going to abide by the concept of Indian self determination, then we must allow the tribes to make the decision on who will receive services," he said.

Tonasket also questioned whether consideration of critical policy issues such as eligibility should weigh so heavily on existing economic conditions. "I just wonder what would happen if in another year or so they cut the budget some more. Do we come back to this meeting and say that eligibility should be cut back to those with one-half degree Indian blood?" He added that setting a blood quantum requirement for services to which Indians are otherwise entitled would be the first step toward "self-termination."

Claire Swan, chairman of the Kenaitze Indian Tribe in Kenai, Alaska, also criticized the rationale of using a minimum blood quantum level for determining whether an individual is Indian for the purpose of receiving services.

"Sometimes our old people are waiting to see a doctor and these other people come in, they are pushy, and say 'Wait a minute, take me first!' They push our old people out."

"Maybe it would be nice if we were built like thermometers so they could just look at us to see if we were one-quarter, one-eighth, or whatever," she said.

Swan also called the proposed recommendation "very dangerous" because it could lead to situations where some members of an Indian family are eligible for health services, while others are not. "This can divide families, and thereby divide the tribe," she said.

According to one unidentified speaker from the Yakima tribe of Washington, restricting the eligible service population is the wrong solution to the problem of inadequate health resources. He contended that the federal government has failed in its trust responsibility to Indian people by not funding Indian health programs at levels needed to provide adequate care.

Although the resolution on eligibility for IHS services was tabled at the NCAI convention, the issue will be addressed again during the organization's executive meeting in Washington, D.C. in January, according to NCAI President Joe de la Cruz. NCAI is preparing a "concept paper" on IHS eligibility that will be reviewed at the January meeting and distributed to tribes for their consideration.

In addition to the matter of eligibility, the upcoming NCAI session will take up a number of other important health-related items that were discussed at the Bismarck convention. NCAI has scheduled a full day of meetings with IHS and other Department of Health and Human Services (DHHS) officials to discuss such issues as equity health funding, urban Indian health care, the Community Health Representative program, health education scholarships, and DHHS block grants.

Additional information about the NCAI meeting can be obtained by contacting: the National Congress of American Indians; 202 E. St., N.E.; Washington, D.C. 20002. Phone (202) 546-1168. ■

Congress Restores \$25 Million for CHR's in '83; Requests Evaluation

CHR Panel Recommends Administrative Changes

WASHINGTON, D.C.—Citing the program's importance to the overall health care delivery system on Indian reservations, House and Senate conferees agreed to a \$25 million compromise to continue the Community Health Representative (CHR) program in 1983.

The compromise was reached during a December 16 House-Senate conference on the FY 1983 Interior Appropriations Bill (H.R. 7356), which includes spending levels for programs of the Indian Health Service (IHS). President Reagan is expected to sign the measure into law.

Earlier this year the Reagan Administration proposed to abolish the CHR program, which was funded at \$29 million in 1982, in FY 1983 because of what some officials termed "non-patient care activities." Tribal leaders were outraged by the Administration's proposal, arguing that many Indian and Alaska Native families, particularly those living in isolated areas, depend on CHR's for a wide range of health services.

While congressional appropriations committees acknowledged the important role CHR's play in reservation health programs, they also criticized the overall management of the program. In its report accompanying the House bill, the committee noted that "the program has come into question again because IHS has not fulfilled its management responsibilities" and called on the agency to develop guidelines for CHR programs.

On the Senate side, the committee stated: "it appears that during the rapid expansion of the CHR program between 1968 and 1981 a number of activities were supported which have little relation to the CHR program." The committee also requested an evaluation to identify such activities.

In an effort to respond to similar past criticisms and strengthen the program's accountability to Congress, a special "CHR Task Force" comprised of IHS staff, tribal health personnel, and representatives from national Indian organizations, has developed a series of recommendations aimed at improving the administration of the CHR Program. These recommendations, adopted at a joint meeting of the task force and 12 area representatives of the National Association of CHR's Phoenix, Ariz., November 1-4, have been distributed to tribes and CHR program personnel for their review, according to Tonya Parker, CHR program coordinator for IHS. A final report of the task force's recommendations will be submitted to IHS Director Dr. Everett Rhoades in mid-January.

One of the major tasks undertaken by the task force was a nationwide assessment of CHR resource distribution. The project was conducted this summer by

distributing detailed questionnaires to all 234 CHR programs to solicit information about their activities and the distribution of resources in FY 1981. Based on 1,186 responses, representing slightly more than half of the estimated full-time CHR's, the assessment "provides a quantitatively accurate depiction of how CHR resources are used," according to Tom Bonifield, IHS senior medical scientist who served as the project's director.

The assessment measures how CHR workers generally distributed their program time among the health care functions, areas, and settings that broadly define the scope of the CHR program. For example, the report shows that 45 percent of gerontological health services were provided in the home setting, compared to 28 percent in hospitals and clinics and 27 percent in the community setting.

Bonifield emphasized that, contrary to some expectations among tribal and federal officials, the assessment project did not attempt to evaluate individual CHR programs. "You can't evaluate something until you first know what is there," he said.

The task force approved the assessment report and recommended that it be used in an evaluation of the CHR program that "allows for measurement of its medical efficiency and cost effectiveness." It is hoped that such an evaluation will satisfy the directive of congressional committees.

In the area of reporting and data collection, the task force agreed that "the CHR program has been criticized as not being accountable and not complying with reporting requirements." The panel recommended that IHS, in consultation with CHR personnel, establish a uniform reporting system that would be mandatory in all CHR contracts.

Other major recommendations developed by the task force include:

- limiting to no more than 15 percent the amount of CHR resources expended on program administration
- requiring that definitions and scopes of work be made consistent with those used in the national assessment report
- establishing effective program directorship at the national level to provide for: an IHS headquarters position of CHR Program Director of equal status to other headquarters program directors positions; a national training initiative that provides for area-based training activities; and a national mandatory reporting activity. Funds for such activities should evolve from the current "set aside" for administration of this program in an amount not to exceed \$400,000.
- emphasizing training for CHR staff, with training needs identified on the local level and training requirements and funds negotiated into CHR contracts
- requiring that training and certification be carried

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Congress Restores ...

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out in accordance with recognized standards of health care

- requiring IHS to develop a methodology for the allocation of CHR resources that will utilize three program modules: scope, effectiveness and needs. This methodology should be developed with the active participation of an advisory group consisting of Indian and Alaska Native community health leaders
- shifting the CHR line item within the IHS budget from "Preventive Health" to "Clinical Services," with the CHR budget line item status maintained.

Comments on these and other recommendations developed by the task force will be considered in the preparation of the final report. Send comments or requests for additional information to: Tonya Parker; Indian Health Service; Rm 6A-55; 5600 Fishers Lane; Rockville, MD 20857. Phone: (301) 443-4644. ■



PENNY DENETCLAW (left), of the Laguna Pueblo CHR program, discusses family planning with a young mother at her home in Laguna Pueblo.

Physicians Oppose Cuts to Community Health Program

by Dale Russakoff, staff writer

The Washington Post

WASHINGTON, D.C. — The Reagan administration's effort to abolish a special health care program for Indians has prompted government doctors from every Indian reservation in the country to sign petitions opposing the proposed cutback as, in one physician's words, "something close to malpractice."

In a rare public break with the administration, 168 doctors of the Indian Health Service, including the directors of all 80 major clinics and hospitals outside Alaska, signed the petitions asking for the continuation of the Community Health Representatives program, in which nurses' aides travel to remote parts of reservations, delivering health services to thousands of Indians for whom hospitals and clinics are inaccessible.

"If this program goes, there could be unnecessary morbidity (advanced disease) and mortality on reservations," said Dr. Terrence Sloan, director of the clinical program at the Indian Medical Center in Gallup, N.M., which serves the Navajo tribe.

"As physicians, we feel that's something close to malpractice," Sloan said. "Without this program, we could see Indian patients coming into the hospital with advanced pathology instead of minor illnesses that could have been caught at home. This is not just another program on the list. It is vital."

The Reagan administration proposed to eliminate the \$29 million program in its 1983 budget, calling it auxiliary or "non-patient care," which means that it has a lower priority than keeping Indian clinics and hospitals open.

The fiscal 1983 cuts in Indian health programs, which are administered by the Health and Human

Services Department, are to be followed by larger reductions in fiscal 1984, according to budget plans announced recently.

Sloan said the doctors spoke out against the administration because they believe that Congress is unaware of the living conditions on reservations, and the impact of health budget cuts there.

The Indian Health Service is essentially the only source of health care on reservations. More than half the residents of most reservations live at least 10 miles from the nearest paved road, often without access to vehicles, meaning they cannot reach hospitals or clinics in harsh weather, Sloan said.

In addition, Indians who still observe ancient traditions and rituals often refuse to seek conventional health care unless prodded by the tribal health representatives, who live in the villages and remote communities and often travel the less developed areas in four-wheel-drive trucks. The same program pays for the only ambulance service on most reservations, Sloan said.

The health representatives visit each home in their area to screen for tuberculosis and other infectious diseases, diabetes, and cancer, and to check residents' blood pressure and other vital signs.

Sloan told of a representative who recently discovered an elderly Navajo man living alone in a traditional hut, suffering from advanced diabetes, his feet and legs covered with ulcers and lesions. At first, the man refused hospital care because of his allegiance to ancient traditions, but the woman persuaded him to accept treatment.

Without her help, Sloan said, the man probably would have died. ■

Long Dead...

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mines in the Southwest described working conditions for some 12,000 miners.

Despite knowledge that radon and dust were causing lung cancer among underground miners in Europe as early as the 1920's, the states and the industry fought stricter standards until the early 1970's, Duncan Holiday told University of Arizona medical students at a seminar last year. "The design was to get out ore, not to get the mine ventilated," he said.

The deaths had started showing up in the 1950's. By 1970, a study of 3,500 men showed that 144 had lung cancer, instead of the 30 cases that might be expected, he said.

Dr. Joseph Wagoner of the U.S. Public Health Service later found 11 cases of lung cancer among 107 Navajo miners who had never smoked. He had expected to find none. Wagoner told the New York Times that "the data clearly indicate the inadequacy of current standards" of radiation exposure in the mines.

For the men who were grateful to have jobs near home that paid \$1.50 an hour in the early years and up to \$5 an hour later on, comprehension of the connection between mining and suffering came slowly.

Beneath the ramada, where Dirty (Dirty) Bedonie was kept company by his wife, Clara, he talked about mining uranium in the richest, most productive mine in Arizona.

Working 700 feet underground, it was just another job. No supervisor ever told him about precautions, he told his cousin in Navajo.

"For one-half day or a couple hours they put air in, to settle down the dust in the main tunnel.

"You stand in line at lunch to drink water from pools filled from openings in the rock.

"You come home, you don't change clothes, you

don't wash your hands, you sit and eat. You wear the same clothes when you go to sleep.

"At the time I left the job," he said, "I was feeling OK. I didn't realize it was going to happen to me like that... the pain, the difficulty in breathing."

Clara Bedonie, who wets down the earthen floor to keep it cool, remarked that when her husband started getting sick four years ago, she knew he would die like the others.

Now, since he stayed in the Tuba City Hospital and received medication, the pain is gone, he said. But he is losing spaces of time, pieces of thought, as the weeks move along toward his death.

Bedonie — reclining on a bright, clean quilt in the cool shade — was asked if he felt anger or bitterness toward the mining companies.

He had neither of those feelings, and he said he had no pain. ■

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