DHHS Opposed to Several Provisions of Indian Health Bills

WASHINGTON, D.C. — Tribal and federal health officials, mindful of President Reagan's veto of similar legislation last year, are keeping an anxious watch on Capitol Hill as congressional committees begin their deliberations on bills to reauthorize the Indian Health Care Improvement Act (P.L. 94-437).

In a legislative year that could dramatically impact the future of the federal Indian health program, House and Senate committees have also taken up consideration of separate legislation dealing with prevention of alcohol and drug abuse among Indian youth, Indian health promotion and disease prevention, and the Indian health budget for fiscal year 1986 (see related articles elsewhere in this newsletter). In addition, the committees are expected later this year to undertake an assessment of P.L. 93-638, the Indian Self Determination and Education Assistance Act, which will likely include an examination of problems encountered by tribal programs operated under P.L. 93-638, regulatory issues, and possible amendments to the act.

Aside from the crucial debate on the FY 1986 budget, the most pressing item on the congressional agenda for Indian health is legislation in the House and Senate that would revise and reauthorize the Indian Health Care Improvement Act through fiscal year 1989. The Senate bill, S. 277, was introduced January 24 by Senator Mark Andrews (R-N.D.), Chairman of the Select Committee on Indian Affairs, with 20 co-sponsors. The House version, H.R. 1426, was introduced March 5 by Representative Morris Udall (D-Ariz.), Chairman of the House Interior and Insular Affairs Committee, with 32 co-sponsors.

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SIX YOUNG WINNERS of the national Indian safety poster contest were presented awards for their artwork in January by IHS Director Dr. Everett Rhoades (left) and Surgeon General C. Everett Koop (right). The six youngsters are: (bottom, l-r) David Baker, 6, Phoenix area; Sacreana girl Torres, 7, California area; Roxanne Curley, 8, Navajo area; and Heidi Quesada, 10, Phoenix area; (top, l-r) Michael Reyes, 14, California area and Darlene Otten, 18, Alaska area, who was the contest's overall winner. About 7,000 children attending Indian reservation schools took part in the contest, which is intended to promote better community awareness of safety and accident prevention.
including Representative Henry Waxman, (D-Calif.), Chairman of the House Subcommittee on Health and the Environment. The Interior committee and the Health subcommittee have joint jurisdiction over H.R. 1426.

In his introduction of S. 277, Senator Andrews stated that the federal responsibility for Indian health care reflected in the legislation “recognizes the legal commitments and treaties made with Indian tribes — of obligations undertaken by the federal government during the early days of our westward expansion, in exchange for the cession of vast amounts of Indian lands to the United States.”

The need to continue targeting federal resources to address the health problems of Native Americans has been well-documented, stated Andrews. “While most Americans — 66.4 percent — will live to age 65 or older, the Indian child born today has only a 35 percent chance of reaching age 65. The fact is that 40 percent of all Indian people will die before they reach 45. These are realities that we cannot afford to ignore,” he told his fellow senators.

Making reference to the President’s veto of last year’s reauthorization bill, Andrews stated, “...we are hopeful that the administration will demonstrate the strong support for Indian health programs that President Reagan expressed in his veto message, and will work closely with interested members of the Senate to assure that this most important Indian health legislation will be approved by the President in 1985.”

S. 277 and H.R. 1426 are similar in most respects. One difference is that the Senate version, unlike the House, specifically spells out the authority of the Community Health Representative and urban health programs under the Snyder Act of 1921. S. 277 also has a new section (under Title II) dealing with health promotion and disease prevention, while H.R. 1426 has no such provisions. Perhaps the most notable difference between the two bills concerns their approach to the reorganization of the Indian Health Service (IHS) within the Department of Health and Human Services. H.R. 1426 would elevate IHS, which is presently one of four bureaus within the Health Resources and Services Administration (HRSA), to the level of assistant secretary, with the move to be accomplished within six months after enactment of the legislation. S. 277, on the other hand, calls for elevating IHS to an agency within the Public Health Service, with the change to take effect May 30, 1987.

Other than these differences the Senate and House bills are essentially the same as the Indian health legislation passed last year, with a few important exceptions. First, the so-called Montana provision has been dropped from Title II. Cited as one of the two major objections in the President’s veto message, it would have established a controversial demonstration project within the state of Montana that would have prohibited IHS from considering an indigent Indian’s eligibility for state and local health care programs funded by property taxes. President Reagan called the project “totally unacceptable,” stating that it “would actually reduce access of health services for Indians.”

But despite its deletion from S. 277 and H.R. 1426, the Montana issue appears far from resolved. Senator John Melcher (D-Mont.), who sponsored the amendment last year, has declared his intent to address the Montana problem and hopes to have some form of the provision eventually added to the legislation. Further, his position is supported by several Montana tribes and by the Montana Inter-Tribal Policy Board. Meanwhile, Dr. Robert Graham, administrator of the Health Resources and Services Administration (HRSA), has made assurances that if the Montana provision is reintroduced it will again be “vigorously opposed” by the administration.

The second major objection cited by the President to last year’s bill, a provision to have a congressionally-appointed commission study on the organizational placement of the Indian Health Service (IHS) within the department, has also been deleted from both bills. The provision was deemed unconstitutional by the Justice Department. Instead, the two bills deal with the issue of IHS’ reorganization more directly.

In addition to the Montana provision and the reorganization commission, the House and Senate bills have been stripped of several IHS reporting requirements and the overall funding authorization contained in last year’s bill has been reduced. According to committee staff, these changes were also made in order to address concerns stated in the President’s veto message.

However, even with these revisions of last year’s bill, the administration remains staunchly opposed to many aspects of the House and Senate reauthorization bills.
Regional Meetings Planned for Congressional Study on Indian Health

WASHINGTON, D.C. — As part of an important study dealing with Indian health technologies and services, a congressional investigatory agency will take to the field to participate in several regional meetings with tribal representatives and Indian Health Service (IHS) beneficiaries during the next few months. The first meeting is scheduled for Portland, Oregon May 1-2, with three other regional meetings to be held before August 1.

The purpose of the upcoming regional meetings is to provide the congressional Office of Technology Assessment (OTA) with technical data and opinions about local Indian health issues, problems, and priorities. At the request of House and Senate congressional committees, OTA is conducting an assessment of health technologies and services for Native Americans, with the study specifically designed to address the following areas: the health status of American Indians and Alaska Native people who are eligible for care through IHS (whether direct or by contract); the most appropriate mix of medical and health services and technologies in light of the health needs of the eligible population; the organization of health delivery systems, with emphasis on adequate and equitable access to services and technologies; health outcomes, and cost effectiveness; and catastrophic health care needs (including current and alternative financing arrangements for those needs).

For a related story on the OTA study, please see page 20.

"The OTA assessment is significant because it will examine several areas that could be crucial for developing long range plans for Indian health care," observes Jake Whitecrow, executive director of the National Indian Health Board, which is assisting OTA in coordinating the regional meetings. "Given the general lack of information in some of the areas that OTA is investigating, these regional meetings are an important opportunity for tribes and Indian health consumers to fill in some of the missing pieces," Whitecrow says.

To date, the OTA study has primarily centered on the gathering and analysis of national demographic and health data on the Indian population, with much of the information garnered from 1980 Census statistics. OTA staff are counting on the regional meetings as a way to gather additional data, gain insights into local health problems, and hear directly from IHS beneficiaries. Explains OTA project director Lawrence Miike, "Our hope is that through these meetings and follow-up activities, IHS's client population will have the opportunity to comment on our study, and we will have the chance to validate information and to collect additional information. IHS's clients will then have the opportunity to see how this information and comments are subsequently used in our analyses and to judge for themselves whether or not our conclusions and policy options are firmly grounded."

All four meetings will have similar agendas and cover the same subject areas, which specifically include the following:

- Characteristics of Indian People:
  - Tribal Membership: eligibility, trends, general demographics
  - Health status and special problems

- Delivery of Health Care
  - Direct IHS services
  - Self determination (P.L. 93-638) funds
  - Contract care
  - Other sources of funding (Medicare, Medicaid, private insurance, etc.)
  - Equity funding: criteria, application, impact
  - High cost ("catastrophic") contract care: impact on contract care funds, types of cases, trends, relationship to presence or absence of relevant IHS direct care

- Other health issues of particular concern to the tribes in the region (e.g., operational problems concerning the administrative procedures required by IHS in contracting, hiring, etc.)

Miike points out that this type of information will be useful both in planning for and in addressing specific issues. For example, he states, "better information on the extent to which other payment programs (e.g., Medicare, Medicaid) are available would be useful in at least two areas: 1) to evaluate efforts to discontinue funding for urban Indian health programs based on the Executive Branch's contention that other sources of services delivery are adequate, and 2) whether there is a significant difference between urban and rural areas insofar as access to Medicaid and other State programs are concerned, since most reservations are located in rural areas."

Meeting Locations, Format

As currently planned there will be four regional meetings between May 1-August 1, with three different IHS geographic service areas to be represented at each meeting. The four meeting sites and their IHS service areas are: Portland, Oregon (Portland area, Alaska area, California area); Phoenix, Arizona (Phoenix area, Navajo area, Tucson area); Rapid City, S.D. (Aberdeen area, Bemidji area, Billings area); and Oklahoma City, Oklahoma (Oklahoma area, Albuquerque area, United South and Eastern Tribes). Except for the Portland meeting, specific dates and other details are still being arranged.

According to Whitecrow, the different sites were chosen as a result of their accessibility to local tribal populations and to provide OTA with as broad a view as possible of the Indian health program. "Ideally, you would like to have the time and resources to hold a meeting in every single IHS area. Unfortunately, that's not possible," Whitecrow said. "However, I believe we've come up with a schedule that will give everyone that's interested a chance to express their views," he said.

Whitecrow added that because of the subjects to be addressed at the meetings, the discussions are likely to be somewhat technical and detailed. "These aren't going to be like hearings or workshops, where a few
Regional . . .

Continued from page 3

presentations get made and everyone goes home. We want a lot of exchange and followup. For these meetings to be successful they have to be real strong working sessions," he said.

To promote this kind of exchange, Whitecrow continued, the meetings will be designed around panel, or roundtable, discussions with OTA staff and 15-18 Indian participants that will be selected by the areas' tribes, health boards and inter-tribal organizations. Other persons attending the meetings as audience members will be encouraged to contribute their views during the course of the discussions, Whitecrow said.

The meetings will open with a short presentation on the OTA project. As described by OTA's Miike, "In the regional meetings, we will briefly present data at the national level on the . . . issues, augmented with our understanding of the situation at the specific regional level when such information is available to us. This will serve as the starting point for the discussion. The relative amounts of time spent on any issue will depend on the importance of each issue to the region. We will also reserve time to discuss other issues of concern to the participants which may not have been covered." It is anticipated that each regional meeting will last 1-2 days.

Along with the discussions planned for the four regional meetings, OTA staff will visit IHS and tribal health facilities in those areas. Separate OTA site visits to Indian health facilities are also being considered for the Alaska, Bemidji, and USET areas. The Alaska site visits will probably be done in June in conjunction with NIH's next meeting in Juneau, Alaska.

In addition to the four regional meetings, OTA is working with urban Indian health projects and will explore other avenues to collect data for the project. OTA plans to complete most of its research on the Indian health study this summer and have a first draft of its report ready by fall.

For additional information about the OTA project or the regional meetings, please write: National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colorado 80231; or Congress of the United States; Office of Technology Assessment; Health Project; Washington, D.C. 20510. ■

Bingaman Introduces Indian Health Promotion Bill

WASHINGTON, D.C. — Citing the need for a stronger emphasis on preventive medicine within the Indian Health Service (IHS), Senator Jeff Bingaman (D-N.M.) introduced legislation in the Senate February 6 calling for a comprehensive policy of health promotion and disease prevention for Native Americans.

In introducing his bill, S. 400: the Indian Health Promotion and Disease Prevention Act of 1985, Bingaman noted that the leading causes of hospital admissions within IHS, including pregnancy complications, injuries and poisonings, and digestive and respiratory diseases, are those in which health promotion and disease prevention services can be most effective.

"Therefore," the senator stated, "in the long term IHS needs to aggressively pursue a comprehensive health promotion strategy, including programs for nutrition and physical fitness, control of high blood pressure, reduced use of alcohol and drugs, and other behavioral changes that individuals can make to reduce the risk of disease."

Three of the four major provisions of S. 400 have been included, at Bingaman's request, in the Senate's bill to reauthorize the Indian Health Care Improvement Act through fiscal year 1989 (S. 277). Those provisions are: development of an Indian health promotion and disease prevention policy and a plan for effecting that policy; continuation and expansion of IHS health promotion and disease prevention services; and continuation and improvement of the Community Health Representative program as the vehicle to carry out health promotion and prevention activities in Indian communities. A fourth provision of Bingaman's bill, authorizing 1-4 preventive health demonstration projects at a cost of $500,000, is not included in S. 277.

Bingaman's bill has been referred to the Senate Select Committee on Indian Affairs. During a March 6 hearing on the Indian health reauthorization bill, Bingaman testified before the committee in support of the demonstration project as well as the preventive health sections already included in S. 277. Additional consideration of the Bingaman bill is expected in the coming weeks. ■
Health News Across the Nation

The following is a regular feature of the NIHB Health Reporter. In this section we present our readers with short briefs on issues and activities from around the country, including such topics as conference and workshop dates, legislative notices, news on local events, etc. We invite our readers to submit material for publication in this section. Additional information on the items mentioned here can be obtained from the NIHB Public Information Office.

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TALIHINA, OKLA. — After months of long and sometimes strained negotiations, the Choctaw Nation of Oklahoma was awarded a $5.8 million contract from the Indian Health Service February 1 to operate the 52-bed Talihina hospital as well as outpatient clinics in Broken Row, Hugo and McAlester. The contract, awarded under the provisions of P.L. 93-638 (the Indian Self Determination and Education Assistance Act), provides for tribal administration of programs for family medicine, internal medicine, pediatrics, obstetrics-gynecology, surgery, emergency medicine, radiology, laboratory and pharmacy services, dentistry, ambulatory care, and community health nursing. In FY 1984, the Talihina hospital admitted 1,172 patients for extended inpatient care; delivered 228 babies; and recorded 23,547 outpatient visits. Nearly 30,000 additional outpatient visits were made at the three outlying health centers during FY 1984.

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ZUNI PUEBLO, N.M. — The American Lung Association will present a special award to the Zuni Indian Health Service Hospital here in early May in recognition of the hospital's new policy to ban smoking on the premises. The policy, which became effective April 1, is intended to promote a goal of disease prevention, says Zuni service unit director Arthur Ray. As health professionals, he notes, it is "hypocritical to suggest to a patient a change in their lifestyles, when we do not do it ourselves." "We should be setting an example," he added. The no-smoking policy will apply to hospital staff, patients and visitors. The Zuni facility is the first hospital in New Mexico to adopt such an initiative, and the second in the IHS system to ban smoking. The IHS hospital at Keams Canyon, Ariz., took similar action last year.

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SHIPROCK N.M. — Health professionals taking part in the first Shiprock Health Fair March 29 called the event a "huge success." About 500 persons, mostly Navajo elders, registered for health screenings, blood pressure checks, and blood chemistry analyses, with information from the screenings interpreted by attending physicians and their assistants. The fair was especially important for persons at risk for diabetes or high blood pressure, noted Dr. Bruce Goldberg, a physician at the fair. About 40 of the 196 persons given blood pressure checks were found to suffer from high blood pressure. Other screenings and information exhibits dealt with vision problems, heart disease, alcoholism, plague control, domestic violence and nutrition. The fair was sponsored by the National Health Screening Council of Volunteer Organizations, the Shiprock Community Health Center, and the Indian Health Service.

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SPOKANE, WASH. — The American Indian Health Care Association will hold its Tenth Anniversary and Annual Health Conference here June 10-13. The theme for the conference is "Survival Strategies for Urban and Rural Indians." The conference fee is $40 for member projects, $50 for non-members. For additional information, contact Mary Mitchell, Annual Conference Coordinator; AIHCA; 245 East 6th St.; St. Paul, Minn. 55101. Phone (612) 293-0233.

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Former Talihina SUD Responds

Dear Editor:

In reference to your article, "Choctaw Tribe, IHS Embroiled in '638' Contract Negotiations For Talihina," Vol. 3, No. 15, January 1985, I need to clarify the statements:

"According to some IHS Staff, the Choctaw Tribe is ill-prepared to take over operations due to strained relations between Chief Hollis Roberts and the present Service Unit Director" (emphasis added).

I do not wish to leave the impression with your reading public that I was a part of Chief Roberts' problem of being ill-prepared to take over the Talihina Service Unit. Hollis Roberts intended and did accomplish removing me from participating in any activity concerning the "638" take over of Talihina Service Unit.

Floyd G. Anderson
(Former SUD at Talihina)
The Southern Ute Tribe abolish all and treatment of a community ones, two days of workshops that the program coordinators. Alcoholism Issues," disabled. Free screenings array of topics from prevention to transition programs for the community members. Free screenings and high problems, and high cholesterol levels will be performed for a slight charge.

LAME DEER, MONT. — With alcoholism long recognized as the leading problem on their reservation, members of the Northern Cheyenne community here took steps to better understand and deal with the disease during an Alcoholism Awareness Week in January. "Alcoholism is a community problem," stated Adeline Whitewolf, one of the program coordinators. "We are all affected in some way by this problem through the dependency of loved ones, leaders, and co-workers." Presentations and community activities included "Disease Concept," "Family Issues," a review of alternatives, a sobriety celebration, and a poster contest. A special day-long presentation at Dull Knife Memorial College covered research, prevention and treatment of alcoholism.

services eligibility under a contract awarded by the agency last fall.

Part of the intent behind the study, says IHS project officer Rich McCloskey, is to determine whether the current eligibility regulations are in need of change. "With the basic eligibility regulations almost 30 years old we need to ask whether they are still serving us properly," he adds. IHS claims that it has become increasingly difficult and time-consuming to determine who is eligible for health services and who is not. For budget and planning purposes IHS has been mandated by Congress to use official Census data. Because the Census allows self-identification, the population identifying themselves as American Indian or Alaska Native does not necessarily correspond to the population that could actually establish eligibility for IHS services. Planning based on actual or projected utilization by those persons eligible for IHS services would be more accurate and appropriate, according to IHS.

There have been a number of suggested options for reviewing eligibility requirements for IHS services. Those under review by the current study are:

1. adopt the definition of the term "Indian" as used by Congress in the Indian Self-Determination Act, P.L. 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 total Indian blood quantum as a requirement;
3. include a residency requirement;
4. abolish all residency requirements;
5. some combination of the above and;
6. as proposed by the White House Committee on Private Sector Initiatives (commonly referred to as the Grace Commission), require that a person be a member of a federally-recognized tribe with at least 1/4 degree of Indian blood.

According to co-project officer Aaron Handler, IHS wants to have the capability to respond to questions about what would happen if various factors were put into effect, including the number of people who would be affected. "When the Grace Commission made its recommendation, we couldn't say whether it was a good or bad idea nor can we respond to any number of alternatives because we are unaware of what the impact would be."

The study is being performed by Native American Consultants, Inc., a business headed by Former BIA Commissioner Louis Bruce. Start of the study has been delayed because the Office of Management and Budget must approve such an information collection. In order to gain OMB approval a pretest of up to nine tribes must be performed. The pretest will be used to help finalize the format, wording and followup procedures to be used during "full scale information collection." Although tribes for the pretest have been selected, IHS prefers not to

Continued from page 5

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TSAILE, ARIZ. — The Diné Center for Human Development will host the 2nd National Native American Conference on Developmental Disabilities in Albuquerque, New Mexico on May 9-11. The theme of the conference is "Making A Difference: Through Transition, Politics, Education, and Parent Power." The conference is intended to provide a forum for professionals, service providers, teachers and parents who work with and advocate on behalf of the developmentally disabled Native American. The conference agenda will feature two days of workshops that will include a wide range of topics from prevention to transition programs for the disabled. The third day has been set aside for parental involvement issues. Other activities will include a banquet, luncheon, pow-wow, films and educational and commercial exhibits. For more information contact: The Dine Center for Human Development, Navajo Community College, Tsaile, Arizona 86556, (602) 724-3351, 3352.

IGNACIO, COLO. — The Southern Ute Tribe will hold its first community health fair here April 29, with a wide array of health screening activities made available to community members. Free screenings will be offered for blood pressure, hearing, vision testing and other health indicators. In addition, a blood chemistry analysis for problems related to heart disease, liver and kidney problems, and high cholesterol levels will be performed for a slight charge.

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LAMIN MARSH, MONT. — With alcoholism long recognized as the leading problem on their reservation, members of the Northern Cheyenne community took steps to better understand and deal with the disease during an Alcoholism Awareness Week in January. "Alcoholism is a community problem," stated Adeline Whitewolf, one of the program coordinators. "We are all affected in some way by this problem through the dependency of loved ones, leaders, and co-workers." Presentations and community activities included "Disease Concept," "Family Issues," a review of alternatives, a sobriety celebration, and a poster contest. A special day-long presentation at Dull Knife Memorial College covered research, prevention and treatment of alcoholism.

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disclose their identity “since the choices are still subject to change.” Those tribes selected are of varied size and geographically-distributed throughout the nation, says McCloskey. NACI is scheduled to begin the pretest sometime in April. Once it is completed, an OMB “clear­ance justification package” will be prepared and, assuming that OMB grants its approval, collection of information on a full scale basis should begin by September, according to NACI.

Current IHS regulations restrict services to people of Indian descent belonging to the Indian community served. Descent means that an individual must have some degree of Indian blood, but no specific degree of Indian blood is required nor is any specific degree of tribal blood.

To be eligible for contract health services, an individual who meets the above requirement must also reside within a specific geographical area called a Contract Health Service Delivery Area (CHSDA). A CHSDA is defined in accordance with IHS “on or near” regulations. If an individual Indian person resides within a CHSDA but off the reservation, the person must either be a member of the tribe whose reservation defines the CHSDA or maintain “close economic and social ties” with that tribe.

In preparation for its full-scale mailout, NACI has developed separate questionnaires for Alaska Native villages, Alaska Native for-profit corporations, Oklahoma tribes, and all other American Indian tribes. The forms will solicit information on the following areas:

- **Residency:** Each tribe will be asked to provide the number of tribal members residing: on the reservation; off the reservation but within the reservation’s Contract Health Service Delivery Area (CHSDA); off the reservation and outside the reservation’s CHSDA but within the state(s) which contain(s) any part of the reservation’s CHSDA; within the U.S. but not in any of the foregoing geographical areas. Each tribe will also be asked for the number of Indians eligible for IHS services who are not among its members but who reside: on the tribe’s reservation; off the reservation but within the reservation’s CHSDA and who work for the tribe, are married to a tribal member, or have close economic and social ties with the tribe.

- **Blood Quantum:** Each questionnaire will ask how many persons’ eligibility status would change (and the total number of persons considered) of tribal members currently eligible for IHS services if: HHS established a requirement that a person must have 1/4 Indian blood to be eligible for IHS services; or established a requirement that a person must have 1/2 Indian blood to be eligible for IHS services. Each tribe will also be asked to estimate the numerical impact on the total Indian population (members and non-members of the responding tribe) currently eligible for service from the local IHS facility if: HHS established a requirement that a person must have 1/4 Indian blood to be eligible, or established a requirement that a person must have 1/2 Indian blood to be eligible for IHS services.

- **Membership:** Also to be provided by each tribe is the numerical impact on the total Indian population currently eligible for service if: HHS established a requirement that a person must be an enrolled member of a federally­recognized tribe to be eligible; HHS established a requirement that a person must be an enrolled member or eligible for enrollment in a federally-recognized tribe to be eligible; HHS established a requirement that a person must be an enrolled member of the federally-recognized tribe on or near whose reservation the individual lives to be eligible; or required that a person must be an enrolled member or eligible for enrollment in the federally-recognized tribe on or near whose reservation the individual lives to be eligible for IHS services.

- **Combination option:** Tribes will also be asked to estimate the numerical impact on the total Indian population served by the local IHS program if HHS established as an eligibility requirement that a person must: be a member of a federally-recognized tribe and have at least 1/4 degree of Indian blood. This option would assume that the current CHSDA residency requirements would apply to both direct and contract services. (This is also the option recommended by the Grace Commission.)

Each tribe will be asked to identify any unique situations, including statutes and court orders, that must be considered in establishing eligibility requirements for its own tribe, Indian community, or area.

- The questionnaire will also provide each tribe an opportunity to submit written views on: which of the options it most favors and why; which of the options it least favors and why; and factors not considered which the tribe thinks should be considered. On this subject, NACI will urge tribes to also submit any position papers or resolutions which they may have adopted.

IHS says it doesn’t know what level of response to anticipate to the questionnaire. Handler says IHS also has “no specific formula” regarding what rate of response would be considered adequate for drawing any conclusions. Both he and McCloskey contend that “it is in everyone’s interest to respond.” Says Handler, “We are asking for views as well as population statistics. This is something which affects everyone it’s sent to. It might have an impact on the health care their people receive.” Adds McCloskey, “Even if people don’t want to change the current regulations they could still be better worded. And for those whose viewpoint is at the other extreme, they can address the matter of people being served who they believe were never meant to be served.”

Some tribes contend they lack adequate data to respond to such a questionnaire. IHS has no plans to make money available to tribes for collection or analysis of such data and this could present a problem, particularly for small tribes. Others have expressed concern that responses by a certain number of tribes will be used to draw conclusions for the entire Indian population. Still others fear that any such study is only the first step in an ultimate cutback of health services to Indian people. To those who would hesitate in answering the questionnaire, NACI staff caution, “If tribes don’t respond, others may interpret this as lack of interest and make changes anyway.”

Tribes will have at least several months to decide whether and how they wish to respond. NACI has until June of 1986 to solicit and analyze tribal data and views under the schedule now in place. Any delay in securing OMB approval could further slow the entire study. ■
Administration Defends $100 Million Cut for Indian Health in FY 1986

WASHINGTON, D.C. — Administration officials had their chance to defend next year’s proposed Indian health budget before congressional authorizing committees here late February. It is a budget perhaps best summed up in the words of National Congress of American Indians (NCAI) Director Suzan Harjo who says, “We’ve seen this budget about four times before.”

The President’s FY 1986 budget seeks $756.09 million for health services and $2.45 million for health facilities for a total $96.82 million less than current appropriations, not counting increased costs for inflation. The administration, as it has proposed for the past four years, would achieve the savings through reductions in clinical and preventive care; elimination of the Community Health Representative, tribal management, and urban Indian health programs; and by halting construction of hospitals, outpatient clinics, and sanitation facilities.

Such cuts, coupled with a proposed 5 percent employee pay cut and a 10 percent cut in administrative costs, would, according to the administration, represent a “freeze” at the 1985 level. With the total proposed reduction amounting to well above $100 million, Congressman Morris Udall (D.-Ariz.), who chaired the House Interior and Insular Affairs Committee hearing on February 26 declared, “I’d call this more than just a freeze; it represents a considerable reduction.”

Udall followed some of his introductory remarks with a reminder to the administration in response to a plan to use $10 million in Medicare/Medicaid collections to offset mandatory cost increases. “The law restricts use of these funds to accreditation activities,” Udall told Dr. Robert Graham, administrator of the Health Resources and Services Administration (HRSA). (Graham appeared as the administration’s chief witness, accompanied by IHS Director Dr. Everett Rhoades.) Udall also called the administration’s projection that IHS will collect $54 million in Medicare/Medicaid reimbursements next year “unrealistic” and asked Graham how such a figure was determined. Although such collections presently total closer to $30 million annually, Graham recounted that “each year we have been successful in collecting substantially more than in the previous year.”

Graham was also asked to explain why the Community Health Representative program has again been proposed for elimination. Congressman John McCain (R.-Ariz.) told Graham that he considers the program “simply the only way we have of implementing preventive medicine and giving attention to small problems before they turn into major ones.” “I understand that this is meant to be a budget-saving measure,” he continued, “but if the CHR program is eliminated it may very likely cost the taxpayers more in the long run.” Graham responded that the elimination is necessary “due to finite budget resources.”

In light of the budgetary constraints under which IHS finds itself operating, McCain questioned Dr. Rhoades about seeking alternate ways of delivering or contracting for health services. Rhoades answered that his objective “is to build a comprehensive community health care system with the hospital as a backup. Such a system would include a great number of kinds of delivery including HMOs.”

At this point McCain interjected that options such as a Health Maintenance Organization are only viable for those tribes located near urban areas. McCain added, “We must experiment because if the present level of funding is maintained we are in danger of not fulfilling the basic obligation of providing an acceptable level of health services to American Indians.” “The level of funding being proposed here will not enable IHS to provide adequate services even though it has the best of intentions,” he concluded.

The administration opened its testimony before the Senate Select Committee on Indian Affairs the following day with Dr. Graham telling committee members, “the budget we have presented will allow us to continue to make strides in Indian health status.” The hearing was presided over by Chairman Mark Andrews (R.-N.D.). Witnesses for the administration were again Graham and Rhoades.

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Administration Defends . . .

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Questioning from the chairman focused largely on the administration's plans for IHS health facilities. Noting that no additional funds for construction or planning are requested despite numerous projects already underway, Andrews asked, "What does the department propose to do about the facilities in some stage of construction at the end of FY 1985?" "The facilities will be made secure and we will await the decision of the department regarding whether to seek additional funds," Graham replied.

Referring to IHS' written budget justification which lists some $97 million in unspent health facilities funds, Andrews asked "How can the department assure accountability for these considering its continued reluctance to spend construction funds?" Graham offered assurances that there is no reluctance on the part of HHS and that IHS expects to obligate between $70 and $80 million of the current amount over the next few months.

Following this with a question raised frequently by congressional committees over the past few years, Andrews asked "Why does it take so long to get these facilities completed?" Graham explained: "We must make sure, it is our number one priority that a facility will be acceptable to the tribes. Then within the department we must work with other offices."

In response to further questioning, Graham stated that approximately $55 million would be needed to bring all IHS facilities up to Medicare/Medicaid standards for accreditation. Citing the FY 1986 budget which allocates $2.5 million for improvements and repairs to existing facilities, Andrews demanded, "Does this mean it's going to take 20 years to bring these facilities up to standard, while all the while other facilities are dropping below standard each year?"

Following the appearances of administration witnesses, the Select Committee heard from representatives of several national Indian organizations. Their testimony challenged the administration's assertion that it will be able to deliver adequate health care services under the proposed budget. "Once again the administration is seeking through its budget request to reverse the improvements achieved in Indian health care over the past 20 years," stated joint testimony presented by the National Indian Health Board and the National Congress of American Indians.

NIHB and NCAI predicted that even in the clinical programs where the administration is recommending slight increases, the net effect will be a reduction in services since the proposed increases are slated primarily for pay raises, within-grade promotions, and other built-in increases. As a result, contend the organizations, every clinical care category would be forced to cut direct services next year.

In the area of preventive care which IHS has identified as one of its chief objectives for FY 1985 and 1986, the administration has requested a 40.5 percent decrease, with a large portion of that cut to be achieved through elimination of the CHR program. Noted the two national organizations: "We cannot understand the administration's reasoning that the health care services rendered by this skilled cadre of tribal health professionals fails to . . ."

William Raspberry

Is This South Africa?

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JOHANNESBURG — The South African government, having forced blacks out of their ancestral lands, is now putting them up in homes that lack even such rudimentary facilities as indoor plumbing.

Not only are there some 20,000 existing government-built homes without indoor toilets, but another 2,900 new homes now being planned also will lack plumbing facilities, officials said.

If you've been reading the papers lately, you know how wildly inaccurate this report is. The numbers are accurate enough, but the dateline should read Washington, not Johannesburg; the residents of the housing in question are not native South Africans but Native Americans, and the government agency involved is not the Ministry of Bantu Affairs but the U.S. Bureau of Indian Affairs.

I only said it was South Africa because it's the easiest way to generate the appropriate degree of outrage.

When it happens in South Africa, we know without doubt that the reason is racial. When it happens here, we find it reasonable to blame it on "budget constraints."

It was "budget constraints," said Robert Graham, head of the agency that oversees the Indian Health Service, that led his Public Health Service administrator to delete the $24 million requested for bathrooms in the proposed new homes and $30 million to upgrade 20,000 existing homes.

"This committee worries about the well-being of the Indian community," said Rep. Sidney Yates (D-III.), who chaired the March 26 hearing, after being told by one government witness that the absence of sanitation facilities can lead to gastrointestinal and other health problems. "What choice does the committee have but to put that money [back] in?"

Sadly, the sorry state of Indian housing does not even rise to the level of serious public controversy. Americans — including those who are moved to protest the latest outrage in South Africa — seem to accept it as a matter of course that the welfare of Native Americans is a low priority. Indeed, most of us hardly think of them at all, hidden, as they are, from the public view.

No one seriously suggests these days that America's non-native "newcomers" ought to go home and give the country back to the Indians. But it doesn't seem extravagant to suggest that their government-furnished housing ought to include at least the basic amenities that the rest of us take for granted. Indoor toilets hardly constitute a luxury these days.

Robert Graham chose not to argue the point, noting only that "under the present budget priorities, it is not possible to seek funds for these purposes."

Nor did he elaborate on the "present budget priorities," but it may be worth noting that the hearings were held on the same day that the House voted to release $1.5 billion for 21 MX missiles, those weapons so dear to the heart of the Reagan administration, despite the fact that nobody knows what to do with them.

At least the Indians know what to do with bathrooms.
WASHINGTON, D.C. — The Indian Health Service (IHS) recently completed its application of the Resource Requirement Methodology, the agency's method of determining unmet health resource needs. Once analyzed, the results will be used in the allocation of the $5 million set aside for the equity health care fund this year as well as to respond to congressional requests for budget information.

The most recent previous IHS estimate depicted a total need of roughly $600 million remaining unmet, three-fourths as much again as the agency's current appropriation ($855 million in FY 1985). Such a projection is not in keeping with administration attempts over the past four years to decrease IHS expenditures. Thus the accuracy of the Resource Requirement Methodology (RRM) upon which IHS bases its estimate was recently subjected to a thorough review. Several changes resulted and were included in the version which has just been applied nationwide.

RRM is used to calculate the personnel, support, and contract health service costs of providing health services at any IHS or tribal health service delivery location. In total, these costs represent the resources required to provide a comprehensive range of inpatient, ambulatory and community health services, as well as administrative support services.

As an assessment methodology for health services, the RRM process uses accepted standards and criteria, actual workload utilization experience, other workload data, and population statistics to determine staffing and contract health service requirements.

As a management tool, RRM is meant to assist program managers make rational decisions about present and future resource requirements. Available resources, including IHS and third party sources, are subtracted from the total resource requirements with the difference being the "unmet need." The level of deficiency, expressed as a percentage, is determined by dividing the unmet need by the total resources required for each program element.

The results of the IHS-wide application of RRM (done once a year) are used to rank tribes in terms of their resource deficiency. The health services priority system includes five levels of deficiency: less than or equal to 20 percent; 21-40 percent; 41-60 percent; 61-80 percent; and 81-100 percent. At the end of FY 1984, through distribution of the equity health care fund, IHS reported that no tribe had an overall level of resource deficiency greater than 60 percent.

According to IHS, the examination of the RRM process identified specific problems and concerns which it now hopes to correct by making four main changes:

- **Workload forecasting:** Guidelines have been developed for IHS area office use in determining workload projections for planning new health facilities. Such projections are based on a current population base and projected growth along with existing and projected workloads (or utilization rate). The standard for determining this last element has been "tightened up." Plan-

ners have previously chosen from among a number of "workload averages" considered acceptable, among them the IHS national, area and service unit averages. Beginning with the new RRM application, the nationwide IHS average will be used as the norm with a population's unmet need calculated as the difference between their existing utilization and the national utilization rate. According to Jean LaBoueff, IHS program analyst, the revised guidelines are "much better and more realistic overall."

- **Relative staffing:** Prior to construction or planning of a new IHS health facility, a Program Information Document (PID) must be prepared. This document includes the necessary staffing level, square footage, population to be served, availability of alternate resources, etc. and must project the facility's population and workload eight years in advance. Planning officials within the Health Resources and Services Administration, the Public Health Service, and the Office of the Assistant Secretary for Health questioned the need for the staffing level reflected in such PIDs and identified specific RRM modules for which staffing requirements appeared excessive. IHS reviewed each module of staffing standards and made interim adjustments based on what it terms "methodological problems with their original development." The standards were up to ten years old and a number of them were updated to take into account changes in personnel functions, advances in technology, and coordination between specialties with the intent of reducing overlap in services. Some areas such as medical records and optometry were increased; others, primarily field health positions, were decreased with a 17 percent reduction in overall staffing requirements. Later this year, an in-depth field review of the personnel needs of individual disciplines is planned. Aimed at further improving the accuracy of the staffing standards, the review will be done by teams (yet to be formulated) representing three general categories: inpatient, ambulatory, and field health.

- **Reporting available resources:** In the past, each IHS area has reported according to its number of available positions. In order to tie the accounting of expenditures directly to the IHS budget, the areas will now be required to calculate positions into the amount of resources actually spent at each location.

- **Support costs:** Although RRM primarily addresses staffing and contract health service requirements, IHS is expanding the process to include other cost factors. During this application, support costs will be included as a resource requirement. This takes into account such operating costs as rent, supplies, utilities, training, travel, and indirect costs in the case of tribal P.L. 93-638 programs. These vary by IHS area office, as well as by tribal program but IHS program planning staff project that the result will demonstrate an increased need for support to the tune of 25 percent above present personnel costs on the average. The increase will be applied not only to IHS programs but to tribal programs under P.L. 93-638 contracts as well.
IHS Revises...

Continued from page 10

Aside from the questions regarding RRM raised by HHS, other concerns were voiced during the last Congress also taking into account the broader subject of resource allocation. The appropriations committees which deal with IHS questioned whether it has adequately addressed tribal concerns about the equity of its allocation methodology. IHS was directed to work with concerned tribes or groups and submit a report on the results of their joint efforts by last December 31.

In response, the director of IHS sent out a letter last September 7 outlining the intended changes in RRM and asking for tribal comments and recommendations with a deadline three weeks later. One of the few responses came from the National Indian Health Board which called this time frame "insufficient." "The October 1 deadline does not allow adequate time for careful examination and submission of the information contained in this tribal involvement plan," stated NIHB's letter.

Response elsewhere was more pointed. One health director whose tribe declined to submit a response says, "Unless you're an expert in RRM that stuff means nothing. It was suggested several months earlier that tribal people be included in the RRM review. If they're (IHS) interested in our comments they need to involve us right up front."

Since that time, IHS has completed its draft report to Congress which is now under review by the Public Health Service.

As for its plans to further involve tribes, IHS says it will conduct training sessions for them regarding the changes in RRM, as well as resource allocation and updating of Tribal Specific Health Plans sometime "early in 1985."

Meanwhile, IHS staff do not expect the recent RRM application to change the overall resource need by much nor any "dramatic changes" to occur as a result of the application just completed. An analysis of its results is expected to be completed sometime within the next few weeks.

Administration Defends...

Continued from page 9

qualify as 'key inpatient and outpatient medical care services.' The CHR's are invaluable to Indian communities, particularly in their ability to provide outreach and home health services to many rural reservation families."

In its budget justification, the administration identifies one of three broad initiatives for strengthening the overall IHS program as the area of "self determination activities." On this note, the two organizations strenuously opposed the planned elimination of the tribal management program. They disagreed with the administration's claim that without tribal management funding, IHS will still be able to provide technical assistance when requested by tribal management. "On the contrary," stated NIHB and NCAI, "many tribal requests for training and technical assistance are not being met under current IHS funding and staffing levels."

In addition to the tribal management program, the organizations suggested that funding for indirect costs associated with P.L. 93-638 contracts is also crucial to improving tribal involvement in the health care system. NIHB and NCAI claimed that the $5 million proposed by the administration to create a new fund for indirect costs is insufficient, and expressed concern that these monies would be taken from other direct health services.

Both the Senate Select and House Interior Committees had until March 15 to report to their respective Budget Committees on funding levels for IHS and other Indian programs in 1986. These recommendations are used to help determine spending ceilings within which congressional appropriations committees are, in theory, to act. The House and Senate appropriations committees are expected to report their recommendations for FY 1986 IHS spending levels some time this summer. The new fiscal year begins October 1.

DHHS Opposed...

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At a House Interior Committee hearing March 19 on H.R. 1426, HRSA's Graham testified, "We applaud removal of the two provisions regarding Indians' eligibility for State and locally-provided health care benefits and the unconstitutional transfer mechanism. However, the bill retains a number of objectionable features."

"In general terms," Graham continued, "the bill retains duplicative authorities, unnecessarily interferes with the organizational structure of the Department of Health and Human Services, inappropriately expands IHS responsibility into areas only indirectly related to primary health care delivery, and contains excessive authorization levels."

Graham specified more than a dozen provisions in the legislation that the administration opposes, including several sections related to the delivery of health services to California Indians; proposed new language dealing with the administration of P.L. 93-638 contracts; establishment of a Catastrophic Health Emergency Fund; a provision that, under certain circumstances, would exempt IHS from the department's competitive bidding requirements; language dealing with IHS' authority to plan, construct and operate safe water and sanitation disposal facilities in Indian communities; continuation of urban Indian health projects; removal of the IHS from its existing placement within HRSA; language calling for a study of health hazards to Indians and Indian miners as a result of nuclear resource development; and a section requiring a plan to reduce Indian infant mortality rates.

Responding to Graham's statement, Interior Committee Chairman Morris Udall noted that the President vetoed last year's bill on grounds that were "understandable," and explained that the Committee had sought to address those concerns by deleting the two most objectionable portions of the legislation. This year, Udall complained, the administration appears to be raising new objections to the bill.

Those objections, as well as other comments and recommendations made during March hearings on H.R. 1426 and S. 277, will be considered in the coming weeks as the committees prepare for markup. All three committees (House Interior, House Health Subcommittee, and the Senate Select Committee on Indian Affairs) are hopeful of reporting out their bills by May 15 in order to have the legislation considered for the FY 1986 appropriations cycle.
WASHINGTON, D.C. — Nearly six years ago, federal regulations made it possible for most tribes to choose to run the Food Distribution Program (and under special circumstances, the Food Stamp Program). With the more recent addition of tribes in Oklahoma, the FDP serves over 100,000 participants and is growing. Some 80 tribes and five states now operate the program on 179 reservations and tribal land areas.

Through these tribes and states, the United States Department of Agriculture (USDA) distributes food to members of Indian households living on or near a reservation and members of non-Indian households living on-reservation.

USDA donates a variety of foods designed to help participants maintain a healthy diet. A list of about 50 different foods is available from which participating agencies can order. These include: canned meats; vegetables, fruits and juices; dried beans; peanuts and peanut butter; egg mix; milk; cheese; pasta, flour, and grains; corn syrup; and shortening. The foods provided are based on a specific number of cans or pounds of each category of food for each person per month.

In determining who is eligible to receive commodity foods, local food distribution offices consider the number of people in a household, the household's income, money in checking or savings accounts, and money paid for the care of a household member while the other members work or attend school.

There were numerous reasons for the initial legislation authorizing the program on Indian reservations. Although an earlier law, adopted in 1974, stipulated that the Food Stamp Program be administered nationwide, food stamp participation among Indian people was low. Several factors were responsible, all linked to the particular circumstances of remote reservations. For one thing, at the time, many families had to travel long distances to the nearest county welfare offices to apply for the program. Each month, they would have to make the trip again to pick up their food stamps. Lack of transportation made it difficult or impossible for many to apply. (In the last few years quite a few neighboring counties have set up satellite food stamp offices on-reservation.)

But practical problems were not the only reason for the low participation. Many Indian people did not feel comfortable dealing with their local county welfare employees. Those who participated in the Food Stamp Program also found that food stamps don't buy much in the small grocery stores on the reservation.

Thus, while the Food Stamp Program somewhat improved conditions for tribal members, with the advent of the Food Distribution Program, a majority have turned to commodities.

The food distribution plan offers some distinct advantages over food stamps for reservation residents. Though food stamps are accepted at reservation grocery stores, food selections are limited and prices are generally higher than elsewhere. To find a regular supermarket, a person usually has to travel at least several miles. And many people do not have transportation readily available.

An important advantage of the Food Distribution Program is that, in most cases, tribes operate it entirely themselves. Participants no longer have to go to county offices. The whole commodity distribution process, from certification to issuance, takes place on the reservation, and nearly all transactions are between tribal members. Says Suzie Roy, director of the program on Minnesota's Leech Lake reservation, "Our program is very important because of the way tribal members were treated by county staff. We're more receptive to their needs. Our people simply weren't on the food stamp program." And, families in immediate need can receive food the same day they apply.

Many participants say they receive much more food through the Food Distribution Program than with food stamps. Under the Food Stamp Program, the amount of stamps a household gets is based on a graduated scale, depending on the number of people in the household and total income, after deductions. One family of four may qualify for $150 in food stamps per month, while another may qualify for only $35. With commodities, all
qualifying households get approximately the same amount of food for each person. The amount does not vary with income. For example, all four-person households get roughly 280 pounds of food each month.

Even so, people may apply for either commodities or food stamps and some find that food stamps are better suited to their particular situation. A household's preference is often determined by where it is located, with those closer to supermarkets more likely to choose food stamps. Meanwhile, according to one tribal FDP director, elderly and small households "usually do better with commodities."

Many Tribal Food Programs Promote Good Nutrition, Better Diets

Poor nutrition is related to several health problems among Indian people, including diseases of the heart, cerebral vascular problems, cirrhosis of the liver, pneumonia, influenza, and diabetes. Recognizing this, the tribes operating the food distribution program work to have a positive impact on their participants' diets and health.

In many tribal communities it's extremely difficult to get the variety of foods needed for good health. People frequently can't get fresh fruits, vegetables, and meats in the small reservation stores, and even if they could, the foods are too expensive. Among the foods commodity participants receive are protein-rich canned meats, dried beans, canned fruits and vegetables, and other items that have often been hard to obtain.

Yet, as Intertribal Council of Michigan program director Harriet Moran puts it, "People have been afraid to take certain items such as brown rice." To acquaint participants with such foods unfamiliar to them, Moran's and many other programs have found preparation and taste-testing demonstrations helpful. Many programs have written their own cookbooks and recipe sheets making creative use of the commodity foods.

"To ensure that participants are getting foods their families will eat," Moran and most other directors also periodically survey participating households regarding their food preferences.

With problems of diabetes and hypertension common among tribal populations, a number of the food distribution programs utilize the services of tribal, IHS, county or other nutritionists to design diets and recipes for those with special dietary needs. Mississippi Choctaw director Mary Lane Allen notes that her program stresses "educating our people not to add more salt after preparing foods."

Tribal organizations operating the commodity program are allocated administrative funds based on 30 percent of their program's estimated food value. Some directors, such as Jerry Levi, whose program serves three Oklahoma tribes, call the value which USDA assigns to the food "unrealistically low." He argues that this results in inadequate operating funds, particularly for programs serving large areas and making time-consuming dis-

ELIGIBILITY FOR TRIBAL food programs is determined through a standard certification process performed by the program. Here, Shawnee program staff person Carol Miller explains certification process to tribal applicant.

tributions, known as "tailgating."

By regulation, each tribe is required to come up with 25 percent matching funds for administration unless it can show "compelling justification" for contributing less. At the time the regulations were proposed, tribal groups opposed any match requirement. Nonetheless, most are finding that the requirement is being enforced with increasing stringency. Says Bob Beard, the program's national director, "The tribes are being asked to look at their budgets very closely."

Regulatory Changes Sought

Another regulation to which a number of tribes take issue limits which off-reservation tribal members may be served. No one living in an "urban place" outside reservation boundaries (any town or city with a population of 10,000 or more by USDA's definition) can participate regardless of the town's proximity to a reservation. The purpose behind this requirement, maintains USDA, is that persons with low incomes in urban areas should have access to the Food Stamp Program while such access may be much more difficult for households located in rural settings. The department has stated that it believes Congress intended the FDP to operate on Indian reservations, "but not to replace the Food Stamp Program in urban areas."

Although tribes may individually apply for a waiver of the regulation and a few such waivers have been granted, others are working for a regulatory change to increase the urban population definition.

Last summer, a caucus of Midwest tribes urged USDA to increase the urban limit to at least 15,000 and preferably 20,000. As a member of that caucus, the Intertribal Council of Michigan also adopted a resolution of its own seeking an increase in the population guideline. Tribal members in at least two Michigan towns located near reservations (Marquette with a 21,967 Continued on page 14
Tribal Food Programs...

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population and Escanaba with a population of 15,000) are affected by the rule.

Explains Moran, "Although there is a city there, living expenses are higher and small households such as the elderly and those with higher incomes would prefer the Food Distribution Program. We would like to give people an option."

The Five Civilized Tribes, who (along with other Oklahama tribes) did not have the option of operating the

Poor nutrition is related to several health problems among Indian people, including diseases of the heart, cerebral vascular problems, cirrhosis of the liver, pneumonia, influenza, and diabetes. Recognizing this, the tribes operating the food distribution program work to have a positive impact on their participants' diets and health.

FDP until after the regulations were already in place, have sought to amend the definition of "urban area" to include towns and cities with a population of less than 50,000. Echoing Moran's statement they reason that "Many Indian people residing within such areas are elderly and required to exist on a very limited income."

Mississippi Choctaw program director Allen says, "We have one town only 10 miles from the reservation with a population of just over 12,000. The families there don't understand why they can't be served."

The nation's largest tribe, the Navajos, are urging that the regulation be rescinded. Flagstaff, Gallup, Farmington, and several other towns near the reservation with a sizable number of Navajo residents have populations in excess of 10,000. Katherine Arviso, director of food programs for the tribe, argues that the regulation discriminates against families who reside in a town above the population limit who would otherwise have been eligible. The Navajos have also enlisted the neighboring mayors in support of their position. Says Arviso, "Many of these Navajo people prefer to receive commodities rather than food stamps."

However, answers Bob Leerd, Administrator of USDA's Food and Nutrition Service, "It's what USDA prefers, not what the people prefer and the preferred program for these people is food stamps."

Objections have also been raised over the regulation which prevents tribes from serving another group of off-reservation tribal members. At present, only Indian and non-Indian households living on-reservation and Indian households living near a reservation may be served. At their annual caucus a year ago, the Midwest tribes asked that the regulation be changed to allow households with Indian children under age 18 living near the reservation to be served as well, regardless of the race or nationality of their head of household.

But again the answer from USDA was no. "We have decided not to serve households near reservations with non-Indian heads of household," says Beard, "because we don't want to get into the issue of deciding who is Indian and who is not. There is an alternative available to those people. We think the program ought to go for its primary recipients."

Aside from such larger issues, tribes have encountered certain practical problems in the course of program administration. Although they like to offer participants a variety of foods in each of the categories not all foods on USDA's list are always available. Some programs report, for example, that chicken has been unavailable for the past three or four months. This makes a real difference for participants who have just five meat choices to begin with. Others report a problem getting a variety of fruit over the past seven to eight months.

Also common are complaints of food deliveries frequently arriving late. Since they must order two months in advance, tribes sometimes run out of certain items by the time of distribution. Beard attributes the delays in delivery in part to misunderstanding. He claims that tribes frequently have the mistaken belief that there is a two week shipping period within which any given delivery is to occur. Another factor, according to Beard, is that some tribes are "chronically late" in submitting orders so that shipping dates cannot be met. And, he says, shipping delays result when the Kansas City Office which controls the FDP inventory gets behind.

Tribes also frequently end up with low inventories as a result of having too little storage space, adds Beard. Many of them, he says, find it frustrating that USDA has no authority to grant construction funds.

In all of these matters affecting the FDP programs which they run and particularly with regard to policy issues, there is a feeling among numerous tribes that they should have a larger voice. Tribes in at least one region have asked to have a representative who has "input" at both the regional and headquarters levels. Responds Beard, "Tribes can comment on regulations and thereby have the same voice as anyone else. They also write their own plans of operation subject to USDA approval." Whether that will be accepted as enough by the tribes remains to be seen.

In spite of any problems encountered in administering the program, tribal FDP directors find USDA on the whole a fairly easy partner with which to work. They are even more convinced that any headaches are well worth the great beneficial impact they believe the program has had. The program serving Oklahoma's Citizen Band Potawatomi, Seminole and Iowa Tribes began operations in June of 1983. Director Jerry Levi says the program now serves about 2,700 people, twice the number projected at the time it began. "Unlike many programs," he says, "we can see the tangible benefits of this one. With each participant receiving about 70 pounds of food each month, it is a major supplement to our tribal members' diet."

"Unlike many programs, we can see the tangible benefits of this one. With each participant receiving about 70 pounds of food each month, it is a major supplement to our tribal members' diet."

Adds Moran, "The program really helps cut our families' food bills. I hope it stays in place; not because I want a job but because it makes a real difference."

Perhaps the sentiments toward the program are best stated by Julia Nasewytwewa, director of the Gila River program which began nearly five years ago: "When we didn't have the program I used to wonder how some households survived. It's called a supplementary food program but many people depend on it to survive from month to month."

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Improved Dental Health for Indian Children is Goal of Tri-Agency Pact

For the past decade many Indian children involved with Head Start programs have benefitted from special attention given to dental health and oral hygiene, attention that is partially the result of a triagency agreement designed to promote prevention, education, and better services in the area of dental care. In the following article, Mary Beth Kinney of the Chemawa Indian Health Center in Salem, Oregon, describes this agreement and the services it provides to Indian children. Additional information can be obtained from Mary Beth Kinney, MPH; Chemawa Indian Health Center; 3750 Hazegreen Road, N.E.; Salem, Oregon 97305. Phone: (503) 370-4200.

ALBUQUERQUE, N.M. — A unique arrangement between three federal agencies is helping promote better oral health among young Indian children enrolled in Head Start programs.

Since 1976, the Indian Health Service (IHS) Dental Program has participated in an interagency agreement with the Administration for Children, Youth, and Families, and the Head Start Bureau for the purpose of assisting Indian Head Start grantees to develop dental health programs. Under the guidelines of the agreement, the IHS Dental Program provides consultation to 106 Indian Head Start grantees in order to promote better dental health among Indian children. This consultation includes evaluating tribal Head Start dental health programs against established performance standards, and providing training and technical assistance to Head Start personnel.

Basically, the IHS Head Start agreement spells out four major roles for the IHS Dental Program: advisor, evaluator, educator, and advocate. In its capacity as advisor, IHS dental personnel work with Head Start staff to design a comprehensive approach to dental care. Dental disease is a common health problem found in Head Start children. A recent national (1982-83) survey by the Indian Health Service indicated that 82 percent of Indian children under 4 had some form of tooth decay. Additionally, over 40 percent of the children had 7 or more decayed primary teeth. This underscores the importance of developing a comprehensive dental health program that includes prevention, treatment, and education.

An example of this approach can be seen in one program where the health coordinator was concerned when she learned that four of the Head Start children had “nursing bottle mouth.” She knew that candy could ruin a healthy smile, but she did not realize that tooth decay could also be caused by improper use of a baby bottle. To reduce the incidence of this unfortunate condition, the IHS consultant and health coordinator recommended that nursing bottle mouth be made a priority issue in the health plan. They designed a health promotion program to inform parents that if they put their children to bed with a bottle, whether it contained juice, soda pop, sugar water formula or even milk, the liquid would drip continuously into the mouth and mix with bacteria to destroy the teeth.

The consultant recommended using audiovisual aids to show the parents what could be done to prevent nursing bottle mouth. During parent orientation, the health coordinator now uses Bright from the Start, a slide-tape series, that explains how parents can prevent this type of dental disease in their children. Nursing bottle mouth is not an uncommon occurrence in Indian preschool children, with survey data indicating a prevalence possibly as high as 50 percent in some Indian communities. Additional intensive and targeted education, promotion and intervention efforts are needed to reduce this problem.

In the area of evaluation, IHS provides dental consulting expertise to Head Start programs in the form of program monitoring site visits. Dental needs for Head Start children may vary from region to region; however, each Head Start program is required to meet certain performance standards. Periodically, an evaluation team visits a Head Start grantee to monitor the program’s compliance with the performance standards. The team, which is composed of consultants with expertise in the various components addressed by the Head Start standards, makes recommendations for strengthening or for bringing an area into compliance with the performance standards. The IHS dental consultant assesses the quality of dental care, makes recommendations for correcting any deficiencies, and offers suggestions for improving the program.

The third major aspect of the IHS Head Start agreement is education. Head Start performance standards require that an organized education plan be developed

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Six New Area Directors Offer Views on Indian Health Concerns, Priorities

ROCKVILLE, MD. — Over the past year, in addition to the reshuffling of veteran Indian Health Service area directors, fully one half of the 12 area director positions have been newly filled.

All of the "newcomers" are American Indian or Alaska Native; all are men; and two are Commissioned Corps officers.

The new directors were asked to express their thoughts working with local tribes as well as priorities for improving the health status of Indian people in their area. Details on each follow.

H. C. Townsley, M.D., Oklahoma Area

A member of the Chickasaw Tribe, H. C. Townsley returned to his native state last April to become director of the Oklahoma Area IHS. He succeeds John Davis who served as Area Director since 1974. Prior to this appointment, Townsley was stationed in Albuquerque, N.M. where he was Director of the IHS Office of National Mental Health Programs since 1975 and concurrently directed IHS Headquarters West operations for the past three years.

Townsley was a 1958 graduate of Tulane University and received his M.D. degree from the University of Oklahoma School of Medicine in 1962. He earned a Master of Public Health degree from the University of Hawaii in 1982.

Following internship at St. John's Hospital in Tulsa, Okla., and residency training at Huey P. Long Charity Hospital in Pineville, La., Townsley was a family practitioner in Bogalusa, La. from 1963 to 1969. He then served a 3-year neuro-psychiatric residency at Central State Griffin Memorial Hospital in Norman, Okla. From 1972 to 1974 Townsley directed the Oklahoma Department of Mental Health's Drug Abuse and Aftercare Program. He is presently a commissioned officer in the Public Health Service.

Along with complying with IHS' nationwide major program objectives for the current year, Townsley would like to see his staff focus on two additional areas. First of all, he is interested in developing a primary prevention and screening program for diabetes, including a computerized register of all patients currently identified as diabetic. An important use of the register would be to subsequently screen the relatives of those already identified, something previously untried in such a systematic fashion, according to Townsley.

Perhaps reflective of his background in mental health, Townsley would also like to place a stronger emphasis on "dysfunctional" behavior in youth, citing alcoholism, drug abuse, teenage pregnancy, and dropping out of school as examples. Townsley would increase both community outreach activities and education in order to "better involve tribal communities" in this effort.

Nonetheless, he remembers well that budgetary constraints are a perpetual problem making it "difficult to do these new things rather than just talk about them." A good relationship with area universities somewhat aids the Oklahoma Area in this resource crunch. Townsley says that in his area, IHS is able to tap into university staff for both training and consultation and cites the IHS relationship with Oklahoma's department of mental health as a good one.

A recent development which Townsley points to with pride is reestablishment of an Oklahoma City Area Indian Health Board. At his invitation, tribes from throughout the state met in September for this purpose and determined what they consider an appropriate composition for the board. In Townsley's view, the board has an important role to "collectively and individually recommend priorities for service units' health care delivery." He expects that the group will also be active in IHS budget discussions.

Michael Lincoln, Navajo Area

Since last April, the Navajo Tribe has had its health services delivered under the direction of its first Navajo IHS area director. An enrolled member of the Navajo Tribe, Michael Lincoln attended Northern Arizona University where he graduated with a Bachelor of Science degree in Biology in 1972. In 1975 he graduated from Harvard's School of Public Health with a Master of Science degree in Health Services Administration.

Lincoln returned to his reservation to work with the Navajo Health Authority, predecessor to the tribe's Division of Health Improvement Services. In turn, he served as Assistant Director for the Office of Student Affairs, Director of Emergency Medical Services, Deputy Director and eventually as the organization's Executive Director from 1977 through 1979. The next year, Lincoln went to work for the U.S. Department of Health and Human Services serving as a Policy Specialist in the Immediate Office of the Secretary. He subsequently served as Special Assistant to the Regional Health Administrator, Region IX of the Public Health Service. In 1982, he joined the staff of the Indian Health Service as Director of the Office of Program Development and Support for the Phoenix Area.

Bringing to his present position his several years of experience with the Navajo Health Authority during which he "viewed things from the other side of the fence," Lincoln says he now regards tribal consultation as extremely important. The Navajo Tribe and IHS are about to enter into a Memorandum of Agreement which, as explained by Lincoln, "will specify how health decisions are to be jointly made." The memorandum will cover such issues as setting medical priorities and the sharing of detailed budget information. It will also be as specific, says Lincoln, as describing how the area IHS and tribe would like to see individual health programs operate.

Lincoln regards an "excellent working relationship" with the tribe as one of the major strengths he has to draw on as director. He praises the tribe's willingness to work as a partner at the service delivery level, citing as an example the excellent relationship which exists between Community Health Representatives and IHS Community Health Nurses. In addition, says Lincoln, the area's service unit health boards have always been

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SIX NEW DIRECTORS have been appointed in IHS area offices over the past year. They are (l-r): Terry Sloan, M.D., Aberdeen Area; Alan Allery, Bemidji Area; Michael Lincoln, Navajo Area; Robert Singyke, Alaska Area; Don Davis, Portland Area; and H. C. Townsley, Oklahoma City Area.

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active. He would like to see their role in determining the acceptability of services increase. He keeps in touch with the area-wide health board and says it is presently undergoing a “rejuvenation.”

Lincoln is approaching the task of improving the health status of Navajo people in two initial steps. He wants to spend his first year or two trying to accurately determine what their health problems are and what problems they are likely to face in the years to come. His staff is busy examining epidemiological and demographic information, which includes not only current information but trends over the past 20 years as well. The health problems have clearly changed, Lincoln says. He gives as an example the 40 percent of deaths among Navajo people in 1960 attributable to deaths among infants under the age of one; in 1980 such deaths made up 8 percent of all Navajo deaths. In an attempt to develop some predictors of the health problems Navajos are likely to be confronted with in the future, the area IHS office is also comparing the Navajo population with the general U.S. population as well as those of developing nations.

The second step Lincoln describes will look at whether “the health system as set up is the best for meeting present health needs and those to come.” In addition to maintaining acute care, health prevention strategies will receive greater focus. This attention to prevention will not be merely a “shotgun approach,” guarantees Lincoln. “Our resources are too limited for that.”

The toughest obstacle seen by Lincoln is that the area’s resources are already “overutilized.” In every major category (including outpatient visits, inpatient days, and deliveries), he explains, the Navajo area experiences the greatest demand. Lincoln finds it difficult to ask his staff to give any extra effort as the area focuses on additional needs such as preventive health since “they have no more time to give.”

Robert Singyke, Alaska Area
Robert Singyke assumed the directorship of the Alaska Area Native Health Service on October 1. He replaced Gerald Ivey who had been appointed Deputy Director of the Indian Health Service.

Singyke, an Eskimo, was born in Nome and has been an active leader in Native affairs. He graduated from Mt. Edgecumbe High School and continued his education at Springfield College, Springfield, Mass., where his major field of study was health, physical education and recreation, and received a Bachelor of Science degree in 1960. He earned a Master of Public Health degree in 1973 from the University of California, Berkeley.

Singyke joined the Indian Health Service in 1970 as Community Relations Officer for the Alaska Area Native Health Service and was appointed to the position of Executive Officer in 1975. He has also served as a member of the Anchorage Federal Executive Association, Cook Inlet Native Association, Alaska Federation of Natives, and the Alaska Native Brotherhood.

During the course of his experience, Singyke says he has learned that “in management you must listen to both providers and consumers.” One of his priorities is to set up a management system which “makes the service units feel themselves to be a vital part of management.”

The other priority he mentions is to implement P.L. 93-638 (the Indian Self Determination Act) to the fullest extent possible in the Alaska Area. “We intend to make it work,” he declares. To date, the operations of three Alaskan service units have been contracted out: Kotzebue, Kanakanak, and Interior Alaska. The area is negotiating with the Southeast Alaska Regional Health Corporation for operation of a fourth service unit (Mt. Edgecumbe), according to Singyke.

The problem in the past with 638, he says, has been that “IHS was so new in the business that our regulations didn’t keep up.” He describes the situation in Alaska where the resolutions process can “present a problem” for those wishing to contract for IHS services. While Singyke believes the Self-Determination Act was geared primarily for a single tribe, in Alaska it is possible that up to 56 resolutions could be required for the process (as would be the case with the Bethel Service Unit). He also recognizes that indirect costs present a significant problem. “We know the costs will be greater to a native contractor and this is unfair,” states Singyke.

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Six New . . .

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The three tribal service unit directors and IHS service unit directors from throughout Alaska have formed a task force at his request to help the Native Health Service "establish a new direction and make organizational improvements as a health provider." Singkye also points to the health boards in each of the state's twelve regions. "It's important to support them as long as they are talking about health. They have strayed from this somewhat in the past," he claims. He says health boards are in a very strong position to speak on behalf of the consumer regarding the adequacy of services. He also sees an important role for the area-wide Alaska Native Health Board. In the past an historic Memorandum of Agreement spelled out efforts between the board and the area office. Singkye expects that the memorandum will come up for negotiation sometime again in the near future.

Terrence Sloan, M.D., Aberdeen Area

When he was assigned to serve as the Aberdeen Area's acting chief medical officer for a month in March of 1983, Dr. Terrence Sloan admits that he wasn't sure what he would find. The impression he had been given beforehand from numerous outside sources was that the Sioux tribes were difficult to work with, more politically- than health-oriented, that health care in the area was a disaster, and that the area's remoteness and isolation were impossible to work with.

So he was pleasantly surprised at the dedication and commitment he found among both IHS and tribal people in the area and surmised that Aberdeen had been given somewhat of a "misreading." Thus when the director of IHS asked him to return as the area's director later in the year, he was encouraged to accept.

Sloan began his duties as area director on November 1. Prior to this assignment he served as Clinical Director and Deputy Director of the Albuquerque Indian Hospital. From 1979 to 1983, he was Clinical Director, Staff Internist, and Emergency Physician at the Gallup Indian Medical Center and had also worked there earlier from July 1974 through June 1976 as a General Medical Officer. Sloan received a B.A. in Chemistry and Business Administration from Adams State College in Alamosa, Colo. in 1969 and his M.D. degree from the University of Colorado in Denver in 1973.

Sloan believes he was selected for the job in Aberdeen largely because of his clinical orientation. The area is probably IHS' worst in terms of the clinical situation, he explains.

Among his initial plans is improving the quality of the area's professional staff. As has been well-publicized, Aberdeen has the highest physician turnover of any IHS area. Sloan adds that of the 120 IHS medical officers with 10 years credit toward retirement only one is in Aberdeen. He wants to develop a professional support program that's the "best," including better housing and benefit programs. He also wants to examine the possibility of allowing tribes to offer the medical staff larger salaries through the vehicle of P.L. 93-638. In all of this, Sloan recognizes the importance of working closer with the area's tribes.

Other plans include a primary care and prevention program to "touch every aspect of Indian life in local communities." The infant mortality rate, often used as an indicator of a people's overall health status, is higher in the Aberdeen area than anywhere else in IHS. Some reservations, according to Sloan, have rates as high as third world countries. Accordingly, he plans to give special attention to Maternal and Child Health.

Sloan's initial priorities also include an "attack on alcoholism" and "a look at the health system in a scientific way to help people lead better and more productive lives."

The support of the area's tribes for health care is something Sloan finds very exciting. "I have a lot of faith and trust in tribal leadership," he states. Sloan said he will be "looking for ways for tribes to assume control and be successful in taking over health care delivery." He wants to assist the area's tribes in taking a much greater role in 638 as "we must eventually have a system controlled by and determined by the tribes." "If I want to leave the Indian people here with anything," says Sloan, "I want to leave them with a well-set up health system."

Alan Allery, Bemidji Area

The Bemidji Area also received a new director on November 1. He is Alan Allery, who previously served as Executive Director for the Aberdeen Area. Allery has been with IHS since 1975, specializing in tribal affairs and self-determination at the Aberdeen Area before moving into executive administration.

Allery received his baccalaureate degree from Mayville State College, Mayville, N.D. He later earned an M.S. degree from Northern State College in Aberdeen, S.D. and an M.H.A. from the University of Minnesota, where he majored in Hospital and Health Care Administration. Allery is a member of the Pembina Band of Turtle Mountain Chippewas.

As area director, he is eager to begin a whole new round of Tribal Specific Health Planning over the next year. Development of the plans ought to be completed by next October, according to Allery. Bemidji IHS plans to offer training sessions for area tribes on how to write a plan. This time around, says Allery, the plans will be entered on word processors making it easier to change and update them in the future. "We'd also like to keep them under 25 pages in length so the tribes know what's in them" he adds.

Allery is also interested in putting an alcohol prevention program in place for the area's grade school and junior high students.

He intends to hold meetings with local tribal chairmen and health directors to keep them informed of the Bemidji and national IHS budgets. Bemidji does not have an area-wide health board and although Allery wouldn't be adverse to working with a board he says he couldn't financially support one either. It is his preference, he says, to work with tribal chairmen.

He compliments those tribes who have assumed their health care operations, including Onelida, Menominee, Stockbridge-Munsee, Grand Traverse, and Lac Court Oreilles. "You can tell something positive is happening there just by walking in the door of their clinics," claims Allery. He mentions that negotiations are also underway for the Red Lake Chippewas to assume control of the IHS hospital on their reservation.

Allery says he is fortunate to have an excellent staff

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HR 1156 Aims to ‘Stop Insidious Hold’ of Alcohol, Drugs on Indian Communities

WASHINGTON, D.C. — A bill which focuses on prevention activities as the way to deal with alcohol and drug abuse among Indian youth was reintroduced February 20 in the U.S. House of Representatives. H.R. 1156 was introduced by Congressman Doug Bereuter (R-Neb.) on behalf of himself and fellow representatives Tom Daschle (S.D.), Morris Udall (Ariz.), Pat Williams (Mt) and Don Young (Alaska).

The bill, stated Bereuter in his introductory remarks, “is the product of months of consultation with Indian people, among them, health and education specialists.” It was originally introduced by Bereuter and Daschle last fall in order to provide time to take into account tribal comments and present a refined proposal to this Congress.

Probably the most difficult section of the bill to formulate, according to committee staff, deals with emergency shelters. The bill would “require” federal and “urge” state law enforcement personnel who arrest an Indian juvenile for an alcohol or drug offense to place the youth in a temporary emergency shelter or community-based treatment facility, in lieu of being jailed.

Many commenters stated that there needs to be an interim plan to deal with youthful offenders somewhere between arrest and placement in an emergency facility or sending them home. Many pointed to the need to have specially-trained people at all stages of the process, beginning with the court. Some expressed skepticism about the ability of foster homes or emergency shelters to “do the job,” and others pointed to the need for specific criteria to guide licensing of emergency shelters.

“The time has come to stop the insidious hold of alcohol and drugs on Indian communities,” proclaimed Bereuter upon introducing the “Indian Juvenile Alcohol and Drug Abuse Prevention Act.” “Our legislation will . . . supplement tribal initiatives already underway by requiring alcohol and drug abuse prevention instruction in reservation schools. It represents a comprehensive assault on the problem — one that engages the resources of the tribes and the Federal Government as well,” he explained.

The legislation would expand upon an alcoholism initiative contained in the House and Senate bills (H.R. 1426, S. 277) to reauthorize the Indian Health Care Improvement Act requiring cooperation between the Departments of Interior and Health and Human Services. Under the proposed “Indian Health Care Amendments of 1985” the two departments would join in a Memorandum of Agreement to share resources and coordinate programs dealing with the prevention, identification, treatment and follow-up care of alcohol and drug abuse. A role at least equal to that of the federal agencies in this cooperative venture would be played by tribes.

The decision to take a preventative approach with the bill was based on a number of factors revealed in the course of a year and a half of research prior to its introduction. During this time, Daschle and Bereuter found that the vast majority of IHS contract health care dollars — up to 70 percent — goes to treat alcohol and drug-related problems. Their investigation also showed that of some 200 IHS alcohol treatment centers, only one or two address the needs of youths. Prevention and education programs were “sporadic at best,” according to Bereuter.

He told his congressional colleagues, “While no one would say that treatment of adult alcoholics should be reduced, we decided that the way to seriously combat the problem would be to develop a program that stressed prevention and taught prevention techniques to children from kindergarten age on up through high school graduation.” “Pursuing such a strategy,” the congressman decided, “would provide a better opportunity to accomplish a permanent change over time in attitudes and self-concept.”

At this point, staff for Congressman Bereuter are extremely interested in receiving American Indian and tribal specific data regarding the “costs” of alcohol and drug abuse. Persons able to supply such information are encouraged to write: Congressman Doug Bereuter, Attn: Wrexie Agan, 1314 Longworth HOB, Washington, D.C. 20515.

H.R. 1156 has been referred jointly to the Committees on Interior and Insular Affairs, Energy and Commerce, and Education and Labor. The Interior Committee plans to hold two hearings here and three in the field sometime in late spring or early summer. The hearings will occur too late for the bill to be considered for funding during the cycle for next year’s budget. Meanwhile, preliminary efforts are underway to develop and introduce a companion bill in the Senate.
OTA Advisory Panel Provides Insights, Direction for Indian Health Study

WASHINGTON, D.C. — A congressional study of “technology” and Indian health care officially got underway here January 29 and 30. During the first meeting of the advisory panel to the study, staff for Congress’ Office of Technology Assessment (OTA) were given a swift orientation on the history of and current problems facing Indian health care.

The 18 members of the advisory group come from diverse backgrounds including tribal and urban Indian health, social work, demography, public health, public policy, economics, law, and medicine. The panel is chaired by Rashi Fein, professor with the Department of Social Medicine and Health Policy, Harvard Medical School.

The study itself was originally requested by congressional authorizing committees during last year’s consideration of revision and extension of the Indian Health Care Improvement Act. It is meant to examine “some of the issues raised by current federal Indian health efforts in order that Congress may fashion effective legislative solutions,” in the words of Congressman Henry Waxman (D.-Ca.), who chairs the House Subcommittee on Health and the Environment. Andy Schneider, counsel for the subcommittee, says that most of the issues identified for study will be dealt with in some fashion by the health care act reauthorization. However, he is hopeful that the study’s findings will assist Congress in its thinking and long term responses to problems even beyond the act.

The discussions here helped define some boundaries and then focused on three areas to be addressed by the study. Indian health status, access to health care including the question of equity, and catastrophic care. A presentation by the OTA staff of their initial health status research contained few surprises for advisory group members. It was noted that on the average, using mortality statistics as a gross indicator, Indian health status has improved over the past decade. However, for many diseases, the death rate for Indians is far greater than it is for the U.S. population as a whole. The staff has so far found morbidity information to be much less available and more difficult to interpret, and that both mortality and morbidity data for specific tribes are not up to date.

As reported in the initial OTA research, Indians have a higher birth rate than the general population: the American Indian and Alaska Native birth rate for 1980-1982 of 27.9 live births per 1,000 population per year (averaged over these three years) was almost twice the 15.8 rate for the general population for 1981. A related statistic cited in OTA’s overview is that the Indian population is also relatively young, with 55 percent of the population under age 25, compared to 51 percent for the general population. Infant and maternal mortality rates have recently equalled those of the general population; however, the mortality rates for postneonatal infants (those aged from one month to one year) continue to be a problem.

Indians also die younger than much of the U.S. population as a whole, according to OTA findings. For instance, of all deaths in the general population in 1981, only 5.5 percent occurred in those under the age of 25, and only 32.2 percent of the deaths were in those under age 65. Among American Indians and Alaska Natives, however, 18 percent of deaths were in those under 25, and 61.6 percent in persons under age 65.

Of the ten leading causes of death in 1980, Indians were also less likely than the general population to die of cancer and heart disease. Accidents are the second leading cause of death among Indians and occur at a rate two-and-a-half times that of the U.S. population. In addition to accidents, Indians are more likely than the general population to die of chronic liver disease and cirrhosis, diabetes, pneumonia, influenza, homicide, suicide, and tuberculosis.

These statistics, state the OTA staff, reflect the most frequently mentioned problems that can lead to poor health among the Indian population: poor sanitary con-
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ditions and water supplies; poor diets; alcoholism; lack of health education, especially with respect to the individual in health maintenance; and high unemployment.

On a follow-up note to the progress made since Indian health was transferred to the Public Health Service in 1955, former IHS director Dr. Emery Johnson stated, “If we now return to the old thinking we are in danger of losing the dramatic improvements of the last 30 years.” Making reference to the current administration’s repeated attempts to discontinue IHS programs which it does not consider central to delivery of direct medical care, Dr. Johnson warned, “the OMB mentality is that IHS ought to be doing what doctors and nurses do in hospitals and clinics, and that anything else is extraneous. We are in danger of returning to a system where if an Indian person could crawl to the door of a hospital then they might be served.”

Larry Miike, study project director, suggested that if a number of the health rates and indicators for Indians are approaching those of the general population it may prove useful to look at statistics on a more localized level in order to get at remaining problems.

Dr. Clark Marquart, advisory panel member and a physician on South Dakota’s Rosebud reservation, asserted that the “problem” with the IHS chart series (widely used to show Indian health trends) is that there are “major pockets of health poverty. But the small numbers get washed out in the larger presentation.”

Added Dr. Johnson, “The Indian infant mortality rate is generally 10 percent above the national rate, yet there are at least ten reservations where the infant mortality rate is at least three times the national average.”

Miike suggested that it may also be important for the study to clearly demonstrate the important connection between prevention and health status. Additional suggestions for improving and expanding the health status data collected so far came from other panel members.

Legislation now before Congress to reauthorize the Indian Health Care Improvement Act contains an “Indian Health Care Improvement Fund” to be used to further reduce disparities in funding among tribes, an effort which IHS began as the result of a 1980 federal court decision. At that time, IHS proposed use of an equity fund to be allocated on a needs-based formula to achieve comparability among tribes in health care funding. From Fiscal Years 1981 to 1984, Congress “earmarked” a portion of the IHS budget for an Equity Health Care Fund.

IHS developed an “equity fund allocation methodology” by approximating the health care resources required and resources available (“unmet need”) for each tribe by its estimated resource requirements to define a percentage deficiency, and ranked all tribes within five levels of resource requirements deficiency. The equity fund is applied to a portion of the unmet needs of the group of tribes in the level of greatest deficiency. Five million dollars has been set aside administratively by IHS for the fund in Fiscal Year 1985.

IHS estimates that such cases currently number 300-400 and cost perhaps $15 million annually. “For tribes operating their own contract care programs, one or two catastrophes can wipe out their budget for the year,” explained Dr. Johnson. The same thing is said to be true for small IHS service units.

Miike says OTA will look at the national catastrophic fund along with other financing options for catastrophic care. Mentioned among the latter were a co-insurance upon which the annual equity allocation is based. Although the methodology has undergone recent revisions, certain members of the group contended that it still fails to take some important factors into account. Among them, believes Marquart, are “tremendous” amounts of undocumented need and the reasons behind certain declines in utilization rates. The utilization rates used to project future needs when planning a facility ignore services needed but not provided, he says. He cites the rates used in planning a replacement hospital for the Rosebud reservation as an example. “The utilization rates used were those beginning the year that the last routine surgery was performed at Rosebud because a portion of the hospital had been condemned,” recalls Marquart.

To carry the criticism even further, Johnson told the group, “New facilities are not designed based on any sense of future reality.”

A major factor in arriving at “unmet need” via RRM is the application of a series of “modules” containing predetermined staffing levels. Mario Gutierrez, executive director of the California Rural Indian Health Board and also a member of the advisory panel, added “You cannot define unmet health need by quantifying staffing patterns.”

One basic problem, as pointed out by one of the observers at the meeting, Northwest Portland Area Indian Health Board director Sheila Weinmann, is that “tribes have not been involved in development and refinement of the formula.”

Advisory panel chairman Rashi Fein recommended that the OTA staff deal with the equity issue by asking, “Is the formula being used a good one? Will it get you to where you want to be over a period of years? And is the whole idea a good approach?” He suggested that some of the problems being encountered with allocation of Indian health funding are similar to those dealt with by the British health system in recent years and that a review of the literature may be helpful. In its examination of equity as part of the larger issue of access to health care, Miike stated that OTA will also look at the role of other resources contributing to Indian health care.

Current legislation to reauthorize the Indian Health Care Improvement Act would also establish a Catastrophic Health Emergency Fund. IHS contract care funds have been in jeopardy partially because of expenses incurred for the care of catastrophic illnesses, for which there is no cap on the amount of money that may be committed to an individual case. The legislation attempts to address this problem with a fund that would be used to pay for illnesses or injuries after threshold costs between $10,000 and $20,000 per illness or injury are exceeded.

IHS estimates that such cases currently number 300-400 and cost perhaps $15 million annually. “For tribes operating their own contract care programs, one or two catastrophes can wipe out their budget for the year,” explained Dr. Johnson. The same thing is said to be true for small IHS service units.

Miike says OTA will look at the national catastrophic fund along with other financing options for catastrophic care. Mentioned among the latter were a co-insurance
Indirect Cost Problems Continue to Hinder 638 Contracting Process, NIHB Told

WASHINGTON, D.C. — The adequacy of the P.L. 93-638 contracting process for Indian health has been challenged with increasing frequency in tribal communities nationwide in recent months. Concern has grown over the matters of indirect costs and delays in approval of tribal applications to contract, as well as over the appropriateness of the contracting process itself. Recognizing such concerns, members of the National Indian Health Board heard from both the Director of Indian Health Service (IHS) and his associate director of tribal activities on the subject during their meeting here the week of January 22.

During the course of the meeting, board members recounted numerous problems experienced either in attempting to contract for their tribes' health activities or problems inherent with the process which have become apparent since contracting. One of the most severe cases was brought up by Maxine Dixon, NIHB's representative from the United South and Eastern Tribes (USET) area. She announced that her tribe, the Mississippi Band of Choctaws, had given notice to retrocede operation of its entire health program because of the problem with indirect costs. (The retrocession was narrowly averted and the Choctaws recently signed a contract to operate their health program for the current year.) Other difficulties with P.L. 93-638 contracting were discussed by NIHB representatives from the Alaska, Albuquerque, California, and Oklahoma areas.

In his presentation, IHS Director Dr. Everett Rhoades agreed that "there are some major problems remaining with 638." As he put it, "not all of these arise from 'within' 638." In agreement with an assertion which has been made by a number of tribes, Rhoades suggested that "the contracting process itself is inappropriate for the whole 638 process." He also called some of the present requirements "burdensome and unnecessary."

"Indirect costs" include expenditures such as compensation for injury, employee benefits, audits, tribal health department structure, financial management systems and personnel systems, and other costs associated with operating a program under contract. The term indirect costs "is confusing and inappropriate and ought to be abandoned," suggested Rhoades. He reported that the administration has recommended that $5 million of the IHS budget be used to expand financing such additional tribal costs related to the contracting of programs under P.L. 93-638 next year.

In the fall of 1983, the House Appropriations Committee directed HHS to provide a full report on the problems surrounding indirect costs in tribal contracts under 93-638 along with recommendations for correction. Reportedly, the document was developed by IHS within a few weeks but the multi-layered clearance process within HHS has been unable, after a year and half, to get the report to Congress. According to the report's chief author, Dr. Joseph Exendine, IHS associate director for tribal activities, it was found that tribal administrative costs have increased 47 percent while salaries increased by 81 percent over the same recent five year period. Tribes with 638 contracts are being required to absorb such costs themselves, confirmed Exendine. The IHS report estimated that between $11 and $12 million would be required on an annual basis over the next five years just to "catch up," Exendine told the members of NIHB. Exendine says he would also like to devise a system that allows tribes to receive the same increases as IHS, including maintenance and repair funds, for their 638 contracts.

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OKLAHOMA CHOCTAW CHIEF Hollis Roberts describes to NIHB members the difficulties his tribe encountered during contract negotiations for Talihina service unit. The Choctaw Tribe assumed operation of the 52-bed hospital and other facilities February 1 under a P.L. 93-638 contract.
TONY SECATERO (left), NIHB Vice Chairman and Albuquerque area representative, confers with Dr. Robert Graham following the HRSA Administrator's presentation at NIHB meeting. Graham reviewed the Administration's objections to the Indian health reauthorization bill and discussed projected IHS budgetary and program cuts, 638 contracting problems, and other Indian health concerns during his presentation.

Indirect Cost

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One of the primary areas identified by IHS as a priority for next year is "acceleration of the development of Indian communities' capacities to staff and manage their own health programs to such extent as they may choose." In this vein, Exendine's remarks also addressed the tribal management program through which a number of tribes are assisted in developing the capabilities to operate and manage their own health programs. Tribal officials and area/program offices have indicated a need of approximately $12 million to meet tribal management funding requirements, cited Exendine. Despite its commitment to "self determination" activities, the administration is proposing to eliminate the tribal management program next year.

Indian Health Service has identified the area of preventive care as another of its chief objectives for FY 1985 and 1986. IHS director Dr. Everett Rhoades told the NIHB group, "The only way to deal with escalating medical costs is to prevent illness." In this regard, he continued, "IHS has to fundamentally reorient itself. I'm not willing to erode any more of our preventive services," he asserted.

Nonetheless, the administration's budget for next year would cut IHS preventive care programs by more than 40 percent. The largest share of this decrease would be achieved through elimination of the Community Health Representative program. National CHR Program Director Nicky Solomon told the group that a revised reporting system scheduled to be in place within the next few months will help provide "the hard data which the program needs to justify its continued existence." Each CHR worker will be required to report activities daily through use of a standard form. At the order of the director of IHS, each area office will be responsible for entering this data for computer use and begin reporting on their respective CHR activities by July 1.

Ada White, NIHB Billings area representative who also serves as president of the National Association of Community Health Representatives, voiced support for the Senate version of the Indian Health Care Amendments of 1985 (S. 277) which spells out the functions and responsibilities of the CHR program and cites its authority under the Snyder Act. NACHR is in full support of this approach to stabilize and support the program from further efforts at elimination, stated White.

(Founder's Note: In other business, the board considered a variety of issues largely dealt with elsewhere in this newsletter. These included presentations by HRSA Administrator Dr. Robert Graham regarding the reasoning behind the President's veto of last year's Indian health reauthorization bill; from Office of Technology Assessment project director Larry Mikel regarding a study of Indian health access and technologies; from congressional staff regarding reintroduction of the Indian Health Care Amendments and the Indian juvenile alcohol and drug abuse bill; and from IHS staff regarding the latest revision of the Resource Requirements Methodology and plans for updating the Tribal Specific Health Plans. Copies of NIHB motions and recommendations adopted at the meeting — including position statements on the IHS Fiscal Year 1986 budget and the Indian health reauthorization bills under consideration in the House and Senate — may be obtained by contacting the NIHB central office; 1602 South Parker Road, Suite 200; Denver, Colorado 80231.)
for program staff, parents, and children. IHS has developed a dental health education curriculum, Ready! Set! Go!, that includes classroom activities and home projects for parents and children. IHS dental consultants also provide teacher in-service training. The emphasis of a workshop may be an update on dental health information or a review of dental health problems of the Head Start child.

Whatever the topic, the objective of the in-service training is to present current, accurate dental health facts that a teacher can use in the classroom and in parent meetings. Some examples of training and technical assistance that have been given in the last year are:

- Orientation for a new health coordinator,
- Managing record keeping through control tracking forms,
- Enhancing parental involvement,
- Emphasizing the role of proper diet in dental health,
- Starting a supplemental fluoride program,
- Communicating the benefits of fluoride.

Finally, in the area of advocacy, the IHS Head Start agreement has a goal of improving the oral health of Indian Head Start children and their families. One cooperative effort toward attaining this goal has been influenced by the involvement of Head Start parents who want to prevent dental disease in their children. In many instances they have learned that fluoride is a necessary nutrient to strengthen teeth, and they want to have fluoride levels in their community water adjusted so that the benefits of fluoride are available for everyone, children and adults. Other parent-policy committees have recommended fluoride supplement programs for the Head Start children who do not have optimally fluoridated drinking water.

Whether the role has been that of advisor, evaluator, educator or advocate, the relationship between Head Start and Indian Health Service has been mutually beneficial. The agreement has been significant in promoting preventive dental health concepts in Indian communities. Prevention of dental disease and the development of good oral health habits in Head Start children yields long term benefits by decreasing the community treatment workload and allowing older age groups, including adults, to gain access to basic dental care services. In this way, IHS and Head Start are working together to improve the oral health of Indian children and their families.

OTA Advisory . . .

OTA expects to have a program report ready by summer and a first draft by fall. The congressional agency will work with the National Indian Health Board to hold four regional meetings May 1-August 1 to obtain views and recommendations from tribal participants.

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EDITOR: John P. O'Connor

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