



# NIHB Health Reporter

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## Continuing Resolution Extends Indian Health Programs at 1982 Levels

ROCKVILLE, MD.— Barring a presidential order to withhold certain funds, Indian Health Service (IHS) operations—including the beleaguered Community Health Representatives (CHR) program—will continue through December 17 at their 1982 levels under a stop-gap spending measure signed into law by President Reagan October 2.

The 10-week spending measure, or “continuing resolution,” is needed because most of the 13 regular appropriations bills that finance the federal government have not been passed. Congress will reconvene in late November for a special “lame-duck” session to take up the remaining FY 1983 appropriations bills.

With the continuing resolution in place, IHS and tribally-contracted health programs have been authorized to operate at their 1982 levels. But IHS officials here indicate that it may be several weeks before they know the agency’s budget for the period of the continuing resolution.

One reason for the delay is the possibility that the President will “defer,” or withhold, certain funds from

the IHS budget. Such action was taken during last year’s continuing resolution when approximately \$10.9 million was deferred by the Office of Management and Budget, forcing widespread cuts in IHS and tribal health programs. These cuts were particularly disruptive to tribally-run CHR programs, which provide home health visits, emergency medical care, and other critically needed health services on reservations across the country.

Since the Administration earlier this year recommended that funding for the CHR program and urban Indian health projects be eliminated from the fiscal year 1983 budget, the possibility of deferral action remains. However, Congress has clearly established its intent that federal programs, including CHR activities, not be reduced under the continuing resolution.

During Senate deliberations on the bill, Senator Dennis DeConcini (D-Arizona) sought and received clarification that “the valuable community health repre-

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*FIVE PARTICIPANTS AT a recent meeting of the National Indian Health Board and Indian Health Service Area Directors take a short break from a busy agenda. Pictured (l-r) are: T.J. Harwood, Albuquerque Area IHS Director; Bennie Atencio, administrative officer for the Santa Domingo Pueblo in New Mexico; Jimmy Moquino, Santa Domingo Pueblo council member; and Dr. George Blue Spruce, Phoenix IHS Area Director. See pg. 6 for related article.*

## Continuing Resolution . . .

*Continued from Page 1*

sentatives program is to be continued by the Indian Health Service at its present level of funding during the term of the continuing resolution." Opposition to arbitrary program reductions is also expressed in Senate report language, which states in part: "The Congress is very concerned over the failure of the Administration to make timely and appropriate apportionment under the continuing resolution last year . . . precipitative program changes during the duration of the continuing resolution could foreclose or unduly constrict the scope of decisions which Congress has yet to make on the regular appropriations bills."

Although IHS issued instructions October 6 to extend CHR contracts for the duration of the continuing resolution, many of the programs have been so devastated by events in recent weeks that they will be hard pressed to resume the full scope of their activities. Due to the uncertainty over funding for 1983, IHS several weeks ago ordered its area offices to close out most CHR contracts, effective September 30. As a result, many CHR administrators furloughed employees and shut down their offices.

The confusion surrounding the CHR program illustrates the budgetary chaos that has plagued Indian health programs during the past fiscal year. Most recently, in early September, IHS officials were frantically seeking ways to cover an \$18 million shortfall resulting from pay increases for IHS employees authorized earlier this year as part of the Federal Pay Act. Only a September 10 congressional override of President Reagan's veto of the FY 1982 supplemental appropriations bill prevented the agency from running out of funds.

In a letter sent out to tribal leaders the week of September 26, IHS Director Dr. Everett Rhoades stated that the \$18 million provided in the supplemental appropriations act for IHS salary increases will enable the agency "to finish the fiscal year 'in the black.'" Addressing the problems of the past fiscal year, which he said "has been nothing short of disastrous for IHS and those working in the field of Indian health," Rhoades stated that Indian health programs were hurt by the five-month delay in the federal appropriations process and by restrictions in the IHS budget that forced IHS to "reprogram" monies for certain line items into the budget category for direct care in hospitals and clinics. He added that the fiscal outlook for FY 1983 is not much better, and funding constraints may "pose further hardships for IHS and the Indian health program."

Funding levels for IHS activities during the FY 1983 continuing resolution, which expires December 17, are still being negotiated. Approximate figures for IHS programs for the entire 1982 fiscal year include: Clinical Services—\$481 million; CHR's—\$28.8 million; Urban Health Projects—\$8.1 million; Tribal Management—\$2.6 million; and Program Management—\$48.8 million. The FY 1982 budget for IHS services (excluding the \$18 million in Pay Act monies) was approximately \$600 million.

The House and Senate Interior Appropriations Committees will convene in late November to complete the regular FY 1983 appropriations bill that includes funding for IHS programs. Failure to enact the appropriations bill prior to December 17 will necessitate passage of another continuing resolution. ■

## DeConcini: Continue CHR Programs at Their Present Level

WASHINGTON, D.C.— Any remaining doubts about what Congress intends for the Community Health Representative (CHR) program during the continuing resolution were officially dispelled on the Senate floor September 29.



*DeConcini*

Noting that the President has proposed the elimination of the CHR program in his fiscal year 1983 budget, Senator Dennis DeConcini told his Senate colleagues: "I hope we can emphasize that it is the intent of Congress to continue the CHR program at its present level until the (appropriations) committee makes a definitive decision in its fiscal year 1983 bill."

DeConcini, who serves on both the Senate Appropriations Committee and the Senate Select Committee on Indian Affairs, explained that CHR activities comprise the major field health program for residents of more than 500 Indian and Alaska Native communities. The program is particularly important to the operation of tribal emergency medical services since it provides 60 percent of the skilled manpower for those programs. Elimination of CHR resources "would be devastating for these rural reservations where immediate emergency care is crucial to individual survival in accident cases," he said.

Terminating the program, which employs persons from tribal communities, would also mean the loss of 1,800 jobs on reservations and would "only aggravate the present extremely high unemployment level among the Indian people," he charged.

In seeking clarification about the CHR program, DeConcini questioned Senator Mark Hatfield, chairman of the Senate Appropriations Committee, whether it was his "understanding and intent that the valuable community health representatives program is to be continued by the Indian Health Service at its present level of funding during the term of the continuing resolution?"

Hatfield responded: "That is correct."

The exchange between Senators DeConcini and Hatfield is known as a "colloquy," a procedure sometimes used by lawmakers to clarify the meaning of bills. The statement becomes part of the legislative history of the continuing resolution. ■

# 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 notices on issues and activities from around the country that relate to Indian health care, including such topics as conference and workshop dates, legislative briefs, news on local events, etc. We invite our readers to submit material for publication in this section. Additional information on items mentioned here can be obtained from the NIHB Public Information Office.**

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WASHINGTON, D.C.— The American Indian National Bank (AINB) recently expanded its depository letter of credit service to all Indian Health Service (IHS) grantees, hospitals, and health clinics throughout the United States. According to a bank official, the bank's proximity to IHS headquarters enables it to expedite the collection of cash for IHS grantees. When the funds are received at the bank they are wired the same day to the grantee's local account. In connection with this service, the bank will offer its clients a line of credit in the event that payment vouchers are delayed. Financing at "advantageous interest rates" is also available to IHS grantees that utilize this letter of credit system. In addition, third party payments may be invested in AINB at market interest rates and used to secure loans for medical equipment and facility expansion. For additional information about the bank's letter of credit system, contact: Dominic Salomone; American Indian National Bank; 1701 Pennsylvania Ave., N.W.; Suite 310; Washington, D.C. 20006. Phone: (toll free) 1-800-368-5732.

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TOPPENISH, WASH.— The Yakima Nation has formally petitioned the federal government to intervene in the application of Puget Sound Power & Light to construct another power plant on the Hanford Nuclear Reservation. Citing numerous risks to human health and the environment, the tribe is attempting to influence the Nuclear Regulatory Commission to deny a license for construction and operation of the power plant, known as the Skagit/Hanford Nuclear Project. The project had originally been planned for the Skagit Valley in Northwest Washington, but community opposition, including protests from the Upper Skagit Tribe, forced a change in the proposed location of the nuclear plant.

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ROCKVILLE, MD.— Indian leaders will be receiving periodic updates about IHS activities directly from the top. In his initial letter sent to tribal chairmen the week of September 26, IHS Director Dr. Everett Rhoades briefly reviewed IHS budget difficulties of the past fiscal year (see related story on pg. 1). Rhoades stated that the purpose of his correspondence, which will be distributed at regular intervals, is to permit him to become better acquainted with tribal leaders; to provide some insight into his personal goals and objectives as Director of IHS; and to keep tribal leadership advised of current developments in IHS. Rhoades stated that his

next letter will address his "plans and objectives for IHS for 1983."

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PORTLAND, ORE.— The Northwest Portland Area Indian Health Board (NWPAlHB) has been awarded a \$44,000 grant from the National Institute of Mental Health (NIMH). Under the grant, the board will operate a mental health training program for tribal employees in Washington, Oregon, and Idaho. The period of the grant is one year, and it may be renewed depending on the success of the training project and availability of funds, according to NWPAlHB Director Felicia Hodge.

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ABERDEEN, S.D.— Eleanore Robertson, Director of the Aberdeen Area Indian Health Service, has received the Administrator's Award for Excellence. Robertson, the first Indian woman appointed to the position of IHS area director, was awarded the citation for her work in attaining high quality health care for Indian people. The award is one of the highest honors bestowed by the Public Health Service. As Aberdeen area director, Robertson has overall fiscal and administrative responsibility for a comprehensive health care delivery system that provides care to more than 60,000 Indians in Iowa, Nebraska, North Dakota, and South Dakota.

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TAHLEQUAH, OKLA.— The Cherokee Indian Nation is seeking an experienced public health administrator to manage the tribe's community health and social service programs. The administrator will be responsible for managing, in cooperation with the Indian Health Service, four rural primary health clinics; administering a home health care program; and managing a variety of human service programs. Applicants should possess a master's of public health degree and considerable experience in managing multi-faceted community health programs. Submit resumes to: Personnel Department; Cherokee Nation of Oklahoma; P.O. Box 948; Tahlequah, Okla. 74464.

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WASHINGTON, D.C.— Final rules implementing seven block grants established by the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) were published in the July 6 issue of the *Federal Register*. The regulations address matters related to application, administration, and funding of the block grants, which consolidate more than 40 categorical programs of the Department of Health and Human Services (DHHS). As provided for in the legislation, Indian tribes and tribal organizations may apply for direct funding under block grants for: community services; preventive health and health services; alcohol, drug abuse, and mental health services; primary care, and low income home energy assistance. Two other DHHS block grants—maternal and child health and social services—currently have no provisions for direct funding to tribes. Copies of the

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# Diet, Weight Control Essential in Controlling Diabetes

*Diabetes is recognized as one of the major health problems among Indian populations today. The disease is especially crippling in its advanced stages, because it can lead to kidney failure, blindness, amputation and death. Particularly distressing is the fact that these complications were once rare, but are now seen with increasing frequency.*

*Numerous tribal and Indian Health Service (IHS) health centers have established diabetes screening programs in an attempt to detect the disease in its early stages and to educate Indian communities about the seriousness of diabetes. A number of tribes have also established weight control and exercise programs to help people combat the illness, since being overweight is a primary cause of diabetes among Indians.*

*In the following article, Dorothy Ghodes, M.D., describes different kinds of diabetes and their prevalence among the Indian population. The information presented here can help protect Indian patients, families, and communities from the complications of diabetes, and we*

*urge our readers to give thoughtful consideration to the points raised in the article.*

*Dr. Ghodes is project director for the IHS Model Diabetes Program. Comments on her discussion here may be sent to the NIH Public Information Office.*

In 1979 the National Diabetes Data Group published a new classification system for diabetes. Data from the National Institutes of Health (NIH) study of the Pima Indians was incorporated into this classification system. Type I diabetes used to be called "juvenile onset" diabetes. This type of diabetes is rare among Indians. Although the exact cause of Type I diabetes is not clear, it seems to be triggered sometimes by a virus in susceptible people. Patients have very low insulin levels and often develop a severe medical complication called ketoacidosis when they do not take their insulin or have infections.

The overwhelming majority of American Indians with diabetes have Type II or non-insulin dependent diabetes. This disease used to be called "maturity onset" diabetes, but the age of onset is not a reliable way to distinguish the types of diabetes. Overweight Indian teenagers can develop "maturity onset" diabetes. The tendency to develop Type II diabetes appears to be inherited in many Indian families. The disease itself can be brought out by obesity or metabolic stress such as pregnancy or surgery.

Most of the people who develop Type II diabetes are overweight at the time the disease develops. One theory suggests that Indian people have a "thrifty gene" which allows them to store fat easily, but also predisposes them to diabetes. The presence of the extra fat cells in the body results in an increase in the amount of insulin needed and one is said to be insulin resistant.

When the body grows heavy, more insulin is required to keep the blood sugar normal. When the pancreas cannot make enough insulin to overcome the resistance, Type II diabetes develops. For some reason the pancreas of a person with the "thrifty gene" cannot make the huge amounts of insulin needed to control the blood sugar in an overweight individual.

Medical researchers are working hard to discover more details about the problems of insulin resistance and why the pancreas cannot respond. Since weight loss makes the body more sensitive to insulin again, diet is the cornerstone of the therapy for Type II diabetes.

People have suggested that Indian diabetics tolerate high blood sugars better than other diabetics. Since most Indian people have Type II diabetes, they are not prone to develop ketoacidosis easily and this probably accounts for the observation.

However, Indian patients can develop other devastating complications from diabetes. The NIH study of the Pima Indians and other studies worldwide have shown that the complications of diabetes

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## Health News ...

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July 6 regulations can be obtained from the NIH Public Information Office.

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DULUTH, MINN.— The Association of American Indian Physicians (AAIP) will sponsor a two-day Pre-Admission Workshop at the University of Minnesota here October 23-24. The purpose of the workshop is to provide counseling and assistance to Indian students intending to apply to schools of Medicine, Osteopathy, Dentistry, Veterinary Medicine, Optometry, Podiatry, or Pharmacy. The workshop, which is held periodically around the country, addresses common problems encountered by Indian students, including: how to select a professional school; how to prepare an application, and how to prepare for the admission committee interview. Additional information about future pre-admission workshops can be obtained from: The Association of American Indian Physicians; 6805 South Western Ave.; Suite 504; Oklahoma City, Okla. 73139. Phone: (405)631-0447.

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ROCKVILLE, MD.— Indian health career students interested in participating in next summer's COSTEP program are being urged to apply now. The COSTEP program gives students the opportunity to utilize their skills at Indian Health Service (IHS) hospitals or other federal facilities. Transportation and room and board are usually provided, depending on the service unit involved. The usual length of the program is four to six weeks. For additional information, contact: John Gimon; Physician Recruitment and Retention Branch: Indian Health Service; Rm. 6A-53; 5600 Fishers Lane; Rockville, MD. Phone: (301) 443-4243. ■

**WITH DIABETES AMONG American Indians increasing at an alarming rate, tribes and Indian organizations are stepping up their efforts to inform the Indian population about the dangers of the disease. Pictured here is National Diabetes Advisory Board member Art Raymond, Oglala Sioux, during a lecture at a diabetes conference sponsored by the Indians Into Medicine (INMED) program at the University of North Dakota. (Photo Courtesy INMED Program)**



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## **Diet, Weight Control...**

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correlate with the durations of the disease. Dr. Kelly West at the University of Oklahoma studied diabetes in Indians for many years. His studies indicated that diabetes was probably rare among American Indians before 1940. Changes in lifestyle, eating habits, and exercise have led an increasing number of Indian people to become overweight. Many people have essentially outgrown the ability of their pancreas to produce insulin in large enough amounts.

In recent years there have been an increased number of patients with diabetes of long duration. It was not until many patients had had diabetes for 10-20 years that the importance of complications began to be recognized among Indians. Thus, the complications of blindness, amputation, cataracts and kidney failure are no longer rare.

Controlling the blood sugar in Type I diabetes is quite difficult, but Type II diabetics can control their own blood sugar and their disease much more easily. Diet is the mainstay of therapy, since diet and weight loss make the body more sensitive to its own insulin. Exercise is also important. Though patients often lose weight as a symptom of uncontrolled diabetes, careful weight loss and blood sugar control together help the body become more sensitive to insulin, thus improving the diabetes remarkably and maintaining a normal blood sugar.

More and more evidence has accumulated to suggest that physiologic blood sugar control can prevent eye and kidney damage. Early identification of eye disease is important now that laser therapy is available to impede progression of the damage. Careful blood pressure control is also important to prevent additional damage both to the kidneys and the eyes. However, physiologic blood sugar control represents the best long term protection against complications. Though Indian patients with diabetes may not feel sick, it is important for them to understand that they must take care of themselves to prevent complications.

Medical research has produced significant new information about diabetes. During pregnancy there is no longer any question that good blood sugar control prevents problems with the baby. Also, the NIH study has shown that if one or both parents have diabetes, the risk of a child developing diabetes increases as the child becomes more overweight. Thus, if there is diabetes in an Indian family, it is important for a child to stay near ideal body weight. This will decrease the child's risk for developing diabetes.

Since there is no shot or pill to eliminate diabetes entirely in the way that antibiotics eliminate infections, patients must learn about diabetes and how to control it themselves. To help address diabetes problems among the Indian populations, the Indian Health Service Diabetes Program was funded in FY 1979 with five model sites. Each project has tailored its activities to the local culture and the facility.

For example, the Claremore Diabetes Project in Oklahoma sponsors a day care program where patients have a complete evaluation and a day long education session. In Albuquerque, special clinics are held not only in the hospital but in the village clinics so that patients can be seen frequently. Both the projects in Fort Totten, N.D. and Winnebago-Omaha in Nebraska help patients learn to use available commodity foods appropriately. Pregnant diabetics are a special target group at the Sacaton project in Arizona. Patients learn how to check their own blood sugar at home to insure excellent control.

Each project attempts to develop efficient and effective education programs in the context of the facility and the culture. New developments in diabetes research have produced important information and the IHS Diabetes Program is adapting this information to the field and clinic setting.

In addition, educational materials have been developed and translated into various Indian languages. A picture diet manual for Southwestern Indian foods was printed in cooperation with the Swanson Foundation and the National Diabetes Information Clearinghouse. ■

# Strapped for Funds, Tribal Struggle to Maintain

DENVER, COLO.— The frustrations of a year-long budget crisis for Indian health boards, tribal health programs, and the Indian Health Service (IHS) served as the focus of a joint meeting between representatives of the National Indian Health Board (NIHB) and IHS area directors here July 27-28.

While the meeting's participants touched on a wide range of health-related topics, the underlying tension resulting from the day-to-day uncertainties of the 1982 fiscal year budget was clearly evident throughout most of the discussions.

Among NIHB representatives, concern centered on financially-strapped tribal health programs, and in particular the Community Health Representative (CHR) program, which is the foundation of many tribal health departments. CHR activities have already been slashed more than 20 percent this year, and the Reagan Administration has proposed eliminating the \$29 million program from the 1983 federal budget.

Attention was also directed to the present status of the area Indian health boards and inter-tribal organizations that represent Indian tribes and Alaska Native villages on the National Indian Health Board. As expressed in reports by the 12 NIHB delegates, this year's budget reductions have shackled the operations of most area Indian health organizations.

Health boards in such areas as Portland, California and Albuquerque have managed to continue providing services to Indians, while other boards, such as Oklahoma City, are on the verge of closing down because of fiscal difficulties. NIHB members also reported that

several areas — Bemidji, Aberdeen, USET, and most recently, Phoenix — are utilizing coalitions of tribal chairmen or inter-tribal councils instead of advisory boards to address their tribes' health concerns.

Speaking from their administrative perspectives, the 12 IHS area directors also addressed the impact of this year's budget cuts. Coupled with the inflationary rise in health care costs, these cuts have reduced the agency's capability to deliver health services by more than \$50 million from 1981 levels, according to IHS estimates.

In addition, area directors contend that this year's fiscal headaches were compounded by their lack of authority to lay off administrative personnel and by the increased patient visits due to the number of non-Indians seeking treatment at IHS facilities. Non-Indian spouses of certain Indian households were declared eligible last year for IHS care.

The program descriptions presented by both NIHB members and IHS area directors attest to the enormous complexity of the Indian health care delivery system. Each area has its own unique circumstances with respect to tribal populations, attitudes, history and culture; economic development; geography; climate; reservation status; and legal relationship with the federal government. Consequently, tribal and federal Indian health programs differ significantly from area to area.

## Aberdeen

Through a system of nine hospitals, four health centers, and numerous field clinics, the Aberdeen area IHS



*INDIAN HEALTH PROGRAMS, both federal and tribal, differ significantly in each area. Representatives and IHS area directors met in Denver July 27-28. Seated at the table are: Area Director Dr. Stan Stitt; Alaska Area, IHS Area Director Gerald Ivey (not pictured); Spruce and NIHB Alternate Billy Kane; Bemidji Area, NIHB Representative Donald L. Smith and NIHB Alternate Ada White; Albuquerque Area, IHS Area Director T. J. Williams and IHS Area Director Robert McSwain; Oklahoma City Area, NIHB Representative Elwood Saganey and IHS Area Acting Director Dr. James Merideth; Tucson Area, NIHB Representative Sylvester Manual and IHS Area*

# and Federal Programs Indian Health Services

office administers care to more than 60,000 Indians residing in North Dakota, South Dakota, Iowa, and Nebraska, reported Aberdeen area director Eleanore Robertson. Approximately 900 persons are employed with IHS in the Aberdeen area including a staff of 80 at the area office.

Robertson, former chief of nursing in the Aberdeen area and the first Indian woman appointed as an IHS area director, stated that many of the health facilities in her area desperately need repair or replacement. With no major construction for health facilities in the last 20 years, Aberdeen tribes are hopeful that building will soon begin on new hospitals at the Rosebud and the Pine Ridge Sioux Reservations in South Dakota. Plans are also underway for new outpatient clinics at Kyle, S.D. and Fort Thompson, S.D.

Administratively, IHS has proposed a reorganization of several health programs within the area in an effort to consolidate and improve services, Robertson said. Included in the proposed changes are the conversion of the Winnebago service unit in Nebraska to a regional detoxification unit and the creation of a regional psychiatric inpatient residential unit at the Rapid City IHS clinic.

The proposed reorganization plan will be reviewed by the area's tribal chairmen before any changes are made, Robertson said. She explained that the IHS area office meets regularly with the tribal chairmen, rather than an area health board, to discuss health and administrative issues. The area health board was disbanded and replaced by a coalition of tribal chairmen four

years ago. Austin Gillette, chairman of the Three Affiliated Tribes of the Fort Berthold Reservation in North Dakota, currently serves as the tribal chairman's representative to NIHB.

Robertson also noted that a recent orientation program hosted by the Rosebud Tribe for the area's new professional health staff "was very successful. We had a great deal of tribal participation, and we would like to see this become an annual event," she said.

## Albuquerque

Tony Secatero, Albuquerque area representative and NIHB chairman, told meeting participants of efforts by the Albuquerque Area Health Board to expand its health services program. The Albuquerque board, with its seven tribes and one urban health center, is one of two organizations representing tribal views on health care matters in the Albuquerque area. The All Indian Pueblo Council, through its health component called the New Mexico Inter-Tribal Health Authority, addresses the health concerns of the area's 19 Indian Pueblos.

Secatero said that the Albuquerque board presently operates an otitis media (middle-ear infection) project that provides screening and treatment services to residents of the board's seven reservations. Efforts are also underway to develop a project to improve alcoholism services to Albuquerque area tribes, he said. Among other things, the board's proposal provides for improved training to physicians and other health pro-

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of the 12 IHS geographical regions, as indicated in area reports presented by NIHB by area, left to right, are: Portland Area, NIHB Representative Mel Sampson and IHS NIHB Representative Ken Charlie; Phoenix Area, IHS Area Director Dr. George Blue Pointe and IHS Area Director John Buchanaga; Billings Area, IHS Area Director James Farwood (not pictured, NIHB Representative Tony Secatero); California Area, NIHB Representative Lawrence Snake and IHS Area Director John Davis; Navajo Area, NIHB Representative Maxine Dixon and IHS Area Director Charles Erickson.

## Strapped...

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professionals and stresses the need for stronger emphasis on prevention in the treatment of alcoholism.

Albuquerque area director T. J. Harwood shared Secatero's concern about alcoholism, stating that tribes and IHS should work together in reassessing Indian alcoholism programs. "I think we have a greater problem with preventing alcohol abuse among adolescents and the young people in Indian Country than we do with drying out the alcoholics and drunks. There needs to be some change in direction for establishing a very strong preventive program" he said.

Harwood added that budget constraints have forced the area office to "take a deep look at what we've been doing historically, and with a \$1.5 million cutback this year we have had to rearrange some priorities." Some 75 full-time and temporary positions have been lapsed in an effort to maintain clinical services, he said.

With the recent certification of the Santa Fe Indian Hospital, all hospitals in the Albuquerque area are fully accredited for Medicare/Medicaid reimbursement. Harwood also noted that a new health center at the Santa Clara Pueblo, constructed by the tribe, will open soon and that plans are being made to improve the health facility at the Alamo Navajo reservation, the most remote location in the Albuquerque area.

### Alaska

In Alaska, residents of more than 200 Native villages receive medical services through six rural hospitals and a medical center in Anchorage, according to Alaska IHS Area Director Gerald Ivey.

Presently the Alaska area operates with 1,300 employees and \$95 million, with approximately \$22 million in contracts with villages and corporations under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. Budget reductions over the past year have resulted in the loss of approximately 100 IHS employees and a cut of some \$1 million in patient travel funds, which Ivey said is a critical part of Alaska's health care system due to the remoteness of many Native villages.

Under a formal Memorandum of Agreement, the IHS area office in Anchorage works with the Alaska Native Health Board (ANHB) which is composed of elected officials from the state's 12 regional health corporations and represents nearly all Alaska Native villages. The Alaska representative to NIHB is Kenneth Charlie.

### Bemidji

One of the country's newest tribal organizations is the Great Lake Inter-Tribal Assembly which represents all 29 tribes in Wisconsin, Michigan, and Minnesota. The Assembly addresses all issues of concern to the 29 tribes, including health, and thereby serves in place of an area health board, according to Donald LaPointe, the Assembly's NIHB delegate.

An emergency session of the Great Lakes tribal leaders was recently convened to protest the proposed reorganization of the Bureau of Indian Affairs (BIA) that would eliminate the area BIA office and shift existing BIA responsibilities to the Aberdeen office, LaPointe said. Tribal leaders in the three-state area are also concerned that IHS will initiate its own reorganization, he said.

Budget difficulties are affecting tribal health services for the Great Lakes tribes on two fronts, he continued. Not only has the IHS area budget been reduced, but state-supported programs for Indian housing and health are threatened by the Administration's block grant proposals and cuts in state aid.

Regarding IHS area operations, director John Buchanaga stated that fiscal troubles have been compounded by a new policy toward non-Indian spouses, who are now eligible for treatment in IHS hospitals and clinics. The policy has led to "an overcrowding of our health facilities. They (non-Indian patients) line up first, and the Indian people we are supposed to serve end up standing last in line or sitting in the lobby," he said.

The Bemidji program presently serves approximately 50,000 Indians with 284 IHS staff and a budget of \$30 million, with \$20 million contracted to tribes under P.L. 93-638. More than 500 tribal employees are involved in the health care system in the Bemidji area, Buchanaga said.

### Billings

With the recent appointment of Area Director James Smith to a new IHS headquarters position, the agency is presently reviewing applications for a new director, reported Billings NIHB alternate Ada White. Montana tribes have been promised a voice in filling that position, she said.

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#### NATIONAL INDIAN HEALTH BOARD

1602 South Parker Road, Suite 200  
Denver, Colorado 80231

*Board of Directors* ..... Tony Secatero, Albuquerque,  
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*Public Information Officer* ..... John O'Connor  
*Board Coordinator* ..... Linda Standing

# Future of Indian Health Programs Hinges on More Than Just Funding

DENVER, COLO.— While unprecedented budgetary troubles have disrupted a number of Indian Health Service (IHS) activities during 1982, other non-fiscal considerations may bring about more substantial long-term changes in the delivery of health care services to American Indians and Alaska Natives, according to IHS Director Dr. Everett Rhoades.

Speaking to a joint meeting of National Indian Health Board (NIHB) representatives and IHS area directors here July 28, Rhoades pointed to the recruitment and retention of physicians, eligibility for IHS services, equity funding, tribal contracting, and the Administration's new federalism initiatives as critical issues that will shape the future of IHS programs.

Citing a recent survey of attitudes among IHS doctors, Rhoades said that "new reasons are being offered as to why physicians are choosing not to stay in the Indian Health Service." One such reason concerns the repeated attempts by the Office of Management and Budget (OMB) in recent years to dismantle the U.S. Public Health Service Commissioned Corps, which accounts for approximately 90 percent of the physicians employed by IHS.

Although OMB efforts to discontinue the Commissioned Corps have failed, Rhoades said they have been demoralizing to Corps medical officers and have hindered the recruitment of new doctors. "You can imagine what this has done to our efforts to recruit bright young individuals into the program. Who wants to join the Commissioned Corps if it appears the intent is to do away with that program?"

IHS clinicians are also becoming increasingly concerned about overcrowded health facilities, inadequate medical supplies and equipment, lack of support staff, and other limitations in their working environment. "For the first time ever, our physicians are saying that conditions are so critical that they have reservations about their ability to provide quality medical care," he said.

The survey further reveals that many IHS physicians do not feel accepted by the Indian communities they serve, which partially accounts for the high turnover of reservation doctors, Rhoades said. He urged that tribes actively campaign to promote community acceptance of IHS physicians and their families, noting that "the places where physicians and nurses stay the longest are those areas where the people have taken them in and made them feel part of the community."

In addition to concerns about the agency's ability to attract and retain health professionals, Rhoades said the question of who IHS should be serving is a crucial issue for the future of Indian health programs. At a time when health care resources are diminishing, IHS is attempting to provide services to an expanding Indian population, which creates an obvious strain on IHS' capability to achieve a level of quality health care, Rhoades said.

Of particular concern is the eligibility of non-Indian spouses for IHS services. Rhoades said he opposes last year's change in federal regulations that permits certain non-Indian members of Indian households to receive treatment at IHS facilities. "I just don't think we can take care of non-Indians, period," he asserted. Adding that he perceives "very strong opposition (among tribes) to extending services to non-Indians," Rhoades said the policy is currently under review by IHS staff for possible changes.

Another area of potential change for Indian health services, said Rhoades, involves the process of "equity funding," which is supposed to "redistribute" certain IHS funds to tribes whose health resources are among the most deficient in the country. Under this process, tribes with the lowest level of health care services are provided additional resources from an IHS "equity health care fund," with the objective of raising all tribes to at least minimal standards of health care.

Although equity funding was established with good intentions the program has been plagued with administrative problems, and "in operation is creating a nightmare for IHS," Rhoades stated. He also expressed concern that because the process requires IHS to identify alternate health resources for Indian people, equity funding "may become one more force that is going to make IHS a residual service, not a primary service." One possible outcome of such a situation is that Indian people would receive care from IHS only after all other alternatives have been exhausted, he said.

## **"Transition State"**

Even without these considerations, Indian Health Service is undergoing substantial changes as a result of increased contracting with tribes under P.L. 93-638 (the Indian Self Determination and Education Assistance Act), Rhoades said. "We are in a transition state from a direct services program administered by a corps of federal employees to a system that is operated by tribes."

While IHS will work to fulfill the policy of self-determination, Rhoades noted that "there are Indian leaders who believe as I do that there is some potential for injury to Indian people in P.L. 93-638, and we must proceed with deliberation. I don't want to injure Indian people by fulfilling any policy of law."

Rhoades added that future efforts to reduce levels of disease, disability and morbidity among Indian populations will require a stronger emphasis on prevention and health maintenance, and that such efforts will be best carried out "through a community-based comprehensive primary care system. I think that is the only way to give optimal care to all people, especially those in rural areas."

One other important factor that may affect the future of both IHS and tribal health programs is the

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Although area board activities have been restricted due to limited funding for staff, office space, and regular meetings, the organization was able to sponsor a successful health career opportunity program, White said. Future directions of the area board will likely be determined following selection of the new director.

White also noted the completion of a new health clinic at Lodge Grass on the Crow Reservation that was constructed by the tribe under a P.L. 93-638 contract. The tribe is presently negotiating for a contract to build personnel quarters for the clinics, she said.

The Billings area office administers a health care delivery system that provides services to 39,400 Indian residents at 8 reservation service units in Montana and Wyoming and a health center in Brigham City, Utah.

### **California**

The California Rural Indian Health Board (CRIHB), representing 15 private community health clinics serving California's rural Indian population, recently dropped its lawsuit challenging an IHS ruling that the board is ineligible for contracts under P.L. 93-638, announced NIHB California representative Timm Williams. The issue was resolved administratively, so that CRIHB is now recognized as a "93-638" organization and therefore eligible for contracting advantages under that law.

Recent discussions on the possibility of IHS contract health services being used in place of existing clinics have disturbed CRIHB members, Williams said, since such a change would further limit health care to California Indians. "Coverage under contract care would be based on Medicare/Medicaid standards, which are lower than what we have now. Our health services would be reduced," he said.

California Indian health centers presently utilize state funds, third party billing, and other resources to supplement IHS dollars, Williams said, which allows the CRIHB clinics to provide a broad range of health services to Indian communities.

Williams also informed the NIHB meeting that CRIHB is actively seeking to become involved in the IHS budget allocation process through a committee made up of IHS officials, CRIHB members and other interested parties. "I think Indian people everywhere should work toward this (involvement in budget allocations), since its the only way to really understand how our health dollars are being spent," he asserted.

California IHS program director Robert McSwain, a former CRIHB director, said that because California tribes were among those targeted for "termination," the 1950's federal policy of eliminating (or terminating) government recognition and benefits for certain Indian tribes, federal hospitals for California Indians were closed and IHS removed its offices from the state.

IHS returned to California in 1977 when the California program office was opened. The Sacramento-based office is presently administered with a staff of 56 and a \$17 million budget, serving 65,000 rural Indians and another 70,000 Indians in urban areas, McSwain said.

### **Navajo**

Reporting for the Navajo Nation, the country's largest tribe, Elwood Saganey said that a number of social welfare services formerly administered by the BIA have been consolidated under the tribal administration. The tribe is also working on a project to provide group housing for the reservation's elderly, said Saganey, a longtime Navajo tribal councilman and Chairman of the tribal council's Health, Alcoholism, and Welfare Committee.

In a major administrative shuffle, the tribe's Division of Health Improvement Services (DHIS) recently moved its offices to a new building, a move that tribal health administrators expect to result in savings that will be reprogrammed into other health activities, Saganey said.

In addition to DHIS, which is part of the tribe's executive administration and responsible for the day-to-day operation of tribal health programs, the Navajo tribe has two other health entities: the Health, Alcoholism and Welfare Committee, and the Navajo Area Health Board, which represents each of the eight reservation service units.

Area IHS personnel meet regularly with all three tribal health organizations for consultation on health issues, according to Dr. John Provaznik, acting area director for the Navajo Indian Health Service.

Reviewing the Navajo area program, Provaznik explained that there are three inter-related components to the delivery of health services on the 25,000 square mile reservation. The first component is the hospital and health clinic system which provides primary medical care to Navajo residents; the second is the preventive health program that utilizes public health nurses and Community Health Representatives; and the third is the environmental health program that has been instrumental in improving water and waste disposal systems on the reservation, Provaznik said. "Many of the major strides that have been taken in health care on the Navajo Reservation since 1955 have come through a combination of environmental and socio-economic improvements," he said.

### **Oklahoma**

Oklahoma City representative Lawrence Snake had some disheartening news about the future of his area board. "The concept of an area Indian health board is deteriorating" in Oklahoma, Snake said. "Funds are going to direct services, and the indications are that health boards are not a priority."

The Oklahoma area has been served by two separate boards during recent years: the Oklahoma City Area Indian Health Board, made up of chairmen from 34 tribes, and the eastern board, representing the Five Civilized Tribes in eastern Oklahoma. Snake said that his board has submitted numerous proposals in recent months to IHS, other federal and state agencies, and foundations, but "the chances of them being funded are slim."

In the area of construction, Snake reported that building on the new hospital at Tahlequah is two months ahead of schedule. Preparations are also underway to begin construction of the long-awaited

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outpatient clinic in Anadarko, with groundbreaking ceremonies likely in late October.

Addressing IHS administrative concerns, Oklahoma Area Director John Davis stated that this year's budget cuts were particularly frustrating because of his limited authority to reduce personnel. He noted that tribal officials and even IHS service unit administrators have urged that a greater percentage of the reductions be taken from area office activities.

But, Davis complained, federal regulations prevent him from reducing staff in order to save resources. "As area director, I cannot reduce one job on my own volition if it results in the separation of an employee. It's ridiculous to say that I'm in charge of administering an \$85 million program and I don't have the authority to abolish one job."

Davis also cited the need for "better guidelines about the target population we're supposed to be serving. We have too many cases where non-Indians are being treated." In one Oklahoma IHS facility, Davis reported that 13 percent of the outpatients are non-Indian, and 25 percent are less than quarter-blood. "It really makes the professional staff wonder. They came into the Indian Health Service to serve Indians, and they end up treating someone else. It sometimes causes them to have second thoughts about what they're doing here," Davis said.

### Phoenix

Phoenix IHS Director Dr. George Blue Spruce described the vast area served by his office as "a microcosm of the entire Indian Health Service." Serving 80,000 reservation Indians in 47 tribes and another 50,000 residing in urban areas, the Phoenix area office administers an array of service delivery programs, Blue Spruce said. The area operates with a \$70 million budget, 9 hospitals, a major medical center in Phoenix, and reservation field clinics.

Speaking of the remote locations of many tribes in Arizona, Nevada, and Utah, Blue Spruce told his audience that "we have a unique problem in our area because the isolation greatly increases the cost of health care."

With respect to communication between the area office and tribes, Blue Spruce explained he did not sign a contract for the continuation of the Phoenix Area Indian Health Board because tribal chairmen had informed him "they wanted a different forum for consultation." Over the last two years, he said, "the tribal chairmen in Utah, Nevada and Arizona have worked to form a coalition with a health committee" to address tribal health issues.

Although efforts to form the coalition have not yet been finalized, area tribal groups agreed to appoint Shoshone Duckwater Tribal Chairman Jerry Millitt as the Phoenix delegate to NIHB.

### Portland

The Northwest Portland Area Indian Health Board (NWPaiHB), which has long been among the most active regional Indian organizations in the country, has managed to carry on a number of activities despite

reductions in its funding over the past year, according to Mel Sampson, a Yakima tribal councilman and chairman of the NWPaiHB. The board represents 34 tribes in the states of Oregon, Washington, and Idaho.

Having recently been awarded a grant from the National Institute of Mental Health, the board will initiate a new mental health training program for the area's tribal employees, Sampson said. Other NWPaiHB programs include legislative analysis, health careers education, technical assistance, and liaison with the area's 12 service units and 34 tribes.

According to Portland IHS Area Director Dr. Stan Stitt, the board's strength rests with its close ties to the area tribal governments. "We're seeing that the people who represent the 12 service units on the area board are not only experts in matters pertaining to health, but they are also members of tribal councils."

Because there are no Indian hospitals in the Portland area, most health services to Northwest Indians must be provided through contract care, which limits administratively what can be accomplished with the program, Stitt said. "If you're operating a hospital there is at least some flexibility. You can always set up a bed in a hallway to meet the need. This can't be done with contract health care."

Another area of administrative inflexibility that has hampered area operations this year concerns the agency's Reduction-in-Force (RIF) authority, which Stitt and several other area directors maintain is necessary to preserve the level of existing services. The Department of Health and Human Services (DHHS) earlier this year disallowed an IHS request to reduce staff as a means of conserving resources.

Despite the absence of RIF authority, the area office was successful in restructuring and lapsing some positions, Stitt said. "We have managed to reduce staff, particularly in the area office, while maintaining the same functions." He also emphasized that if the budget is cut further in 1983 his office will issue another RIF request.

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### Tucson

Reductions in the Tucson area Community Health Representative (CHR) funds have so decimated the Papago tribal health services that the entire program will likely be restructured, stated Tucson representative Sylvester Manual.

CHR cuts have forced the curtailment of tribal programs for the elderly, environmental health, disease control, alcoholism, mental health and nutrition, said Manual, who serves as the tribal CHR director. He added that the tribe is seeking alternate resources through federal block grants and state agencies, but without much success to date.

One possibility for health care assistance is a new state program called the Arizona Health Care Cost Containment System, a demonstration project similar to Medicaid. However, in an apparently discriminatory ruling, state officials claim that Indians residing on reservations are ineligible for benefits under the program, a decision Arizona tribes will probably appeal, Manual said.

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Approximately 15,000 Papago residents receive their medical treatment at the reservations 40-bed IHS hospital in Sells. In addition to the Papago service population, the Tucson area includes the recently-recognized Pascua-Yaqui Tribe, according to Tucson Area Acting Director Charles Erickson.

Health care for the 5,000 Yaquis, which is provided primarily through a Health Maintenance Organization, has been reduced this year to basic inpatient and ambulatory services because of fiscal constraints, he said.

The final component of the Tucson area is the Office of Research and Development (ORD) which despite losing 60 full-time positions in the last two years, is still operating programs for research, quality assurance and training at the Tribal Management Support Center, Erickson said.

NIHB's representative from the United South and Eastern Tribes (USET), Maxine Dixon, expressed her board's concern over the Administration's proposed elimination of the CHR program in 1983. Since all USET area tribes except the Eastern Cherokees administer comprehensive health programs under P.L. 93-638 contracts, the loss of CHR funds would terminate a number of tribal health services, Dixon said.

On her own reservation in Philadelphia, Miss., the Choctaw tribe's program for home health visits, ambulance services, school health education, communicable disease control, medical records, and child immunization would be eliminated or diminished by the loss of CHR monies.

The USET board, with administrative offices in Nashville, Tenn., is comprised of chairmen from tribes in New England, the mid-Atlantic and southeastern states. The board meets regularly to address all issues, of interest to the area's tribes, said Dixon, who has served as the USET delegate to NIHB for the past two years. ■

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## Future...

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Administration's "new federalism" policy of turning over control of federal services to local governments, and the overall effort to reduce the size and scope of the federal government, Rhoades said. An example of the ideas proposed under this federalism policy is the "concept of abolishing Indian Health Service and block granting health services to tribes," a process that Rhoades regards as "a very efficient termination technique." Another rumor frequently alluded to calls for the transfer of IHS back to the Bureau of Indian Affairs for the sake of program consolidation.

Although such drastic actions as this are unlikely, Rhoades said it indicates the kinds of ideas entertained by some Administration officials. He predicted that Indian Health Service would continue, but added: "I think that if you look at all these different things going on you have to conclude that Indian Health Service is going to be quite different than what we have known in the past three decades." ■

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