



# NIHB Health Reporter

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## Interior, Energy Committees Reach Tentative Accord on H.R. 4567 Differences

WASHINGTON, D.C. — A controversial legislative proposal to allocate future increases in Indian Health Service (IHS) funding solely on the basis of population will be withdrawn from further congressional consideration under the terms of a preliminary compromise reached by two House committees here June 26. The tentative agreement between the House Interior Committee and the House Energy and Commerce Committee resolves most of the differences between the committees' separate versions of H.R. 4567, the Indian Health Care Amendments of 1984, possibly clearing the way for a joint bill to be brought to the House floor in late July or early August.

Although the tentative agreement is under negotiation and "the whole thing could still fall apart," as one committee staffperson noted, it nonetheless represents a potentially important step in securing House passage of an Indian health care bill during this shortened session of Congress.

The preliminary compromise was reached partially as a result of an agreement by several California tribes and

tribal organizations to drop their demands for a per capita allocation formula in exchange for acceptance of certain other amendments to H.R. 4567 (see page 11 for a statement by the California Rural Indian Health Board regarding the amendments, and page 6 for a related story on discussion of the bill differences at NIHB's national health conference in Reno June 4-7).

Of the various items tentatively agreed to by the committees, the most significant by far concerns the different "equity" approaches proposed in Sec. 201 of the Interior and Energy bills for the purpose of reducing existing health resource deficiencies and funding disparities among the IHS service areas.

The Interior bill proposes establishing a needs-based system in which all tribes would be evaluated and ranked in categories according to their relative health resources deficiencies (with Level I, 0-20 percent deficient, the highest and Level V, 81-100 percent deficient, the lowest). A special "Indian Health Care Improvement Fund" would be authorized to raise all tribes below

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**WHETHER RUNNING COMPETITIVELY** or simply walking for exercise, more than 100 persons took part in the NIHB 5 K and 1 Mile Fun Run at the Sixth National Indian/Alaska Native Health Conference in Reno, Nevada. Winner of the 5 K was Mike Robertson, a 17-year-old Cuyapaibe-Kumeyaay Indian from Alpine, Calif., with an outstanding time of 15:46 minutes. The non-runners also appeared to enjoy the event — at right is Inez Vance, of the Wichita Tribe in Anadarko, Okla., finishing the 1 Mile Fun Run. Photos and stories of the conference will appear in the next two issues of the Health Reporter.



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Level II (21-40 percent deficient) to at least that level over the next three fiscal years.

An entirely different approach was recommended by the Energy committee. Under its methodology, the 27 so-called reservation states would be ranked in descending order of their per capita allocation (the total amount of IHS funding in a given state divided by that state's eligible Indian service population), and then split into four nearly-equal groups, or "quartiles." Increases in IHS appropriations (excluding construction) above the FY 1984 level would be allocated to tribes in states within the last quartile, with tribes in the upper three quartiles basically held on their FY 1984 funding levels. The amendment also provides that decreases in IHS appropriations would be applied to tribes in the upper three quartiles, with funding for tribes in the lowest quartile "protected" at their FY 1984 levels.

Since early May, when the two committees reported out their respective versions of H.R. 4567, the different equity approaches have been vigorously debated by Indian health officials, tribal leaders, and House committee members. Supporters of the Energy amendment, primarily from the state of California, argued that the past IHS methodologies have led to gross inequities in the allocation of health care funding among the Indian service population. Citing the 1978 *Rincon v. Califano* federal court decision, a 1982 General Accounting Office report entitled "IHS Not Yet Distributing Funds Equitably Among Tribes," and statistics that indicate a fivefold variance in per capita spending for IHS beneficiaries nationwide, proponents of the Energy amendment contended that a per capita allocation formula is the best means for insuring equal access and adequate funding levels for all Indian people.

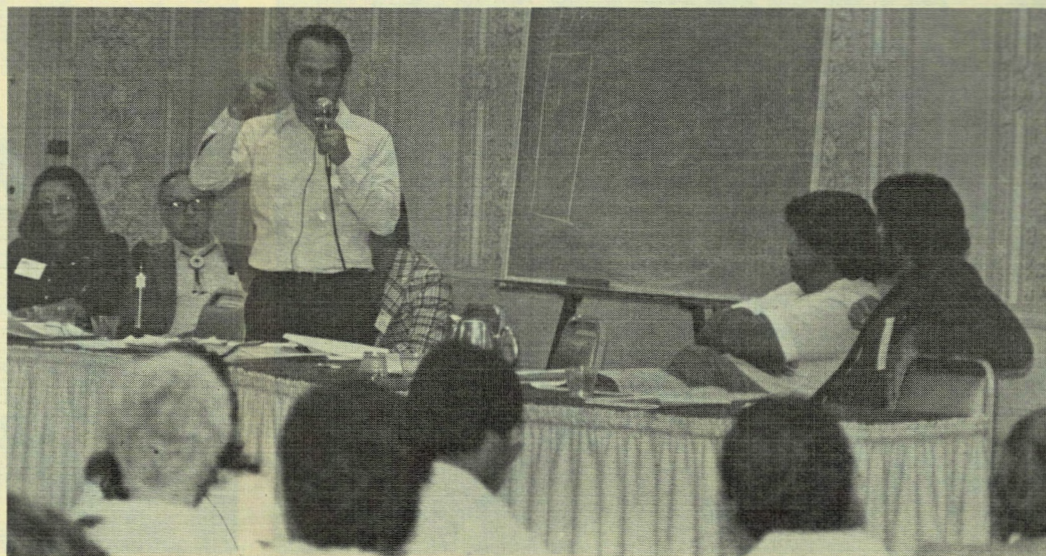
Opponents, on the other hand, condemned the Energy committee's per capita formula as a funding method that would unfairly reduce health services to many tribes by

forcing them to "absorb" mandatory cost increases related to inflation and pay raises; would be virtually impossible to administer given existing problems in accurately identifying the IHS service population and the committee's emphasis on state (rather than IHS area or service unit) boundaries; and would ignore factors other than population — such as transportation, variances in costs of living, medical care, hospital rates, etc., and the availability of alternate resources — related to the delivery of health services in different regions of the country. Critics of the Energy amendment also asserted that the per capita proposal treats IHS as though it were a grant-in-aid program rather than an agency charged with a mission of providing medical care to Indian people.

Concern over the different equity provisions was clearly evident at the Sixth National Indian/Alaska Native Health Conference, where the issue was deliberated extensively during workshops and general assembly presentations on the House and Senate reauthorization bills (H.R. 4567, S. 2166). In response to this concern, the National Indian Health Board, at a special meeting June 7, formally supported efforts by California tribes and tribal organizations to increase their health care funding; however, the Board also opposed adoption of an allocation methodology based solely on service population. In addition, the Board passed a resolution strongly urging the Interior and Energy committees to work toward resolving the differences in H.R. 4567 in order to ensure passage of a bill this session.

At the June 26 meeting between Interior and Energy representatives, which was also attended by representatives from the California Rural Indian Health Board and NIHB, it was tentatively agreed that the per capita allocation amendment would be dropped in favor of the Interior Committee's equity provision, with minor changes, in Sec. 201. Preliminary agreement was also reached on

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FRANKLIN DUCHENEAUX (standing), staff director of the House Interior Committee, emphasizes a point during a NIHB conference workshop on House and Senate reauthorization bills. Other panelists (l-r) are Interior Committee staffperson Debbie Brokenrope; former IHS Director Emery Johnson; NIHB Portland Area Representative Mel Sampson; CRIHB Chairman Joseph Saulque, and CRIHB Executive Director Mario Gutierrez.



# Senate Vote on S. 2166 Delayed Over Objections to IHS Elevation

WASHINGTON, D.C. — Pending legislative proposals to elevate the Indian Health Service (IHS) to a higher level within the Department of Health and Human Services will likely draw "the Administration's strongest opposition," according to the Department's highest-ranking health official.

In a sharply-worded letter to Sen. Orrin Hatch (R-Utah) June 15, Assistant Secretary for Health Dr. Edward Brandt expressed his objections to a provision of S. 2166, the Indian Health Care Amendments of 1984, that would raise IHS to an agency level within the Public Health Service. The Senate bill had originally called for elevating IHS to the level of assistant secretary, but the revised version, reported out by the Senate Select Committee on Indian Affairs May 9, modified the proposal to provide IHS with an agency status within PHS.

Hatch, in apparent response to opposition from Department officials, has placed a hold on S. 2166 which prevents the bill from being debated on the Senate floor. Senate passage of S. 2166, which would amend and extend the provisions of the Indian Health Care Improvement Act, had been anticipated by mid-June prior to the action taken by Hatch, who chairs the Senate Labor and Human Resources Committee.

The Senate proposal is one of three legislative initiatives now under consideration in Congress to change IHS' position within the DHHS bureaucracy. In the House, the Interior and Insular Affairs Committee version of H.R. 4567 recommends an elevation to the assistant secretary level, while an Energy and Commerce Committee amendment would remove IHS from its present location in the Health Resources and Services Administration (HRSA) and make it a separate agency in PHS. The IHS elevation has been widely supported by tribes, Indian organizations (including NIHB) and health professions organizations as a no-cost initiative to improve IHS' management, accessibility to Department decision-making levels, and accountability to Congress and Indian tribes.

Responding to the elevation proposal contained in S. 2166, Assistant Secretary Brandt stated in his letter to Hatch, "As introduced, the bill contained a proposal to place IHS under a newly established Assistant Secretary for Indian Health. We strongly opposed that original provision and while we recognize that the current version represents a modification, our strong objections still remain."

"The Indian Health Service should remain a component of the Health Resources and Services Administration," Brandt continued. Noting that major improvements have been made in the health status of Native Americans under the existing bureaucratic arrangement, Brandt stated, "I am firmly convinced that the present organizational structure enhances this effort . . ." He maintained that IHS receives "a major share" of HRSA's administrative support and depends on a number of HRSA programs, including the National Health Service Corps, for its operation.

Brandt also asserted that, "If enacted, the proposal would also result in a series of administrative shifts

within the Public Health Service that would increase costs and decrease efficiency of operations in all of the affected components of the present HRSA structure." He concluded by urging Hatch to attempt to delete the IHS elevation provision from S. 2166.

Brandt's letter is the strongest indication to date of the Department's opposition to the elevation of IHS. Although the Senate Select Committee on Indian Affairs formally requested a legislative report on S. 2166 last December, the official Department report is still under preparation.

In response to these concerns and the current stalemate over S. 2166, NIHB Executive Director Jake Whitecrow wrote that "we believe this change (IHS elevation) is necessary for a more effective operation of the Indian health care program, and that it would significantly improve the management and accountability of IHS." Whitecrow added that "we believe the elevation of IHS would be a strong symbolic gesture to the Indian community that this Congress and this government are truly committed to improving the health care of Native Americans, a gesture which would come at a time when many Indian people fear that the Federal government is moving to reduce the size and scope of the Indian health program."

Whitecrow also expressed concern to Hatch that additional delays in Senate consideration of S. 2166 may jeopardize the bill. Stated Whitecrow: "Given the extremely short timeframe within which the Senate has to act during the remainder of this session, we are fearful that your continued hold on this bill may prevent its passage, which would have a devastating impact on the quality of health care provided to this country's Native Americans."

Without enactment of a bill, the provisions of the Indian Health Care Improvement Act will expire at the end of the current fiscal year. In addition to extending existing P.L. 94-437 authority through FY 1988 for Indian health recruitment and scholarship programs, health services, construction, and urban Indian health projects, S. 2166 includes the following key amendments to the Act:

- provides for a tribal needs-based health equity system designed to eliminate existing disparities in tribal health resources. Under this system, supplemental funding would be authorized to raise all tribes to at least a level of 20-40 percent deficiency in their total health care needs. Determination of deficiency levels would be based on updated tribal specific health plans. In addition, the bill expands "Health Services" activities to include emergency medical services, accident prevention programs, and the Community Health Representative (CHR) program.

- provides that indigent Indians residing on non-taxable reservation or restricted Indian land will be considered ineligible for state and local health assistance programs funded by property taxes when determining those Indians' eligibility for direct or contract care funded by IHS.

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# Health News Across the Nation

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

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WASHINGTON, D.C. — The Senate by unanimous consent approved S. Res. 127 June 6, making the Select Committee on Indian Affairs a permanent part of the U.S. Senate. Under a compromise extension agreed to by the Senate last November, authority for the Indian Affairs Committee had been scheduled to expire July 1, 1984. Since its creation in 1977, the Indian Affairs Committee has played an important role in Indian health matters through the oversight of Indian Health Service (IHS) operations and the development of Indian health care legislation. Stated NIH Executive Director Jake Whitcrow: "Tribal governments and Indian people have for the past several years supported making the committee permanent, and we are extremely pleased to

## Senate Vote...

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— expands authority for the collection of Medicare and Medicaid reimbursement to include (in addition to hospitals and skilled nursing facilities) health centers, health stations, and home health agencies. The requirement is also added that at least 50 percent of the amounts collected by each IHS service unit be returned to the service unit responsible for the collection.

— provides authority for urban Indian health projects through FY 1988 and requires specific evaluation, reporting and contract standards for those projects.

— extends the authority for studying the health hazards to Indian miners and Indian communities on or near reservations involved in nuclear resource development.

— amends the health services eligibility requirements for California Indians to conform to existing IHS practice.

— provides authority to continue current efforts to reduce and control the incidence of Hepatitis B among Alaska Natives.

— provides statutory authority for a National Indian Health Advisory Board comprised of 12 representatives from the IHS geographic areas and two representatives from urban Indian health programs; creates a 7-member Indian Health Advisory Panel to develop recommendations on a long-range Indian health policy, and authorizes IHS to develop and implement a management information system.

Efforts are underway to resolve the current impasse over S. 2166 and bring the bill to a Senate vote. With Congress working a shortened session due to this summer's national political conventions and this fall's elections, there remains only a limited schedule for the two chambers to consider the Indian health bills. The House and Senate, which recessed June 29, will reconvene July 23 for a three-week working session before breaking again August 10. ■

finally see this action taken. It ensures that the many complex issues of the Federal-Indian relationship, including those related to the provision of quality health services to American Indians and Alaska Natives, will receive the attention they deserve." Members of the Indian Affairs Committee are Sen. Mark Andrews, (R-N.D.), Chairman; Sen. John Melcher (D-Mont.), Ranking Minority Member; Sen. Barry Goldwater (R-Ariz.); Sen. Slade Gorton (R-Wash.); Sen. Frank Murkowski (R-Alaska); Sen. Daniel Inouye (D-Hawaii); and Sen. Dennis DeConcini (D-Ariz.).

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FORT HALL, IDAHO — "Let Eagles & Health Soar in '84 — Think Prevention for Health's Sake" is the theme of the Sho-Ban Symposium IV and Rocky Mountain Youth Conference to be held here August 6-8. The Symposium, sponsored by the Health and Human Services Department of the Shoshone-Bannock Tribes, will address such topics as the Indian Child Welfare Act, alternatives to substance abuse, stress management, and problems of Indian youth. Also featured are traditional storytelling, dancing, Indian games, and adventure activities. Additional information may be obtained from Nancy Murillo, Tribal Health Director; P.O. Box 306; Fort Hall, Idaho 83203.

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DULUTH, MINN. — The Association of American Indian Physicians (AAIP) will hold its 13th annual meeting at the Fond du Lac Reservation Aug. 1-2. The conference, sponsored jointly by AAIP, the Fond du Lac Reservation, the University of Minnesota School of Medicine and the Mash-Ka-Wisen Treatment Center, will address "Chronic Diseases Relating to the American Indian" as its theme. Health issues to be discussed include diabetes, obesity, nutrition, hypertension and cardiovascular diseases. For more information, contact AAIP; 6805 South Western; Suite 504; Oklahoma City, Okla. 73139. Phone: (405) 631-0447.

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PHOENIX, ARIZ. — Honorary awards were presented to two outstanding health providers at separate meetings here in early June. Kenneth Peterson, Chief of Pediatric Services at the Alaska Native Medical Center in Anchorage, Alaska, was presented the 1983-84 National Council of Clinical Directors Outstanding Clinician Award at that organization's annual meeting here June 1. Peterson was cited for his clinical performance, technical expertise, compassion and patient rapport. On June 4, Mary Beth Skupien, community health nurse at the Indian health center in Peach Springs, Ariz., was named Indian Health Service Nurse of the Year during the 19th annual meeting of the Public Health Service Professional Association in Scottsdale, Ariz. A member of the Sault Saint Marie Chippewa Tribe in Michigan, Skupien was honored for her ability as "an effective leader on the community health team" and for coordinating "the efforts of both federal and tribal health professionals" at the community level.

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The National Indian Health Board joins other Indian organizations, tribes, Indian Health Service officials and those from the Indian health field in mourning the passing of Dr. E. S. "Stu" Rabeau. Dr. Rabeau was the third director of the Indian Health Service and former director of the IHS Office of Research and Development in Tucson, Ariz. As expressed by IHS Director Dr. Everett Rhoades, Dr. Rabeau "personally directed many of the efforts which led to pioneering achievements for which IHS has received wide recognition. His intelligence, dedication, and innovative thinking will influence Indian health for many years. His style was in the category often referred to as 'inimitable' and his own life added color to brilliance." Dr. Rabeau's commitment to improving the health care of Indian people will be long remembered by us all.

#### Health News...

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LINCOLN, NEBR. — Service providers working with "at-risk" youth may obtain referral and resource materials from a unique organization here called CONTACT, INC. Through collection and dissemination of resource information, CONTACT responds to needs, questions, and interests of youth and youth service providers, particularly tribal, state and private agencies working with at-risk Indian youth. These at-risk youth include runaways, homeless youth, young people being released from correctional facilities, and youth handicapped by such problems as alcohol and drug abuse, illiteracy, or unstable home lives. For additional information about the organization's services, call or write: CONTACT INC.; P.O. Box 81826; Lincoln, Nebraska 68501. Phone: (402) 464-0602.

SACRAMENTO, CALIF. — The California Rural Indian Health Board (CRIHB) is seeking qualified applicants for three positions within its administrative office and clinic operations. At the organization's central office here, the Board is seeking applicants for Financial Officer to manage its contract and financial operations. Minimum qualifications include at least three years experience in a similar capacity and relevant educational background; salary for the position is \$24-28,000. Applications are also being sought for the position of Program Administrator (salary: \$21,902) at the Sonoma County Indian Health Project in Santa Rosa, Calif.; and for Director, Alcohol Half-Way House (salary: negotiable) to supervise provision of alcoholism-related services to an Indian community in the Central Valley Area of California. All positions will be filled according to Indian preference requirements. For additional information, contact: California Rural Indian Health Board; 2020 Hurley Way; Suite 155; Sacramento, Calif. 95825. Phone: (916) 929-9761.

MINNEAPOLIS, MINN. — A series of courses designed to assist Indian alcoholism program directors is the focus of the Third Annual Minnesota Indian Institute on

Alcohol and Drug studies here August 5-17. The institute offers a rigorous schedule of more than 30 courses dealing with counseling techniques, prevention, program planning, and treatment. Registration is \$44.50 per credit, and Continuing Education Units can be earned through the Institute. For additional information contact: Conference Staff; 335 Nolte Center, University of Minnesota; 315 Pillsbury Drive, S.E.; Minneapolis, Minn. 55455-0118. Phone: (612) 373-3685.

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ROCKVILLE, MD. — Two new directors have been appointed for the Indian Health Service (IHS) area offices in Oklahoma City, Okla., and Window Rock, Ariz. H. C. Townsley, M.D., a member of the Chickasaw Tribe of Oklahoma is the new Oklahoma Area IHS Director and will oversee administration of a program that provides comprehensive care to some 170,000 Indians from 40 tribes in Oklahoma and Kansas. Townsley, who had served as director of the IHS Office of Mental Health Programs since 1975, replaces John Davis, who will become a special assistant to the IHS Director. The other area director appointee is Michael Lincoln, a member of the Navajo Tribe, who assumed the duties of Director of the IHS Navajo Area Office May 1. Lincoln, who holds a master's degree in health services administration from Harvard University, is former director of the Navajo Health Authority and has previously worked with the Public Health Service and with IHS Phoenix Area Office. He succeeds Dr. John Provaznik, who has been Acting Director of the Navajo area since 1981. Provaznik, who was not an applicant for the area director's position, will continue as Chief of Surgical Services at Gallup Indian Medical Center, Senior IHS Clinician in Surgery, and IHS Medical Director of Emergency Medical Services. ■

#### NATIONAL INDIAN HEALTH BOARD

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# Conference Panel Debates Provisions

RENO, NEV. — In a sometimes heated exchange, staffs of the House Interior Committee and Energy and Commerce Health Subcommittee described their bills for reauthorization of the Indian Health Care Improvement Act at the closing day of the Sixth National Indian/Alaska Native Health Conference here June 7. They were joined by Dr. Emery Johnson, former IHS director, who explained the Senate's version of the legislation.

Although there are more similarities than differences between the bills it was the latter with which the three panelists chose to concern themselves. Chief among them are widely varying methods for achieving the goal of health parity for American Indians and Alaska Natives. All three bills adopt a new approach. The one which has provoked the most controversy to date is contained in H.R. 4567 as amended by the House Energy and Commerce Committee. The so-called "Waxman amendments" (for their author Henry Waxman, D.-Ca., who chairs Energy and Commerce's Health Subcommittee) would create a per capita resource allocation formula designed to increase the proportion of IHS funds spent in states deemed to be in the lowest "quartile" of per capita IHS funding. The formula would apply to most increases over the FY 1984 appropriations levels for IHS.

The House Interior (H.R. 4567) and Senate Select Committee on Indian Affairs (S. 2166) versions, on the other hand, would rank tribes in categories from Level V to Level I depending on their unmet health care needs, with a Level V designation representing an 80 to 100 percent deficiency and a Level I designation representing a 20 to 0 percent deficiency. Supplemental funding would be authorized to raise all tribes below Level II (20 to 40 percent deficient) to a Level II. This approach, based upon IHS' "Health Services Priority System," also provides authority for updating the tribal specific health plans that form the basis for determining health care deficiencies.

The Waxman approach was developed at the behest of a number of California tribes. Andy Schneider, Assistant Counsel for the Health and Environment Subcommittee, told the conference attendees, "There is inequity out there. The courts have spoken on this issue that California Indians are entitled to parity in health resources. There is still great inequity after the Equity Health Care Fund. This provision says you (IHS) are in the business of rationing health care and you're not doing a very good job." (Schneider was referring to the 1979 *Rincon* court decision which resulted in IHS implementation of the Equity Health Care Fund. The fund is to be discontinued at the end of fiscal 1984).

"The Interior Committee understands the disparity of treatment and disparity of funding for tribes in California, and the level of unmet needs," Frank Ducheneaux, Interior staff director, told those in the audience. "For that reason the committee steered the focus of Title II toward trying to achieve greater parity of health services and resources for more deficient tribes," he explained. "That way," he continued, "is not to take from some tribes to raise the level for others." "To adopt the Waxman amendments is a cop-out on the obligation of the United States to raise the level of health care for all Indians," asserted Ducheneaux.

He explained that the Energy and Commerce approach would work as follows: All FY 1984 IHS funds would be considered. The amount of those funds allocated in each of the 27 reservation states would be determined and the number of eligible Indians would be divided into the FY 1984 funds to figure each state's per capita allocation. The 27 states would then be divided into "quartiles," with the lowest quartile comprised of the seven lowest states. Using the IHS service population as a determining factor, these states would be: New York, Oklahoma, Nevada, California, Washington, Utah, and Iowa. According to the bill's language, "any increase in FY 1985 appropriations excluding construction would be allocated among eligible Indians in the lowest quartile." Any mandatory increases would be included in this amount. Thus, predicts Ducheneaux, "it is unavoidable that tribes in other states would lose services."

Adding to the explanation of the differing approach taken in the Senate bill, Dr. Johnson stated that he believed the Select Committee is "trying to define health services needs tribe by tribe." "The Senate and Interior versions have the capability to begin to provide the equity we're all talking about," he maintained.

Johnson criticized the Waxman amendment on a number of counts. "The whole concept of per capita allocation is fatally flawed," he maintained. "The laws and policies of the United States have made it clear that Indian people are also citizens of states in which they reside and may not be denied services. Yet the formula does not include alternate resources," he pointed out.

Johnson further criticized use of the IHS service population figures in determining resource allocations. The former IHS director explained that the figures are those "given to IHS by the Bureau of Census." "These figures are a myth and have always been a myth," he said. He continued, "That's why IHS never used per capita to allocate resources. IHS would have done a worse job of rationing health care if we had been using a per capita basis."

And finally he stated that in his opinion, "the Waxman version is moving away from the government-to-government approach and establishing eligibility based on race . . . I would call the Waxman amendments the 'Indian Lawyers Relief Act of 1984.' "

## "no intent to interfere"

"There is no intent to interfere with the relationship between tribes and the federal government," meant by the Energy and Commerce bill, answered Schneider. What the bill does intend, he says, is that for the next three years increases in funding for health services will be targeted to tribes in states with the lowest per capita funding. Assuming annual mandatory increases of five percent, the spread between the lowest and highest per capita states will drop from a ratio of 5 to 2½ thereby, in Schneider's words, "eliminating the extreme and unfair variations in funding allocations."

"We're not talking about facilities or Medicare/Medicaid funds," he noted. Schneider added that while states above the lowest quartile will receive the same



# of House, Senate Reauthorization Bills

per capita allocation as they had in FY 1984, the committee does recognize that they will "lose for inflation."

The allocation formulas had been the primary topic of private discussions all week prior to this panel on the last day of the conference and the audience response following the presentation was vigorous. JoAnn Kauffman, former president of the American Indian Health Care Association, told Schneider that the association wants urban health resources excluded from the Waxman formula. He promised to recommend that to the Congressman.

Others were more concerned about the factors apparently overlooked in devising the resource allocation method. Violet Hillaire, of the Lummi Tribe in Washington, stated that the cost of health services in any given state must be considered. Schneider agreed but said the committee had found no timely data available with which to make such comparisons.

And citing the *Rincon* decision (the case upon which the California tribes are basing their arguments for the Energy and Commerce Committee's approach), Bob Crawford, health director for the Colorado River Tribes, reminded those present, "The judge in *Rincon* said that population is a significant factor but only one factor to be considered in devising any allocation process. Accessibility, cost, and quality of care factors must also be considered."

The panelists also discussed less dramatic but nonetheless important differences between the reauthorization bills. Among them, the House Interior version alone contains a provision establishing a "Catastrophic Health Emergency Fund" for the purpose of meeting extraordinary costs associated with health or medical disasters or catastrophic illnesses. \$15 million is authorized for this fund, with additional monies authorized to restore

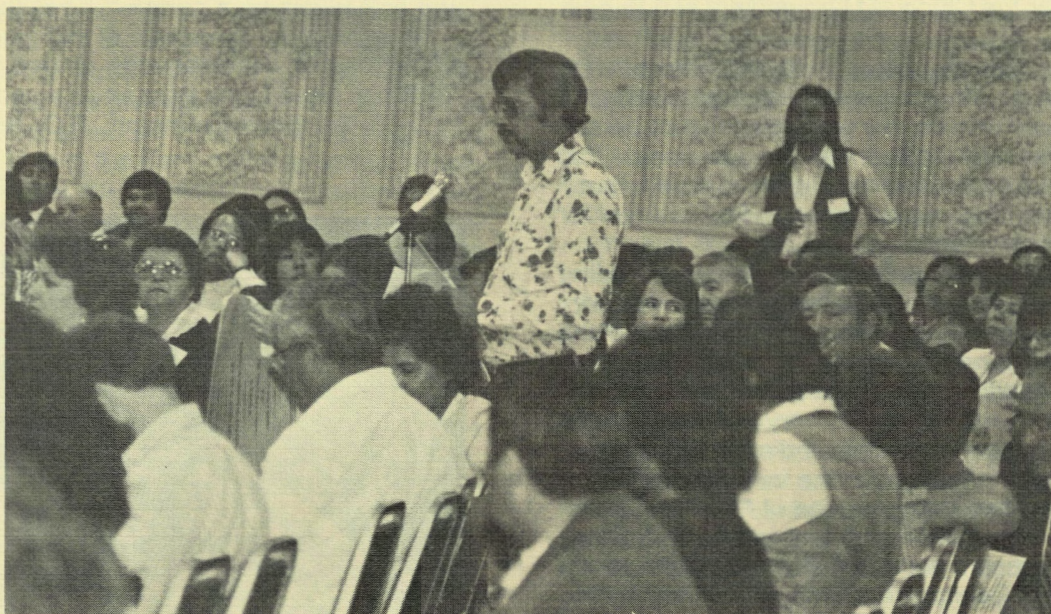
the fund to a \$15 million level in subsequent years. The provision is designed to protect the contract care budget of a service unit in such an event.

Ducheneaux recounted an example of why the Interior Committee considers the provision to be "critical": Last August, a propane vapor cloud ignited while a truck loaded with propane gas was refueling a large underground storage tank located on the Santee Sioux reservation in South Dakota, seriously burning eight young children who had been playing around the tank. The closest burn center was located at St. Luke's Hospital in Sioux City, Iowa, 107 miles away.

Santee's costs for care for the burn victims seriously depleted the Wagner Service Unit's contract health care budget. IHS in Aberdeen paid the bills to St. Luke's for four of the children, amounting to some \$206,000 and representing 22 percent of the total contract health care budget for the service unit. The high percentage of the total allocation for contract health care that was spent for Santee meant that lower medical priorities for other people could not be funded. And with almost a quarter of the contract health care budget expended on one emergency, the quality of health care for three tribes — Santee, Rosebud and Yankton — was seriously jeopardized.

The bills also differ in their restrictions regarding provision of services to otherwise non-eligible persons. Both House versions would permit tribal governing bodies to extend health services to persons otherwise ineligible for IHS care including: the minor children of an Indian person where they are not otherwise eligible; ineligible spouse (however, these persons must pay for service and their numbers would not be included in IHS' determination of resource needs for the area); non-Indian women pregnant with a child of an eligible Indian

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**BOB CRAWFORD**, Health Director of the Colorado River Indian Tribes in Parker, Ariz., questions panel members about differing "equity" provisions of H.R. 4567 during an NIHB conference workshop. The problem of equitable funding was one of many crucial Indian health issues addressed at the conference.



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for the duration of the pregnancy through post partum; non-Indian emergency patients (until they are stabilized; these persons would also be required to pay for services); immediate family where such care is directly related to treatment of the eligible person, and other ineligible persons (if a tribe so requests, subject to payment and if no diminution of services to Indians occurs). The Senate bill has no such provision.

### **IHS Organizational Status**

The organizational status of IHS is yet another area of difference between the committees. The House Interior bill would elevate IHS to the Assistant Secretary level, a proposal which has uniformly received tribal support and Administration opposition, according to Ducheneaux. The provision is designed to "get IHS out from under massive layers of bureaucracy," he explains. He reasons, "If it is important enough for there to be an assistant secretary in the Department of Interior with BIA, then it's important enough for Indian health." Ducheneaux predicts that such an elevation "will have a long term beneficial impact on the health care received by Indian people."

The House Energy and Commerce and Senate versions would remove IHS from the Health Resources and Services Administration (HRSA) and establish it as an agency within the Public Health Service. As an agency within PHS, IHS would be on the same organizational level as the National Institutes for Health, the Center for Disease Control, HRSA, the Food and Drug Administration, the Agency for Toxic Substances and Disease Registry, and the Alcohol, Drug Abuse, and Mental Health Administration. An additional change contained in the Energy and Commerce version would give IHS "budget bypass" authority. As Schneider explains it, with this power the IHS budget would no longer be required to clear the Office of Management and Budget for approval.

Describing a feature unique to the Senate bill, Dr. Johnson explained, "In many states medical services to indigents are paid with county taxes. If an Indian person lives on non-taxable land, under the provisions, that person would not be considered eligible to receive such services. Rather, IHS would be the first source for providing such services."

The Senate bill is also unique, he noted, in providing statutory authority for a National Indian Health Advisory Board comprised of one representative from each of the 12 IHS geographic areas and two representatives from urban Indian health programs and creates a seven-member Indian Health Policy Advisory Panel to develop recommendations on long-range Indian health policy.

The current authorization for the Indian Health Care Improvement Act expires at the end of FY 1984. Therefore adoption of reauthorizing legislation during this congressional session is crucial. S. 2166 was reported out of the Select Committee on May 9 and is pending floor action. However, the bill has been placed on hold by Labor and Human Resources Committee Chairman Orrin Hatch (R-Utah). His staff and that of the Select Committee are working to resolve his concerns as quickly as possible.

In the House of Representatives, staffs of the Interior and Energy and Commerce Committees have reached a preliminary compromise on their respective bills. Both House and Senate committee staffs are hopeful that their respective bills will receive floor consideration in late July or early August. ■

## **NIHB Adds Three New Staff**

DENVER, COLO — The National Indian Health Board is pleased to announce the addition of three new staff members to fill the recently-created positions of health planner/analyst, associate editor, and executive secretary.

According to NIHB Executive Director Jake Whitecrow, the new staff "are exceptionally well-qualified and will assist us tremendously in carrying out the responsibilities of this organization. There are a number of critical issues to be addressed in Indian health over the next few years, and we are now in a much better position to assist Indian people in dealing with those areas."

NIHB's new health planner/analyst is John Compton, Rosebud Sioux, whose background includes extensive experience in education and social work. He holds a master's degree in social work and is a doctoral candidate at the University of Denver, where he worked as an assistant professor for five years. Compton's health background includes work in the areas of nutrition, alcoholism, health planning, mental health, and specialized services for children, the elderly, and families. He is also an accomplished public speaker and technical writer.

In his new capacity with NIHB, Compton will assist in the analysis of budgets, health legislation, statistical data and prepare NIHB positions, analysis papers, and policy recommendations; will present health materials at workshops and conferences; and will provide technical assistance and training to tribes, Indian organizations, and individuals on a number of health-related topics.

To expand its coverage of national legislative and administrative developments related to Indian health, NIHB has hired Linda Bossert as an editorial consultant to work in the Washington, D.C. metropolitan area.

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*John Compton*



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Bossert worked for two years as a health information specialist with the National Congress of American Indians; worked as a public information officer with NIHB; and is a former reporter and managing editor of the *Navajo Times*. As NIHB's editorial consultant, she will research and write articles for the *NIHB Health Reporter*, cover key congressional hearings and depart-

mental meetings, and serve as a Washington, D.C.-based information liaison for Indian health matters.

NIHB's third new employee is Cathleen Cruz, an enrolled member of the San Juan Pueblo in New Mexico, who will be the organization's executive secretary. A former technical assistant and secretary with the Affiliation of Arizona Indian Centers, the All Indian Pueblo Council, and the Indian Health Service, Cruz will handle most of NIHB's secretarial and clerical duties, including receptionist, typing, filing, and preparing minutes of NIHB staff and directors' meetings. ■

## Navajo Hospital Combines Modern, Traditional Medicine

by Gina Begay  
*The Navajo Times*

CHINLE, ARIZ. — Combining modern medicinal practices with traditional Navajo ceremonialism is unique to the Chinle Comprehensive Health Care Facility.

The relatively new hospital, dedicated Aug. 28, 1982, houses the only built-in Navajo healing room on the reservation available to patients who desire prayers, or "sings", while in the hospital either for spiritual or healing purposes, said Elizabeth Mumm, health educator, community health department.

The healing room, situated at the northeastern corner of the hospital in-patient unit, is a small room which appears to look like a traditional hogan from the inside.

So far there have been several ceremonies done in the room although it doesn't have a traditional dirt floor. It does, however, maintain earth to sky contact through a tube that runs from the fireplace down through the concrete floor. Fire can also be lit inside, said Ms. Mumm.

Much of the planning for the healing room was done in the spring of 1977 by the Chinle Hospital Steering Committee and approved by the Medicinemen's Association and the Chinle Service Unit Health Board. The estimated cost for building the healing room was \$10,000. Discussions of providing patients with a Native healing room were taken seriously from the beginning because, "Chinle is in the center of the Navajo Nation, people who live here are the most traditional," she said.

Many hospitals make provisions for Navajos requesting traditional ceremonies but they are short and not in the right setting, she said. Medicinemen are often interrupted during their ceremonies by daily hospital routines. For example, temperature, blood pressure, medication, or lab tests must be taken at regular intervals as requested by doctors.

Chinle hospital provides an alternative because one of the guidelines set forth in a Native healing policy is to not allow medical or nursing procedures to be done while a ceremony is in process.

She said the original design of the healing room was done by a medicineman; the door faces east, there is earth-to-sky contact, a fireplace, lighting and no contact with the in-patient unit.

Many traditional Navajos are apprehensive of visiting hospitals because of the deaths which occur there but Ms. Mumm doesn't see this as a problem for the healing room. She said the room has two outer walls and the

walls on the inside are fireproof, acting as a barrier to the in-patient unit.

"It's very isolated from where the other patients are. In designing the healing room we had to meet the needs of the patient but also respect the medicineman's wishes," said Ms. Mumm.

Prior to its establishment about 90 percent of the doctors on the staff favored the idea of a healing room. Some, however, were opposed to it because some people thought it would not help. "They don't believe it (traditional ceremonies) works or helps the patients," she said. Possibly, many doctors have not been on the reservation for long and are new to traditional healing methods, she said. "The hardest thing for people from another culture, not exposed to (Navajo) culture, is to accept a concept that there are other ways to heal," she said.

Ms. Mumm said she believes the patient should be given every opportunity for recovering or rehabilitation and to get well. If Native healing is the opportunity to do this, the patient has a right to have it, she said.

Jo Castine, director of community health nursing, agreed that all the patient's needs and well-being are the major concerns of the hospital staff. Patient care includes tending to their cultural needs as well, and the health care system has to be "accessible enough" to meet those needs, she said.

There are certain limitations set forth by the hospital and health board, said Ms. Mumm and Service Unit Director Florine Jones. A consent form must be signed between the patient, physician, medicineman and in some cases the interpreter on what treatment the patient is to receive. Some patients may be too ill to sit up or take different herbs or even be covered by charcoal—the physician must give permission for a patient to receive traditional health care from the medicineman, said Ms. Mumm.

The healing room can only be used for one-night ceremonies, if so desired, and not for two-day or nine-day ceremonies because patients may be too ill, she said.

Part of the problem with the healing room is finding ways to let Western medicine and traditional healing work together. They should not conflict with each other, said Ms. Mumm. "The two have to find ways to work together to find what is in the best interest of the patient in the healing process."

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# House Committee Challenges IHS Budget Request for FY '85

WASHINGTON, D.C. — For the second year in a row, House Interior Appropriations Committee Chairman Sidney Yates (D.-Illinois) and Health Resources and Services Administrator Dr. Robert Graham met in a clash of wills over the annual Indian Health Service budget. Graham testified here May 9 on behalf of the Administration's proposed fiscal year 1985 budget for Indian health.

Despite repeated requests by Congressman Yates to provide the committee with "all the pertinent facts, not just those in support of the Administration's position," Graham held to the position that he was there to present a budget which "reflects the President's priorities." Those priorities resulted in a budget which asks \$741.95 million for Indian Health Services, some \$28.46 million less than appropriated in FY 1984. No money is requested for Indian Health Facilities whereas \$53.56 million is allocated for the current fiscal year.

Congressman Yates maintained that "this priority approach is just touching on the needs." He voiced his frustration with the Administration's testimony in part by quoting from a letter he had received from former IHS Director Dr. Emery Johnson. In his correspondence Dr. Johnson claimed that the budget submitted to Congress "doesn't reflect the whole story." Stated Yates, "Dr. Johnson was right. We don't get the whole story . . . There ought to be some way of having an overall delineation of the health needs of each tribal community."

IHS Director Dr. Everett Rhoades, who accompanied Graham, explained that his agency plans to reinstitute

tribal specific health planning as part of its annual budget preparation process. However, if the 1980 IHS National Plan (which was based on tribal specific health planning done at that time) had been followed, a doubling of the IHS budget would have been required, added Graham. He continued, "This budget (for FY 1985) has never been represented as meeting all the needs of Indian people. That's why we speak in terms of priority." Yates accused the HRSA administrator of "not carrying out your mandate because the budget does not reflect the health needs of Indian people."

Throughout the day-long hearing a number of assumptions and proposed cuts in the IHS budget were called into question. Citing Dr. Johnson's letter, Congressman Yates suggested that the projected amount of funds for Medicare/Medicaid collections is "significantly overstated and bears no relation to past experience." Graham said that although the collections have not met the Administration's projected level they "have always outstripped others' expectations." When asked how the \$55.4 million figure was arrived at, he said he would "have to defer to OMB."

Yates asked why a reduction of almost 50 percent in preventive services is being sought "despite the Administration's touting of prevention as the way to save health care costs." Graham's explanation was that the cut is largely due to the recommended elimination of the Community Health Representative program and did not elaborate further.

The Administration's omission of money for facilities drew even sharper criticism. "What do you do about hospitals that are obsolete, dilapidated, or in need of repair?" demanded Yates. "OMB has said that in future years it may be possible to request some funding for facilities," offered Graham. Upon considerable pressing by the chairman, Graham stated that the original request by IHS for facilities in FY 1985 had been \$191 million. Yates also asked for a thorough accounting on the status of facilities on the IHS priority construction list. He criticized HRSA for "taking longer than any other agency" to review construction documents and reminded Graham that these Indian health facilities are "way behind schedule."

The Administrations's budget also requests no funds for sanitation facilities construction. Nevertheless, testified Dr. Rhoades, there will be 1,000 BIA homes constructed next year for which IHS must provide sanitation facilities. He estimated the cost for this will amount to \$8 million. An additional \$16 million is necessary to supply sanitation facilities for the tribally-constructed homes to be completed over the next year, he said. Coupled with this expected need, Rhoades estimated that a backlog of 20,000 Indian homes requiring sanitation facilities already exists.

The Appropriations committees in both the House and Senate are expected to complete action on the Interior appropriation bill by late summer. The new fiscal year begins October 1. ■

## *Committee Recommends \$914 Million for IHS in FY '85*

WASHINGTON, D.C. — The House Appropriations Committee approved the FY 1985 Interior Appropriations Bill here June 28. Among other items, the bill includes funding for Indian Health Service (IHS) programs next year.

The bill recommends continued funding for the Community Health Representatives program (\$27 million), urban Indian health services (\$10 million), tribal management (\$2.6 million) and facilities construction (\$96.1 million), all of which have been slated for elimination under the Administration's request for IHS.

A total of \$914 million is recommended for IHS in FY 1985 — \$818 million for health services and \$96 million for health facilities. The total is \$172 million more than the funding requested by the Administration earlier this year. The bill must still be approved by the full House.

On the Senate side, the Interior Subcommittee on Appropriations is expected to report out its version of the bill in late July.



other differences between the committees' bills, including:

- acceptance of a definition for California Indians that will provide IHS health services eligibility to: (1) members of federally recognized tribes; (2) Indians of California as defined in the first section of the Act of May 18, 1928; (3) Indians who hold trust interests in public domain land, national forest lands, or Indian reservation allotments in California; and (4) Indians in California who are listed in the plans for distribution of the assets of California rancherias and reservations under P.L. 85-671 (authorized only through October 1, 1988).

- designation of the state of California as a Contract Health Service Delivery Area, exclusive of certain counties with large urban Indian populations.

- agreement that, in California only, where IHS contracts with a private or non-Federal organization for the delivery of health services, tribal consent for such a contract will be presumed unless a majority of the non-tribally affiliated California Indians in the service population object to the contract.

- agreement to exclude California from a provision which stipulates that, in the case of a multi-tribal service area where all the tribes have agreed to a plan to provide health services to otherwise non-eligible persons, revocation of such approval by a single tribe will result in termination of services to non-eligible persons.

- agreement to an Energy Committee amendment to permit tribes to contract for the planning, design, and construction of water and sanitation facilities, health centers, and hospitals under the authority of P.L. 93-638.

- agreement to an Energy Committee amendment requiring IHS to fund programs and facilities operated by tribes and tribal organizations under P.L. 93-638 contracts on the same basis as programs and facilities that it operates directly. The amendment expressly covers maintenance and repair, employee training, and cost of living increases for employees.

- agreement to an Energy Committee amendment prohibiting the removal of National Health Service Corps personnel unless assurances are made that the affected

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## CRIHB Chairman Explains Compromise, Urges Unity and Support for Health Bills

*On June 18, the executive committee of the California Rural Indian Health Board (CRIHB) agreed to withdraw its support for a controversial per capita resource allocation amendment to H.R. 4567, the Indian Health Care Amendments of 1984. The Board's action led to a preliminary agreement between the House Interior and Insular Committee and the House Energy and Commerce Committee, an agreement that will hopefully allow one version of the bill to be brought to the House floor in late July. In the following paragraphs, Joseph Saulque, CRIHB chairman and chairman of the Utu Utu Gwaitu Paiute Tribe in Bishop, California, explains the Board's decision and urges tribes and Indian organizations to unite in supporting enactment of the Indian Health Care Amendments of 1984.*

The CRIHB decision to request Mr. Waxman to withdraw his amendment regarding the "per capita" allocation was obviously not an easy one for us, given the funding difficulties the tribal health programs have historically faced in California. However, through the support of Mr. Waxman and the rest of the California congressional delegation, we had actually put forth a total package of 11 amendments which are designed to correct or clarify the most significant problems faced by Indian people in California in our relationship to the U.S. Government and their responsibilities regarding the provision of health care to our people.

One thing that has been lost in the whole controversy regarding the so-called Waxman Amendments is that, on the whole, these proposals represent some of the strongest statements to date since the passage of P.L. 93-638 on expanding the roles and responsibilities of tribes and tribal health organizations to assume all or part of the government's involvement in health care delivery to Indian tribes.

If there has been any advantage in the system we have in California due to our unique historical and political circumstances, it is that all health services, direct and contract, are provided exclusively through contracts with tribes and tribal health organizations. That is an immense responsibility which has magnified for us the weaknesses and deficiencies in the P.L. 93-638 process and the reluctance of the government to fully view us as an equal partner in its policy formulation and operations.

So, in the interest of insuring the successful passage of these other very important amendments, and in the interest of achieving strong national unity among tribes and area Indian Health Boards, we were able to negotiate what we hope will be a single House bill (minus the per capita amendment) that will have the joint support of Mr. Waxman and the Energy and Commerce Committee and Mr. Udall and the Interior Committee so that we may secure the timely passage of this Reauthorization Act. One thing, however, we must make clear is that our withdrawal of support for the per capita allocation amendment does not in any way detract from what we feel is a broad-based dissatisfaction with the unfair allocation methodology currently used by IHS that has led to be to the disproportional low funding among tribes in other states besides California, such as Oklahoma, Utah, Washington and New York.

We urge NIHB and the other area health boards and organizations to continue to pursue a long-term solution to this problem, as suggested by representatives of the Intertribal Councils of Arizona and Nevada, through joint discussions and study with the IHS administration. In the meantime we urge all tribes, area health boards, and regional and national Indian organizations to unite solidly behind H.R. 4567 and S. 2166 to secure its successful passage this year. ■



## Interior, Energy...

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Indian population will experience no reduction in health services as a result of the transfer.

— agreement to an Energy Committee amendment which provides that restrictions on IHS funds for lobbying and litigation shall not apply to other non-IHS public or private revenues received by an IHS contractor.

Still unresolved are two important differences between the committee bills. The first is an Interior provision that would create a \$15 million Indian Catastrophic Health Emergency Fund to assist IHS in meeting the extraordinary costs associated with a catastrophic illness or a medical disaster. The Energy version deletes this provision.

The second issue involves the committees' different proposals to elevate the Indian Health Service to a higher level within the Department of Health and Human Services. The Interior bill creates a new Office of Indian Health under the direction of an Assistant Secretary for Indian Health, and transfers all Indian health responsibilities to the new office. The Energy Committee proposal would remove IHS from its present location within the Health Resources and Services Administration and establish it as a separate agency within the Public Health Service. The Energy amendment would also require IHS to submit its annual budget directly through the President to Congress and provides that IHS directly receive all funds appropriated for its programs.

Despite these remaining differences, Interior staff director Franklin Ducheneaux expressed satisfaction with the overall agreement. "I believe that we've reached an understanding on the most serious issues. It's all preliminary, and the whole thing could still fall apart... (but) I think we have a good chance to get a joint bill as a result of this," he said.

The House reconvenes July 23 for a three-week session before recessing again August 10. Committee staff are hopeful that H.R. 4567 can be brought to a floor vote during that time. ■

## Navajo Hospital...

Continued from Pg. 9

She said accepting the idea of Native healing is not a question of whether a staff member believes in the practices or not, and even if she were against the idea of Native healing, she said she wouldn't let her beliefs get in the way of the patients well-being.

There are many different kinds of healing practices around the world and many ways of doing things, she said. "If it works, it's fine,"

The hospital provides the room and additional equipment and supplies, none of which are used in any other part of the hospital; a grinding stone, dust pan, bow and arrow, broom, basins, pails and water dipper. But the patient and family must provide their own wood, medicineman paraphernalia, blankets, and more important, payment for the medicineman, said Ms. Mumm. ■

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NIHB encourages readers to submit articles and comments for publication. Please send correspondence and mailing requests to John P. O'Connor, National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colorado 80231.

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