



# NIHB Health Reporter

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## Scholarship Money May be Restored

ROCKVILLE, MD.—Health Professions scholarship awards under title 1 — Indian Health Manpower — of the Indian Health Care Improvement Act were made to 51 students late in May for the Spring academic term. Applications for the late fall semester are already being reviewed and the next cycle for review of applications will begin this winter.

Dr. George Blue Spruce, Director of IHS Indian Health Manpower Development reports good news for future scholarship hopefuls in that the House appropriations subcommittee has restored Title I funds for Fiscal Year 1979 at their present level and the Senate appropriations subcommittee is expected to do the same.

For further information on the Indian Health Scholarship programs, contact the Scholarship Coordinator at your nearest IHS Area/Program Office.



*DR. GEORGE BLUE SPRUCE, IHS Indian Health Manpower Development Director, signs awards for students made under Section 103, the Health Professions Preparatory Scholarship Program for Indians and Section 104, the Health Professions Scholarship Program.*

## S. 666: Impact for IHS Remains Uncertain

WASHINGTON, D.C.—With S. 666, a bill to allow certain employees of the Bureau of Indian Affairs and Indian Health Service to retire early, expected to become law in the near future, there is strong disagreement about its likely effect on the Indian Health Service.

Karl Funke, Assistant Counsel for the Senate Select Committee on Indian Affairs, says the committee has compiled "a file about seven inches thick" of BIA and IHS employees who have inquired when the bill may become law "because they are ready to go."

While the number of IHS employees desiring to take advantage of the proposed legislation may be large, "the impact would not amount to very much at all at any one service unit level," according to Dr. Joseph Exendine, IHS Deputy Director. He forecasts the law's effect as minimal because "we're talking about a number of people over a large area and over a long period of time."

"We may get hit on the administrative side of our house," admits Exendine. But, he says, "a good portion of our personnel are health professionals. All our doctors are commissioned as are some of the nurses."

Director of the IHS, Dr. Emery Johnson, testified on behalf of the bill before the Senate Subcommittee on Civil Service and General Services last September and the Carter administration also favors its passage.

The Senate adopted the measure by a voice vote January 30 and it was most recently amended and reported out of the House Committee on Post Office and Civil Service. It was tentatively scheduled to come before the full House on June 26 and congressional sources reported that it would likely pass with little trouble.

Non-Indian employees in higher level positions of both the Bureau and IHS have complained for years that the policy of Indian preference has kept them from further advancement. Yet Funke, who helped litigate the Tyndall case, which resulted in an absolute Indian preference requirement for IHS, disagrees. Calling the bill in light of such arguments "a hoax" he says he doubts that "any job opportunity for a non-Indian was adversely affected" prior to the Tyndall decision.

*Continued on Pg. 7*



# Testimony Sought for IHS Oversight Hearings

WASHINGTON, D.C.—The Senate Select Committee on Indian Affairs reports that it has received such a tremendous response to announcement of oversight hearings on the Indian Health Service (IHS) that it now plans to schedule an additional day of hearings.

So, sometime late in July, the committee will hold two days of hearings here, the first for tribal and the second for administration witness. The additional day will come in the form of a field hearing to be held either in Seattle or Denver in late July or early August. That hearing will confine itself to testimony from tribal or native people from Alaska and the western states.

On these two occasions, recipients to health care provided by IHS, tribal health workers and representatives will have a chance to voice their dissatisfactions with the agency.

As explained by a committee staff member, the decision to hold such hearings was prompted by numerous complaints

and by the committee's responsibility to hold oversight hearings on those agencies within its jurisdiction.

Exact dates for the hearings are expected to be determined the second week of July. The primary purpose of this process is to examine the satisfaction of IHS health care recipients and IHS' fulfillment of its requirements in both delivering services and fulfilling its legislative mandates. Tribal persons are urged to voice their grievances with suggested subjects including needed improvements, areas of neglect or unresponsiveness, and lack of resource allocations.

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

To contact the committee with comments or to receive further information write or call: Karl Funke; Senate Select Committee on Indian Affairs; 5331 Dirksen Senate Office Building; Washington, D.C. 20510; Phone (202) 224-3415.

## Chance for 641 Improvement Arrives

WASHINGTON, D.C.—Over the past two years, Indian tribes have received repeated warnings that unless they become involved with the Health System Agencies in their areas they might soon be left out in the cold regarding health planning.

Many of them have now done so or are moving in that direction with the help of groups like the Intertribal Council of Arizona (ITCA), which is working to familiarize tribes in that state with HSA's and the entire 641 planning process.

As presently worded, the National Health Planning and Resources Development Act (P.L. 93-641) gives tribes great cause for concern, for the local bodies it establishes (Health Systems Agencies) are empowered to plan for the health needs of their entire area, including Indian reservations. They are further empowered to "review and comment" on all tribal applications submitted to HEW for funding grants available under certain health acts.

But in light of more recent legislative developments initiated by NIHB, HSA's may soon cease to represent a threat to tribes and their right to sovereignty and self-determination. Earlier this spring, NIHB proposed amendments for inclusion in DHEW's package of suggested changes submitted on the law. After being ignored there, NIHB presented its amendments to the congressional health subcommittees directly and was successful in having them adopted by both subcommittees in some form.

While the language differed from House to Senate, according to Daniel Press, NIHB General Counsel, the effect of the language in both Houses is to require HSA's to respect tribal sovereignty and self-determination.

"If they pass, these bills make it clear that HSA's have no right to plan for tribes," he told members of the Arizona tribes attending a May 641 symposium sponsored by the ITCA.

The amendments have now been adopted by the full House Interstate and Foreign Commerce Committee and the Senate Human Resources Committee as part of the larger group of amendments to the Health Planning Act. According to Press, they were expected to be voted on sometime in mid-July before going to a conference committee.

But, he cautions, tribes may not rest easy yet. Although NIHB carried out a mandate of participants at the Second National Indian/Alaska Native Health Conference earlier this year, by securing the amendments, he says "the legislative language represents only the tip of the iceberg."

In order to assure that HSA's do indeed respect tribal sovereignty and self-determination appropriate actions must be spelled out through regulations which will follow adoption of the basic amendments, suggests Press.

NIHB will continue to play a lead role in this process and has requested a meeting with the head of the Health Resources Administration within DHEW in order to discuss means to assure Indian participation with the regulations and the development of a comprehensive policy on Indians and the law itself.

Tribes and their health planners in particular are urged to submit information on problems they have experienced with their own HSA's and on proposed areas for the forthcoming regulations.

Press suggests several possible areas that regulations need address.

Specific regulation language must spell out that Indian tribes are to remain the sole authority for health planning and development on their reservations. In order to limit the HSA's powers in compliance with this concept, Press maintains that regulations must define the term "review and comment" limiting an HSA's comment on tribal proposals only to those aspects of the proposal that will have a significant impact on the non-Indian health system. Regulations must also define how state agencies must respond to requests for certificates of need by tribes for construction of health facilities, he says.

As clarification of the relationship between 93-641 and the Indian Health Care Improvement Act, Press suggests that regulations be written to insure the Tribal Specific Health Plans are recognized as the official planning instruments for

*Continued on Pg. 3*



*Continued from Pg. 2*

Indian health programs. The regulations might also be written to insure that these plans shall be incorporated, intact, into the Health Systems Plan of the relevant HSA and that the HSA and state agency shall have no authority to alter or amend them, suggests Press.

He stresses that cooperation between HSA's and tribes could improve the planning activities of both and points out that regulations could promote this "necessary" cooperation. Toward this end, he says, the Secretary should develop model agreements that tribes and HSA's could use as a starting point for their agreements, and should encourage and assist HSA's and tribes to work out arrangements on their own.

Benefits to tribal health planning efforts might be available in two concrete forms, as further suggested by Press. One provision pending congressional approval would empower the Secretary to increase planning grants to HSA's which have "extraordinary expenses." Tribes could foreseeably receive some financial assistance with health planning if regulations required the Secretary to establish tribal entitlement to a part of these discretionary funds.

And, in addition to the technical assistance promised by IHS in health planning, the Centers for Health Planning established under 641 might provide an additional source, if regulations to that effect are written.

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## **Push for Return of Child Welfare Matters to Tribes Continues**

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WASHINGTON, D.C.—The Indian Child Welfare Act moves closer to becoming law as it was adopted by the House Interior and Insular Affairs Committee on June 21 and is expected to reach the House floor for a vote by mid-July.

The act, which would establish standards for the placement of Indian children in foster and adoptive homes in order to prevent the breakup of Indian families received Senate approval last November. As stated in testimony presented by the National Indian Health Board at Senate hearings and addressed to members of the House committee, "if enacted, this specific legislation could play a key role in the strengthening of Indian families and returning the major role in placement of Indian children for adoption and foster care to its proper place: with Indian people themselves."

Numerous other Indian tribes and organizations have voiced strong support for the act, testifying before both Senate and House subcommittees.

S. 1214, the Senate version of the bill, gained approval last November. The bill was introduced in the House on May 3. Its chief sponsor, Congressman Morris Udall (D.-Ariz.) cited that "the record indicates that many Indian children are removed from their families on the flimsiest of reasons and without regard to the standards and norms prevailing in the Indian community. The record indicates that many times, Indian children are routinely placed with non-Indian families on the arrogant assumption that obviously the child would be better off in a non-Indian home than an Indian home."

Along with attempting to eliminate abusive child placement practices, the Child Welfare Act also aims to provide a mechanism for Indian communities to strengthen their own family life calling for the establishment and operation of on and off-reservation "family development programs."

A \$26 million authorization for this purpose during the first year of the law's operation contained in earlier drafts of

*Continued on Pg. 6*

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## **Commission Gets Carter's Support**

WASHINGTON, D.C.—Native Americans can be hopeful that greater attention will be paid to their mental health needs and to their tribes' requests for mental health facilities and services thanks to the work of the Native American Task Force of the President's Commission on Mental Health.

The full commission presented its report, including a separate report on the mental health status of Native Americans, to President Carter at a White House ceremony April 27.

Indian people around the country knowledgeable in the mental health area participated in several of the commission's task forces, gave testimony at commission hearings, and helped formulate the final report on Native Americans. Phyllis Cross, who served as special assistant to Commissioner LaDonna Harris, calls the work of those Indian people who lent their efforts, "remarkable, given the very short time frame in which we had to work."

Indian people now stand to benefit from the full report, the product of an intense, year-long study. It asks about \$600 million in new Federal funds over the next five years and tries to target help to those deemed most needy.

Outlining the commission's recommendations, Honorary Chairperson Rosalynn Carter, said that one of the major findings — the inadequacy of current mental health services for children, minorities, teenagers and the aged — had been made evident over and over again in public hearings held by the commission.

The report noted half the \$17 billion spent annually on mental health care is spent in large state institutions, and called for revamping the system so that smaller institutions and community-based mental health centers can take over the role of large public facilities.

During the White House presentation, President Carter announced that he would support the increases in the mental health budget sought by the commission.

White House Domestic Policy staff members are analyzing the report and an HEW task force has been appointed to respond to it.

However, Commission Chairman Thomas E. Bryant predicts that it may take several months before the Carter administration readies its strategy, including what new legislation and appropriations it wishes to seek.

Interested persons may obtain copies of the final report of the President's Commission on Mental Health, plus the reports of 32 task panels and sub-task panels.

Volume I is the 94-page report itself. The report dealing with Native Americans is contained in Volume III under the section on Special Populations. Any of the documents may be obtained by writing to the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.



# State Interference in Tribal Affairs Cited in Move for Direct Funding

PHOENIX, ARIZ.—Although residents of this nation's Indian reservations are included in the population figures claimed by each state for its share of federal social services money, relatively little of that money is ever seen on those reservations in the form of social services coming from the state.

With \$270,000 funding procured from DHEW, the National Tribal Chairmen's Association, through several sub-contractors has conducted a study to determine the feasibility of direct funding to tribes as an alternative to the current "state intermediary system." With the initial phases of the study complete, an amendment to Title XX of the Social Security Act of 1975 (P.L. 93-647) is currently being refined. Developed through the joint efforts of NTCA, the Intertribal Council of Arizona (ITCA), the Denver Research Institute, the Mississippi Choctaw Tribe (located in one of three states selected for study) and legal counsel, it calls for a separate grant program for services for Indian governmental units.

Several Arizona tribes, tribal lawyers, state and Bureau of Indian Affairs representatives attended a workshop spon-

sored by ITCA here May 4 to voice their comments and suggestions on the draft amendment.

Several barriers resulting in P.L. 93-647's failure to meet the needs of Indian people were outlined during the course of discussion.

While the federal government provides 75 per cent of the funding for social services programs, it requires a 25 per cent match from local sources. States claim inability to provide such funds since reservation areas are non-taxable and therefore ask that Indian tribes or groups themselves pay the match. When unable to come up with the funds, tribes are effectively prevented from participation.

Administrative problems are complicated for those reservations falling within the boundaries of more than one county or in some instances, more than one state.

Perhaps an even more serious deterrent to tribal participation is that in states which do provide benefits, programs often result in what tribal members see as interference in their internal affairs. State standards and licensing regulations often conflict with tribal norms and at worst, are seen as blatant incursions into tribal self-determination.

One example involves Children's Services programs in which the state determines which children should be placed for adoption. Another instance, pointed out by Roger Hodges of the Arizona Department of Economic Security, arises when state or county funds are used for foster care payments. "This immediately presents a problem with the state desiring to monitor or control the program on reservations," he explained.

The conflict of state regulations versus tribal standards has arisen with other programs as well. As described by Nancy Evans, Director of the Navajo Area BIA Social Services program, the Navajo Tribe has run into plenty of problems since it began contracting for social services in 1972. "The reality of state standards and licensing shut down our day care centers which have never been reopened," said Evans.

Presenting a strong argument for direct funding, she added, "Social services delivery involves values such as how you want your children raised. There is no reason in the world why an outside agency should determine how social services are provided to tribal members."

According to ITCA Executive Director John Lewis, the amendment is geared toward building toward the concept of tribal sovereignty. "We're trying to give tribes the decision and option of how they want to handle this resource," he told workshop participants.

The federal government spends \$2.5 billion annually on social services under Title XX, awarding funds to each state on the basis of population. As proposed by the amendment in its draft form, a certain percentage of that amount would be reserved and awarded to the governing body of each federally-recognized tribe on a quarterly basis.

No matching payment would be required and a state or state agency could administer a program only at tribal request. If asked to do so, the draft amendment provides

## Census Figures a Must in Specific Health Plans

ROCKVILLE, MD.—In a May memo to all area directors, IHS Director Dr. Emery Johnson clarified the issue of population figures to be used in Tribal Specific Health Plans which has confused and irritated tribal health planners for months.

Dr. Johnson's directive provides little relief for those who had hoped the population figures established through their own experience could be substituted for those contained in the 1970 Census, figures widely-recognized as outdated.

As directed, tribes must use the 1970 census population data, as projected by the IHS, in their basic computations for their specific health plans.

However, added Dr. Johnson, "the tribes . . . may also develop a second set of computations based on tribal . . . population data, if properly justified."

All Tribal and Urban Specific Health Plans will, remaining intact, comprise a national plan to be presented for consideration by the Secretary of HEW in making his report to Congress at the end of Fiscal Year 1979. At that time, the Secretary is to review progress of the act and present a plan for its continuation, including recommendations for any additional authorizations.

The result of the IHS memo is that there will be two IHS National Plans forwarded to the Secretary, "one based on census data and one on tribal or urban data."

Another aspect of the memo, much more likely to be welcomed by tribal health planners, was its instructions to each area director to assure that both funds and technical assistance are available from his/her office to tribes and urban groups in developing their plans.

*Continued on Pg. 5*



*Continued from Pg. 4*

that a state agency administering child care, child custody, adoption, foster homes, child support or other social services, "will not defy, impair or fail to recognize jurisdiction of an Indian government or court."

Along with Arizona, in which tribes retain their own jurisdiction, state-tribal social service relationships were also studied in Mississippi and in Minnesota, a "280 state" in which, generally, the state holds jurisdiction on reservations. Workshops similar to the one here have been held in those two states and, according to Project Director Angela Russell, "there has been much support in general from the tribes."

Both the National Indian Health Board and the National Congress of American Indians have supported the concept of direct funding and such an amendment in resolution form.

The states, on the other hand, "would be supportive only if their social services budgets were not cut, but of course, this is politically impossible," says Russell adding that they would be likely to support a request for a separate authorization.

Regional workshops for Indian people within the remaining states will be held beginning sometime in early July and extend into early August. Tentative sites include Albuquerque, N.M.; Billings, MT.; Portland, Ore. and Atlanta, Ga.

At the workshop here, Lewis pointed out the need for continued tribal support as the amendment is developed and as finally introduced to Congress.

NTCA hopes to conclude its project by September and along with representatives from ITCA, has already raised the issue of direct tribal funding in testimony before the House Ways and Means Committee in late May on an amendment seeking to increase the overall Title XX ceiling.

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## Billings to Host Aging Conference

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BILLINGS, MT.—The Second National Indian Conference on Aging, sponsored by the National Indian Council on Aging, will be held at the Montana Convention Center, Holiday-Inn West here August 16-18.

About 2,500 participants from throughout the U.S. are expected to attend the session which aims to reach a "coordinated approach to the provision of effective and adequate health-related services needed by the American Indian elderly by combining input from the Indian community with that of service providers and representatives to the governing bodies of the national Indian community."

The conference agenda includes several workshops. Presently slated are those on Housing of the Indian Elderly, Alcoholism and the Indian Elderly, Spiritual Aspects of Aging, the Physical Well-Being and Mental Health of the Indian Elderly, Community Services for the Indian Elderly,

and Alternatives to Institutional Care for the Indian Aged.

Numerous speakers "with a demonstrated interest" in the total well-being of the Indian elderly have been invited to address conference participants.

Efforts are also underway to include a congressional hearing on the Indian elderly either through the Senate Special Committee on Aging or the House Select Committee on Aging. Resolutions will be accepted from Indian tribes, organizations or individuals regarding the conference focus of Physical Well-Being and Personal Environment.

Those who wish to attend are urged to pre-register. Tribes and organizations which have received letters asking for the name of a participant to be sponsored by NICOA are urged to return them without further delay. For additional information contact: Robyn York, NICOA, (505) 766-6520



*BOTH NIHB and the Billings Area Indian Health Service have pledged their support for the NICOA conference. Shown here with conference coordinator Robyn York (center) are John Belindo, NIHB executive director and Jim Smith, Billings Area IHS director.*



# Determination of IHS Bed Needs Due Soon

WASHINGTON, D.C.—A final resolution of the bed planning controversy which has delayed construction of replacement facilities in nine areas and a new hospital in Chinle, Ariz. where residents must now drive 75 to 100 miles to the nearest facility, was in the works here at press time.

At a joint hearing before the Senate Appropriations Subcommittee, the Department of Health, Education and Welfare (HEW) in attendance, IHS Director Dr. Emery Johnson was to present the latest, and what IHS officials are hopeful will be the final, revised version of the "IHS Acute Care Bed Need Methodology."

Previous versions of the methodology, which predicts the inpatient care bed needs of the American Indian and Alaska Native population in specific service areas, were deemed excessive in their projections by the GAO in findings reported in May at the request of the Subcommittee on Interior and Related Agencies, Senate Appropriations Committee.

GAO initiated its review of the IHS proposed construction program after consultation in late 1976 with staffs of the two Congressional appropriations subcommittees.

This February, the agency advised the IHS that it could not endorse their final bed planning methodology, because it failed to reflect the continued declining trend in the use of inpatient hospital facilities in most IHS areas. According to GAO findings, the IHS' proposed bed planning methodology was based on assumptions which were "questionable and contradict existing patient hospital utilization."

As explained by Joseph Hobbs of GAO at NIHB's spring board meeting in Portland, Ore., a GAO study of the situation on the Navajo reservation found "that the average daily patient load has steadily declined over the past 10 years." Such a trend is reflected throughout all IHS areas, he contended.

GAO does not question the need for new facilities, he stated, but rather the IHS projection of needs for the number of beds.

In light of such findings, IHS was ordered to revise its methodology and has done so a number of times, all unsuccessful in winning GAO concurrence up to this point. At the behest of the Senate appropriations subcommittee, a meeting was held June 14 with the three parties involved (IHS, GAO and HEW). At that time, according to Jim Neifert, Title III Project Manager for IHS, the agencies were directed to resolve their differences or be prepared to accept the subcommittee doing so for them.

Since that meeting, IHS has secured the concurrence of Assistant Secretary for Health, Dr. Julius Richmond with its latest methodology.

In its Executive Summary of the newest revision, IHS states that "... the facilities to be built using this methodology would fulfill the anticipated need of the Indian population ... while at the same time being consistent with

the Administration's recognition of a national excess of hospital beds and the plan for reduction in beds."

A total of 462 beds are projected, providing 67 and 395 beds for the new and replacement facilities, respectively. (The nine replacement facilities currently have 362 beds.)

The 10 facilities are planned to provide expanded services for alcoholism detoxification and for acute mental illness and to care for a population in 1985 which will be 22 per cent larger and will be older in age distribution. "Thus," contends the IHS summary, "the need to increase the total bed supply by 100 beds is well justified."

The summary points out that considering the new and nine replacement hospitals to be constructed, "all ... would meet the national health planning guideline of less than 3.7 beds per 1,000 population or 80 per cent occupancy or higher." How such an argument will sit with the GAO remains to be seen.

Meanwhile, construction authorized for this fiscal year remains frozen and the Congress refuses to appropriate any additional money for next year until the number of beds needed is finally agreed upon.

(Immediately before time of publication, NIHB learned that substantial progress was made during the June 22 meeting and a tentative "go-ahead" was reached on construction of several hospitals.)

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the bill "drew much fire from the Office of Management and Budget and conservative congressional elements," according to congressional sources. Proponents concede that deletion of a specific figure is probably necessary to secure adoption of the bill at all and the \$26 million was eliminated from the document prepared for consideration by the House Committee on June 21.

Authorization for programs such as those proposed by the law is available under the Snyder Act, say supportive congressional staff who are hopeful that funds will later be appropriated.

Support in the House was termed "good" by Special Counsel on Indian Affairs to the House Interior and Insular Affairs Committee. But both the Department of Health, Education and Welfare and the Bureau of Indian Affairs have opposed the legislation on the basis that the Carter administration has its own proposal for foster and adoptive care generally. They maintain that the Indian proposal should be incorporated into the Carter measure.

And so, according to another committee staff member, demonstration of tribal support to their individual congressional delegations remains crucial and tribal members, groups and organizations are urged to write or call their congressmen urging their support shortly before the legislation is introduced on the House floor.



Continued from pg. 1

In fact, "IHS tried to do away with Indian preference when they testified for this bill," he claims. (A charge flatly denied by IHS.) "They tried to put in as many exceptions to Indian preference as possible" in an attempt to return to their previous stance regarding Indian preference, adds Funke.

(Behind-the-scenes consultation between the congressional committee staffs resulted in some very specific exceptions to the absolute Indian preference policy.)

Another argument espoused in favor the bill claims that early retirement of non-Indians would allow promotion for Indian people. As reported by the *American Indian Journal* last year, however, "studies indicate, that relatively few large-scale increases in the number of Indian people or promotions will occur with the passage. . ."

Specifically, the proposed legislation would make a non-Indian employe with 25 years service or one 50 years of age with 20 years service eligible to retire.

In the event that such a person's departure would jeopardize "essential services to Indian people" or the "essential interests of the United States," either the Secretary of Interior or Health, Education and Welfare would be authorized to postpone the person's retirement, for not more than 12 months at a time or up to a total of five years. In order to do this, however, the employe must consent.

In formation of a clear statement of the Indian preference policy deemed necessary for the bill, several exceptions were formulated.

Three of these involve transfer situations. If the health or safety of a non-Indian employe or a member of his/her household required a move, a transfer would be allowed but only to a position at the same or a lower grade.

To avoid displacing an Indian person lower on the BIA or IHS retention scale during a reduction in force, a non-Indian employe could be reassigned.

And in the event that a non-Indian employe's relationship with the tribal people in his or her area so deteriorated that effective services could not be provided, a transfer would also be allowed.

One additional exception, which may be welcomed by those tribes who have claimed they are overrestricted by the absolute Indian preference policy, allows for the waiver of Indian preference when the tribes involved so request. This exception would allow a tribe to delegate its authority for such a decision to an appropriate tribal agency in a given instance. For example, if an Indian-controlled school board preferred that a specific non-Indian be hired as principal of a reservation school, the tribe could delegate its authority in this particular matter to the school board, and the board, in turn, to the BIA.

However, as stringently specified in the proposed legislation, with a job position concerning more than one tribe, every one of them must consent to the waiver. For instance,



KENT C. WARE II, Director of Indian Public Affairs, Gulf Oil Corp., Denver, Colo. presents a \$500 contribution to NIHB Chairman Howard E. Tommie to help defray expenses for the Second National Indian/Alaska Native Health Conference, which took place February 13-15.

if a tribe within an Indian Health Service area wished to see a particular non-Indian hired as area director, not only a majority, but all other tribes within that area must agree to the waiver.

## Boards Cooperate in Planning Effort

BISMARCK, N.D.—The sharing of ideas was the outstanding feature of the reservation health planning workshop cosponsored by the Four State Indian Health Board and the Billings Area Indian Health Board. The workshop was held here June 14-16 with over 150 people attending from 20 reservations in North and South Dakota, Nebraska, Iowa and Montana. Workshops on specific health areas such as Emergency Medical Technician programs, an alcoholism drug dependence unit, material child health programs, aging, community mental health and so forth heard from speakers from outstanding area health programs. In addition, small group sessions provided a ready exchange of ideas and information.

Governor Arthur Link of North Dakota and Mayor Eugene Leary of Bismarck opened the session. Keynote addresses were delivered by Dr. Rice Leach, Director, Aberdeen Area Indian Health Service and Jim Smith, Director, Billings Area IHS. Dr. Leach challenged the group to ask themselves how they could work together to make the most of what they had. He stressed the importance of naming priorities and trying to achieve them. Jim Smith commended the workshop on its cooperative spirit and efforts to further sharing of program ideas and functions.

Other topics covered at the workshop included reservation health planning background and techniques, urban health planning and techniques, development of health plans, and the IHS budget process. A full day of the workshop was devoted to small group workshops and planning exercises.



# TRAIS Developer Just NIHB Hears CAD Resp

PORTLAND, ORE.—Members of the National Indian Health Board met for three rainy days here at the end of April, spending one of them in session with the IHS Council of Area Directors (CAD).

On numerous past occasions board members have criticized the expenditure of Indian Self Determination (P.L. 93-638) funds for operation of the Tribal Resource and Assistance Information System (TRAIS) being developed by the Indian Health Service. On April 25 (the first day of their session) NIHB members had a chance to meet the man in charge of TRAIS and as could be expected, repeatedly challenged him to justify the 638 expenditure for TRAIS as opposed to delivery of direct health services.

### **'IHS No Longer Had a Choice'**

Jack Knight, Director of the Tribal Management Support System at IHS' Office of Research and Development (ORD), says that IHS no longer had a choice about instituting the system which will monitor contracts and grants awarded under 93-638. He said there is presently no system for keeping track of the contracts and grants and "Congress won't be particularly happy about pouring more money in because we don't know what's happening with the money awarded now."

He stressed that TRAIS, which will cost \$2 million to set up and \$200,000 to operate each year thereafter, is "not just an IHS system to monitor tribes."

TRAIS is a word processing system which will operate through the use of cathode ray tubes with information

shared and exchanged via telephone and computer.

### **TRAIS Operating by September**

It should be operating by September and ORD is considering training between six and eight tribes to use TRAIS within the next year, said Knight. Already the Senecas and San Carlos Apaches have indicated an interest and Knight says thereafter interested tribes would be brought into the system as fast as possible.

Also being funded with 93-638 money is the Project Officer Training program being conducted by Knight's office. IHS is trying to train 200 of its estimated 400 project officers needing training before September. The training is designed "to get them to better discharge their duties," explained Knight. Next year, the remainder of the project officers will be trained and the following year, he said, the training will be fully available to tribal project directors and managers.

Meeting jointly with the IHS Council of Area Directors two days later, NIHB members heard from Dr. Emery Johnson (see separate article) and from those area directors or others within IHS involved with certain matters of common interest dealt with in resolutions adopted at the Second National Indian/Alaska Native Health Conference.

One resolution which grew out of probably the most controversial discussion at the conference requires IHS to provide culturally sensitive Indian counselors for women considering sterilizations or abortions and demanding that IHS immediately initiate an investigation of alleged abortions and

*CHAIRMAN Arthur Bensell of the Siletz Tribe, tells of the Siletz' plans now that their future has been brightened by regaining federal recognition. Bensell spoke during an NIHB visit to the Northwest Portland Area Indian Health Board April 26.*





# ifies \$2 Million Program; ponses to Resolutions

sterilizations being performed by IHS personnel without the informed consent of the patients involved.

Dr. James Felsen, Deputy Director of IHS' Division of Program Operations, told those present that while IHS endorses the majority of the resolution it objects to a statement that the GAO report found serious problems within IHS sterilization and abortion counseling procedures.

IHS has received no allegations of abuse, said Felsen, but added that it is IHS policy to investigate if such an event were to occur.

Both Indian and non-Indian counselors are employed at most IHS facilities now but counseling procedures will be strengthened, he said. But, he added, there may be some objection to the exact type of counselors suggested by the resolution: "there may be some objections to local Indian people as counselors because tribal people don't want to confide deeply personal matters to another member of their own communities."

Felsen also responded to the conference resolution requesting NIHB to continue to work with the National Commission for the Protection of Human Subjects and that IHS institute a moratorium upon any form of medical experimentation involving Indian subjects. Current IHS research involves such areas as otitis media, dental work and mental health all requiring stringent measures for the protection of human subjects, he explained.

He maintained that IHS has long cooperated with the commission and has observed its guidelines into IHS research and asked that the board reconsider its moratorium request.

A concern facing "all of us in Indian communities" according to Navajo Area Director Dr. Marlene Haffner, is that of health needs of the Indian elderly. Dr. Haffner spoke of the work of the CAD committee she chairs on long term care in response to a resolution seeking advocacy for the health needs of the Indian elderly by NIHB and all levels of IHS.

The CAD Long Term Care Committee (one of several CAD committees which propose IHS policy) recommended several important policies regarding long term care in a report to Dr. Johnson in January. These have since been essentially approved by him, reported Dr. Haffner.

They are: IHS will conjointly with tribes develop planning methodologies in all areas of long term care; because of the availability of alternative (EDA) funding at the present time, and because of the overwhelming need in acute health care areas, IHS should not build long term care facilities; the Bureau of Indian Affairs and IHS must agree on national level definitions of terms regarding care needed; BIA and IHS must jointly agree on the responsibilities of each agency in regard to levels of care, and money should be sought by IHS to increase capabilities in such areas as home health care, thus lessening the need for more expensive custodial or skilled care.

Another area director, Jim Meredith of USET, spoke to the resolution requesting support of Indian enrollment into a medicine program and Master of Public Health Degree program. Although the CAD supports efforts such as INMED and the Berkeley MPH programs in concept, Meredith told those in attendance that regrettably the area directors, "cannot afford to appropriate any funds for their support since money is currently inadequate for even urgent health delivery needs."

## 'A good bit more accountability'

IHS Director Dr. Emery Johnson himself addressed two resolutions, one requiring IHS to engage in more effective and consistent contracting and grant procedures. DHEW Secretary Califano has expressed great concern over contracts and grants awarded by the department, said Dr. Johnson and making indirect reference to TRAIS added, "there will have to be a good bit more accountability with how the money is spent once awarded."

The other resolution answered by Dr. Johnson requested Congress to make supplemental appropriations to Contract Medical Care programs. In testimony before Congressional appropriations committees, said Dr. Johnson, IHS requested \$6.9 million in supplemental appropriations for contract care for FY 79. He said he had no predictions about the outcome but is "not highly hopeful based on Congress' distinterest in supplemental awards this year."

NIHB members adopted several new resolutions at one of their regular business sessions later in the day. Winning NIHB's support were resolutions to the following effects:

- Support for a non-recurring cost appropriation request for the Southern Cheyenne-Arapahoe Tribes
- Opposing the moratorium on IHS hospital bed construction and calling for a joint meeting of GAO, IHS and NIHB to resolve critical differences in bed planning methodology
- Support for the Second National Indian Conference on Aging and the continuing efforts of the National Indian Council on Aging (NICOA)
- Support for a \$15 million supplemental appropriation to the Northwest Portland Area Indian Health Board for unmet contract health care needs.

An update on the status of the Indian Food Resource Center was presented by Bernice Williams, local member of the Indian Advisory Board to USDA. NIHB Chairman Howard Tommie had signed the proposal to adopt IFRC into the NIHB organization the previous week, she reported. Once funding from the Community Services Administration is received for the new center (still pending at press time) it will assist tribes in setting up their own food stamp and commodity distribution programs as provided for in the Farm Act, she explained.

*Continued on Pg. 11*



# IHS Active in Legislative Inter-Agency Health Efforts



*DIRECTOR Emery Johnson responded to questions concerning IHS' stance respecting P.L. 93-638 as reported in the GAO report by saying, "... If the government were pressed to initiate 638 we would be doing what a number of tribal leaders have accused 638 of being — termination by contract." Here he chats with USET Area Director Jim Meredith.*

PORTLAND, ORE.—Often a target in the past for criticism for failure to cooperate with fellow federal agencies exerting some influence on Indian affairs, the IHS appears to be making at least some positive strides in this direction.

Evidence of this was given in several statements made by Dr. Emery Johnson, Director of the IHS, in a presentation to the NIHB and the IHS Council of Area Directors here April 27.

Dr. Johnson spoke of joint initiatives being undertaken by the Public Health Service, Bureau of Health Manpower and the Health Services Administration to enable tribes to be treated in a manner similar to states in application for grants under the Health Services Administration. With Dr. George Lythcott, head of the HSA, having already given his approval, such a set-up would, according to Dr. Johnson, "allow tribes to participate in programs they were formerly largely excluded from." He said the first test of this will take place with family planning on the Navajo reservation where the tribe is to identify a single entity to handle the entire family planning program now under three separate agencies.

And Dr. Johnson reported that IHS is working with the Bureau of Indian Affairs on "some major policy issues," one of them being funding for tribal nursing homes. The two agencies are also working with the Bureau of Census on concerns regarding up-to-date population figures.

Higher up in the health echelons, DHEW Secretary Joseph Califano has established "New Initiatives on Indian Affairs" based on recommendations of the Interdepartmental Council on Indian Affairs. As a result, said Dr. Johnson, by September every operating component of the department will be required to submit a program for improving its responsiveness to its Indian constituents.

Dr. Johnson also briefed the gathering on IHS involvement with legislative happenings in the Washington arena. He spoke of his own testimony before Congressional appropriations committees requesting IHS funds for FY 1979. His testimony further requested legislative language to transfer authority to IHS for expenditure of money collected

94-437. The latter was contained in President Carter's budget as well.

As the full impact of the National Health Planning and Resources Development Act (P.L. 93-641) on Indian tribes remains unclear, IHS has been making efforts to minimize the authority of Health Systems Agencies for reservation areas. Dr. Johnson told the group that his agency has been working with the health committees chaired by Representative Paul Rogers and Senator Edward Kennedy to try to assure that language will be included within the amended version of the act providing for Tribal Specific Health Plans as the official health plans for reservation areas.

He also spoke of a bill (S. 2518) introduced by Senator Bellmon of Oklahoma which would require Indian representation on local and state level 641 bodies and the Director of IHS to serve as a member of the National Health Coordinating Council.

Speaking of a long-awaited Administration proposal on National Health Insurance, Dr. Johnson said that President Carter has promised to submit by early August a proposal to Congress for discussion during the election period. He added that "it is clear that no NHI legislation will be passed this congressional session and may still be a year or two away."

(Dr. Johnson's predictions have since borne out for, according to more recent reports, although the President had promised to send an NHI bill to Congress this fall, he now intends to wait until next year. He will hold to the spirit of his promise soon by announcing his insurance plan's "principles" and providing Congress with a "discussion outline" on the subject.)

## GAO Finds IHS Lacking on 638

PORTLAND, ORE.—A March 1978 GAO report has cited the Indian Health Service with making no progress in elimi-

*Continued on Pg. 11*



*Continued from Pg. 10*

nating tribal fears of P.L. 93-638 or in helping tribes to make informed decisions about contracting under the law.

An explanation of the reasons behind such findings was given by GAO officials to members of the National Indian Health Board at their meeting here April 25. (See separate article on a second GAO study of IHS in relation to bed planning methodology.)

Initiated at the request of congressional committees, the investigation looked into the activities of both the Bureau of Indian Affairs and IHS since the law took effect. It found in essence that "federal dominance over the Indian programs and services of the Bureau of Indian Affairs and the Indian Health Service has changed little since the enactment two years ago of the Indian Self-Determination and Education Assistance Act. . ."

Bob Farabaugh, Assistant Director of GAO's Human Resources Division, told the gathering here that the report, based on study of five tribes and areas, found very little shift in control of tribal programs and no reduction in federal employment in any of the contracts selected for study.

He named several obstacles to 638 implementation, including some cited by Federal officials as inhibiting to their activities. Inadequate funds and/or staff, the fear that contracting will lead to termination, lack of knowledge by tribes of what can be contracted, tribal lack of technical and administrative skills, and tribal rejection of what they perceive as accountability to BIA and IHS were among them.

Although, the GAO's report seems to reflect negatively on IHS, according to Director Dr. Emery Johnson in a presentation made here April 26, there are sound reasons for the way it has proceeded.

Said Dr. Johnson, "... GAO is somewhat unclear on the purpose of 638. 638 is to be initiated by tribal governments, not the federal government. If the government pressed to initiate 638 we would be doing what a number of tribal leaders have accused 638 of being, termination by contract."

GAO says it recognizes that the Bureau and IHS could violate the concept of self-determination by pushing tribes into contracting for programs which they are not ready for or do not want. However, in its view, the act "allows the agencies to encourage and assist the tribes toward con-

tacting . . . without violating the concept."

There is room for federal agencies to take time to give tribes a better understanding of the law, argued Farabaugh. Presently, he contended, "training concentrates on processing a piece of paper to acquire a contract rather than helping tribes identify which programs or program segments they might contract for."

Congress, said Farabaugh, was receptive to GAO's report and plans to monitor the progress of BIA and IHS regarding 638 over the next year.

## TRAIS . . . .

*Continued from Pg. 9*

In further board business, several representatives reported on recent activities within their areas. Each of the area boards has been active of late in trying to secure increased health services for Indian people in their areas, and reportedly almost all of them testified for additional appropriations before congressional health subcommittees the week prior to the meeting here.

### Dedication of Two Hospitals

Albuquerque Area representative George Platero noted the May 20 dedication of the Acoma-Laguna-Canoncito Hospital and dedication of the Santa Fe Hospital May 21.

In the Billings Area, reported Ada White, new clinics have recently been constructed for the Rocky Boy Reservation, Northern Cheyenne and Ft. Peck.

Not all areas are as fortunate and Violet Hillaire, representing the Portland Area said that there continues to be great concern over the lack of a referral hospital for Indian people in this region.

On a more positive note, the Portland Area hopes to set a precedent by contracting for local hospital beds, an idea supported by local Health Systems Agencies and has also established a catastrophic fund for emergency needs.

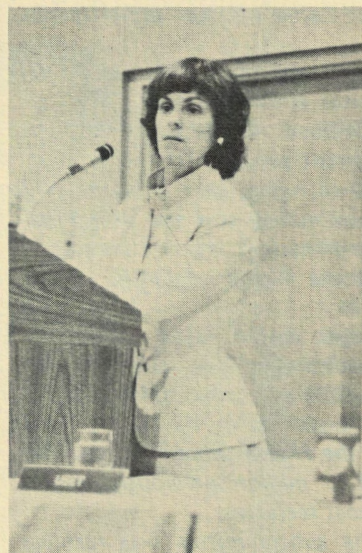
Alaska Area representative Ethel Gonzales reported that the Alaska Native Health Board would soon meet with the other native organizations in that state in order to develop a united stance.

Alaska continues to be plagued, perhaps to an unequalled degree, by 638 contracting difficulties due to what Gonzales termed "the staggering number of tribal governing bodies."

*Continued on Pg. 14*



*ROGER JIM, President of the Affiliated Tribes of the Northwest, welcomes NIHB meeting participants to the Northwest, an area which he said "in recent years has become organized for health."*



*THE ISSUE of long-term care for the elderly "is one facing all of us in Indian communities," Dr. Marlene Haffner told NIHB members April 27. Dr. Haffner is area director for the Navajo area IHS and chairperson of the CAD Long Term Care Committee.*



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## Health Planners Sought

The American Health Planning Association maintains a DHEW sponsored contract to provide resumes to health planning agencies throughout the United States. Currently, there is an urgency for individuals with expertise in health data management, economics, the planning process, resource development and others. People with knowledge and experience in preparing plans, in implementing plans, in project review, or in financial analysis are strongly encouraged to apply. There is no fee or charge for utilizing the Recruitment, Employment and Referral Service (RERS). Applications from minorities are especially welcome. For further information and application forms contact, Robert Davis, RERS Director, AHPA-RERS, 2560 Huntington Avenue, Suite 305, Alexandria, Virginia 22303. Phone (703) 960-4990.

# Guaranteed Benefit Package Proposed for IHS Patients

IHS officials here seemed thankful but less than overjoyed with the first go-round of congressional markups of their budget for the coming fiscal year. "They restored what the President took out but it's nothing like last year," was the description given by Sol Orden, IHS Financial Management Branch Chief, of the figures slated by the House Interior Subcommittee on Appropriations.

On June 1, members of the House Subcommittee saw fit to restore the current levels of funding plus an allowance for cost increases in four areas of the IHS program which suffered major cuts in President Carter's budget submitted to Congress in January.

Largest among these, was the return of some \$6.8 million for Indian Health Manpower activities under Title I of the Indian Health Care Improvement Act (P.L. 94-437). In addition to continuing the current program of recruitment, preparatory and professional scholarships, externs, and continuing education allowances, money was also designated for the support of two Native American training programs: INMED in North Dakota and the Master of Public Health Program at Berkeley.

While the President's budget would delete money for Title V of P.L. 94-437, discontinuing new urban Indian health projects started in FY 1978 and reducing funding for urban Indian health projects expanded in FY 1978, some \$3.7 million was restored by the House subcommittee. The slight increase above the \$3.25 million previously appropriated once again allows for cost increases.

One area with which the subcommittee was far less generous was that of facilities under Title III of 437. It

added \$600,000 for sanitation facilities and special projects to the President's proposed allocation of \$70 million, still well below the \$84 million allocated in the current fiscal year. Any further funding action pends approval of the IHS bed planning methodology which has been disputed by the General Accounting Office and which continues to delay construction of new hospitals provided for under present appropriations.

Apart from the 437 allowances, the subcommittee also restored to their current levels, the IHS Community Development program and implementation funds for P.L. 93-638: the Indian Self-Determination and Education Assistance Act. Among other items, the latter includes funds for technical assistance and tribal leadership training. Taking cost increases into account, the subcommittee designated some \$3.2 million for community development and another \$3.2 million for 93-638 programs.

Overall the subcommittee increased the President's budget for IHS by a total of 491 positions and \$17.8 million. The figures for 437 are well below authorized levels and IHS officials are hopeful that the Senate appropriations committee may be more generous in its markup expected to come towards the end of July. According to Orden, a conference between the Senate and House appropriations committees is likely soon afterwards and it will probably be August before the actual appropriations are signed by the President.

Continued on Pg. 13



*Continued from Pg. 12*

WASHINGTON, D.C.—“The Indian people are sorely disappointed, angered and feel betrayed by the Administration’s proposed budget for Indian health programs.” So spokespersons from five national Indian organizations told members of congressional appropriations committees here at the end of April.

The representatives decried President Carter’s request for \$65.5 million in FY 1979, nearly \$130 million less than the amount authorized under the Indian Health Care Improvement Act (P.L. 94-437). The reduction would effectively eliminate Indian Health Manpower activities, discontinue new urban Indian health projects started in FY 1978, and reduce funding of urban Indian health projects expanded in FY 1978.

Indian people packing the hearing room of the Senate Subcommittee on Interior on April 17 and the House Subcommittee on Interior and Related Agencies on April 20 heard the organizations’ spokespeople “ask simply that Congress keep the commitment it made in that Act (P.L. 94-437) by fully funding the appropriations authorized for basic health services to Indians.”

For, they testified, “the proposed budget, if adopted, will increase the backlog and will cause Indian people to fall

## PROGRAM ANALYST II JOINS NIHB STAFF

DENVER, COLO.—Recently joining NIHB’s central office staff is Rick Nordwall, 25, a Pawnee/Chippewa/Cherokee from Pawnee, Okla. A graduate of Harvard University with a Bachelor’s Degree in Political Science, Nordwall will work in cooperation with NIHB’s present program analyst, Howard Bad Hand.

Nordwall’s responsibilities will include gathering, disseminating, and analyzing health information and legislation, and providing technical assistance regarding the same to Indian tribes and organizations. Meanwhile, Bad Hand will focus his activities specifically in the areas of National Health Insurance and the National Health Planning and Resources Development Act (P.L. 93-641).

Nordwall says he “enjoys working with legislation” and sees it as one of the best ways to effect change. He completed two years of law training at Denver University and has worked as a law clerk for both the Regional Solicitor’s Office here and for the Native American Rights Fund in Boulder, Colo. He also served as an intern for the Quinalt Tribe under the American Indian Lawyer Training Program in the summer of 1976.

A graduate of Muskogee Central High School in Muskogee, Okla., Nordwall helped found the Indian student organization at Harvard.



**NORDWALL**

even further behind the rest of the country in terms of their health status.”

This marked the second consecutive year in which spokespersons for the National Indian Health Board, the National Tribal Chairmen’s Association, the National Congress of American Indians and the American Indian Health Care Association gave joint testimony for full funding of the Indian Health Care Improvement Act. Also joining them this year was the National Indian Board on Alcoholism and Drug Abuse.

Along with requesting authorized levels of funding for the coming year, looking beyond that, the witnesses said they also recognize “that improvement in Indian health programs requires more than just additional funding.” They asserted that also needed are improved methods for identifying funding needs and for allocating funds appropriated so that “the limited money available is used in the best manner possible.”

Several possible changes in the budgeting, appropriation and allocation system were outlined. Pivotal among these was a request that the Administration institute a guaranteed benefit package approach for funding of the basic health care services provided by IHS, beginning with next year’s appropriations cycle.

In justification, the spokespeople asserted, “This Congress has already acknowledged the right of Indian people to basic health services and we do not understand why it is necessary to come in year after year and argue for sufficient funding for in-patient care, out-patient care and contract health care.”

The committees were also asked to consider three additional changes in the appropriation system. First, it was suggested that “certain changes in the 638 appropriations process would engage a closer working relationship between IHS and the Indian people.”

“Every tribe, no matter how small,” would be enabled to “establish an effective and independent health agency,” suggested those testifying, if IHS were required to allocate 638 grants to tribes on a formula rather than a discretionary basis.

The subcommittee members were told of concern by tribal leaders that IHS is “siphoning off” P.L. 93-638 funds for non-self-determination purposes and were urged to require IHS to spell out in greater detail how these funds will be used when submitting its budget request.

Secondly, it was requested that IHS be exempted from all position ceiling requirements. “We believe that a program involved in the direct delivery of health care is one of the most appropriate agencies for elimination of the ceiling,” testified the Indian spokespeople.

And lastly, the committee members were reminded that the President has proposed that Federal agencies be authorized to make incentive payments to effective managers, as one means of increasing productivity within the Federal government.

It was explained that a major problem encountered by Indian people in IHS is providing adequate incentives to keep physicians and other health professionals committed to their work. Since IHS doctors are on an annual salary, they pointed out, the usual financial incentives that motivate private physicians are not available.

Physician motivation problems within IHS might be partially overcome if the incentive payment system were applied for those who provide good and sensitive care to Indian people, it was finally suggested.



# Health Conference II...Continued

The Second National Indian/Alaska Native Health Conference sponsored by the National Indian Health Board was held February 13-15, 1978 in Albuquerque, N.M. In addition to the coverage which appeared in the last edition of the *NIHB Health Reporter*, reprinted, with permission, below are newspaper accounts of two of the concurrent workshop sessions held on the final day of the conference.

A transcript of all general assembly sessions and summaries of each of the concurrent workshops will be included in the conference proceedings (currently under preparation) to be made available to conference registrants upon its publication.

## Resolution Calls for Long-Term Funding

By J. W. Schomisch, *Gallup Independent*

ALBUQUERQUE, N.M.—A resolution asking Congress to provide long-term funding for an American Indian School of Medicine (AISOM) was approved unanimously Wednesday by delegates to the Second National Indian/Alaska Native Health Conference held here this week.

During a Wednesday morning workshop, Dr. Taylor McKenzie, president of the proposed school, said long-term federal funding was the only roadblock standing in the way of the establishment of an Indian school of medicine. Costs for the school are estimated to be between \$6 and \$15 million for construction and approximately \$18 million for operations until the school is fully-operational.

Financial projections estimate it will cost \$5.5 million to operate the school in 1986-87 with 255 students contributing \$2 million in tuition. All but \$100,000 would be from federal sources.

Dr. McKenzie said the Liaison Committee on Medical Education (LCME), which accredits medical schools, listed 14 requirements which must be met before being accredited. All of the requirements can be met, he said, except assurance of at least 20 years of financial support.

"LCME must have assurances of long-term funding to make sure the school will not fold up on the students," McKenzie said. "At our last meeting with them they told us not to come back until there is long-term funding."

Dr. Jasper McPhail, Dean of the American Indian School of Medicine, said he was "90 per cent sure Congress will approve long-terms funding but then I'm a perpetual optimist."

Dr. George Blue Spruce, with the Indian Health Service, who was part of an AISOM study group warned, "Congress is not looking favorably and is less likely to fund things which are separate and apart or something special."

"Congress will ask what's so different about Indians that they need their own medical school?" he said.

Dr. McPhail said "while most Indian students do very well academically, the ones who drop out do so mostly for non-academic or social and cultural reasons which the American Indian Medical School would be sensitive to."

"It is difficult to come back after 11 to 13 years absence from the reservation," said Mike Lincoln, the executive director of the Navajo Health Authority. "We have to look at how to bring the students back to their original areas in a positive way after they are doctors," he said.

The school would sponsor a summer work experience program where students would work with "ideally Indian health professionals in an Indian community," he said. AISOM residencies would be at Indian hospitals in the students' home area "to keep up contact between the Indian medical students and Indian patients and people."

The school will also recognize native healing services. "The utilization of native healing is resurgent," he said. "We want to make sure there are not confrontations between our students and native healing."

"The ideal would be to bring the two together in a good working relationship which would be a great deal of help to Indian peoples," he said.

Workshop participants said a feasibility study of the proposed school had been completed in August of 1977 and has since been tied up in review by the Department of Health, Education and Welfare.

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### TRAIS . . . .

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*Continued from Pg. 11*

In the Tucson Area, where 638 contracting may be proceeding a bit more smoothly, all 10 service programs administered by the Papago Tribe were recently converted to 638 contracts, reported representative Irene Wallace.

Forerunners in development of good relationships under a law which continues to confuse many tribes in other areas, the Papagos are continuing their participation in the P.L. 93-641 model project in Arizona under the Intertribal Council of Arizona.

The Papago Executive Health staff has also been successful in "getting down to solving some of the internal problems" of their hospital by holding monthly joint planning sessions.

Meanwhile, the neighboring Phoenix Area is still trying to get an IHS area director on board, reported Perry Sundust.

Charles McGeschick, Bemidjii Area alternate, told NIHB members that the tribes in Minnesota, Iowa and Michigan have yet to replace the tri-state health board disbanded in 1974.

And finally, the Aberdeen Area continues its busy schedule of meetings and training for tribal health employees and planners under the new chairmanship of Clare St. Arnaud, Health Planner for the Santee Sioux Tribe of Nebraska and Andrea Fastwolf, Executive Director for the Four State Indian Health Board.

Fastwolf told of plans for an allied health workers conference for the Aberdeen Area and for a joint health planning workshop with the Billings area Indian Health Board scheduled for June in Bismarck, N.D.

The next NIHB meeting will be held July 25-27 in Rhinelander, Wisc. with a special board meeting to be held in conjunction with the Second National Indian Conference on Aging in Billings, Mont. August 16-18 to follow.



# IHS Officials Put on Firing Line Over Counseling Procedures

By Evelina Zuni, *Pueblo News*

The Indian Health Service was put on the firing line by a woman-dominated audience in sometimes emotional exchanges of opinion over sterilization and abortion at the recent National Indian Health Conference at the Albuquerque Convention Center.

While the issue of abortion has been frequently bantered at Congressional levels over HEW funding and, as of yet, has not impacted IHS policy on the procedure, sterilization reached a dramatic peak last year when a governmental report revealed several thousand IHS-authorized sterilization operations of Indian men and women.

Release of that report prompted many tribal leaders to charge IHS with "bureaucratic genocide" of the Indian people.

IHS officials were able to put the report into better perspective during a panel discussion at the conference but not without sharp criticism of its counseling procedures that are supposed to enlighten patients about the effects of both abortion and sterilization operations.

Dr. Jock Pribnow, an IHS physician from Salem, Ore., told the group that IHS policy regarding abortion, to date, is unaffected by Congressional restrictions on the use of HEW state welfare funds for abortions. That is, IHS, even though under HEW, receives its monies through the Department of the Interior and is able to provide abortions for eligible Indian patients who go through normal IHS procedures.

## Questions Counseling.

Panel member Patty Marks, representing the Senate Select Committee on Indian Affairs, questioned IHS counseling and consent procedures for abortions.

Pribnow said IHS has "no set standard procedures" on counseling and described procedures some IHS units proscribe, but added, "I hate to see more regulations. You have to be flexible about different situations."

"If a woman desires an abortion, and it's medically all right, it's up to her," he said.

Marks said, "A lot of people are quick to scream genocide. But it's something that does not have to be planned to do it. It seems there is a real need to get counseling procedures together across the board."

Of a report prepared by the General Accounting Office in 1976 on permanent sterilization of Indians, Marks said Sen. James Abourezk (D-S.D.), who requested the study, never took a position against sterilization or abortion.

"We received complaints from Indian persons who didn't understand the full ramifications of sterilization, that the operation couldn't be reversed," she said. "Could they be substantiated?" he asked."

For the record, the report said from 1973 to 1976, IHS authorized 3,406 sterilization procedures for female Indians in the Aberdeen, Albuquerque, Oklahoma City and Phoenix areas. Of those, 3,001 were performed on women of child-bearing age (15-44). It also said that while consent forms were found for the sterilization procedures reviewed, area offices "were generally not in compliance with the Indian Health Service Regulations."

## Forms in Non-Compliance

The most widely used consent form, the report said, did not indicate that the elements of the consent were presented orally to patients, that they did not contain a statement at the top of the form notifying patients they could withdraw their consent.

One audience member said he personally knew of 56 Indian men and women who were sterilized without fully realizing the consequences. Another man claimed he had "three daughters under 30 who for no reason are sterilized today."

A man from the Washington state area said 50 per cent of the women of child-bearing age in one tribe "can have no more children."

*Continued on Pg. 16*

*LEADING the discussion on the hotly debated issue of IHS sterilizations and abortions are Patty Marks, Professional Staff Member of the U.S. Senate Select Committee on Indian Affairs, Violet Hillaire of the Northwest Portland Area Indian Health Board and Jock Pribnow, M.D.*



Photo courtesy of the Papago Runner.



*Continued from Pg. 15*

One young lady, near tears, said she knew of "infants today who are getting sterilized in public health hospitals who don't find out about it until later in their lives. It's been happening since 1932."

Another woman said she knew of a lady who went to IHS for an abortion and was released from the hospital sterile.

Pribnow said allegations that infants were being sterilized in public health hospitals must be based on "misinformation because IHS does not do that." He also said IHS never permits abortions to result in sterilization.

The breakdown in communication between IHS and Indian patients can be, in large part, attributed to language barriers, the panel observed. It was noted that some medical terminology does not have an equivalent in certain Indian tongues, and the need for Indian counselors was raised by panel members.

Jim West, an Indian medical student for three years, said Indian tribes are involved in health policies that "we've little control over."

Bessie Allen, a Navajo counselor, said, "We're all saying that IHS doesn't tell the woman what she's going through. I do a lot of sex education things with CHR's. From my standpoint I've found even middle age women who never knew where their babies came from. Then some of the men don't even consider what happened to a woman when she had a child. This is where the basic problems are at. They're at the grass roots level."

Dr. Jim Felsen, deputy director for IHS Division of Program Operations in Washington, D.C., who did much of the research for the GAO report, said IHS has taken a number of steps to ensure that patients desiring sterilization are properly oriented about the consequences.

He said HEW has proposed several changes to present IHS sterilization policy. One stipulation would prohibit anyone under 21, no matter what reason, from undergoing a sterilization operation.

Another stipulation is that there be a 30-day waiting period before IHS provides a sterilization operation.

The new regulations would also provide that hysterectomies can never be done as a sterilization, and physicians must now sign consent forms.

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

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EDITOR: L. Joy Bossert

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