



THE SECOND NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE

Convened by the National Indian Health Board

Albuquerque, N.M.

February 13-15, 1978

Our painting on the front cover, "Chippewa Wild Rice Harvest," is the work of Carl Gawboy, Chippewa artist from Minnesota.

Our special thanks to Melvin McKenzie, Navajo Division of Education, and Stan Throessel of the *Papago Runner* for their photographic contributions and to Corrine Deal and Patti Manus for their endless hours of typing and other clerical help.

"INDIAN HEALTH IN AMERICA '78"

PROCEEDINGS OF THE SECOND NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE

Convened by the
NATIONAL INDIAN HEALTH BOARD

Albuquerque Convention Center
Albuquerque, N.M.

February 13-15, 1978

This report was prepared by L. Joy Bossert and John P. O'Connor

FOREWORD

The Second National Indian/Alaska Native Health Conference held February 13-15 in Albuquerque, New Mexico, was the second conference at a national level to deal solely with the health needs of Native Americans. The first such conference was held in Palm Springs, California in the summer of 1976.

Since the time of the 1976 conference, the status of American Indian and Alaska Native health had been affected by important congressional actions, paramount of which was the Indian Health Care Improvement Act (P.L. 94-437).

And so, once again, the National Indian Health Board accepted the responsibility of providing Indian and Alaska Native people with a forum for expression of national health issues, geared toward improving their health. An estimated 1,500 persons seized the opportunity and demonstrated their interest in the status of "Indian Health in America '78", nearly five times as many people as attended the previous conference.

With this second conference, NIHB encouraged greater involvement of tribal leaders, members of area and local Indian health boards, tribal health departments, Indian Health Service, and concerned individuals and from the earliest planning stages to the actual realization of "Indian Health in American '78", sought their guidance and participation.

Conference participants heard a broad range of thought presented on key national health issues, given by some of the most knowledgeable individuals in the health field. Panels considered the subjects of National Health Insurance; P.L. 93-641 (the National Health Planning and Resources Development Act); and Mechanisms for Effective Implementation of P.L. 94-437 and P.L. 93-638 (the Indian Self-Determination and Education Assistance Act).

Following the general assembly presentations, participants were given a chance to examine and discuss these subjects as they applied to their own unique situations. Concurrent group workshops and presentations headed by persons with expert knowledge provided additional information and lent an opportunity for development of position papers and resolutions for adoption by the entire assembly, including an update of the National Indian Position on National Health Insurance.

In addition to the foregoing workshops, participants were given a choice among numerous other informational sessions held on the last day of the gathering.

Not only did a number of these sessions provoke lively discussion and sometimes heated debate, but most produced recommendations or resolutions considered by the general assembly and later adopted by the NIHB Board of Directors. Such initiatives have and will continue to provide NIHB with valuable tribal direction.

Considering the conference a significant success and a productive endeavor with value for the future, members of the National Indian Health Board decided at their meeting in July 1978 to begin planning for a Third National Indian/Alaska Native Health Conference to be held July 22-26, 1979 in Spokane, Washington.

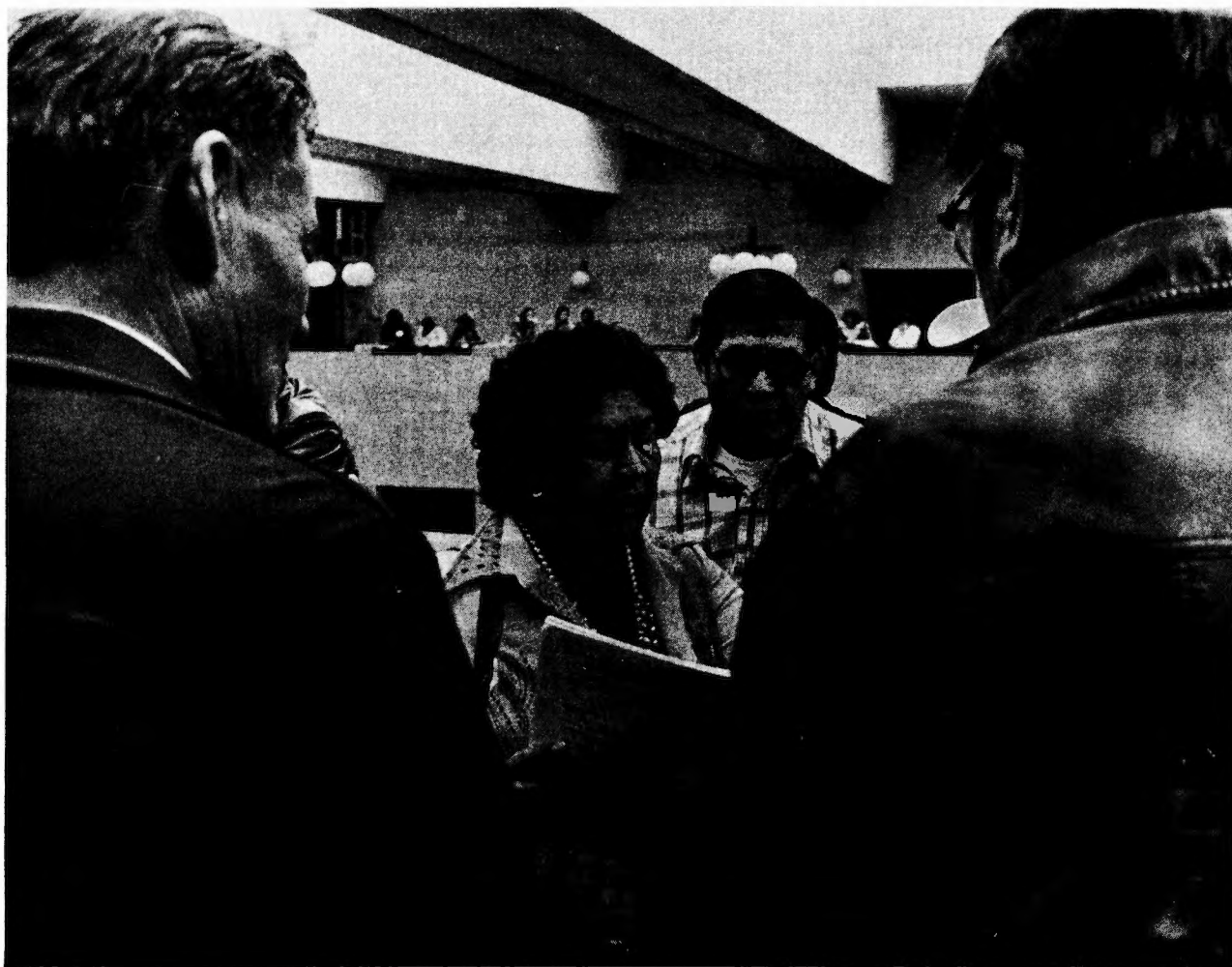


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NATIONAL INDIAN HEALTH BOARD, INC.

BROOKS TOWERS BUILDING—ROOM 4-E
1020-15TH STREET • DENVER, COLORADO 80202
303/534-5482



NIHB Chairman Howard E. Tommie

Dear Friends:

The Second National Indian/Alaska Native Health Conference was well attended. The National Indian Health Board and other sponsoring groups of the conference feel that all of the people who attended received information on health issues and the general status and much positive progress in improving the health care delivery system to American Indians over the year.

P.L. 94-437 and P.L. 93-638 and other related laws passed by Congress gave the conference attendees some assurance that the United States has tried to uphold its commitment to providing health care in an effort to better life on reservations and for all American Indians.

I am hopeful that this conference is not the end of informing American Indians on important health issues. I also hope the National Indian Health Board will continue to hold meetings in each area of the U.S. so you as recipients of funds and resources will be able to express your ideas and inform the proper officials so all areas can have input on policies and regulations, etc.

I personally want to thank all of the people that helped the National Indian Health Board to make the conference a success, including: the Albuquerque Area Indian Health Board, IHS Area Office staff, and the National Indian Health Board.

NIHB wants to thank everyone who took time off from their jobs, or whatever to attend the conference. Until the next conference I remain.

Sincerely,

Howard E. Tommie
Chairman



NATIONAL INDIAN HEALTH BOARD, INC.

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303/534-5482



Conference Chairperson Ada White

The interest generated at the 1st Annual Indian/Alaska Native Health Conference (Palm Springs, California) prompted the National Indian Health Board to host the Second Indian/Alaska Native Health Conference in Albuquerque.

"Indian Health in America '78", the theme for the Second National Health Conference is reflective of the interest and concerns of Indian/Alaska Native health issues throughout the country.

Many of you have assisted the Conference Planning Committee of the National Indian Health Board in the preparation and design of conference proceedings. This obvious display of commitment, coordination and participation has enhanced the NIHB dedication to Indian self-determination in the field of Indian health.

On behalf of the Conference Planning Committee of the National Indian Health Board, I extend to you, my appreciation.

BUQUERQUE AREA INDIAN HEALTH BOARD

610 Gold Avenue, SW Room 202
Albuquerque, New Mexico 87102
(505) 243-6697, 6698

*GEORGE PLATERO, NIHB Albuquerque
representative and Albuquerque Area
Indian Health Board Director.*



Dear NIHB Member:

As the Albuquerque area representative to the NIHB, it was my pleasure to serve as the host Board member to the Second Annual National Indian/Alaska Native Health Conference.

Last year, the first conference was a beginning of unity among health programs across America. Since the coming of age of P.L. 93-638 and P.L. 94-437 to compliment other existing legislation, such as P.L. 93-641 and Title XX of the Social Security Act, health needs among Indians now have a chance of being met in a greater way. Again this year, participants from all walks of life lent their support and knowledge to make this conference an even greater success than expected. The many general sessions, panel discussion groups, area caucuses and workshops were coordinated extremely well by the pre-planning and on-the-job efforts of the core staff of the NIHB national office. A note of thanks and commendation should be expressed to Mr. John Belindo and staff for their job well done. Even though the agendas were long, the information received by the participating groups will act as a basis for the full development of more comprehensive health programs for our people.

We look to the positive future that this Second National Indian/Alaska Native Health Conference points to--Better Health for all Native Americans.

From the Albuquerque area, we thank you, NIHB for bringing to us a conference well done.

Sincerely,

George Platero

George Platero, Chairman
Albuquerque Area Indian Health
Board

SECOND NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE OF THE

NATIONAL INDIAN HEALTH BOARD ALBUQUERQUE CONVENTION CENTER

P R O G R A M

SUNDAY, FEBRUARY 12, 1978

Garden Level

4:00 — 8:00 p.m. Registration: Albuquerque Convention Center

12:00 Noon — 8:00 p.m. Exhibitors into Exhibit Hall: Exhibit Hall — South

MONDAY, FEBRUARY 13, 1978

9:00 a.m. — 5:00 p.m. Registration (Garden Level)

FIRST GENERAL ASSEMBLY

Kiva Auditorium (Street Level)

8:30 a.m. Call to Order: Howard E. Tommie, Chairman
National Indian Health Board
Presentation of Colors: Kirtland Air Force Base Color Guard
Indian Flag Song: Ralph Zotigh
Invocation: Adam Trujillo; Taos Pueblo
9:00 a.m. Welcoming Address: Howard E. Tommie, Chairman
National Indian Health Board
9:15 a.m. Welcome from the Host Tribes: Delfin Lovato, Chairman
All-Indian Pueblo Council
9:30 a.m. Fernando E. C. DeBaca, Executive Director,
Health & Social Services Dept., State of New Mexico
9:40 a.m. Leo Watchman, Legislator; State of New Mexico
9:50 a.m. Welcome to Albuquerque: Mayor David Rusk
10:00 a.m. Keynote Speaker: George Lythcott, M.D.
Assistant Surgeon General; Administrator, Health
Services Administration; Rockville, Maryland
10:30 a.m. Keynote Speaker: Dr. Emery A. Johnson, Director
Indian Health Service; Rockville, Maryland
12:00 Noon L U N C H

SECOND GENERAL ASSEMBLY

Kiva Auditorium

1:00 p.m. Call to Order: Ms. Ada White, Vice-Chairperson
National Indian Health Board — Presiding
Report on activities of National Health Insurance Core Group and
Indian Position Paper:
William Wilson, Administrative Officer
Association of American Indian Physicians
Luana Reyes, Director, Seattle Indian Health Board

1:20 — 4:30 p.m.

Panel — National Health Insurance

Moderator: Howard E. Tommie, Chairman
National Indian Health Board

Cecil Williams, Chairman; Papago Tribe; Member,
Advisory Committee on National Health Insurance Issues

James Felsen, M.D., Indian Health Service
Rockville, Maryland

Howard Bad Hand, Program Analyst
National Indian Health Board, Inc.

Daniel Press, NIHB General Counsel

Ron C. Wood, Planner; Division of Health Improvement
Services, Navajo Tribe; Window Rock, Arizona

Luana Reyes, Director; Seattle Indian Health Board

William Wilson, Administrative Officer
Association of American Indian Physicians

4:30 — 5:00 p.m.

Area Health Board Caucuses on NHI Position Paper
(meeting rooms will be made available)

TUESDAY, FEBRUARY 14, 1978

THIRD GENERAL ASSEMBLY

Kiva Auditorium

9:00 a.m.

Call to Order: Mel Sampson, NIHB
Representative, Portland Area — Presiding

Announcements

9:15 a.m.

Panel — P.L. 93-638 (Indian Self-Determination and Education
Assistance Act) and P.L. 94-437 (Indian Health Care
Improvement Act)

Implementation and Progress Report

Erin Forrest, National Tribal Chairmen's Association

Veronica Murdock, President
National Congress of American Indians

Jo-Anne E. Lutz, President
American Indian Health Care Association

Howard E. Tommie, Chairman; National Indian Health Board

Jim Meredith, Director; United Southeastern Tribes Indian
Health Service

Edward Monetatchi, Associate Director for Community
Development

IHS Office of Research and Development —
"The Tribal Response System"

Ethel Gonzales, NIHB Representative, Alaska Area

11:00 a.m.

Panel — "New Indian Initiatives Within DHEW"

James Kissko, Executive Director, Intra-Departmental Council
on Indian Affairs, DHEW; Washington, D.C.

12:00 Noon

LUNCHEON — Sponsored by the American Indian School of Medicine
(Details to be announced)

FOURTH GENERAL ASSEMBLY

Kiva Auditorium

1:30 p.m.

Call to Order: Irene Wallace, NIHB
Representative, Tucson Area — Presiding

Panel — National Health Planning and Resources Development Act
of 1974 (P.L. 93-641)

Herb Semmel, J.D., Chairperson
Consumer Coalition for Health, Washington, D.C.

Ron Carlson, Deputy Associate Administrator for Planning,
Evaluation and Legislation; Health Services Administration
Rockville, Maryland

John Hubbard, Executive Director
Navajo Health Systems Agency; Window Rock, Arizona

John Lewis, Executive Director
Inter-tribal Council of Arizona; Phoenix, Arizona

Theresa Carmody, Health and Social Welfare Director
National Congress of American Indians

Gordon Belcourt, Director, Tribal Health Department
Blackfeet Indian Reservation

3:00 — 5:00 p.m. Workshop — P.L. 93-641

Cochiti/Taos Room Facilitators: Daniel Press, NIHB General Counsel
Charmaine Segundo, Researcher/Liaison
Papago Executive Health Staff
Gordon Belcourt, Director, Tribal Health Department
Blackfeet Indian Reservation
John Hubbard, Executive Director
Navajo Health Systems Agency; Window Rock, Arizona

Santo Domingo Room

3:00 — 5:00 p.m. Resolutions Committee Meeting
Donald LaPointe, Chairman

BANQUET

Ball Room A (6:00 — 10:00 p.m.)

Master of Ceremonies: Welcome
Jay Harwood, Area Director
Albuquerque Area Indian Health Service
Invocation: Jose Rey Toledo
Jemez Pueblo
Laguna Indian Dancers
Taos Indian Dancers
Speaker: Peter MacDonald, Chairman; The Navajo Nation
Banquet Speaker: Senator Pete V. Domenici, New Mexico

Ball Room B (9:00 p.m. — 1:00 a.m.)

Western Dance: The Navajo Sundowners

CONCURRENT WORKSHOPS AND PRESENTATIONS

WEDNESDAY, FEBRUARY 15, 1978 (9:00 a.m. — 12:00 Noon)

Acoma Room Tribal Specific Health Plans
Moderator: Mel Sampson, NIHB Representative
Portland Area
Facilitators: Tom Seidl, Chief; Evaluation and Special Projects
Portland Area Indian Health Service
Charles Erickson, IHS-ORD
Tucson Area Indian Health Service
Sid Edleman, Assistant General Counsel for Public
Health, DHEW; Washington, D.C.
Erin Forrest; National Tribal Chairmen's Association

Sandia Room Title VI of P.L. 94-437: The Need for and Feasibility of
Establishing an American Indian School of Medicine
Moderator: James R. Smith, Director
Billings Area Indian Health Service

- Facilitators: Taylor McKenzie, M.D., President
American Indian School of Medicine
George Blue Spruce, D.D.S., Indian Health Service
Rockville, Maryland
Mike Lincoln, Executive Director, Navajo Health
Authority; Window Rock, Arizona
John Belindo, Executive Director, National Indian
Health Board, Inc.; Denver, Colorado
- Santo Domingo Room Indian Preference
Moderator: Duane Pratt, NIHB Representative, Oklahoma Area
Facilitators: Karl Funke, Assistant Counsel, Senate Select
Committee on Indian Affairs; Washington, D.C.
Sam Deloria, Director, American Indian Law Center
Ed Perkins, Liaison Officer, Navajo Health Authority
Window Rock, Arizona
- Tesuque Room Mental Health, Alcohol and Substance Abuse
Moderator: Perry Sundust, NIHB Representative
Phoenix Area
Facilitators: David Vallo, Director, California Indian Alcoholism
Training Program; Sacramento, California
Phyllis Cross: Special Assistant to LaDonna Harris,
Member of President's Commission on Mental Health
Wanda Frogg, President, National Indian Board
on Alcoholism and Drug Abuse
- Navajo Room Accident Prevention
Moderator: Donald LaPointe, NIHB Representative, Bemidji Area
Facilitators: Frank Clarke, M.D., Clinical Director
Orin Tonemah, Executive Director, National American
Indian Safety Council
- Zuni Room Sterilization and Abortion
Moderator: Violet Hillaire, Northwest Portland Area Indian Health Board
Clinical Director's Position — "Abortion Issue"
Facilitators: Jock Pribnow, M.D., Portland Area Indian
Health Service
Patty Marks, Professional Staff Member
Senate Select Committee on Indian Affairs
Washington, D.C.
David Hall, M.D., Senior Clinician for Obstetrics and
Gynecology, Indian Health Service; Gallup, New Mexico
- Santa Ana Room Health Related Problems and Provision of Services to Indian and
Alaska Native Elderly
Moderator: Andrea Fast Wolf, Executive Director, Four State
Indian Health Board; Aberdeen, South Dakota
Facilitators: Sophie Thompson, Board Member, National Indian
Council on Aging
Juana Lyon, Director, National Indian Council on
Aging; Albuquerque, New Mexico
- Apache Room Patient Rights and Representation
Moderator: Elwood Saganey, NIHB Representative
Navajo Area
Facilitators: Elliott L. Booth, Executive Director, Phoenix Service
Unit, Indian Health Advisory Board
Gloria Keliiaa, Executive Director, National Indian
Health Center; San Francisco, California

Vernon Antone, Team Leader, Patient Representative
Program; Phoenix Indian Medical Center

Laguna Room	Serving the Mentally and Physically Handicapped Moderator: Ethel Gonzales, NIHB Representative Alaska Area Facilitators: Theodore Marrs, M.D., Chief, Albuquerque Area Maternal, Child and Health Branch Arthur L. Thomas, Special Assistant to the Director Indian Health Service Movie Presentation: "Waiting for the Dawn" A School for Me and Incorporate Tohatchi, New Mexico
Cochiti/Taos Room	Urban Specific Health Plans Moderator: Timm Williams, NIHB Representative California Area Facilitators: Jo-Anne E. Lutz, President American Indian Health Care Association Hickory Starr American Indian Health Care Association Wes Halsey, Title V Coordinator Indian Health Service Luana Reyes, Director, Seattle Indian Health Board
Picuris Room	Indirect Cost Principles for Federal Grants and Contracts Moderator: Darryl Trigg, NIHB Alternate, Alaska Area Facilitator: Allan Keaton, Negotiator, Division of Cost Allocation DHEW Regional Office; Dallas, Texas
Nambe Room	Title XX Social Services Amendment to the Social Security Act (P.L. 93-647) Moderator: Elloise DeGroat, Tribal Affairs Liaison Navajo Area Indian Health Service Facilitators: Bobby George, Director, Division of Social Welfare The Navajo Tribe Donna Bissell, Director, Great Lakes Inter-tribal Council Food Stamp, Nutrition and Advocacy Program
Jemez Room	1980 Census: Supplemental American Indian Questionnaire Moderator: John W. Davis, Director Oklahoma City Area Indian Health Service Facilitator: Edna Paisano, Statistician, U.S. Bureau of Census Washington, D.C.
12:00 Noon	L U N C H

FIFTH GENERAL ASSEMBLY

Cochiti/Taos Room

1:30 p.m. Call to Order: Elwood Saganey, Chairman, Navajo Area Indian
Health Board — Presiding
Report of National Health Insurance Position from NHI Core
Group — Vote
Reports from Workshops
Report from Resolutions Committee
Conference Wrap-up and Closing Remarks
Howard E. Tommie, Chairman, National Indian Health Board

ADJOURNMENT OF THE SECOND NATIONAL
INDIAN/ALASKA NATIVE HEALTH CONFERENCE

PROCEEDINGS OF THE SECOND NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE

(Abbreviated Transcript)



FIRST GENERAL ASSEMBLY
February 13, 1978

BE IT REMEMBERED that the 13th day of February, 1978, at approximately ten o'clock in the forenoon, the meeting of the Second National Indian/Alaska Native Health Conference was held at the Albuquerque Convention Center, Albuquerque, New Mexico.

Mayor David Rusk: Thank you very much, Mr. President.

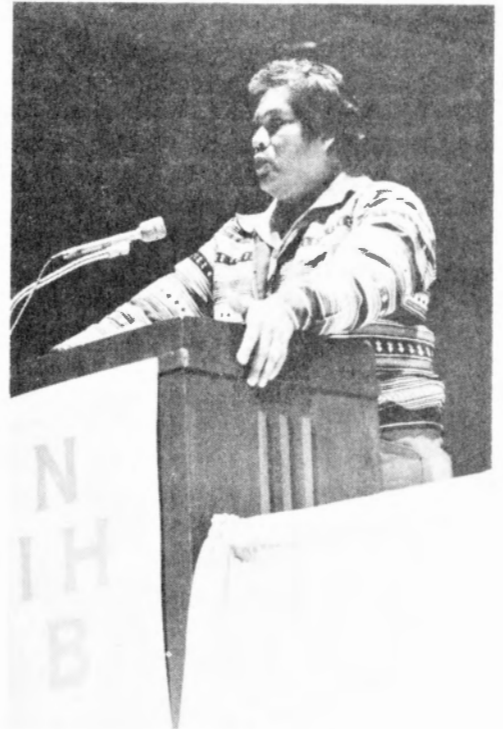
I was listening to the president's remarks and noticed that he used the word "backlash". It's a word that I have seen in Indian publications a good deal this last year. I want to assure you that there is no backlash in Albuquerque.

Number one, we have a very active affirmative action program for Native Americans in city government In the last year, we have doubled the number of Native American employees in our city government, and we look forward to meeting our overall goal of four per cent by the end of my administration.

Number two, it's very appropriate for me to have the opportunity to welcome the National Indian Health Board convention here this week, because just last week, our City Council approved and I have signed a resolution which authorizes me to engage in negotiations with the Laguna Pueblo and the Indian Health Service. These negotiations will lead to the extension of the city's water facilities some twelve miles beyond our current city limits, especially for the purpose of providing municipal water supplies to a new facility to be built on the eastern limits of the Laguna Pueblo where it joins Interstate-40 to the west of us. That facility will be a treatment center for crippled Indian children. And we are very pleased to be able to provide this support for such an important undertaking.

Chairman Tommie: Delfin Lavato, the Chairman of the All Indian Pueblo Council could not be with us, but we have Secretary-Treasurer. Frank Tenorio, who will be representing him.

At this time, I would like to present from the All Indian Pueblo Council, Frank Tenorio.



NIHB CHAIRMAN Howard E. Tommie welcomes participants to the Second National Indian/Alaska Native Health Conference. An estimated 1,500 persons attended the three day session. (Photo courtesy of the Papago Runner.)

Mr. Frank Tenorio: Thank you, Chairman Tommie and Indian Friends from throughout the nation. Welcome to New Mexico, Albuquerque, the heart of Pueblo country.

As you know, without the good health that is to be enjoyed by everyone, every individual from day one up until their last days, it's impossible to lead the kind of fruitful life that we all want to live.

The Indian people have been categorized far down the ladder, as you know, statistically, in education reports.

As I look toward the audience, I know I'm facing a group of people who would definitely be instrumental in implementing those things that are certainly curing measures or certainly those people who will be instrumental in making things gel throughout your communities.

I look at your agenda here. It is a very ambitious agenda and I don't envy you to the extent that some of the issues that you will be talking about are big issues. I know you have ideas regarding Public Law 94-437, the Indian Health Care Improvement Act and the many acts that will definitely be addressed or be issues over the next three days.

You definitely have a challenge before you, and I want to encourage the participation that is necessary of all the conventions that do happen throughout our nation. It definitely is encumbent on the participants to give their all, to put forth their best foot, to be an integral part in the planning and in the input of making or coming out with solutions as far as those issues are concerned.

I think I got ahead of myself in regard to my main purpose up here. I think I speak for all the Pueblos in welcoming you and if time permits, to invite you to come up to each one of our Pueblos and see how we do things and how we live.

I know this is going to be a very, very intense work schedule that you have here. I see many people who are very knowledgeable in the matters of health. And I wish I could stay with you throughout the three days that you are going to be here, and I will try to. The staff of the All Indian Pueblo Council will certainly be around assisting in any way possible.

Although we don't belong to the National Indian Health Board, we have more or less a parallel one that focuses on the Pueblo health needs called the New Mexico Inter-Tribal Health Authority established by the All Indian Pueblo Council to zero in on some of the dire needs that confront the Indian people.

With all the luck to you and certainly may the Great Spirit encourage you and open up the perspective that is needed to confront those issues and problems that will be discussed. I wish you all the success possible.

Chairman Tommie: What I want to do at this time is call on Dr. Emery Johnson to introduce our next keynote speaker, his boss.

Dr. Emery Johnson: It is a real privilege and honor for me to introduce my boss, Dr. George Lythcott.

Dr. Lythcott is the Administrator of the Health Services Administration, and it's been my good fortune to work with him.

The first thing I think I told him when I met him last August--he came on board in July--is that I certainly hoped that he would be with us for a good long time.

One of our joint problems here, his and mine, is in working with him in a complex system which is what HEW is. If the levels above you either don't understand what is happening at the reservation level or are really apathetic toward it, this makes your life and my life all that more difficult.

We were particularly fortunate in President Carter's selection of Dr. Lythcott. Dr. Lythcott is a physician, he is a pediatrician, and his entire life has been spent working to improve the health of people, and in particular, of children. As we all know, children are the basis of all future Indian people and any other people.

He went from the faculty at the University of Oklahoma to Africa where he spent a number of years as the Director of the Small Pox Eradication Program for West Africa.

I can tell you from very brief personal experience in West Africa that that is a monumental task. It requires someone of great patience, great perseverance and great skill, which Dr. Lythcott has demonstrated; and small pox is, in fact, eradicated from the part of Africa that he was responsible for.

He came back from that and spent some time in academic medicine in places like Columbia and finally ended up at the University of Wisconsin where he served as Associate Vice Chancellor for Health Sciences and professor of pediatrics.

During the past year, Dr. Lythcott served as a member of the U.S. Delegation to the World Health Assembly, which is an arm of the United Nations and the health organization which looks at health throughout the entire world.

He began to distinguish himself there and I suspect, in part, as a result of his performance there, when Carl Bunnell was looking for the ideal person to handle one of the most difficult and one of the most challenging health jobs in the United



OPENING CEREMONIES featured the Presentation of Colors by the Kirtland Air Force Base Color Guard and the Indian Flag Song sung by Ralph Zotigh of the National American Indian Safety Council. (Photo courtesy of the Gallup Independent.)

States, they settled upon Dr. George Lythcott.

As the Administrator of the Health Services Administration, he presides over those federal health programs that really address the basic health services and needs of the U.S. population with particular emphasis on those population groups that have been left out, ignored or otherwise been disadvantaged. Last and in our direction, but certainly not least, this includes the Indian Health Service.

In this relatively brief period of time that Dr. Lythcott has been with us, he has visited in Oklahoma and he's visited down in Navajo and up in Alaska. He has been out here in Albuquerque, he's been out in Pueblo country. Next month or so, we'll be up in the Great Plains.

He has addressed himself to grass roots communication with the Indian people to the degree that the support that we've gotten from Dr. Lythcott and his staff could not have been better.

It gives me great pleasure to introduce to you Dr. George Lythcott, Assistant Surgeon General and Administrator of the Health Services Administration.

Dr. George Lythcott: Emery, Chairman Tommie, honorable chiefs, ladies and gentlemen, I bring greetings and best wishes from the Secretary of Health, Education and Welfare, Mr. Joseph Califano, who has personally asked me to extend warmest regards from him.

I'm aware that the Secretary has been in personal contact with Mr. Tommie to express his regrets in a telegram which has been shared with you.

It is, however, a genuine pleasure for me to accept your kind invitation to make remarks at this Second National Indian/Alaska Native Health Conference, to meet and to discuss with you health care issues of vital importance to every one of us at this gathering, and to every person and organization which we represent.

Since I became Administrator of the Health Services Administration in late August, and took over responsibility for the agency and for Indian health, this marks my fourth presentation at the request of the Indian people.

Please know that I intend to remain responsive to your needs and especially to the opportunities for dialogue.

The importance of this conference for each of us and for posterity is clear by the subjects to be covered in this thoughtfully planned and organized examination of basic issues which shape Indian Health in America in 1978.

Make no mistake about it. What is done this week and during the months ahead will affect Indian health in America for the rest of our lives, and for the lives of our children, and for the lives of our children's children.

It is the future welfare of your family, your friends, and your neighbors,

now and yet to come, which is at stake. The fact that these people in groups have asked you to represent them is a clear indication of the trust and confidence which they have placed in each of you, and of the respect and high regard in which they hold you. I salute this recognition of your credibility and leadership and am honored to have been asked to address such a group.

During the years when I was growing up in Oklahoma, the times were such that a meeting like this did not and, perhaps, could not have taken place, except in the minds of those who could envision the kinds of things which should be done and some day had to be done.

Those visionaries knew that the problems of Indian people would never be adequately met until their concerns were voiced to those who controlled the programs serving Indians, and until the voices of Indians were not only heard, but also thoughtfully considered.

We all know the historically significant things which have happened since those days.

A great wave of demand for increased Indian and Alaska Native control of their own affairs has emerged. That demand is shaping a new relationship between the federal government and the tribes.

I see that new relationship as a partnership, predicated on the continuing federal responsibility toward the tribes, on mutual trust and confidence in each other's integrity, abilities and actions; and on the free and equal exchange of ideas.

One reflection of the role of the Indians and Alaska Natives in the relationship is the clearly observable strengthening of tribal government and the other community institutions and organizations through which the voices of the people are heard and translated into action.

In the health field, the people have strengthened their voices through the development of tribal government health boards and departments, local and area health boards, the National Indian Health Board which has organized this conference, and through their community organizations.

Thus, the visions of the past have become the realities of today.

It is sad to note that many of the giants who had those visions some years ago are no longer with us. But many are still with us and some are here at this conference.

Also, here today are new visionaries, the young who have come to join forces with the "not so young" in a common undertaking.

Together, you are the people who best foresee what Indian and Alaska Native health affairs should be like, and must be like, in the years to come.

Thus, you bear the responsibility for assuring the continuity of a great tradition passed on to you by the visionaries of yesterday.

Indians and Alaska Natives throughout America look to you to understand health problems and health affairs as they are today; to set objectives

about how you believe today's problems should be solved, and how we should proceed in health affairs tomorrow; and to provide guidance in the process of moving toward those objectives.

Let us take a look for a few minutes at where we are, to see from where we have come, and where, indeed, we need to go.

What is the current health assessment of the Indian people?

You know the facts too well, but to cite a few:

The infant death rate for Indians is still 1.3 times as high as the infant death rate of the general population.

The death rate for Indians as a result of alcoholism is about $5\frac{1}{2}$ times as high as the rate for the rest of the population.

Unacceptable levels of death and disability from preventable diseases and accidents remain hard realities.

Too many homes of Indian people do not have modern systems for solid waste disposal and for many, the long walk for pure drinking water is a heavy burden and is time consuming. And we all know the health problems brought on by drinking contaminated water.

However, the picture is not totally bleak, for, to be sure, many of the trends in the health field over the last two decades tell of some successes.

The infant death rate for Indians and Alaska Natives, though still too high, has been reduced by 71 per cent since 1955.

During this same period, the death from diseases of early infancy has dropped 70 per cent.

Tuberculosis, a great scourge that struck eight out of every one thousand Indians in 1955, now strikes less than one per thousand, representing a drop of 88 per cent.

Indian people can now expect to see their children live longer. An Indian baby born today can be expected to reach the age of 55, an increase of five years since 1950.

Dramatic increases in the number of visits to hospital out-patient departments and field clinics have occurred; increases from 455,000 in 1955 to more than 3,035,000 today, reflect the very positive results of the stepped-up focus on early detection and prevention in Indian health care delivery services.

The work which is ahead is extensive and the needs are many, to be sure and while the issues and problems we face are, indeed, complex, I see the principal ones confronting us at the moment, being those with which all of us are very familiar, and which will be discussed in detail in this conference, namely:

1. The prospects of National Health Insurance and the impact of a national health care financing program on the Indian/Alaska Native in this country.

2. The impact of the National Health Planning Act, P.L. 93-641, relating to the Indian constituency and the necessary role of Native Americans in the health planning process.

3. The implications of the budget in carrying out the Indian Health Care Improvement Act, P.L. 94-437, and the prospects for health professional educational opportunities for the Indian people in this country.

Let's begin with perhaps the most difficult: The prospects of National Health Insurance.

First of all, I think the entire National Health Insurance issue must be looked at in the context of the department's commitment to the Native American organizations in shaping any program that will affect the Indian and Alaskan people.

I am well aware of the position of the National Indian Health Board and of the National Congress of American Indians which states that Indians should not be included in the basic National Health Insurance program, and that they should be permitted to continue a completely separate system.

We recognize that you have unique health needs, needs which will not be covered under any of the health insurance benefit packages being proposed.

Nevertheless, for those types of Indian health services which are included in a guaranteed National Health Insurance package, funding could be made available directly to the Indian Health Service from the National Health Insurance resources. In this way, Indians, if they chose, would receive their per capita share of the same guaranteed benefit package that is available to the rest of the population.

Above all else, Indians must have the right to choose where they receive their health care services, just as the rest of the population must have that right.

Many Indians feel that they receive better attention to their needs, including the recognition of cultural differences, in their own health care delivery system. This is a critical issue, deserving full attention in striving for overall health care effectiveness. Certainly, under any National Health Insurance plan, the right of Indians to choose Indian health service settings must be retained, along with the option of National Health Insurance, as some Indian groups may choose. This choice is particularly vital for the urban Indian who must be able to go to the nearest health center and receive quality care.

The Health Services Administration has recently issued a position paper on National Health Insurance. In that statement, I make it very clear that a new financing scheme will not necessarily correct the geographic maldistribution of health services and resources. We know this based on our experiences with the Medicare and Medicaid programs. For even today, we are working toward ways of getting care to the more than eight thousand medically underserved areas in this country.

The Indian health needs are similar in many ways to those problems which exist within and throughout inner cities and rural America.

My agency strongly endorses a balanced national health care approach, one

that incorporates both financing and resource development efforts; that is, developing health services in medically underserved areas and guaranteeing financial access to utilize those services as essential components in a national health care program. The Indian Health Service, a program geared to a specific mission, will, therefore, be reinforced.

A second major issue is that of the growing regulatory programs, especially the questions surrounding the National Health Planning and Resources Development Act, P.L. 93-641.

The importance of P.L. 93-641 cannot be underestimated anywhere, including the Indian community. This act does not change the relationship of the Indian Health Service and the Indian community. However, it does offer Indians and Alaska Natives an opportunity to participate and share in a larger planning effort that now covers the entire United States.

As you know, every geographic area in the country is covered by Health Systems Agencies and other associated state level planning organizations. Participation in the activities of these organizations is urgent. This is especially true for tribes wishing to assume increased responsibility for their health affairs. These tribes need to utilize all available resources; HSA's will be available, at times, to direct such resources to tribes, but only if they are aware of the tribes' needs and plans.

Sharing information in plans, however, is not the only way to be involved. There must be Indian and Alaska Native representation on the various boards and committees being established by the HSA's and other state level planning organizations.

As members of these committees, advocating either consumer or provider interests, or both, tribal representatives can influence decision-making related to allocation of resources. They can also speed up the review and comment process required when federally recognized tribes apply for funds administered under the Public Health Service Act and certain other legislation: for example, funds for family planning and alcohol programs.

This kind of involvement is equally, if not more, critical for urban Indian organizations since their applications for such funds must be reviewed and approved by their respective Health Systems Agencies.

For the most effective results, tribes and urban organizations should seek a consensus among themselves as to whom their representatives for P.L. 93-641 planning and resource development activities will be, and give those individuals their full support.

Further, all such Health Systems Agencies' actions are public information and should be monitored closely by tribes and urban Indian organizations alike.

If there are differences of opinion regarding any HSA's activities and decisions impacting on the Indian community, these should be expressed. In fact, mechanisms are provided for this kind of input into the planning process.

Next, let's look at the budget for the coming year. The ramifications of the F.Y. 1979 budget, especially on the implementation of the Indian Health Care Improvement Act, P.L. 94-437, are surely of great concern.

The act cannot be fully implemented in 1978 due to the budget constraints with which we are faced. Competing priorities at the federal level are intense and the competition for federal health dollars, especially for health service delivery, has never been more keen. Briefly, let's examine what the 1979 budget does provide for in that year.

As we have reported to the area offices, the F.Y. 1979 budget for the Indian Health Service continues most programs at the 1978 operating level. It provides for 80,700 hospital admissions, 3,277,000 out-patient visits, dental services to 250,000 people, and public health nursing services to 32,400 families.

Where are the difficulties as I see them?

First, the budget allowance does not provide for certain new costs. In order to operate five new facilities scheduled to open in F.Y. 1979 and to finance mandatory costs, such as the increased costs of contractual services, transportation, maintenance and repair some reprogramming will be required. To the extent possible, increased staffing requirements have to be accomplished through the reallocation of positions. Those which cannot be met through reallocation will need to be contracted for. It is going to be a tough year, but you can be sure that, although there will be some cuts to accommodate the available dollars, there will be no cuts in patient care activities. High quality patient care will continue.

In another direction, you should know that the President's 1979 budget now before the Congress has a supplemental request concerning Medicare and Medicaid dollars earned by the Indian Health Service facilities. These dollars are now being placed in a special fund held by the Secretary of Health, Education and Welfare, as mandated in Title IV of P.L. 94-437. These dollars cannot be released to the Indian Health Service until appropriated. Language to provide for this release of funds is in the 1979 budget request.

Since collections began in August 1977, the Indian Health Service has deposited over a half million dollars in this special fund. These are dollars to increase, not replace, the regular Indian Health Service budget. They are to be used to help the Indian Health Service facilities meet and maintain standards required by licensing authorities. When spent for additional staff, facilities and equipment, the dollars should result in better health care for all of the Indian Health Service population.

Now, let's look at an area of mutual concern, the shortage of trained Indian health workers. Let me say that I believe strongly that the shortage of Indian people trained in various health disciplines has a direct bearing on health care effectiveness and that I fully support the expansion of educational opportunities for the development of more Indian and Alaska Native health professionals. In the new budget, we will not be able to continue our steady gain in scholarships.

The Health Resources Administration has recently completed a study on the feasibility of options for medical education for Indians. I have reviewed those findings carefully and have submitted my recommendations on behalf of my agency. That proposal calls for the expansion of the Indian Health Professional Scholarship Program and the establishment of pre-college and pre-medical school programs for Indians. In addition,

our recommendation endorses the coordinated development of the following: one or more strong schools of allied health for Indians, affiliations between existing medical schools and Indian health facilities for the training of Indian medical students, and initiation of residency programs in Indian health facilities.

This approach would bring basic health training to major Indian communities, expand the pool of potential Indian medical applicants, provide culturally sensitive medical training, both graduate and undergraduate, to Indian students and providing major portions of training in Indian communities, increase the potential for Indian students to practice in such communities.

Finally, I would like to comment on what I perceive to be very encouraging developments within the totality of the Department of Health, Education and Welfare with respect to you and your constituents, which the Secretary has called the new Intra-Departmental Initiatives on Indian Affairs. They are designed to improve the delivery of services to Indian people and to increase their involvement in their programs and decision-making.

The new "Intra-Departmental Initiatives on Indian Affairs" set out concrete actions and objectives to heighten department responsiveness to Native Americans.

Secretary Califano is strongly committed to the policy of Indian Self-Determination. To fulfill this commitment, the Secretary has mentioned the following actions to be undertaken by early spring and fall of 1978:

1. In consultation with Indian people, to begin a new effort to disseminate accurate information for and about Indian people;
2. To identify, in consultation with Indian representatives, needed actions by each HEW agency to improve delivery of its services to Indians; and
3. To assume the initiative to define and distinguish the responsibilities of HEW from those of other federal departments regarding services to Indian people.

The Health Services Administration has assumed the leadership role in assisting the Secretary to formulate this overall initiative. It is my desire that HSA continue to demonstrate leadership in the implementation phase of this very positive development.

These are exciting times. To be sure, we face a vast potential for progress. Successes will come. They will be successes that are borne in large measure from community and staff team work in the health field.

I am sure you do not find the tasks to be easy; no one would. They may be easier for those who are able to keep their attention focused on long term objectives as opposed to the short term objectives.

Thus, it is important not to be discouraged by short term setbacks and disappointments, because history tells us that these will be more than offset by gains and victories. The end result, in spite of temporary "ups and downs", is long term, steady gain and true progress toward the

achievement of objectives.

Secretary Califano, the Assistant Secretary, Dr. Richmond, Dr. Emery Johnson and myself are, and will, continue to work closely with you, to serve as your advocates in helping to translate your concerns, needs, your hopes, and even your dreams, into positive program action.

As the Administrator of HSA, I am urging my people to respond, not as an agency with a face that is a bureaucratic blur, but rather as an agency with clear, sharp features, working with you as partners, both aware and deeply sensitive to the very real problems and concerns you face.

I have a deep and abiding faith that you will keep your eye on your target, overcome temporary adversities as they come along, and reach your goals in the best traditions of the American Indians and Alaska Natives.

I wish you well in your deliberations during this conference.

Chairman Tommie: Thank you, Dr. Lythcott, for a very encouraging presentation.

The theme for our conference is Indian Health in America '78.

The person who will give us some information from the Indian Health Service has been with us for quite some time. At times we have questioned many things and he has come up with answers and gave us some leeway or some hope along the line so that we could continue to take care of the health of the American Indian people. He has worked with the board since its formation.

So, when you talk about Indian health, Dr. Emery Johnson, the Director of Indian Health, with full responsibility vested in him, will be directing that service.

At this time, without any further introductions, I would like to introduce Dr. Emery Johnson.

Dr. Johnson: The issues that we have before us this morning, I think, have been very well made out by the preceding speakers. I think Frank Tenorio covered very well some of the fundamental issues that we all need to deal with. Certainly, Dr. Lythcott has given you a good panorama of the department, the Health Services Administration, and some of the major issues ahead of us.

When we look at the program, this is not a meeting in the sense of going and having a good time. This is a meeting in the sense of learning, gaining knowledge, gaining skills, taking them back home and putting these skills to work.



KEYNOTE SPEAKER Dr. Emery Johnson,
Director of the Indian Health Service
(Photo courtesy of the Papago Runner.)

I notice on the ribbons that folks are wearing, it doesn't say speaker, it says faculty. I think that is the sense in which NIHB has put this together. We are here to learn together, to share together, and then go back home and work together.

I would like to spend a few minutes that I have with you formally to try to look together at where we've been over the past number of years, where we are today, and, hopefully, some vision as to where we are going in the years to come.

Prior to 1955, and the earlier part of this century and the latter part of the last century, Indian health programs were, oh, somewhat haphazard. There was no actual budget for Indian health in the federal government until, I think, it was 1911.

A number of studies that were done over the next several decades, one by the Public Health Service in 1913, the famous Merriam Report in 1928, reports done by the American Medical Association in the '40s, all come to, I think, very prevalent conclusions.

The conclusions were that federal Indian health services were deplorable, to say the least, the health of the Indian people was far behind, a generation or two behind.

There were certain illnesses that were ravaging in Indian communities that had long since been brought under control in the general population. Dr. Lythcott has mentioned some of them, tuberculosis, infant and maternal mortality, infectious diseases, and we could go through a number of others.

It is perfectly clear to Indian people, to health professionals and to many others, that these terrible conditions were shocking, were outrageous and absolutely intolerable in the United States at that time.

As a result of this study and these conclusions, the Congress determined to take an active role in the direction of Indian health. They recognized that the central role must be played by an organization of resources and by the provision of resources. As a result, the Congress passed Public Law 83-538, which was the Indian Health Transfer Act. This act passed in 1954 transferred the health programs from the Department of the Interior over to the Public Health Service, the Department of HEW.

On July 1, 1955, the Indian Health Service was created.

I came into the Indian Health Program on the 30th day of June, the last day the Bureau of Indian Affairs had the program. At midnight, it transferred to the Public Health Service.

So, my comments today are based, not so much on theory or the reading of literature, but on the actual experience of the reservation position of Indian Health Care administrator as we worked together, almost twenty-three years now. And going from that point to where we are today.

In 1955-56, a study was done under the direction of the Congress to try to determine what was the status of Indian health, what would need to be done to bring it up to the level of the general population, how long it would take and what it would cost. That study was published in 1957 with the title of Health Services for American Indians.

In going back and reading that study and its findings recently, it was, I think, encouraging to realize that many of the things that had been talked about at that time, had proved to be fact. Many of the concerns that had been expressed at that time had been dealt with. Much of what we who participated in that study, and I was the reservation physician at one of the nine reservations in the United States that served as the detail part of that study, to see that things we talked about, things that we had been concerned about, that many of them had, in fact, been addressed and resolved.

It was also continuing, I think, and somewhat discouraging to find that many of those issues had not ever been completely resolved, and that we, in fact, had considerably more left to do. We will get to those things as we go on.

Out of the last study, however, came the development of the Indian Health Service goal, the goal that says we must bring the health status of the American Indian and Alaska Native up to the highest possible level; and as an interim goal, at least, to bring it up to the level of the health status of the rest of the population.

How do you do that?

Well, the first thing that seemed necessary to us was to try to determine what the Indian community felt were their needs, not what did the health professionals or other bureaucratic types back in Washington feel were the needs, but what were the needs felt by the reservation communities.

I remember my experience as a reservation physician, what our community wanted. They wanted medical care. They wanted good health services. They wanted somebody to treat babies so they wouldn't die. That was our concern, and that was their concern.

Together, we set about to try to develop the system of health services delivery that would be adequate in quality, sufficient in quantity, and responsive to the unique needs of that community.

To say that the health system at that time was primitive is perhaps an understatement; having come from the great university medical center, I couldn't believe the circumstances under which we had to practice.

We also had then, and I'm not sure where that originally came from but it certainly proved to be ultimately correct, and that is that there was an absolute need for community participation in the health program, that many of the things that had to be done were not things that doctors could do, that nurses could do even among themselves, but were things that required the active participation of the community. And out of that, we began to develop, with the tribal groups, health committees and various spokesmen for health, workers for health, the mothers' committees, the sorts of things that could really begin to get the community actively participating in the health program.

The first twenty-three years of our Indian Health Service,--when I say "ours", I mean yours, not just the Indian Health Service or the federal government's, but your Indian Health Service, ours--to develop a health services delivery system, and we, in fact, had developed a wide variety of tribal organizations devoted to the delivery of health care.

What are some of the results of this development?

First, as Dr. Lythcott has pointed out, the health status of Indians has improved. The health status of the Indian people in the United States has improved more rapidly than that of any other population group. We have extended services to Indian groups that, for one reason or another had been denied services or left out. I'm thinking of groups such as tribes in Wisconsin, Michigan, Florida, Louisiana, New York, California.

Even now, with the President's budget for this coming year and the supplemental for Fiscal Year '78, there is provision for Indian health services.

A large group of Indian people who had been left out of federal health programs have now been brought in and are beginning to get an opportunity to strive for the level of health services available to other tribes.

Certainly, there has been increased use and Dr. Lythcott mentioned those, an increased use of health services, and we must point out the increased availability of facilities.

We have provided, working with you again in the best of partnerships, some 110,000 Indian homes which have been improved through the addition of sanitation facilities.

We have some seventeen new hospitals. We are improving three--two, at least, that were completed in places that had no hospitals at all, thinking of the Acoma, Laguna and Canoncito hospital, just some fifty miles to the west of us here in New Mexico.

We have a new health center and we have new health stations. For example, in Alaska there are some one hundred and seventy villages that have full time aides.

These are all services that were unavailable. There were no full time health people in Alaskan villages as little as a decade ago. And we certainly have an increased staff, not nearly the increased staff that all of us think and feel is necessary, but they are there. And the increased staff, increasingly has been made up of trained, professional, Indian people.

When I first came into Washington, we had very, very few Indian people at professional levels. Now, most of the chief professional offices in the Indian Health Service are manned by highly competent and highly skilled professional people of Indian ancestry. We have area directors who are Indian. We have service unit directors. Our nursing staff and a number of our physicians and dentists are Indian. We have many pharmacists who are Indian. And it was rare to see an Indian face on the professional side of an Indian facility in the 1950's. It is no longer rare, and as the years go on, it will become increasingly common.

Now, we have come to a point where there are new changes and there are going to be new challenges. Those are things that we are going to have to come to grips with.

What are the changes?

The changes have occurred in a fashion, just within the last few years.

We talked earlier on, of the very beginning of the program, of the absolute essentiality of community participation in the health care delivery system. We talked a little bit about health committees, the women's committees and so forth.

But what has really happened in the last, oh, less than ten years? There has been a massive and an expansive movement toward the development of tribal health.

For example, today, we find that there are three tribes, or tribal organizations that are actually operating hospitals--unheard of a few years ago.

We have many tribes that are operating major health centers. We have many, many more tribes that are operating major segments of their health care program, operating their preventive services, operating environmental health, mental health, alcoholism, maternal and child care.

You name a health delivery system element, and we can probably find you a tribe someplace that has, of its own choice, of its own development, decided to operate it; and I can assure you that those activities are handled well, effectively and responsively.

Nearly all are involved in health planning, in health evaluation, in training, in setting priorities, and a wide variety of health activities.

From that base, which has been developed together over the last, perhaps, eight or nine years, we now have facing us a new challenge. Fortunately, for us,--us, again, this means you, it means us, and the Indian Health Service--we have had a long experience together. We have sorted out some of the things that had to be begun. We have made some of our mistakes together and we have learned from those.

We are in a position, I believe, to meet the challenge.

What is this challenge?

The Congress has, in fact, set the course for Indian affairs in health, under Public Law 93-638, the Indian Self-Determination Act, Congress has provided to Indian tribal governments the right and the opportunity to decide what, if any, part of a program they would choose to operate.

I might add here, however, that the decision not to contract is also an act of tribal self-determination. And those tribes who feel that the Indian Self-Determination Act is 'termination by contract', to quote one very significant tribal leader, is, in fact, not a requirement at all, but is up to each tribe's determination.

Tribes do not have to use the authorities under 638. If they want to continue to contract under some of the other authorities, they have a right to do so.

The Indian Health Service has no right to demand of the tribe or to push tribes into contracting. That must be the free determination of the individual tribal government. And we will support your right to make

that independent decision.

However, 638 has some great concerns for us as well as for tribal leaders. The right to assume responsibility and authority over a health program is a meaningless right if the resources to do that job adequately are not available.

If you don't have the resources at your reservation that will permit you to take over and operate a particular health program with adequate staff, adequate physical resources, adequate support, you then are setting yourselves up for potential failures.

It was really a recognition of that crucial issue that stimulated the Congress to pass the second major landmark legislation, the Indian Health Care Improvement Act, Public Law 94-437. That act is clearly one of the most significant federal laws in Indian health, and it does several things.

I think we ought to spend just a moment to define those things, and to show you how that act fits in with the concept of tribal self-determination, tribal self-government, that is identified in 93-638.

The Indian Health Care Improvement Act, for the first time, defined in law the right of Indian tribes for federal support of health services. Prior to the passage of that law, the statutory authority for Indian health care was in the Snyder Act of 1921, which said the Secretary may spend such funds as Congress may, from time to time, appropriate for the needy and for the hiring of a physician and for other little things, those are the major ramifications of the Snyder Act.

Now that, I would submit, is not a very firm, clear definition of what your rights were in terms of health care.

In 437, the Congress said, under the Constitution, under the laws and under the treaties, the federally-recognized Indian tribes have a right to federal support in health care.

The second major activity from that law was that the Congress define a general benefit package for Indian health care, that they define a benefit package that included in-patient care, dental care, mental health, preventive services, sanitation facilities, the whole series of things that are defined within the titles of that act.

In addition to defining what should be included in the benefit package, Congress also defined the quality of that care. They defined that quality not in some abstract terms, but by comparing Indian health care to national standards of quality.

For example, they said that hospitals serving Indian people should meet the standards of the Joint Commission on the Accreditation of Hospitals, which is the national accrediting body that serves all hospitals, private, community, governmental, in the United States.

So, they said, then, you have a right to federally supported health services. You have a right to have those services be comprehensive. And you have a right for those services to be of the highest quality. And finally, they said, you have a right to have your health system brought up to a par with the health system available to the general

population of the United States.

That was, in fact, the landmark legislation, clearly defined, the federal commitment for Indian health care.

Now, these two laws have provided us with an opportunity and a challenge. Now, what do we do from this point in time?

The first requirement, I think, is for us to get about our business of attempting to deliver health services with our current resources, whether they be Indian Health Service resources, resources from third party mechanisms, whether the delivery system is Indian Health Service, or whether the system is tribal, whether it's a combination of Indian Health Service and tribal, it is our first responsibility to deliver the highest quality of health services that we can in the most efficient and effective manner, and in the most responsible manner to our communities as we possibly can. Only if we are, in fact, doing that do we then have the right to come back to the Congress and say, "Here is what we need to do in addition."

Secondly, the challenge ahead of us then follows from the first. We need to develop, in an objective, professional, responsive, tribally supported fashion basic health plans for each tribe. We are talking here about Tribal Specific Health Plans.

437, in its development, identified a time when each tribal community would have available to it a health delivery system, comprehensive in scope, responsive in character, high in quality. In order to reach that objective defined in the law, each tribe must, in fact, develop this package for themselves, what they need for their community to reach that common level.

We have, jointly with NIHB, NTCA, NCAI, national urban groups, as well as individual tribes throughout the country, developed some tools that we all can use together to help us get along with this job of tribal health.

We have systems analysis and health services which you can use to determine the status of your current health delivery systems and begin to look at some of the standards for health services, and compare them to your own reservation programs.

We have developed tribal health clinics that are in the hands of the tribes. We have developed resources available under 638; under the Section 104 grant program that enables tribes to put the health planning staff on, to be able to contract for consultants who can give you professional expertise in your tribal health plans.

We have developed together a resource allocation program, to take your tribal health plans and cast them into resources required, so that you can come to Congress and say, "Here is where we are in our tribal health delivery system today. This is where we ought to be. These are the steps that need to be taken to get us from where we are to where we need to go."

We have then the opportunity to present these tribal health plans to HEW for use in the report that must be sent to Congress at the end of Fiscal

Year '79. Under 437, the Secretary must send a report to Congress and a plan to Congress of what is to be done, from Fiscal Years '81 to '83, to bring the status of health delivery systems on your reservation up to this prescribed level, scope, quality, responsiveness. You will have the mechanism to present your plans made available to the Secretary for his use in presenting his plan to Congress.

You will also have that health plan to be used for your own tribal health decisions, as you look at resources that may be available to your tribe through other agencies, through other funding mechanisms. Some of the programs under Dr. Lythcott and the Bureau of Indian Affairs, for example, and the National Health Service Corps have potential resources that could be made available to you. As long as you can define what those resource needs are, you have a better opportunity to go out and find the things that fit within your plan.

We talked a good bit about tribal self-determination, about tribal sovereignty, and I'm not going to get into that red hot area at the moment, but I would like to just leave one comment with you this morning.

There is a final decision in terms of what the tribes may do, and in terms of what tribal resources they need, and that rests, in fact, with the Congress of the United States. The Congress does pass the laws, and the Congress does appropriate the resources. And for us to be successful, for you to be successful, or the Health Services Administration, the Indian Health Service to be successful, we must have the resources that are provided by Congress through the appropriations process.

And third and finally, it requires the decision of Congress, looking at your needs with that professional assessment, and then making the final decision in the distribution of resources and the passage of legislation as it relates to your interests.

Dr. Lythcott talked about the visionaries of the past, visionaires whose dreams have become realities, the realities of today.

He talked about the partnership of the tribes with the federal government, Frank Tenorio also talked about that partnership.

We now need new visionaries to match the challenges and the opportunities that are presented to Indian people, and to their health standards, whether they be tribal or Indian Health Service.

So that our dreams today will become the realities of our tomorrow. And our experience in the past convinces me, in a partnership together-- we can and we will meet that challenge.

Thank you.

Chairman Tommie: Thank you, Dr. Johnson.

Mr. Fernando E.C. DeBaca: As director of that agency of state government which is charged with seeing that health services are made available to all New Mexicans, I strongly support the position which unites you at this conference, that Native Americans are entitled to the fullest measure of health care available to any American citizens.

As I studied the program for this conference and as I listened to Drs. Lythcott and Johnson, I was struck by the high quality of the speakers and participants you have gathered here. The breadth of their knowledge and experience should be immensely valuable to all who take part, but I could tell, also, from the outline of discussions you have planned, that this is not to be just a mere intellectual experience.

You have obviously gathered to make things happen, to create action, and, after all, action is what is needed.

You know, without me telling you, that a nation which has not always done for its needy families must now take positive steps to redress that law. The statistics on health conditions among our Indian tribes, bands and nations make one fact indisputably clear. It is our obligation to do much more than the mere minimum now to make up for the neglect of that past, but you know the problems you face.



GEORGE LYTHCOTT, M.D., Administrator of the Health Services Administration chats with conference participants following his keynote address. Lythcott spoke eloquently of past accomplishments and future hopes in the field of Indian health. (Photo courtesy of the Gallup Independent.)

There is what I call the drag of the past, habits and attitudes of mind which are difficult to change, and the minds of those who consider any departure from the way things have been done as radical as a revolution.

There is, also, to be perfectly frank, something which could be referred to as the drag of bureaucracy. Now, I am a bureaucrat; I've been one for more than twenty years. And I feel that I've been able to use that very bureaucracy to help a variety of people in many ways.

I mean no blanket indictment of bureaucrats, but you know and I know that if you are going to achieve what you need to achieve, you must break through the inertia which so often prevents or hinders forward motion in all government bodies. Both of these drags can be overcome, but overcoming them, it has always seemed to me, takes two characteristics, both aspects of strength, determination and unity.

I take it from your presence here that you are determined, especially in these times and that as Native Americans, you have seen the increasing clarity of what you can accomplish when genuinely determined.

I also take it that this is an example of true unity, people of many different backgrounds, from many parts of the country moving together for a single unifying aim.

The simple fact is that this nation has never learned to mobilize its resources in such a way that the basic human right, the right to be healthy, is achieved for its citizens, even those of the dominant majority.

It is long past time for us to begin moving toward that very ideal.

Perhaps you, by your determination and unity, can help to bring that about not only for your own people and their multitude of needs, but also, to some extent, for those other Americans who have, as history shows, often scorned you and ignored your pleas. To do that would be ironic, but then it would also be good for all of us.

Chairman Tommie: We will proceed to clarify several things before we proceed with our agenda.

At this time, I would like to call on Donald LaPointe to clarify the procedures on the resolution that was presented to this General Assembly.

Mr. Donald LaPointe: There have been some changes concerning the resolutions.

All of the resolutions should be turned in to the Resolutions Committee located right outside this door in front of the Kiva Auditorium.

The resolutions will be officially logged in, given a number, and classified according to subject.

To streamline the procedure, similar resolutions may be combined by

the Resolutions Committee.

The representative for each resolution should, therefore, leave their phone number or a hotel room number where he or she can be notified for a possible modification in his or her resolution.

The deadline for accepting resolutions is at two p.m., Tuesday, February 14. The only exception to this rule is for the resolutions resulting from concurrent workshops on Wednesday morning, February 15, at one-thirty p.m.

No resolutions will be accepted from the floor during any General Assembly.

The first meeting of the Resolutions Committee will take place on Tuesday, February 14 from three until five p.m.

No more than two representatives for each resolution may participate in the meeting.

SECOND GENERAL ASSEMBLY
February 13, 1978

The meeting of the Second National Indian/Alaska Native Health Conference was resumed on February 13, 1978, at 1:30 o'clock p.m., as follows:

Ms. Ada White: My name is Ada White. I'm the Vice Chairman of the National Indian Health Board, and I welcome you to the Second General Assembly of the Second National Indian/Alaska Native Health Conference.

Before I go any further with the agenda, I would, first, like to make some announcements.

I am reminding all conference participants of the resolution procedures that have been established. Resolutions are being received at the Conference Room right off the Kiva Auditorium here. The deadline for accepting the resolutions will be two p.m. tomorrow.

The only exception is for those resolutions developed at the workshops Wednesday morning.

The first meeting of the Resolutions Committee will take place tomorrow from three to five p.m.

A brief update on the resolutions that have been received as of one o'clock: The Resolutions Committee has received ten resolutions. Seven of these concern local issues. Two of the three national resolutions concern sterilization and abortion. The other national resolution deals with supplementary appropriations for contract medical care services.

Before we proceed with the presentation on the National Health Insurance issue, I would like to call upon Orin Tonemah, who is the Executive Director of the National American Indian Safety Council.

Mr. Tonemah: My name is Orin Tonemah, Executive Director for the National American Indian Safety Council. We are headquartered here in Albuquerque.

I asked for this time to make a special announcement that affects all of our tribes across the country with industry and commercial enterprises. As you all know, there's a law that's called the Occupational Safety and Health Act of 1970, that says in part that each employer must provide a safe and healthful work place for their employees. In part, it says that no Indian tribes will be treated any different than the non-Indian employer.

Since 1973, we have been working with the Department of Labor, Occupational Safety and Health Administration. I'm trying to get some action into

Indian country as it relates to this law because there are some problems as it relates to jurisdiction, et cetera.

The Occupational Safety and Health Administration, known as OSHA, has contracted to perform a preliminary study to assess the occupational safety and health needs of Native Americans. The project is now underway and is to be completed by the end of March.

The project team has identified major federal and state reservations and trust lands in the Continental United States and Alaska. Listings by the reservations of the type of industrial, commercial or agricultural enterprises, tribally or privately owned, which exist on or near the reservation, have also been compiled.

For selected industries, which employ substantial numbers of Native Americans, the occupational safety and health hazards will be identified through research and site visits to several reservations.

Site visits will be conducted solely to collect information that would help determine needs. It must be emphasized that there are no compliance implications associated with these site visits.

The results of this project will be recommendations to OSHA for specific areas of assistance which the agency could provide to enhance the occupational safety and health environment of Native Americans.

To accomplish this project, OSHA needs your help. Members of the project's team will be available at this conference. They are interested in getting four types of information.

1. Descriptive information about major firms or industries employing Native Americans. This would include descriptions of work activities, equipment use, and products manufactured or services provided.
2. Descriptions of the safety and health environment of Native Americans in places where they work.
3. The major occupational and safety and health needs or problems of our people as you see them.
4. Knowledge of existing programs which have aided in improving the working life of Native Americans or your own suggestions.

If you have any of this information or want to discuss the project, members of the project team can be contacted through the National American Indian Safety Council's booth. They will be happy to talk with you and learn about the occupational safety and health programs and needs in your areas.

Ms. White: Howard Bad Hand, program analyst for the National Indian Health Board, working very closely with the National Health Insurance Core Group, has been asked to make the introductions of the panel members.

Mr. Howard Bad Hand: I would like to introduce individually the members of the panel who are here. Starting from my right is Mr. Howard Tommie, who is Chairman of the National Indian Health Board and also chairman of his tribe in Florida.

Next to him is Daniel Press. He is counsel to the National Indian Health Board and works very closely with legislation in Washington and keeps us apprised of all the happenings legislatively that affect Indians.

ms Next to Mr. Press is Ms. Luana Reyes, who is the Director of the Seattle Indian Health Board. She works with that health board as an administrator.

y Next to Ms. Reyes is Ron C. Wood. He works with the Division of Health Improvement Services of the Navajo Nation.

ral To my left is Mr. Cecil Williams. Mr. Williams is Chairman of the Papago Tribe. He is also the Indian member to the Advisory Council on National Health Insurance Issues, which is the Carter Administration's panel, more or less, on National Health Insurance. Mr. Williams works very closely with our staff at the National Indian Health Board keeping up with monitoring National Health Insurance legislation as well as performing his duties as Chairman of the Papago Tribe.

ed Next to Mr. Williams is Dr. James Felsen, who is the Deputy Director of Program Operations for the Indian Health Service.

nce And last, but not least, is Mr. William Wilson. He is the Executive Director of the Association of American Indian Physicians.

ic Ms. White: Mr Howard Tommie, Chairman of the National Indian Health Board, will now serve as moderator for the presentation on National Health Insurance.

ct's Chairman Tommie: The National Indian Health Board along with NCAI and NTCA, impressed upon Secretary Califano the need to appoint an Indian person on the Advisory Committee on National Health Insurance issues. When he agreed to that, Cecil Williams was appointed and accepted that position. He will be presenting the Indian position to representatives of the total population who will be meeting to advise on the direction of National Health Insurance.

es, So, we think we have some people up here that can give you a real good overview of the National Health Insurance issue.

ans There have been some changes made that I just learned about last week, alternatives to Indian people since Kennedy came out here and spoke to various Indian leaders, and he outright said that there will be no exception, not even for Indians. Since then, there have been some developments which they impressed me with. And I think we are ready to give you some information here.

our So, at this time, Daniel Press.

bers Mr. Daniel Press: I'm going to begin my presentation simply by providing a brief overview of what National Health Insurance is. And in some ways, it's a difficult task because you are really not going to know what National Health Insurance is until the Congress and the President finally agree on it. It could be something very large; it could be something very small. The most general description is that it's a program, hopefully to be adopted by the federal government, that would give the federal government a much larger role in the financing and regulation of health care in this country.

e, It could be a very broad program, with the government paying for most or of all of the health care that all Americans need and use, and very strictly controlling the amount of money doctors can earn, how they practice, how 1th many hospitals are built and so on.

Even the broadest program doesn't call for the federal government to actually hire the doctors. It would not be federal employees developed, delivering the health care, even under the broadest National Health Insurance program, but the federal government would be financing most or all of the health care services needed by all Americans.

On the other hand, it could be a very narrow program. It could just be patching up some of the gaps in the present federal health program. You have Medicare and Medicaid, and then, most employers offer private health insurance.

Well, under a narrower plan, it simply would be taking that system and plugging a couple of the gaps because, right now, a lot of people fall through the slots, and very little increased federal involvement in the regulation of health care in the country.

What kind of National Health Insurance bill is actually adopted depends, first, on what President Carter proposes; and secondly, on what the United States Congress accepts.

The demand for a National Health Insurance program has come basically from two directions. First, there is a growing agreement in this country that health care is a right. It no longer should be limited just to those people who can afford it in the same way that public school education is a right for all Americans, rich or poor.

Medicare and Medicaid established that principle for certain groups of the population, and the principle behind the push for National Health Insurance is it is now time to expand that right to all Americans.

The second, has come from the desire to reform, or the word used by the administrator, to rationalize the health care system in this country.

Right now, it takes up an enormous percentage of the Gross National Product. They figure about a hundred and fifty billion dollars a year is spent on health care, but there is very little rationality to it. You have individual doctors. You have hospitals duplicating the same services just a few blocks down from each other. You have hospitals putting on new wings, adding new beds, while hospitals two doors down have empty beds, all of which does several things. It adds to the cost of health care. As I say, an empty hospital bed costs almost as much as a full hospital bed because you still have to pay for the cost of the building and the cost of the nurses to staff the ward and all those other things.

The second thing that this irrationality has done is lead to a disparity in the availability of health care. In the fancy sections of New York City, there is an overabundance of doctors and hospitals. If you go a few miles north into the ghettos, there is a shortage of doctors and hospitals. If you go out into the rural areas, there is a shortage of doctors and hospitals.

So the second objective of National Health Insurance is to try and rationalize the health care system in this country by controlling the costs and by spreading the services and the deliverers around so that nobody goes without health care because of a lack of either facilities or doctors and nurses to provide it. And the problem of access to health care is clearly one that Indian people have had a long and unhappy experience with.

Briefly, to give you something more concrete on what National Health Insurance is, I'll describe two bills that Congress has been considering over the last couple of years.

The first one is the Kennedy-Corman Bill. This, to some people, is the broadest -- some people call it a visionary or a dreamer's bill. Senator Kennedy and the group that supports him consider it the only realistic approach to National Health Insurance.

Under the Kennedy approach, National Health Insurance would be universal. That means that everybody who sets foot in this country would be covered, whether you live on a reservation, whether you just walked off a plane, whether you snuck across the border, or what have you. It would be compulsory; everyone would have to participate.

The government would pay for all health care. There would be a very broad benefit package. Just about every basic health care service would be covered. You could walk into a doctor's office, you would receive the care, and the doctor would be reimbursed through the National Health Insurance program. There would be very strict cost containing provisions.

Each hospital would be put on a prospective budget, the way IHS is now. They would have to estimate how many people they would expect to serve, the cost of those services over the year, and the National Health Insurance administration would give them that money, and they would have to live within that budget, the objective being to keep hospitals from raising their rates. Right now, it's very easy for a hospital to add on fancy new equipment. All they do is raise the rates, pass it on to Blue Cross/Blue Shield, who pass it on to your employers. There are no incentives to hold down costs.

So, one of the main purposes of the Kennedy Bill would be to impose strict ceilings on hospitals to hold down costs.

The program would also have a broad preventive health care program. It would be what, I think, most picture or think about National Health Insurance, the government getting in up to the neck in the delivery of health care, doing everything but actually delivering the care.

Another kind of bill says, let's just improve the present system. Most people in this country pay for their health care through health insurance offered to them by their employers. Not all employers offer health care, and some of those that do offer very weak packages. So, the government will say, "We will require every employer to offer health care insurance to their employees and have to agree to pay for at least seventy-five per cent of it. We would mandate what the minimum benefit package would be."

It would be up to each employee to decide whether he or she wanted to participate in that program. If you wanted to participate, you would pay the other twenty-five per cent or whatever amount your employer is not willing to pay. If you didn't want to participate, you would say, "No, I will pay for my health care on my own."

The minimum benefit package that employers would have to offer through their insurance program is really a minimum benefit package. It would cover basic in-patient and out-patient services and probably some catastrophic health care, so nobody would ever go broke if a health emergency hit their family. It would be financed by the employer and

the employee with very little federal financing, except to take care of those people who are unemployed or poor, and, therefore, can't afford either the twenty-five per cent contribution or, because they don't work, don't have access to health care through their employers.

State and private health insurance companies would probably do the broadest amount of the administration of the program. There would be very few controls and very little reorganization or rationalization of the health care system in the country.

So, those are, perhaps not the extremes, but two of the possible approaches that are being considered in Congress. It's very hard to say at this point what is going to come out.

The one thing you can say is that whatever approach Congress adopts, it's going to be the largest federal involvement ever in health care, and it's going to have an impact, one way or the other, on every health program the federal government now funds, including, of course, Indian Health Service and some of the tribal health programs, which are funded through other HEW programs besides IHS.

So, regardless of what kind of bill passes, it can have an impact on you. Fortunately, I'm not on the controversial part of the panel this year, and the rest of the panel will focus on what's being done and what still needs to be done to make sure that whatever NHI bill passes ends up helping and not hurting the Indian health care program.

Mr. William Wilson: To give you a little background, Dan has told you the reason for the paper. A number of years back, I guess about 1975, the Papago Tribe took the initiative and had a health meeting.

Following that, in Palm Springs, in June 1976, the National Indian Health Board had a National Health Insurance meeting. At that meeting the Core Group was initially started. Many of the people who were interested and had been working on National Health Insurance decided that a position paper should be developed.

Historically, one of the problems that we have as Indian people, and there is nothing wrong with it, is we all take different positions. I stand up and say, "this is the right way, me and my tribe believe this is the right way," and then we go before Congress and talk that way. And the next tribe comes up behind us and says, "No, this is the right way to go." Then, somebody else says straight up is the right way to go, and then down and this way and that way. So, before long, we are so split, Congress decides, well, you know, we are going to do it this way and they do it that way. Again, the Indian people get left behind.

So, at that point, it was decided that, if possible, and we don't know that this is possible, it would be interesting for a consensus Indian position paper to be developed, one that would be broad enough in principle that most tribes and Indian people could subscribe to and endorse it. So that when National Health Insurance legislation finally came around, that the Indian consensus position could be worked into one of the bills.

So we started developing that paper based on the Palm Springs meeting.

Now, there were some developments in that position paper which followed at a number of different meetings. And at the National Congress of

American Indians meeting in October of 1976, this consensus Indian position was adopted by the Health Committee and by the General Assembly.

All the while this was being done, there were changes being made from the original paper to the one you see before you now, because many people addressed different issues and the Core Group wants to take that into consideration. And through a series of compromises, we will try to work it out, again talking about broad, general principles, a position that everybody could support.

In October of 1976, the Core Group was invited to Washington, D.C., to testify before the Congressional people.

Now, from that point until May of 1977, there was a series of meetings, but of course, the administration changed. According to President Carter, National Health Insurance was one of his primary issues and was going to be passed. He had his own Advisory Committee set up on National Health Insurance which did not have any Indian person on it.

Through the efforts of the Core Group and the National Indian Health Board, an Indian person was selected, who appropriately, is Cecil Williams, Chairman of the Papago Tribe.

There have been a series of meetings that Cecil has been attending since, almost monthly.

The Core Group met June 16th in Phoenix and went over some issues, and I'm just going to highlight this very quickly. On June 18th, November 3rd and 4th, November 17th and 18th other important meetings were held. The Core Group met with the Kennedy staff and got their ideas which you will hear about later. Then, on January 11th and 12th, the Core Group met again with the HEW staff to discuss the Indian position.

Now, the role of the Core Group is one of wanting to assist the tribes, organizations and the Indian people in developing a consensus Indian position paper. We have no authority, we have no power, we don't claim to have any. But if we can develop the position that you can endorse, then we can all move forward together, hopefully, and get something in the National Health Insurance bills as they come down.

At this point, I would like to read the names of those people who are currently on the Core Group: Theresa Carmody, of the National Congress of American Indians; Aldine Farrier, National Indian Youth Council; Luana Reyes, with the Seattle Indian Health Board; Irene Wallace, from the Papago Tribe; Stanley Tenorio, from the All Indian Pueblo Council; Pauline Tyndall, from the Four States CHR Program; Hickory Starr, a Cherokee; Edwin Tanyan, Seminole; Erin Forrest, NTCA; Ellouise DeGroat, Navajo. The National ex officio members are Cecil Williams, Chairman of the Papago Tribe and also a member of the President's Advisory Committee; John Belindo, Executive Director of the National Indian Health Board; and Howard Bad Hand, Coordinator of the National Indian Health Board Core Group.

All right. Very quickly, I'm going to go over the position paper itself. And then, like I say, later on in the meeting, we can discuss it and choose up sides and have a big bull fight.

American Indians along with other citizens, have been concerned about the planned adoption of the National Health Insurance program in this country.

On the basis of their unique legal, historical and moral relationship with the federal government, Indians receive their health care from the Indian Health Service, HEW, and more recently from tribally run health programs as well.

National Health Insurance, as the largest health program ever adopted by the federal government, promises to have a major impact on Indian health programs. National Health Insurance could be of great benefit to Indian people, helping them to improve their level of health, which is now the lowest of any population group in the country.

On the other hand, National Health Insurance could result in great harm to the Indian people, destroying the existing Indian health system, which they wish to retain and to which they are entitled. These issues must be resolved before National Health Insurance legislation is adopted.

Indian tribes, health boards and organizations have spent more than a year analyzing the various National Health Insurance proposals and discussing their possible impact on the Indian health system. Out of this effort, the Indian community has developed a consensus position on National Health Insurance.

The position which is presented herein, is in the form of certain basic principles that the Indian community believes must be incorporated into any National Health Insurance legislation to insure that it benefits Indian health and does not diminish the level of health services now available to Indian people.

Whatever National Health Insurance approach is adopted by the federal government, it must, in the legislation, recognize and build on the dual rights and status that Indians hold.

The core of the Indian consensus position is that Indians should not be included in the basic National Health Insurance program, so that Indians can continue to build their own unique Indian health programs.

However, a section of the NHI legislation must specifically address Indian concerns by:

1. Reaffirming the Indian people's right to their special Indian program;
2. Defining the relationship between NHI and the Indian health programs; and
3. Strengthening the Indian Health Service by incorporating several of the basic elements of NHI into the Indian Health Service system, so as to achieve equity between Indian health programs and those available to all other Americans.

In particular, the NHI legislation should amend the IHS legislation to provide a guaranteed benefit package within Indian Health Service comparable to the one that will be offered other Americans through NHI.

NHI legislation must also recognize and preserve the principles of tribal sovereignty and tribal self-determination. It must also define the relationship between non-reservation Indian health programs and NHI.

Because the Indian health system is unique, the principles set out will not fit precisely into NHI legislation; instead, it will require a separate section dealing specifically with Indians. However, because of the significant impact NHI could have on the existing Indian health care system, we believe that this separate section is justifiable, and in order to protect Indian rights, the Indian community considers it essential.

Since the final shape of the NHI legislation has not yet been determined it was not possible to provide specific legislative language. However, when the final form of NHI is determined, representatives of the Indian community will be pleased to work with the federal government to transform the basic principles contained in their position into concrete statutory language.

Principle Number One. The NHI legislation must specifically support the continuation of the IHS-tribal -urban Indian health system as the special federal mechanism for financing and delivering health services to Indians; and, as such, NHI must not, in any way, become a substitute or supplement for this financing mechanism or be used to replace or weaken this delivery system.

Principle Number Two. Indian people should be exempted from any compulsory NHI financing charge.

Principle Number Three. Certain elements of the NHI approach, the guaranteed benefit package, the individual's entitlement to that package, and prospective funding to implement that guarantee should be incorporated into the IHS system in conjunction with the adoption of NHI.

Principle Number Four. Indian tribal governments must be recognized as the appropriate governmental entities for administration of health programs for their reservations.

Principle Number Five. The principles of Indian tribal self-determination must be incorporated in National Health Insurance legislation.

Principle Number Six. I'm going to let Luana Reyes address that issue.

Ms. Luana Reyes: I'm representing the American Indian Health Care Association, but I work for the Seattle Indian Health Board in Seattle, Washington.

Before I talk about the specific principle of number six, I want to give a little update on the urban involvement in the Indian position paper, and also give credit to two other people who have been actively involved in working with the Core Group who may or may not be here. Hickory Starr, who has been working also through the Health Care Association and the Oklahoma City Health Project with the NHI group since Palm Springs, and also Dr. Walter Hollow, who will take over the responsibilities as Medical Director of the Seattle Indian Health Board next July.

Since 1976, there really haven't been any full discussions or an updating of principle number six, the urban position on National Health Insurance, due primarily to the unknown quantity or any final National Health Insurance bill that might come up as was outlined by Dan Press.

We did place National Health Insurance on the agenda of a meeting that was held by the American Indian Health Care Association in Minneapolis

last November. We had some very pressing problems of another nature to take care of so National Health Insurance was not dealt with adequately.

In the meantime, I guess, the only thing that I can say is that the representative from the American Indian Health Care Association will continue to watch the National Health Insurance legislation as it is introduced by the Administration and by various members of Congress to see how the impact of such insurance will affect urban Indian health groups and Indians who are living in certain areas where Indian Health Service facilities are not available.

I think that eventually principle number six needs to recognize a little more than it does at the present time. It needs to recognize that there is no question but what National Health Insurance is going to be passed, and about Indian people living in urban areas, affected probably much more than people who live on reservations. And that impact, I think, will come primarily by jeopardizing the category of programs that urban health programs are funded through currently, those programs that deal specifically with mental health, alcoholism, medically related social services, comprehensive dental programs, all of those things which are not specifically dealt with in any NHI legislation; and yet, which urban Indian health programs are currently delivering to Indian populations in several major cities. And that number of cities will grow in the next few years, I am sure.

Bill Wilson indicated that those positions that have been developed and adopted at two NCAI conventions, now, are really kind of broad, general principles that should be incorporated into any NHI bill.

In the urban position, as many of you already know, the principles are so broadly stated that it is a little hard to understand what is being said. And I think I need to say that Congress, at least representatives from Senator Kennedy's staff, were having equally difficult problems in understanding just exactly what the urban position is.

We do have an American Indian Health Care Association meeting going on during this meeting, and we will have another one in the spring in Washington, D.C. I hope that some of the language that is really needed to see the urban position more clearly will be determined.

Basically, what the position says right now is that whatever kind of National Health Insurance program is enacted, it should not jeopardize the continued existence of urban Indian health programs as they have grown up in the past seven or eight years. And we would hope that this group would continue to support that position, however it is stated.

Mr. Cecil Williams: First of all, I would like to thank all of the people who had anything to do with my getting on the National Health Insurance advisory committee.

It has been a tremendously hard job to try to represent the Indians and voice my concerns as certain issues come up.

I want to make one thing very clear in that the committee was formed to try to get the opinions of people from all walks of life.

I would like to just explain a little bit more about the composition of the committee. We had business people, insurance representatives, people

from labor, a state legislator, a Mexican American from Texas, a psychologist, blacks, nurses, at least one veteran, and myself. I was kind of out-numbered there thirty to one.

One of the things we did was travel across the country to look at different health systems. And as you probably already realize and recognize, each area is very different from every other and there are different types of people, and all kinds of different minorities.

We were invited to the barrios in L.A., where they have a children's clinic which provides treatment for children from one through eighteen. One of the interesting things about the clinic was that it employs the team approach to some of the health problems. This was composed of a physician, a nurse, psychologist, social worker and community health worker.

I think my interest is whether some of these things are going to be taken into consideration if National Health Insurance is going to be employed.

I asked some questions about whether this was costed out, but there really wasn't any answer.

The other experience that we had was going to Texas, and again, going out to rural areas to talk with farmers and the Mexican communities.

One of the things that we found out, which made a great impression on the committee, was that the Texas Medical Society exerts strict control over health in the state. There is almost nothing you can do in Texas without a representative of the Texas Medical Society involved. And this led to a lot of questions regarding the federal and state roles.

I would like to point out some of the things that became my concerns as our discussions evolved.

One was financing. Now, how is this going to be financed? Is it going to be like Texas, which would come out of general revenues, or is there going to be co-sharing? Are there going to be co-payments, which means that for every service, you have to pay on an ongoing basis? Co-sharing involves deductibilities, or co-insurance, which means that you pay a hundred dollars the first time, and twenty per cent of the costs from there on.

These were some of the questions that came up and caused very heated discussion.

One of the things that the labor movement was very strong about, was that they didn't want any kind of payment, which would mean that funding would have to come out of a general tax of some sort. And they were very adamant about people, or at least poor people or even their own labor groups, not wanting to go through the process of paperwork.



AMONG MEMBERS of National Health Insurance panel were Howard Tommie (left), Chairman of the National Indian Health Board and of the Seminole Tribe of Florida and Cecil Williams (right), Chairman of the Papago Tribe and member of the HEW Advisory Committee on National Health Insurance Issues. (Photo courtesy of the Papago Runner.)

One of the other major questions was the method of delivery. One of the things that the committee was very concerned about is continuing service to the poor, especially in rural areas. Since IHS essentially services Indians, we have a very strong position for maintaining our hospitals. That became one of the major concerns, especially from one of the black representatives from the South, for he maintained that in spite of legislation, that they have never received the kind of medical service in rural Black America that was needed.

One of the other questions involves breaking up the entire United States into regions, and how that's going to be done as far as health services are concerned. There was quite a bit of discussion but we weren't aware of how this might be considered eventually.

One of the basic principles, which many of the HEW health staff believe and that poses a big question to the Indian communities, is that NHI must be universal.

The other one, with which the majority of the committee agreed, is that it has to be very comprehensive.

And one of the very strong basic principles is accessibility, which must be maintained.

The other major issue was administration, and the federal and state roles therein.

The Texas experience, I think, had the whole committee leaning towards a federalized system, although we had hearings with counties and cities and some of the states, and they continued to maintain that they have to have a say in what kind of health insurance is implemented. But, I think, the majority of the committee agreed that it has to be some kind of federalized system. This was a very strong recommendation.

As far as we are aware, right now, these recommendations are going to be put together. They will be combined with our comments and recommendations on discussion papers.

At our last meeting there was quite a bit of complaining about only recently getting orientated and recognizing and realizing that we have, as a group, been able to work together and discuss many of these issues.

What is now going to happen is that, by late March or early April, President Carter will make a statement on the principles of National Health Insurance.

The Administration is committed to a timetable, and we were told, possibly between May and September, there will be a National Health Insurance bill. Just from one of the exclamations from one of the staff who is putting the bill together, it probably will be in July. And one of the principal features of the bill will be universality.

It seems to me that since myself, Dan Press, and Howard, also Bob Lukacs from IHS, have gotten to know the HEW staff, it's going to be extremely important that we try to maintain continuous contact from here on in.

I think we are probably ending our discussion stage. From here on in, there is going to be an implementation stage. And we can maintain our contact and try to get our input in early on what that bill may be.

Mr. Howard Bad Hand: For the last six months, I have been acting as a National Health Insurance coordinator.

I'm supposed to talk about the testimony at the national and regional hearings across the country.

Let's go back a little way. On October 4th of 1977, the National Indian Health Board gave testimony at the national hearing chaired by Secretary Califano. Mr. John Belindo, Executive Director of the National Indian Health Board, appeared personally before Secretary Califano, and gave the National Indian Health Board's testimony on National Health Insurance. Our testimony did not deviate from the position that you have in your packets. In fact, the whole testimony was developed on the principles defined in that position.

Throughout October, we tried to maintain contact with the tribes in whose areas there were to be hearings held on National Health Insurance. For any tribe who asked for information on those or National Health Insurance itself, we sent it out, we made telephone calls. We tried to reach tribes and say, you know, "This is the Indian position. We would like to help you develop your testimony around these principles." In some cases, as later testimony proved, our mailings did help the development of some testimony, but some tribes did deviate a little bit from the national position.

Now, I'm just going to give a summary of some of the tribal testimony given in October on National Health Insurance.

There was an overriding concern about the fate of the Indian Health Service, and also, there is a general acceptance of the position that non-Indians need National Health Insurance. Indian people prefer continuation of an expanded and adequately financed Indian Health Service. Also, that Indians do not wish to participate in financing National Health Insurance.

And a recurrent theme within the testimony of Indian people was the issue of self-determination. It seemed to be the opinion of most witnesses from both tribal groups and Indian organizations that the Indian people should administer their own health delivery system. That's in the contracting, 437. In fact, a lot of Indian tribes did say that they would prefer tribes to beef up the monies through 437, and other like mechanisms so that the financing could be given to the tribes to run their own programs.

It was also stated very strongly by some tribes that Indians already have their position in National Health Insurance programs within the Indian Health Service. In fact, some representatives also said that there is no need for National Health Insurance for Indian people.

So, I hope that you are beginning to understand that there is a conflict in testimony among Indian people. On one hand, we are saying that Indian people should use NHI as a supplement. On the other hand, we are saying that Indian people do not need National Health Insurance.

Many of the Indian people, I believe, need to have a system that is more adequately funded and more fully implemented, both on and off the reservation.

In reference to National Health Insurance, and in reference to Public Law 93-641, some tribes, in their testimony, stated that there should be one HSA for many smaller tribes. This is a kind of notion to consolidate Indian groups for greater self-determination across jurisdictions.

Other testimony dealt with the need to initiate special programs to encourage and enable Indian people to enter the health professions.

Secondly, was the need in some form to preserve the vital groups for medicinemen, established in some Indian communities. The medicineman is the counterpart of the traditional, family doctor, as you know from experience with the predominant society, combined as sort of a personal, psychological counselor. It was felt by many that care should be taken not to undermine the Indian medicineman.

And that is as far as I have summarized the testimony that came across my desk.

Chairman Tommie: At this time, we would like to call on a person involved with the IHS National Health Insurance activities, Dr. Jim Felsen.

And after that, we will turn the attention back to different issues that have arisen since the last conference. Ron Wood, from Navajo, will be discussing that after Jim Felsen.

Dr. James Felsen: I have been aware of some recently expressed concern and criticism inferring that Indian Health Service has been uninvolved and uninterested as regards serving as a federal health advocate to communicate the feelings, concerns, views, analysis and recommendations of Indian people relevant to National Health Insurance to the Administration and Congressional decision-makers.

Let me assure you that this is not the case. The concern, commitment and dedication of Indian Health Service in this regard remains high. All that has changed is the strategy, and let me elaborate.

For over three years, I have met with Indian groups of this type concerning National Health Insurance. Many of you were present at the original NHI discussions in Tucson three years ago, where issues were outlined, initial analysis begun, and strategy devised.

Those efforts came to fruition at Palm Springs and the position adopted at that session, endorsed by many tribal groups and national Indian organizations.

Subsequently, these groups have carried the word to federal legislators, Administration officials, and most importantly, the Indian/Alaska Native people. The position has been and continues to be revised and developed as necessary.

IHS has continued to support, both financially and through endorsement of the basic position adopted, such efforts. We feel that this is a legitimate role as the principal federal health advocate for American Indians and Alaska Natives.

At the same time, we have decreased certain activities as relate to National Health Insurance. We have emptied our file drawers of numerous

papers, analyses and recommendations outlining how we thought Indians would feel and react to National Health Insurance. Such documents are obsolete.

There is no need to speculate, for a position has been adopted by the Indian people, not for them. We basically endorse this concept and communicate it to numerous Administration officials and other legislators and concerned individuals who solicit our view or opinion.

The Indian people are in the forefront of what we perceive as a great defensive effort to educate decision-makers before the fact, not react after the fact, to a piece of legislation that would once again attempt to put square pegs in round holes.

Does this mean we have done little? No.

We remain active, but primarily in a support capacity. We do not attempt to carry the primary National Health Insurance message for American Indian people. You have been doing an excellent job in this regard and hardly need our assistance.

I should say that you should be aware that our assistance always runs the risk of being interpreted as nothing more than our attempt to assure institutional survival or enhance our bureaucratic presence.

We have attempted to document, to provide the facts and figures to justify why American Indians feel as they do regarding National Health Insurance.

For instance, we have attempted to document the unique health needs and delivery conditions of Indians and Alaska Natives: the present deficiencies of fifty per cent or more of the resources necessary to provide adequate health services to American Indians; the lack of accessibility of health providers for most Indian communities, illustrating that guaranteeing financial accessibility does little to assure the accessibility of health services.

The past failures of state health programs and private institutions to deliver equitable, accessible and acceptable health services to Indian people.

The failure of individual, Indian people to receive a guaranteed benefit package for personal medical services.

The fact that most proposed NHI covered services would only represent a percentage of health services received or needed by Indian people, and the fact that fifty per cent or more of the services needed in dollar terms might well have to continue to be provided by direct appropriations. Specifically, we talked, for example, about environmental health, community health education, outreach, those types of services.

And finally, the inability of Indian communities to adequately utilize their federal, third-party entitlements to effect local health program capacity building.

Such documentation was provided to our current organization, the Health Services Administration, which incorporated it into its National Health Insurance analysis, and forwarded this to the Administration decision-makers.

This HSA document clearly illustrates the unique needs of Indians, and the fact that financial accessibility of National Health Insurance would only be a partial answer to guaranteeing Indian people an equitable and acceptable level of accessible health services.

I think Dr. Lythcott gave you his views and concerns regarding this subject this morning. I think you can get some idea of where the Health Services Administration leads. I should point out, though, I feel that it could be a little bit dangerous to push Indian Health Service too far into a specific position. We have and continue to endorse the basic position and supply support as to why Indian people feel as they do. I'm afraid that if we get pushed too hard in this regard, there is always the possibility that we could be dictated to take another position and to develop data and so on of a contrary nature.

The same type of support information and justification that we have given to the Health Services Administration, which was forwarded to the decision makers, has been shared with Dr. Mongan and his staff, who are more or less the Administration engineers of the National Health Insurance proposal. I met with him personally and discussed it, as well as other people have from the Indian community.

Likewise, we provide numerous individuals and legislators with this support information along with a position paper.

In conclusion, I wish to state that we strongly support the principles of the National Health Insurance position previously endorsed by this group and a large number of Indian tribes and organizations. We support your attempts to educate the Indian population and other concerned individuals and institutions regarding this position and the rationale for its formulation.

We will attempt to continue to be responsive as regards the position of backup material which we feel will assist in justifying this position.

Mr. Ron Wood: Good afternoon. My name is Ron Wood. I work for the Navajo Tribe, Division of Health Improvement Services. I'm a Navajo-Seminole. My dad was a Hill Seminole from Oklahoma.

In October in Phoenix, the statement was presented for Chairman Peter MacDonald of the Navajo Tribe, and also a statement for the Chairman of the Health and Welfare Committee of the Navajo Tribe, Elwood Saganey.

I will briefly summarize some of those remarks and make some additional comments, not necessarily the tribal position, but some of my opinions concerning National Health Insurance.

On the Navajo Reservation, we have a form of National Health Insurance or Navajo Health Insurance. It's called IHS, but it's a benefit package which is very limited, with eyeglasses, dentures, and hearing aids considered not essential or not available for adult Navajos. I realize that IHS is very underfunded and understaffed, but I also know that there must be a better way of delivering health services to a population.

I would like to summarize some of Chairman MacDonald's testimony that was given in October in Phoenix.

Currently, the health insurance is extended to eighty per cent of the American population, and twelve per cent are not supposed to have health insurance at this time. The Indian people are considered to be covered by health insurance of some type by IHS.

It is the Navajo Tribe's contention that the coverage given to the Indians is not adequate. So, we should be considered as part of the twelve per cent that doesn't have adequate health services provided to us.

We've all heard about Public Law 94-437, the Indian Health Care Improvement Act. Additional money is to be pumped into the Indian Health Service to enable Indians to catch up with their health status.

If the Indian Health Care Improvement Act were funded at its fully authorized amount for the next seven years, estimates have been given that the health status of the American Indian might catch up by only about fifty per cent. So, even if that were totally funded, the Indians could not catch up in health status. It's currently funded at about sixty per cent. As the President proposed the '79 budget, monies for Titles I, II, and V are deleted. I'm sure the monies will be added back in, but it does indicate thinking on the part of the Administration.

And if it does come to pass that the Health Care Improvement Act doesn't receive adequate funding, this will become just another empty -- or another appeasement act toward the American Indian people. More money needs to be appropriated for IHS to fulfill its health responsibilities to the Indian people, but with the advent of National Health Insurance, I don't think it's realistic to think that IHS will get additional funding.

In the chairman's testimony in Phoenix, we basically endorsed the National Indian Health Board position, with the exception of principle six, urban Indians. We didn't understand that position well enough at that time. It's the feeling in the Navajo Tribe, and I know a lot of other reservation Indian groups, that there should be no diminution of their funding. The urban Indians have alternatives to IHS.

In the National Indian Health Board recommendation, I believe they want funding for both IHS and National Health Insurance.

The reservation Indians don't have alternatives to IHS. And it was felt that there should be no diminution of funding for reservation Indian groups, IHS. It seems that IHS funding for the urban Indians is not diminishing the reservation funding.

At some point, the urban Indians and the reservation Indians are going to have to discuss specifics and come to a consensus.

I would recommend that as soon as the Administration's National Health Insurance proposal becomes public, that NIHB and the Indian people formulate a new, more specific position statement.

I think the current NIHB statement sounds very good. I think it's easy to reach a consensus on it, but I also think it might be a dream

sheet in the harsh realities of the situation that we are facing with Carter advocating universal health insurance.

I think the question or problem that we are going to face is how much are Indians going to have to compromise and how much consensus can the Indian population arrive at when it comes down to dealing with the specifics of the Carter National Health Insurance proposal.

You know, when you look at the overall picture, we're less than one per cent of the total population of the U.S. and we are going to need all the help we can get to maintain a unique status in the National Health Insurance scheme.

I think we should fight for additional resources based on our underserved populations and substandard health status. I think, until the health status of the American Indian population becomes comparable to the health status of the U.S. general population, we are entitled to funds and health resources above and beyond what the general population is getting. And it's going to be many, many years before we get there.

To conclude, I would like to quote Dr. Romano in a statement he made in 1964. He stated that the Chinese word for crisis is written in two characters. The first character means danger; and the second character means opportunity.

I think we are seeing the danger right now. And it's up to us to start looking for the opportunity within National Health Insurance.

Chairman Tommie: To finally summarize different concerns that the Congressional people have with the Indian position, and the positive challenge put forth by the HEW staff, before we get into our floor discussion, I will turn the meeting back over to Howard Bad Hand.

Mr. Bad Hand: I have been asked to summarize, basically, some of the National Health Insurance concerns that the HEW staff has and some that the Congressional people have concerning the Indian position on National Health Insurance.

Before I do that, I would just like to bring you up on what's been happening so far. We started working with the National Health Insurance staff in December, and tried to really approach the whole issue of National Health Insurance toward Indians in the way that we could work with the National Health Insurance staff and get Indian concerns *into any legislation that they were proposing.*

Now, to my knowledge, the National Health Insurance staff will come out with the National Health Insurance principles by the end of March or early April, with the intent to have legislation before Congress by July or August. And that leaves us very little time to start having input as Indian people into National Health Insurance, as far as the Administration is concerned. With the idea that we are beyond the discussion stages on National Health Insurance, we are now into the implementation stage. And we, as Indian people, really have to keep on top of whatever is happening in National Health Insurance to insure that our concerns are addressed in some form with any NHI proposal before Congress.

Now, we've heard Dr. Johnson and Dr. Lythcott give their views on National Health Insurance. And the basic idea is for Indian people to tap from National Health Insurance without really saying so.

Now, our position, as I'm sure most of you have read it, says that Indians do not want to participate in National Health Insurance in any form.

Okay. Now, we have testimony in October which really pointed out that we do not have a consensus Indian position, because some tribes do want to use NHI as a supplement. Other tribes don't want NHI. And, of course, when you get down to the principles, we start to have problems there also.

When you look at principle number one, people want to break that principle down into two parts: One, a financing component; another, a delivery component. And, as a matter of fact, to get into more specifics, Congressional people, particularly Kennedy's people, anyway, really cannot accept the Indian position as it is. And the reason why I think this is so, is because, as Ron pointed out, we have an Indian position that is really final in its statements. We accept that position as our position, but the political reality of it in terms of Congressional people, is that they cannot accept it as it is. So, again, we have a conflict here.

Now, Kennedy's people say that they cannot accept the Indian position because they believe that the Indian people can tap into National Health Insurance. And, as a matter of fact, in the statements from Kennedy when he was talking about National Health Insurance for Indian people, he said this, and I quote:

"Under our health security type plan, for example, I could envision that the Indians would be entitled to the same guaranteed benefit package available to the rest of the population, and that that package could be -- The Indians would then get their per capita share, perhaps just for the special health care needs and problems of Indians of the NHI benefits paid to their Indian Health Service agent and be paid on a per person basis rather than on the usual service fees as now under Medicare or Medicaid."

ice Now, Kennedy believes that everyone should have universal coverage. He also believes that it should be under general financing, with no specializing as far as financing is concerned.

So, according to the position, we are saying, "We don't want to accept any NHI proposal." And on the other hand, the Congressional people are saying, "Okay. We are going to push for a universal plan."

So that, mostly, the Congressional people basically are saying that Indians cannot be treated separately from others in the country, especially under the financing system.

osal So, we have had talks with Kennedy's staff and are starting to touch on other staffs within Congress, trying to achieve some type of understanding, as far as our position is concerned and what their position concerns.

Now, I think we are using Kennedy because we have worked with his staff and we are just giving you these as facts and you can use these as examples for the kinds of things that we run into in terms of concerns that we, as Indian people, have with National Health Insurance. This would bring me into the whole idea that the HEW staff has.

The HEW staff's basic concern is urban Indians and, from my understanding, those Indians who aren't considered urban but not considered reservation either. And they base their belief that IHS is not really a National Health Insurance program, as some Indian people do believe because, for one thing, and I trust this does not apply to Indians all across the country, we leave out a major share of the Indian people. That's the urban Indians and those Indians not living on reservations, but not living in urban areas.

So, the HEW staff, composed of Mr. Tony Imler and Dr. James Mongan, whom we have met with, they all say basically that they could only accept the Indian position if we would comprise a team of IHS, the Indian people, and HEW, to really look at IHS and try to fill those gaps; in other words, have National Health Insurance provide for those Indians who IHS is not providing for.

So we have a positive challenge from HEW to move ahead and look at IHS and try to fill those gaps or try to define those gaps where they exist, and try to create a plan that will, in a sense, not touch IHS, but make NHI responsible to those Indians not covered by IHS. Now, that's the possibility of where we're at.

And as far as the congressional people are concerned, some would say that they stand for self-determination, they support tribal sovereignty, but they cannot interchange their positions as far as the Indian position is concerned. And that's a plain reality that I think we have to look at.

Now, we had a meeting of the National Health Insurance Core Group in Washington, D.C., in the middle of January. And our position, from our discussions there, was that we would not change the position as it is now, but use that as our position to get a better position within National Health Insurance.

So, where does that leave us? I guess, what I'm saying is, in political reality, we are trying to maintain the position as is, but we may have to change it. And whether we like it or not, I think we have to look at something else very critical. And our position, the Core Group's position, is to keep the position as is in order to gain a better, in a sense, retrospect, and to gain a better foothold on National Health Insurance.

Chairman Tommie: Of course, I don't have to tell you that the position is real, and it can be helpful as a document that will be greatly depended upon when the discussion is held before enactment of this law.

And I think we are well aware that the future health of our children is really dependent upon this law that we have been talking about.

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All of these issues that people are concerned with, speaking on behalf of the Indian people, have already been stated. Therefore, we feel any questions or general comments that need to be made could be discussed in your area caucus, but board members are interested in seeing if there are any people who would like to make any statement or ask questions of the panel that we have up here. This would be the time to do it. We will have a floor discussion at this time.

A Voice: Mr. Chairman, does this mean any program in the tribe or area where it is implemented will require approval of IHS, or will the money, in part, be controlled by the tribal council?

Mr. Bad Hand: That is an issue which has not really been addressed. I think, right now tribes contract and have less control over the money coming down through IHS than they probably need.

I don't think anyone has addressed that issue, but I think that Kennedy and the Administration would be very receptive to any proposal of your tribe to seek greater Self-Determination in handling the money. In fact, people think that 638 doesn't give you sufficient power, sufficient flexibility. This may be another vehicle to increase tribal control.

Jim will now disagree with me.

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Dr. Felsen: No, I won't disagree, but I think you were partially asking another question, and that is, what might happen to a lot of the categoricals with the National Health Insurance and with this type of mechanism. And I think the reality of it is that tribes might look to a lot of the categorical programs to fill in the spaces in their Tribal Specific Health Plans, which they can't get through NHI or through IHS.

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A lot of those categoricals might significantly decrease, as I see it. You know, whether we like it or not, I think that when we go through the arduous task and pass National Health Insurance, a lot of people are going to say, wow, it's all over, you know. We've really solved this thing, this major health problem, and I think a lot of people know that's nonsense. It's not going to fill in the cracks and gaps of the special community service type programs. Most National Health Insurance programs are just not going to do that, even the Kennedy bill. And I think that in the paper we sent down to the Administration, for instance, we predicted that even with the Kennedy-Corman, about thirty to fifty per cent of funding for reservation health, would probably still have to come through direct appropriations of another type. That is not saying IHS specifically, but even if you have the guaranteed benefit package, even at thirty to fifty per cent, some of the other bills, even would be more. While, obviously, the rest of the country is going to say, "Hey, wow, it's all over. National Health Insurance is going to take care of it."

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We are going to see the categoricals from family planning to internal and child health and TB and immunizations and they go on and on. There are already plans to consolidate some of these, but I think you can see a lot of these drop out later on when everyone feels it's all going to be covered under NHI, especially the benefit package.

Then, it could be tough to fill in the gaps in the categorical programs.

So, I think that it's a very real problem. Unfortunately, I don't really have the solution. And no matter what the Indian position is on National Health Insurance, that's probably going to occur anyway, you know, a relative decrease in categorical programs. At least, it will probably occur for a matter of years, and then cycle back like it has for thirty or forty years now.

Ms. Gloria Keliiaa: My name is Gloria Keliiaa. I'm with the Urban Indian Health Board in San Francisco.

In looking at the agenda, at four-thirty, we are going to break into area caucuses to discuss the position papers. Is that still going to happen?

Ms. Ada White: The question, or the position that we're at now is to wait until after we feel where the audience seems to be with their questions. If the need is present for the people here to break into area caucuses to discuss more fully the NHI position, then we have the mechanism set up whereby rooms have been identified for the area groups.

Gloria Keliiaa: In your planning, did you set aside an urban room?

Ada White: I don't think we did. I think we have just one, like California identified, but we didn't say California, California urban.

Gloria Keliiaa: I would like, at this time, to request that a room be set aside so that the urban people can sit down and take a look at this stand.

Chairman Tommie: Personally, I don't know why a room was not provided. So, I am going to call on my area National Indian Health Board member, George Platero, and see if we can identify a room for the urbans to have their caucus.

Ms. Luana Reyes: I guess we need some clarification. There were area caucus rooms that were identified. And I think that, at least in our area, the Portland area, assumed that with 437 and some other issues, the urbans and the others were meeting together. And, it was my understanding that if there were going to be any area discussions, that the urban people in their area would discuss them.

Now, I think we need some clarification on whether the urbans will discuss the positions all by themselves, irrespective of what area they come from, or whether California would like to go to the room that was designated for California.

A Voice: Let me say this, you know, we have a situation that is confronting all Indian people, but it's different in the urban setting on this particular issue. And I think that we will achieve more grounds by all of the urban people sitting down and talking about it, because there are really two sub-issues in this. And what happens on the reservation as far as National Health Insurance is not going to affect the urban Indian people in the same way.

And there is no way that we are going to have any type of consensus from the urban group unless we all sit down together.

A Voice: I don't think anyone is going to argue with you on either of those issues. I guess my only point was to clarify where the rest of the others want to go.

A Voice: -- or would they like to meet together? I think that we have identified a room for the American Indian Health Care Association, who meet off and on during this meeting.

A Voice: The American Indian Health Care Association does not represent all urban Indian projects.

A Voice: I realize that.

A Voice: We would like to have a room where the urban projects can sit down and discuss the position of National Health Insurance.

A Voice: I guess, maybe, I would like to respond to indicate that there seems to be some implication that no one but Seattle or a couple of other city groups have talked about National Health Insurance. Urban people are involved who were involved in the meeting in 1975. The National Indian Health Conference involved largely what we are talking about, the urban Indian position on National Health Insurance. We talked about it again in Minneapolis, in November of 1977, and we will talk about it again now.

The room has been identified as the Acoma Room for urban Indians to hold their discussion.

Chairman Tommie: The gentleman from Leming.

A Voice: I've heard concern about the rural areas and a lot about the urban. I want to express my opinion as a member of one tribe, expressing my feelings toward equality and, also, us getting involved in an act that somebody is thinking that they are doing the best thing for America and for its first citizens.

You know, that without the federally recognized tribes, there would be no Indian programs. That's my first point.

Second, is that there has been a move since 1971 to start segregating within the tribal community. In the early days, health is where it started to make little satellite groups out of Indian groups. I don't see any great representation here of tribal governments, other than the delegated authority going to its health boards.

When we start talking about a policy change, of creating equal opportunity for all Americans in health care, that's okay for the immigrants, but it's not okay for the Indian landlords.

We gave up something for the rights that we have. We gave up ninety per cent of this country. That's why we have Indian rights. For the

other ninety per cent that we gave and for the two hundred and eighteen million Americans, they have the privilege here and the government has a certain responsibility to them.

But the Indian people, we have to give that to them. So, I cannot understand and I feel uncomfortable when we get included as we did in the Native American terminology in the past ten years. Now, we're getting into equal.

I don't think I want to be in that category of being equal, knowing that we still have a long way to reach sub-zero, because we're behind in education, we are behind in law and order, we're behind in housing. How suddenly can a bill that a lot of the tribal governments haven't even seen -- it's all taken care of by your standby groups of tribal representatives, know anything about National Health Insurance.

So, I think the urban people have a right and a concern, along with the rural people. I want to hear more tribal governments, how they feel because they are the ones with the ultimate responsibility to their constituents, tribal groups. I don't think that I'm going to go home with a real comfortable feeling that we can make a decision here, that we can be a part of National Health Insurance.

Chairman Tommie: The gentleman over here in the green jacket.

A Voice: I agree with the last gentleman. We talked about urban and we talked about rural people. These people that we call urban and rural come off the reservation from other states. They come into the different states, different areas. They still are Indian people, but they are not recognized. They call them rural and urban, even though they are counted back home on their own reservations. We have very big groups of people in the State of California and some very large reservations throughout the United States, but they are considered as urban people.

Chairman Tommie: The gentleman over here on the right.

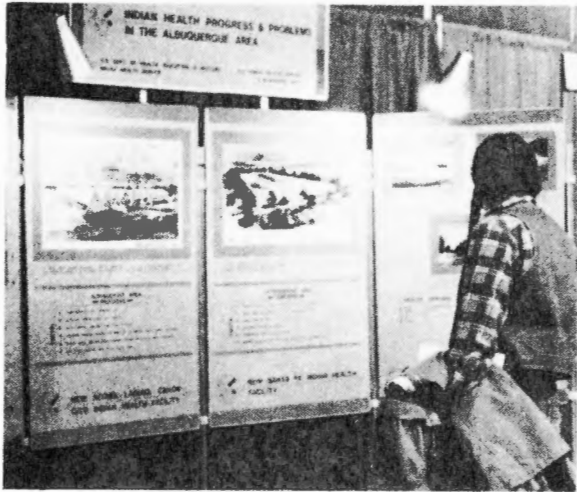
Mr. James McKay: I guess I would just like to reiterate practically the same position taken by Sam here, because I think it's extremely important to try to preserve the integrity of the Indian Health Service with the upgraded funding for it.

I don't know how many people have studied the Canadian health insurance or British. I happen to know a little bit about what happened up in Vancouver because I had an aunt who was eighty-three years old who could not be admitted to a hospital because she wasn't determined to be eligible because it wasn't an emergency. The only way you could get into a hospital is to go through the emergency entrance, and if you are elderly and sick, you couldn't get in.

The same thing happened in Bellingham, where we are. Everybody in those hospitals -- we have two of them, and I presume that with National Health Insurance coming along, we will be at the bottom of the totem pole again as far as admittance is concerned.

Certainly, our health needs are a good deal greater than many other peoples, like, in housing, employment, and all the rest. Of course, we're getting a clinic now. We are going to try to beat some of these things by early detection, but, nonetheless, when a person does need general hospital care, she should be admitted on the basis of need. And I'm afraid when the National Health thing comes along, why, we'll be out of the running again.

Chairman Tommie: Would any of the panel members like to respond to any of the comments that have been made? If not, we will be assigned to rooms and you will have a little bit more time in your area caucus. Ada White will give us the names of the rooms that each area will be meeting in.



Onlookers Browse Conference Exhibits



THIRD GENERAL ASSEMBLY
February 14, 1978

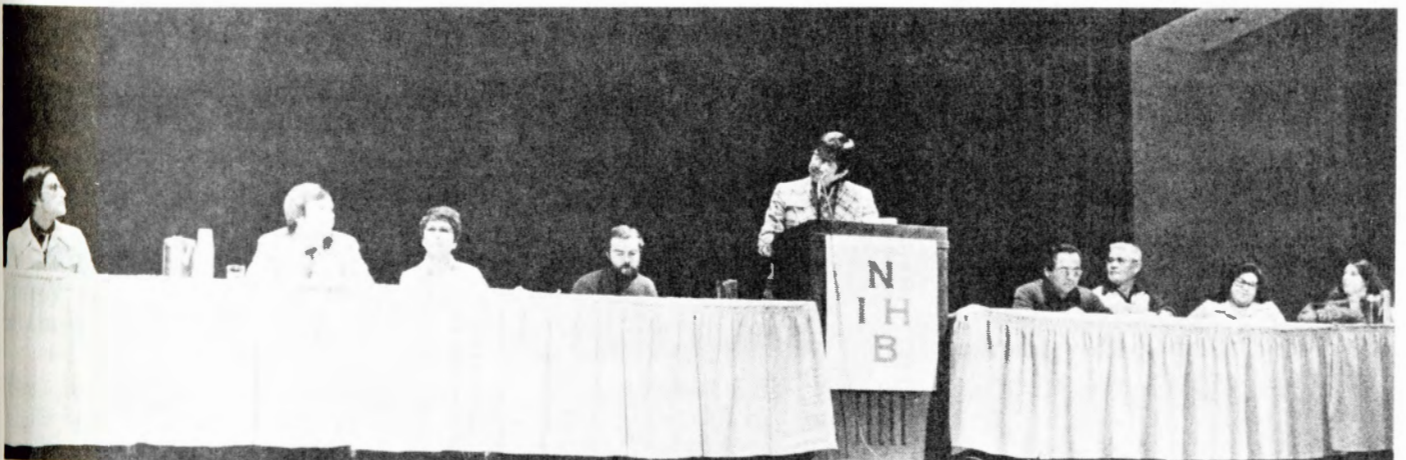
BE IT REMEMBERED that on the 14th day of February, 1978, at approximately nine twenty-five o'clock in the forenoon, the meeting of the Second National Indian/Alaska Native Health Conference was resumed at the Albuquerque Convention Center/Inn, Albuquerque, New Mexico.

Mr. Mel Sampson: I would like to make a brief comment on the number of people who came to Albuquerque here to participate in our second health conference. It kind of tells me that, finally, health is getting the recognition that other Indian related issues have been getting. It is finally being elevated to where I think it belongs and should have been all along.

I appreciate all of the people who have come from as far away as Alaska and all the other parts of the United States and Canada to participate. I would like to pay tribute, also, to the board members, specifically, the Planning Committee and the staff of NIHB who you see running around here trying to keep things in order. I think they've done a real good job, at least up to this point.

An update on the resolutions: as of five o'clock yesterday, they have received seventeen resolutions eleven of which concerned local issues.

Of the six national resolutions two concern abortion and sterilization,



INTRODUCING members of the Implementation and Progress Report panel on P.L. 93-638 and P.L. 94-437 is Mel Sampson, Chairman of the Northwest Portland Area Indian Health Board. (Photo courtesy of Melvin McKenzie, Navajo Division of Education.)

one concerns supplemental appropriations for contract medical care services one concerns HSA authority over tribes, one concerns the Indian Health Service role in National Health Insurance, and one concerns the validity of the 1970 Indian census.

The Resolutions Committee is going to meet from three to five. And the resolutions concerning the national issues will be voted on by the final General Assembly tomorrow afternoon.

Resolutions concerning local issues will be voted on by the National Indian Board in its Wednesday meeting.

Also, there is a gentleman who came all the way down here from Ottawa, Ontario, Canada. He's the Health Coordinator with the National Indian Brotherhood up there in Canada, which is, I guess, comparable to the National Congress of American Indians down here.

Mr. Raymond Obomsawin: I would like to wish you a good morning, and special greetings from the National Indian Brotherhood, which is an organization which represents Canada's approximately three hundred thousand registered Indian people.

In a very short time, Indian people in Canada, through the organization of the National Indian Brotherhood, will be establishing a national health policy committee. I will be chairman of this committee, and there will be representation from each of our provincial associations, from British Columbia to Nova Scotia, as well as some territorial representation from the Yukon and Northwest Territories.

With regard to this committee, there is something that I feel needs to be zeroed in on, and I would like to address that at this time. History portrays the Indian people of this land as once being a healthy and virile people. Out of over thirty thousand known diseases, only eighty-seven were known to exist among pre-contact Indians of North America. Tuberculosis, cancer, nervous prostration, cavities, rheumatism, arthritis, syphilis, and numerous other health impairments were once virtually unknown among Indian people.

Through misfortune, we have traveled on a long and difficult road, from being among the healthiest of world peoples to what seems to be a complete reversal of that situation.

Today, infant mortality, suicide, respiratory ailments, obesity, anemia, gall bladder infections, tooth decay, diabetes, alcoholism, mental and emotional diseases, and other avoidable illnesses to an unprecedented degree plague the Indian of North America.

Massive sums, in the hundreds of millions of dollars have been expended to curb this deterioration of Indian life, Indian health. To what effect?

At least from the perspective where I work, I can say without fear of contradiction that it is worse than it has been.

The proposed National Indian Brotherhood Health Policy Committee will be addressing political concerns, policy concerns of Canada's Indian leaders but it will also be critically examining the basic causes and reasons that have led up to and perpetuated the present deplorable state of health

breakdown among Canada's Indian people.

The committee will seek to answer vital questions that demand a clear and full explanation. What, in fact, effected the tragic transformation of a people once strong and well, to the present documented condition of backslidden health and resultant disease? To what degree did the traditional living mode and habits of adherence to nature's biological laws have to do with maintaining Indian health and well being? Is there a practical value and relevance to today's Indian people, and to all people, in the personal health care, hygiene, diet and disease preventive measures that were inherent in traditional Indian lifestyles?

What are the chief reasons the previous and current strenuous government efforts to remedy the situation have failed and continue to fail?

I must point out that the basic principles of a foundation, if they are incorrect or incomplete, even the most elaborate super-structure or scheme is doomed to fail or fall.

It is of major consequence and immediacy that these all essential foundation principles of the Indians' grave health situation must be reviewed and addressed.

Our weakened physical condition can well be argued with overwhelming documented evidence as being among the greatest of hindrances in striving for Indian development, mentally, socially, spiritually and, yes, even economically and politically.

Although health services and treatment have their place and necessity, we can no longer afford to complacently ignore the fact that, despite tremendous expenditures by the government and planning energy and needs to remove symptoms, Indian health remains far, far from what it must and should be.

I believe the greatest discovery of this century, surpassing in value all other discoveries that may be made in this or any other succeeding century, is the true and reliable science of health, or more precisely and properly, a science of life and living. It will render life and health as certain as chemistry, physics, electricity and even astronomy.

I must ask, how may a high state of health be found and maintained? How may we assure our fullness of development, physical strength and the freedom from disease and suffering?

How may Indian people be returned to that soundness and the integrity of structure and vigor and force of life that was once our heritage?

Friends, the Great Spirit has not set us adrift on a sea of chance in these matters. He has given us a chart and a compass to steer by, and we are without excuse if we wreck our ship on the shore of sickness and disease.

Yes, friends, disease is always a result of violating those sacred laws that were written by the Creator.

In concluding these remarks, I believe what is required, in fact, to achieve the Indian health that we all dream of and hope for, is the policy and the means to effect a massive re-education of Indian people in the

principles and laws of sound, healthful living, hygiene and diet, this being found in a life that is close to nature, obeying the Creator and his laws, keeping what he has written close to our own lives for our own benefit and happiness.

There is a better way, and I hope that we will find it and walk in it.

Mr. Sampson: Scheduled next is the panel on Public Law 93-638, the Indian Self-Determination and Education Assistance Act with which we have all become somewhat familiar over the last two or three years. And then, Public Law 94-437, which is the Indian Health Care Improvement Act.

So, with us today, we have some distinguished members of various organizations that have been involved in different capacities in working with these two pieces of legislation.

I would like to introduce them first, if I could, and then, we'll bring them up here to make a presentation in order as they appear on your agenda.

First, with the National Tribal Chairmen's Association's Health Committee and, also, chairing NCAI's Health Committee, from California, Mr. Erin Forrest.

And the very distinguished President of the National Congress of American Indians, elected at the past convention in Dallas, Veronica Murdock.

The President of the American Indian Health Care Association, which I think was formulated about a year plus ago, is Jo-Anne E. Lutz.

I want to introduce him, but he's not here. Mr. Howard Tommie will also be up here a little later.

And then, playing a very active and consistent role, are our area directors within Indian Health Service, and the chairman of that group is the Area Director of United Southeastern Tribes Indian Health Service, Jim Meredith.

Next, is the Associate Director for Community Development, the Indian Health Service Office, Edgar Monetatchi.

And last, but not least, is the representative to the National Indian Health Board from Alaska, Ethel Gonzales.

Erin will be first, and is going to give us kind of an overall presentation in reference to these two issues.

Mr. Erin Forrest: I'm going to talk to you a little bit about the position paper adopted by the National Congress of American Indians and the National Tribal Chairmen's Association, which is very, very similar.

I thought I might be able to relate to you some of the things that have occurred with that position paper. You know, it's one thing to adopt position papers and resolutions, and I think, too often, Indian people think it's the end of it when you adopt a resolution or position paper and something is going to happen. Well, it doesn't really happen. Somebody has to do some follow-up work.

And in this regard, I have been having a lot of responsibility. And I

will say this: That the report that I'm going to give is the result of cooperative effort between the National Congress of American Indians, the National Tribal Chairmen's Association, the American Indian Health Care Association and the National Indian Health Board.

We have worked very closely during the past year to bring about some changes in problem areas of the past.

The first item I would like to relate to you is on project officers. As you will recall, the position paper said that project officers ought to be retrained. They have taken an investigative role. They breathe down Indian people's necks, looking for mistakes. And we said, "We don't like that. The project officer ought to be a very helpful kind of person, an educational person, if necessary, to help or keep Indian people from making mistakes rather than waiting until they make them."

I would like to report to you that the Office of Research and Development has designed a training program to reorient and train project officers. And, you know, I think we ought to give them a hand for that somewhere along the line here.

Some of these project officers have been trained already, I understand about twenty-nine of them. During the next few months, there will be a great deal of activity in training additional project officers in various areas. I understand they will be training three from each area immediately.

Now, we were meeting with some of the people from the Indian Health Service last week in Reno. And our Health Committee thought, you know, this training ought to also involve Indian people. And I thought there were really two good reasons that were given.

Number one, 93-638 money is going to be used to train these people. And, after all, the office was primarily designed to train Indian people in how to manage their own health programs.

And number two, I think that Indian people ought to get involved because they ought to know what to expect in the future from project officers. And hopefully, the Indian people who will be attending these training sessions will come back to their various areas and acquaint you with what they've learned in the project officers' training program.

The next item, I think, was a matter of partnership. I think that something very, very interesting has happened this past year in the way of partnership.

Our Indian organizations have developed a partnership, but it's from the top down and not a logical sequence of events from service units on up to area directors on up to the central office.

We've been involved in partnership efforts from the top level down. The first one I can think of is the 437 regulations in which we've worked very closely with IHS people at the top level. And, I think they are doing an excellent job in communications, at least from the central office level.

I know that Indian people are concerned that some of the things that you should have had in your hands that came to the area office may not have

gotten into your hands, and so, you may have some complaints.

And while I'm at it, I might say that the latest 437 update progress report is on the table up here, and during a break, you might want to come up here and get a copy of it.

But, in any case, it's been very interesting because some of Dr. Johnson's staff people have been working very closely with the Indian health committees, primarily through what used to be called the Policy Council, and they have been very much involved in developing the regulations and, also, the next effort followed was the development of Tribal Specific Health Plan guidelines.

And I would like to assure you that the Indian people did have a major hand in designing the guidelines.

And it didn't stop there. The Indian people were also asked to participate in the development of the training for people who provided the orientation to you in your various areas. So, we have had and we have exercised, during the past year, a considerable partnership effort with IHS. Unfortunately, this partnership hasn't been developing so well at the service unit level, and more particularly, at the area directors' level, but I think we are getting there.

One other thing that I would like to mention, one of the first cooperative partnership efforts by Indian Health Service with Indian people was the development of the 93-638 handbook. That handbook has been ready to publish for two years, but somebody is still sitting on it, and if I were you, I'd ask some questions why. It ought to be hatched out pretty soon because that's a long incubation period, two years.

I might say that during the past week, we've made some contact with the Council of Area Directors Community Development Committee, and we discovered that we have the same concerns. We discussed problems of resource allocation with them. And I think, in the future, we will be meeting with them, provided the Council of Area Directors adopts their recommendations. So, Indian people will be involved in local service unit problems and area problems trying to resolve things together.

I was a little bit amazed at some of the problems they talked about, one of them which was directly related to implementation of 638 and 437. There seems to be a communication problem within the Indian Health Service. I notice that they made some recommendations and they didn't come out and tell them what the real problem was.

They asked for clarification, which is the best way to do it when you've got a big boss. You don't come out and say, "Hey, who is responsible for health programs administration in Rockville?" They just said, "Why don't you clarify this for us so we'll know."

Part of your problem is in the fact that nobody seems to know who is responsible for programming in the Rockville office. And I think that maybe, in some of your recommendations, you might want to have that clarified because it is a stumbling block in the processing of applications with which they are having problems. And nobody seems to know who is responsible. And therefore, nobody gives the answers.

Well, we've indicated in the past that we had a communication problem and

I've sort of alluded to that, so I'll not go any further into it.

One of the delightful things that has happened in the past year has been with performance and communications. Dr. Johnson has delegated it, Mr. Monetatchi designed it, a communication method by which you can have your problems heard at the highest levels. And I won't go any further in saying that because he's going to make that presentation, and I don't want to steal his stuff.

Anyway, in that paper we talked about the role Indian Health Service ought to play. And I'm not satisfied that we've reached a level of IHS advocacy that we deserve or need. And I make particular reference to Public Law 641 and to National Health Insurance.

I think with all the experts, and I almost didn't say experts, with all the experts at Indian Health Service, certainly they ought to come up with some people who could help us.

Now, I know that you will be discussing Public Law 641. I happen to come from an HSA area where a plan has been submitted, and there's very little mention of Indian people in the plan, although the Indian people are involved in the delivery of health services in that area. And I think that ultimately HSA's throughout the country are going to be submitting plans to your exclusion.

I think you need a lot of help. You need a lot of legal help. And so, one of the things that we're going to be doing collectively among Indian people is asking for specific assistance in designing the kinds of materials you will need to deal with the problem of exclusions and HSA's, National Health Insurance, you name it.

One of the bigger problems, I think, that we are faced with and we are going to do something about is the fact that the procurement regulations in HEW are being applied to Indian programs.

Public Law 94-437 provided for the Secretary to exercise waivers whenever he felt it was possible. And the Bureau of Indian Affairs has exercised some of those waivers, and it's not very difficult, as a matter of fact, it's quite easy and can be done very quickly.

Not so with Indian Health Service. It's a long, drawn out process which you and I brag about, and we brag about it to IHS employees, and really the major part of that problem is within the procurement regulations in HEW, not Indian Health Service.

So, we are going to be suggesting to Dr. Johnson in the next day or so that a task force be created including Indian people and some of the best experts they have in Indian Health Service to study the law, review the regulations and design some procedure with alternatives to simplify procurement by Indian people.

We are not in a competitive field such as cities, counties, and state governments. In Indian programs, we are seeking contracts and rights that are very specifically for Indians and for the tribes. So, we feel very strongly that the regulations ought to change so that Indian people need not have to go through the whole process that currently exists in procurement for competitive type programs.

I expect perhaps that we're going to be getting some help in that area.

The last item I want to mention is in appropriations. As you know, last year the President's budget was presented to the exclusion of funds for most of the programs authorized in Public Law 94-437. I don't know how many of you have seen the 1979 budget, and it's worse than the previous one.

We overcame some of the difficulties in the '78 budget by doing something I think that you ought to know because it's very unique. Testimony was presented on behalf of the Indian people jointly, among the National Indian Health Board, the American Indian Health Care Association, the National Congress of American Indians, and the National Tribal Chairmen's Association. We decided we had had enough of this pulling one way and pulling the other way. And we were going to go jointly together, prepare testimony together, present it to Congressional committees together, and it worked.

We had a considerable amount of money restored to the programs for 94-437, and I expect we are going to do the same thing this year because I think, collectively, we sort of are surprising them by showing them some resemblance of unity, at least in testimony.

So, as far as the progress report goes, I think that we can say that we've made some gains. It's been slow. Things are beginning to move, people are beginning to listen to us, particularly within IHS. And I think that as we continue to work together during the next few years, and these are going to be critical years, maybe we will realize the objectives that were set forth in Public Law 93-638.

Some of you will recall what I thought those objectives were, and for those of you who were not in Palm Springs, I visualized a partnership of something other than the Lone Ranger and Tonto type relationship. You know, the Lone Ranger rides a great, white horse and some of our IHS people had better get off their high horses and get down to work where our dumb horse is because that's where the work is at. And I really believe that some of them think that they are on pedestals and I think they had better get down because we are very willing to work with anybody.

However, if some people feel that we are too dumb to work with them, I think that they have a problem and we don't.

I also alluded to the Lone Ranger's mask. I said, "My God, us Indian people don't have any masks because we don't have anything to hide." And I have to say that some IHS people are still wearing that mask as if they had something to hide. And I think maybe we can talk to them and work something out with them so we can all look each other in the eye and say, "We're doing a job for Indian people."

The last thing I said was that the Lone Ranger hadn't ought to feel that all we're limited to is saying, "Kimo Sabi," because in the future, we are going to have a hell of a lot to say. I think in that regard, Indian people are speaking up more, and I'm real pleased that at least some progress is being made.

I'm kind of optimistic. I think during the next year, we will finally establish a relationship with this body they call the CAD's, the Council of Area Directors.

And hopefully, we can sit down, since we have the same goals in mind and are in charge of the same responsibilities, to provide the best kind of health services to Indian people that can be provided.

Mr. Sampson: Our next guest and panel member is the President of the National Congress of American Indians, Veronica Murdock.

Ms. Veronica Murdock: I was glad to read within the program, that one of the objectives of the National Indian Health Board is to promote close coordination with area health boards, service unit boards, the National Tribal Chairmen's Association, and the National Congress of American Indians.

I think that as Erin has told you this morning our objective as national organizations has been, to work together in trying to address many of the issues that face our people.

And I think that this came about just because we recognized there was a great need for us to speak with a united voice. And I think that that doesn't say that we don't have differences and that we don't have difficulties in determining the method in which we think legislation should be written or how it should be addressed and what the problems are, but I think that it shows that as national organizations, we can get together, come to some agreement and that we can move forward. And we felt that we can fight it out on one level, and make what we feel is a good decision and the best decision, and taking into mind that we represent a number of tribes, a number of people, and move forward in the best way that we can.

Some of the people that you see at this conference are the very same people who serve on the National Congress of American Indians board and the National Tribal Chairmen's Association boards and committees.

So, I think that when we say that we're going to continue that effort, that we will, because I think it's an effort that we find has been good for us and that we find a great satisfaction in working together with all the people who are interested in the health situation.

One of the things that the National Congress of American Indians is doing is making up progress reports. And we provide those to members of the National Congress of American Indians and those people who are on the national boards or other areas who request this information.

A lot of times, people feel that if they are non-members of the organization that they will not receive this material, and I know of many tribes and organizations that do not belong.

And when they do request information, it's not very often that they are refused or not provided the information that we have.

I would like to talk with you about some of the problems I see from my own area and from my own reservation. I have not seen Indian Health Service take a very active or stable role in Public Law 93-638 or in Public Law 94-437. I think that many times Indian Health Service hides behind the image of the doctors. And really what they are is, a big corporation that needs direction and guidance of the Indian people who are here and the Indian people who they are intended to serve.

One of the things that was greatly disappointing to me was that in June of last year, when they had the Public Law 93-638 oversight hearings here in Albuquerque, most of the testimony was directed toward the Bureau of Indian Affairs. Erin Forrest was there and did address Indian Health Service, but his testimony was certainly over-shadowed by the great emphasis on the Bureau of Indian Affairs.

And the one thing that I remember from that testimony is that one of the leaders was asked, as they were getting up to leave the table where they did testify, "Well, what about Indian Health Service? What specifically can you say, and say in one statement."

And the tribal leader responded, and I believe it was Pete MacDonald, by saying, "you can take the testimony that we gave today on the Bureau of Indian Affairs and multiply it by ten, and that's how bad the situation is."

And it appeared to me at that time that the fault lies in many places. And I, as a tribal leader serving on the tribal council on my own reservation, have to take much of that responsibility, too, because I've seen the economic boom on the reservation take the lead. And this is where many of the leaders are putting much of their effort.

And I think that you, as individual members of those tribes, individual health board members, and people who are interested in the health and survival of our people need to have communications with your tribal leadership so that more emphasis can be put on health, because I think it is so important. If you don't have health, there is just very little that you do have.

On the other hand, I think that you, also as tribal members and Indian people, have a responsibility to delve into what goes on in tribal government and why it is so necessary for tribes and the individual members of tribes and Indian organizations and groups, to recognize that tribes must maintain their sovereignty. And it's so important in today's world, with many of the bills that are facing Congress today, trying to abrogate the rights of Indian tribes, to take away their lands and water rights. I think this makes it even more important.

So, on one hand, it has to be a two-way street with our local tribal governments and with what we try to achieve on the national level as well.

I have been to meetings with the Indian Health Service on 437, on 638, and I felt that they were not productive at all. In fact, I thought that they were counter-productive because they are taking people away from their duties at home to come and listen to someone read from a piece of paper or from a set of proposed regulations that could have easily been sent out, digested, and commented on.

This is another area where we lack the kind of responsiveness that we need from the Indian people on the local level. I was just placed on the Human Resources Committee which handles health on my reservation.

Now, we are very lacking in the legislative area. I think that the tribal governments and you people who are in the health field have to assist tribes in the development of comments on legislation.

And I know that we have very many duties at home, but I think that if we

are going to be responsible leaders and advocates of the Indian people, then we have to take the time, we have to make the effort to let them know exactly what we want because I've also found, in the very short time that I've been in the Presidency of the National Congress of American Indians, if someone does not take the leadership role, there is always someone there ready to step in. And they may be Indian or a non-Indian, but there is always someone there that's going to do your job for you. And then you, as the person who was going to be the reciprocate of what they achieved, some people are not going to be very satisfied with it.

Another concern that I have is that, on my local level, the Indian Health Service is trying to initiate the formation of incorporated boards. I know that the National Indian Health Board and many others are incorporating for various purposes. And I question what the purpose would be for pulling the health board or the control of a local health board away from the local tribal government.

And the trouble with that is that the people come in and advocate incorporation, and yet, they never let you know what problems with such an action may be.

So, to me, it appears to be somewhat of a snow job, and we've asked to have it clarified, for them to really let us know what it can accomplish for us and why the tribe can't accomplish it itself, because, after all, we're talking about self-determination. And I know that it is necessary in many places to incorporate to accomplish your goal, but I think on the reservation, that we, as Indian people, have to advocate a strong, tribal government in order to insure our sovereignty and our survival, really.

So, I think we have to be accountable and we must make other people be accountable to us because this is the way to achieve self-determination.

And it goes the same for any kinds of boards that you set up, such as the National Indian Health Board. That board should be accountable to you. The National Congress of American Indians, if you are a member, should be accountable to you. The area representatives that you select should be accountable to you. Are they here? Are they representing your area? Are they listening?

And on the same hand, I say to you, the federal employees that serve Indian people who never come to an Indian meeting, we have a quorum here where we are discussing our concerns and our problems. And I understand that many of you yesterday directed some questions toward Dr. Johnson. I don't know whether he could answer those.

However, I think many of our problems are on the local level, and where are these people? Are they here to listen, to learn, to discuss with you and talk with you about your individual problems?

You know, we can have all the good relationships we want on the national level. The national organizations can be working together, they can be working with IHS, they can be working with Dr. Johnson, whatever, but if it doesn't go down to the local level, we have achieved nothing.

The area directors, service unit directors and others are impeding the advancement of our people in the health field. Then, we really have achieved nothing. And I've seen it because I've worked on that local level.

So, I'm saying to you, maybe we should address our issues to those people. They should sit in these meetings. And as I've said, I've sat in many meetings where they've told us what self-determination was and how we could achieve it, but where were the contract officers when they talked about how easy it is to contract? Where are the contract officers that give us the hassles in the area offices?

Were they sitting there and listening to how easy it was? No. They are sitting back there trying to find every rule and regulation and cop out that they can, so that Indians can't contract and so they can't achieve that self-determination. I've seen this and I've worked with people in this way. And I've gone to very expensive meetings funded by the Bureau and by IHS where people are telling you all of these things, but they are telling the wrong people.

And I think that if people are truly concerned and interested, then they have to make a commitment, also, because we can make all the commitments we want on the national level but if those commitments aren't made on the local level, then they ain't anyplace as far as I'm concerned.

And I think that we, as Indian people, have to all work together in a cooperative effort for the advancement of our people in the health field.

And I think we've gone a long way in that direction, and I think that Erin spoke to those issues fine enough.

And I pledge to you the continued cooperation of the National Congress of American Indians. And don't be afraid to say these things to people that you work with. Get them into your meetings. Make them aware of your problems. Make them go to that IHS doctor when they have a 104 degree temperature and are having a heck of a time getting any kind of attention. Make them sit in there with you. I think this will bring to them what we have to go through. And, I mean, they talk about a fever not being a real concern. And when it's your child, it is a concern. When it's their child, I'll bet it's a concern. So don't be afraid to speak out to these people.

And on behalf of the National Congress of American Indians, I would like to thank Howard Tommie and the board and all of you people for having the dedication and the interest that you have in the health of the American Indian people.

Mr. Sampson: Jo-Anne Lutz, if you would, please, Chairman of the American Indian Health Care Association.

Ms. Jo-Anne Lutz: I'm just going to do the little spiel on what's been happening with regard to 94-437, Title V.

If you remember, I think it was back in November of 1976, and I think it was here in Albuquerque, that a meeting was held dealing with all titles of the American Indian Health Care Improvement Act.

After this, supposedly well-organized training workshops were held, and those individuals were to go back to their areas, solicit responses and provide input on the rules and regulations.

The urban Indians went beyond that. They called a meeting in Chicago in

December of that same year to come back with information that came from each of those areas and put together a paper to submit to the Indian Health Service on the proposed rules and regulations.

We did not stop there. Another meeting was held in Seattle in February of 1977. At that time, along with discussing what was going on with Title V with particular urban health programs, we discussed problems with coordinating testimony, working on full authorization under Title V.

The American Indian Health Care Association was able to get seventeen people who were willing to testify. We believe that we played a crucial role in getting money appropriated under Title V. Although the authorization was for five million, we were only able to secure three-point-two, but we believe if it had not been for that effort, we probably would be sitting with nothing under Title V, staying with our base which, at that time, was three-point-six million.

Again, those people who are involved in existing urban Indian health programs, as well as those who have identified themselves as being interested in forming health programs, wished to have another meeting to comment on the proposed rules and regulations.

A workshop was developed and held in San Francisco in June of last year. There were over two hundred participants.

We came up with a position paper based on the recommendations of the people who were there to submit final recommendations on the proposed rules and regs to Indian Health Service.

Again, I think we were able to demonstrate to Indian Health Service that the urban Indians were going to appear and continue to appear as a unified group. That, again, was cited as our strong point.

We directors and people involved with urban Indian health programs have been faced with dealing with a system within IHS that was not completely defined for everyone. It was pretty much left up to the individual programs to decide how they were going to apply for funding, how they were going to run their programs, et cetera.

We saw a need. And at the request, and after meetings with several people in Indian Health Service, recognizing that the rules and regs would be coming down very shortly, we still didn't have this mechanism available.

How do you decide funding for urban Indian health programs? What criteria do you use? Is there a package that can be uniformly applied to all programs?

In August of 1977, four representatives met with people in ORD to come up with a package that would apply to the full rules and regs at that time, since they had not been finalized.

The group came up with a very lengthy package on guidelines for existing programs and in programs under Title V.

Recommendations came forth that there should be three phases of development and funding under Title V.

According to the rules and regs proposed at that time, a phase one project would be that urban Indian organization, wishing to define what the unmet health needs were, and then applying that Indian population.

Phase two would include those programs that had already done their needs assessment, defined their population, and wished to get into addressing the existing health care delivery system, and that may be in the form of the plural outreach services.

A phase three program would represent a program that was delivering actual, direct patient care.

So, we were dealing with recommendations for those three phases of development under Title V and existing money. Within that, the group made a recommendation that existing programs, currently funded without the Title V money, would receive priority funding.

And then, one million out of that new Title V money would go to the establishment of at least six new urban Indian health programs, whether they be phase one, two, or three.

The group also recommended that within that new money, phase three would receive priorities in funding, and down the line to phases two and one.

This packet was finalized shortly after that meeting in Tucson.

The American Indian Health Care Association wished to have further input allowing all existing urban Indian health programs and also those who have expressed interest in obtaining funding under Title V, to review, comment on or change that paper of proposed guidelines.

We were able to complete that in Minneapolis, in November of 1977.

After three days of much discussion, it was finalized and submitted to IHS. And IHS has adopted that package.

The American Indian Health Care Association views its position as acting as an urban Indian health facilitator.

We have been fortunate up to this time that, based upon the input that we get from those people in urban Indian health programs and those desiring to put together a position, it has been accepted by IHS.

Right now, we are faced with many recommendations that will be made to Indian Health Service. We see and identify needs and try to draw some type of line communication to serve not only programs and people in the urban areas, but conveying that information to Indian Health Service.

Now, in November, the rules were finalized and the requests for proposals had gone out. The package that was developed and adopted was also sent out to each of the IHS areas.

Among the recommendations that came from these workshops was one that a review committee be established. (Keep in mind, these recommendations came from urban Indian people that are in health programs.) It suggested that a review committee consisting of

people in urban Indian health be established to review these proposals that were being submitted to the areas to make recommendations on funding.

The American Indian Health Care Association, in a meeting in November in Minneapolis, requested those individuals who would be interested in sitting on such a committee to submit their names to the association. We were fortunate, and I would like to thank the National Indian Health Board, for providing space for the American Indian Health Care Association to conduct some business, to review those proposals, and to make the recommendations to IHS of this review committee.

We have not received a guarantee that these people will be accepted to sit on a review committee. It's IHS' prerogative, of course, to add to it or take away, but all we wish to do is serve as a voice. And hopefully, if we are successful, as we have been in the past, IHS will respond.

We have identified many things that must be addressed, as far as urban Indian health programs are concerned. Usually, they will either give you programming or money, or the two are all intertwined.

Last year was the first time that all the national organizations, the National Congress of American Indians, the National Indian Health Board, the American Indian Health Care Association, the National Tribal Chairmen's Association, had the opportunity to provide testimony jointly before the Senate Hearings Committee. We hope to do that again this year.

In addition to that, the American Indian Health Care Association will be meeting with urban program people who are interested in providing testimony as they did last year, to go before Congress again, if they so choose, to prepare testimony for Title V.

We are faced with a total cut for Fiscal Year '79. We didn't receive full appropriations in '78. We will be trying to recover that two-point-eight, or whatever the difference was of the five million, and add that to the ten million, which is authorized in 1979.

Our work is cut out for us. And the American Indian Health Care Association firmly believes that this can only be accomplished by the involvement of the people in each of the areas, in each of the local programs. That has been our strength. That is the only reason why we were able to get money under Title V last year, that and the hope that we will not be enemies among ourselves. And I think that sometimes we have people outside the urban areas, some people within Indian Health Service, that try to encourage division among those programs.

So, we are trying to keep that outlook, not only on that basis, but also on a national basis because that's our survival.

1s We, as Indian people, as Veronica said, can deal with the nitty-gritty by disagreement at this level, but when we go up there and testify, we had better be pretty well united because Congress looks at that very seriously, and it can make or break us.

I would like to mention that, for those people who are interested, the American Indian Health Care Association does have a room available throughout this meeting for preparing testimony. If you have questions on testimony or are interested in how to prepare testimony, the Acoma

Room is available all day to do that.

And at three o'clock, we would ask that all existing programs meet. And at that time, hopefully, we will take a vote to see whether or not we do go in. That doesn't include if you would testify individually, but at least to make that impression upon Congress that we are unified as urban Indians in relation to urban Indian health.

Mr. Sampson: Just arriving on the scene in time, as usual, is the Chairman of the National Indian Health Board who has been involved in some of these meetings that reference has been made to as far as the guidance council and so forth.

Howard?

Mr. Howard Tommie: The first representatives to the council from national organizations included Erin Forrest from NTCA, Theresa Carmody from NCAI and myself from the National Indian Health Board. We were selected by our organizations to serve on what was then termed the Policy Council. But a regulation indicated that the Policy Council should be appointed by the higher ups and we could not appoint ourselves, or the organizations could not appoint themselves.

So just to give you a brief overview, that was the first thing we ran into. Then, they turned and changed the name of this group that was monitoring 437 procedures to consultants from the Indian organizations.

As consultants, there were a lot of things we had to learn as far as the procedures in writing regulations.

I don't believe that you're here for me to talk about our activities. I think you probably want to hear -- and some people have probably already explained 437 procedures and all of the past delays that we've encountered. And we are also concerned with various difficulties that we are running into right now.

Speaking of past experiences, the regulations were not signed on time by the Secretary, and I really felt that there was a strategy going on, and the consulting group was very concerned with experiencing this type of maneuvering on behalf of the agency or HEW Secretary, that is ignoring signing off on the rules and regulations on time.

Of course, I'm really expressing only my own view. If anybody wants to have equal time on this particular issue, I'm pretty sure that we can provide it.

But then again, the rules and regulations that were being published were not what the majority of Indian people had hoped for, and we encountered a lot of expressions of discontent concerning them.

The majority of the concerns we now have involve the lack of money involved in 437. As we were informed by Dr. Lythcott and Dr. Emery Johnson yesterday, funding is below what was authorized in the original bill when it was passed a few years ago.

The consultants will be meeting periodically to review funding progress. And after the budget hearings which will be conducted in the latter part

of this month, the consultant group will be meeting in Rockville March 5 and 6 to review the proposed allocation and see what kind of a budget or what kind of recommendations IHS has made along with their reasons. We will also be reviewing it prior to the budget hearings.

Of course, we have been talking about the budget that the President is recommending. Congress did make a commitment to us as far as 437 authorizations are concerned and I think it will be sympathetic in its funding of all titles. I'm not saying that they are going to fund the full amount authorized. Dr. Lythcott indicated that a strict budget restraint is being imposed, yet we will be asking at the hearings for the majority of money to be put back into the 437 proposed budget that's being written up.

So, that's one of the responsibilities that the 437 consultants have to monitor how IHS proceeds.

Of course, there is a process going on for getting scholarships. Each area director or area office has pertinent information and all the booklets and pamphlets have been sent out to each area as far as submitting applications for scholarship grants or loans.

We also are encouraging that other funding agencies be tapped for scholarship grants or loans in conjunction with 437.

We found that information was not getting down to the grass roots level to interested students, and therefore made a strong recommendation that each area office start some sort of a PR program on recruitment.

As I said a while ago, we will be meeting on the 5th and 6th, after the budget hearing.

Dr. Birch? The hearings are when?

Dr. Birch: The 2nd and 23rd.

Mr. Tommie: The 2nd and 23rd are the hearings. There are people who will be interested in testifying on trying to get money back into 437.

I do not want to get into, you know, the ramifications of people asking questions and the consulting people from the various organizations. We've had a lot of activity there, but many times there were policy changes that had to be made at the headquarters level because of the Council saying that this cannot be done. I know that some two thousand comment cards came in with specific requests and most of them have been answered.

I do have an activity report of the 437 consultant activities and I think that we might be able to share it with people who want -- or an organization that might want to write to us and find out exactly what type of activities have been going on.

Dr. Birch is the coordinator for 437 consultant activities, and we have been working with him, and will be serving until 437 is fully implemented.

And I understand that, because of the consultant activities involved with 437, the idea has been adopted for other laws including 638. In my way of thinking, that is a very good idea.

Mr. Sampson: Next, the Chairman of the Council of Area Directors.

Mr. Jim Meredith: I would like to share with you some of the concerns of the Council of Area Directors with respect to 638 and 437 that we have been discussing.

First, I wonder if all of you know who the Council of Area Directors are. They are made up of the directors of the eight IHS area offices, program offices, Office of Research and Development, and the Office of Program Operations in IHS headquarters.

Well, somebody would ask then: What is our purpose?

We discuss management issues concerning the Indian Health Service health care delivery system and make recommendations to Dr. Johnson as to what we envision as the best approach for improvement of that system.

We do try to share this decision-making with you and with the health providers.

As I said, I would like to share some of the concerns with you that we have been addressing lately. I have thought of three of these which I think are most important, which we have been spending quite a bit of time on.

One of those is: Are health providers concerned that it is their mission to provide health services, and is this being pushed aside by top management, both Indian Health Service and tribal?

The second concern is the increasing negative or Dooms Day feelings that occur during discussion of Indian health care and health care programs.

The third is the lack of emphasis put on quality of delivery of health care services, when a contract with an Indian tribe or tribal organization is being negotiated.

We go back to our health providers. I'm talking about the doctors, dentists, nurses, nurse practitioners, physician extenders, tribal outreach workers, lab people, engineers, sanitary and so on. They feel, in looking at the agenda, for meetings held by the Council of Area Directors, tribal councils, health boards, tribal health organizations, other federal agencies, that when we are talking about dealing with the issues of 638 and 437, most of the time on the agenda these items are dealing with contracting policies and procedures, meeting dates, selection of staff, hiring of staff, Indian preference and so on.

They wonder: What about health care and delivery of health care? Why aren't these items of main importance on agendas for meetings these people have?

Another discussion they had with us regarded coming up with proposals for contracts and entering into contracts for health care delivery being proposed by Indian tribes; why are they not included all the time? Why aren't they involved in writing up these proposals?

They ask this with good reason. Again, most of the time, all the way through the proposal, through the final negotiation and the contract, they are not involved, but when the contract is executed and the services are being provided, they are the ones who are asked to provide and define what services are being delivered, deliver those services, and make the reports, so that the contract can be met.

We have listened to them quite a bit lately. And I think we are hearing them. I just hope that it isn't too late.

As to the negative approach, the solutions and decision-making, area directors found themselves, during the past couple of years, meeting and looking at the negative side of the issues concerning 638 and 437.

I'm sure all of you have at one time or another been watching a football game and you've seen a quarterback run a play, and you thought, "What a stupid play. Boy, I wish I could have called that play."

Well, that quarterback was worried about the play he just called all the way back to the huddle and wasn't thinking about the next play that he was going to run. Most likely it's going to be a bad play, also.

So, I think that, to me, sort of sums up what I think all of us should try to do in the future, and that's to think positive. Think about the good parts, of which there are some, and I think a number of them are in Public Laws 93-638 and 94-437 which, if we want, we can use together and get on with the job that we have, and that's providing health care.

Another item is contracting for health care delivery systems, particularly in insuring the quality of health care is carried out when a contract is written with an Indian tribe for the delivery of those services.

As has been mentioned, ninety per cent or more of most government contracts that I've read deal with legal terminology, payment methodology, budget, government requirements to make this policy or that policy or that act.

There's usually not much time spent on the scope of work, method of providing this service and method of evaluating the services provided. It seems to be of less importance. But with respect to health care delivery systems, it's the most important item that is going into the contract.

As someone mentioned, the contracting procedures seem to be very difficult as to the difference between BIA and Indian Health Service. I think maybe part of the problem is in the past, we did make contracting too simple; and now, this is coming to bear in working out these contracts for delivery of health care.

We have been into this. Area directors are spending a lot of time on this subject. We have a subcommittee that is trying to work with IHS headquarters and contracting people to solve this.

One agreement has been reached, and that is that the present methods of government contracting, such as those we are presently using to contract with tribes, were never meant to deal with recurring delivery of health care services. Yet, that's what we have to work with. I think we are finding ways to use these methods and provide that service with quality built in.

Quality is another subject within these contracts that is difficult to deal with. Indian Health Service has all kinds of reporting systems which I think most of you are familiar with. Within these systems, there is a lot of statistical data, but I cannot think of one of these reports that determines if quality of health care is being delivered.

To pass this responsibility on to Indian tribes in a contract becomes even more cumbersome because, to take one of the terms that Dr. Johnson uses, the bean counters need to have a written report in the contracts in order to assure that the contract is in compliance. A written report to be used as the only evaluation tool is impossible with the kind of services that we are talking about.

We do not have a solution for all of these concerns, but we have identified them and are searching for an approach to solve them.

And in answer to Erin, I can say for myself and I think for most of the area directors, that we are trying to work with the Indian people in finding these solutions and delivering better health care.

I've only touched on some of these. I would ask that if you do have some answers to talk to us. I would only ask that you try to do it in a positive way.

Mr. Sampson: Next, we have someone to give some indications of ORD on the Tribal Response System.

Edgar Monetatchi?

Mr. Monetatchi: On your agenda, it says that I am supposed to speak about the Tribal Response System. Well, what we are really talking about is how Public Law 93-638 can be implemented in a manner that is more responsive to people submitting proposals.

What we are trying to do is to look at the process.

Erin talked about a partnership, and that's what I've heard throughout this conference, partnership.

Well, some months back, statements were made that Indian Health Service was not really responding to implementing 638 in the manner that it was supposed to be.

Several meetings were held, and Dr. Johnson gave me the charge to look at why 638 is operated the way that it is.

So, we have a method to approach this situation. Number one is that we are going to look at what 638 really is, what are the requirements of the act, what are the requirements for contracting, what are the requirements of personnel services and so forth, and outline these requirements.

Then, we are going to look at specific cases of proposals that are held up in the process and analyze these cases and find out why. Where did the system go wrong if it went wrong?

Then, we are going to look at a communications system. It's true that we have problems with communication, but so does everybody else.

The only way that we can really look at what's happening is for you to point out to us what your problems are. Now, innuendos and general allegations are no good to me. I've got have specific instances, with dates, and who did what to whom.

Now, in saying that, I don't mean to imply that we are looking to find fault with anyone. What we are really looking at is the process.

If a statement is made such as, "Well, those Indian Health Service employees take too long to process my proposal," how long is too long? In some instances, one day may be too long.

So, my point is that, if you want me to look at your case, then give me some specifics. Tell me how long it took your proposal to go through and the kinds of situations that you ran into. Then, I will take that case and look at it against the requirements of the act.

Again, let me emphasize, I am not looking for who is right and who is wrong, but rather, what it is that we can do to speed up the process. Maybe some of the rules have to be changed. I don't know that yet.

Dr. Johnson wants to know what it is which is impeding the process. Why is it that so many people are unhappy? If it is really the system that is holding it up, fine. Systems can be changed.

Behavior can be changed. It takes a little bit longer for attitudes but they can be changed also.

But we need the information and the data. Therefore, we have to come to you.

Now, I've heard all of the general allegations as to how bad Indian Health Service is at responding to 638 proposals, but yet, I've only had one case in two months.

Now, I'm sure that there are people out there with specific proposals. If you would, call me up. My telephone number is area code (602) 792-6701. If you have access to an FDS phone, it is 8-762-6701. If you wish to write this down, my name is Edgar Monetatchi, Jr. I'm at the Office of Research and Development, Post Office Box 11340, Tucson, Arizona. I would really appreciate hearing what kinds of problems that you are running into because without those cases, I have nothing to analyze but general allegations, and those are no good to me.

Mr. Sampson: Next, representing the Alaskan Native area, and also a member of the National Indian Health Board, we have with us now, Ethel.

Ms. Ethel Gonzales: I would like to extend greetings to each and every one of you here today from our beautiful state of Alaska, and on behalf

of our delegation, I would like to express our pleasure at being with you today.

We have a group of about thirty-five people from our state, composed of health board members from the local, regional and state levels, executive directors of our health corporations, staff people from our area office, our area director, and I would like them all to stand up and offer their greetings to you along with me and be recognized. Please?

We are very proud to have them here, I'll tell you.

In talking with John Belindo about my participation on this panel, he asked that I speak on the difficulties we have encountered in the Alaska area in the implementation of this law.

The foremost and major problem we have faced in Alaska in our tribal organizations designed to contract or obtain grants from 638 has been obtaining resolutions from our tribal governing bodies. And this is because of the large number of tribal governing bodies that exist in the state of Alaska.

There are two hundred and twelve recognized villages. And since Indian Health Service and BIA have chosen to recognize a number of groups in these villages as tribal governing bodies, this further complicates it.

IRA Councils that have been dormant many years have been restored by BIA. And if they exist in villages, they are the recognized tribal governing bodies. If they do not, the village corporations that were established under the Alaska Land Settlement Act are recognized. And in the absence of these, the traditional village councils.

In addition to this, the twelve regional areas established by our Alaska Land Settlement Act were recognized in the regional corporations.

So, all together, we have in excess of four hundred tribal governing bodies in the state of Alaska.

When you multiply the number of tribal governing bodies by the size of our state, it creates a real problem. Even those of us who were born and raised and lived all of our lives in the state of Alaska are constantly -- well, we find it awe inspiring, the vastness and the beauty of our state.

When we offered testimony to the President's Commission on Mental Health, we told Mrs. Carter that Alaska was ten times the size of Georgia. It is three times the size of Texas.

Of the two hundred and twelve villages scattered across the large state of Alaska, one hundred and sixty of them are inaccessible, except by plane. There does not exist a network of roads in our state that can join them.

To give you an idea of the cost of transportation in our state, in 1977 the Tanana Chiefs Conference spent forty thousand dollars traveling in an area larger than the state of California to the site of their region, just to get these consenting resolutions. In this area, there are about forty-five villages.

The Alaska Federation of Natives planned to contract with BIA for development programs. And prior to entering into discussion with BIA, it was necessary for the Alaska Federation of Natives to get consent resolutions from all of the villages affected by the area office. This was the Industrial Development and Tourism Division.

If AFN wanted to consider contracting for this, the cost of getting consent resolutions for this project would be in excess of one hundred thousand dollars. These are administrative dollars that we feel could be better utilized.

The costs of all services in Alaska are excessive. I was talking with Darrell Trigg this morning, and he pointed out that in his area of Norton Sound, there was a little boy who developed an appendicitis on the Island of Diomed. Before care could be taken to him, his appendix ruptured and it was necessary to send a helicopter out to bring him in. They do not have the helicopters that have pontoons necessary to travel over water. So, they had to dispatch two helicopters in the event something happened.

So, the cost of transporting this young boy into Nome was in excess of three thousand five hundred dollars, and this was for a distance of a hundred and twenty-six miles.

It cost less to come down here to Albuquerque, in turn, than it does to go from Anchorage to the Aleutian Islands, a distance of eight hundred miles.

In addition to the distances and the number of tribal governing bodies, the political implications that we face of so many tribal governing bodies does not alleviate this burden, and this is particularly true in the southeast area, where I come from.

Villages themselves are often uncertain which of the numerous native organizations in the communities need to be recognized as tribal governing bodies, plus the fact that the regional non-profit corporations that are delivering these services are not recognized by the Indian Health Service or BIA as tribal governing bodies.

I might point out, just as an aside, as a member of the National Indian Health Board, I am aware of the problems that exist in some of the areas in selecting a representative to the National Indian Health Board that is representing all of the tribes. And I think that it is a reflection on our state that we have so many groups and so many tribes and such a diverse number of people and problems, and we have one representative to the National Indian Health Board, and we've never had a conflict about that, yet.

In addition to this problem, in the contracting process in 638, we find we have resistance from the Indian Health Service to accept 638.

We feel that the Indian Health Service and our regions should enter the negotiation process as equal partners, and not one side telling the other, "These are the guidelines you will have to be directed by, and these are the deadlines you will meet."

We feel the tribal organizations should be part of this determination process. Certainly, they need to become expert in the process and the transition of the law into the guidelines and into the regulations.

We face a lack of flexibility in our programs because of this need to check with the Indian Health Service before we make any moves.

We have a problem with 638 carry over funds. Public Law 93-638 states that funds can be carried over from one fiscal year to the next. Our Alaska area office states that the appropriations act governs, and unless it specifically states the money can be used in more than one year, it cannot be carried over. And this creates numerous problems. We are not making optimum use of these funds. If we feel they could be better utilized, they could be carried over to the next fiscal year, and be utilized by that means.

On May 23, 1977, we received a memorandum issued by the senior attorney, PHS, indicating that non-native board members could preclude a native organization from consideration for contracts and grants under the authority of P.L. 93-638. And this has created some concern in Alaska.

Certainly most of our boards are local, state or regional and composed of native people. Many of our villages have limited populations ranging from twenty-five to two hundred people. And we feel that they should have the right to select whomever they see as meeting their needs as a representative to the boards. In other words, we feel that the rights of self-determination should extend to selecting a board member. So, this is one other area.

These are the only three areas I am going to touch on right now. And certainly, these are areas of difficulty. Certainly, we will be working to find solutions to them so that 638 can become a working instrument for all of us.

Mr. Sampson: I would like to thank all of the panel participants here. As you well became aware, they represent miles and miles and miles of experience, as well as hours and hours and hours of experience. So, at this time, we will excuse them and enter right into our next project.

Your agenda shows Mr. James Kissko, but he has others with him, the people who are representing the various areas here that are going to address new Indian Initiatives within HEW.

First of all, we have Mr. Wilfred Forebush, Deputy Assistant Secretary for Budget from HEW.

Then, we have Mr. William Fitch, Director of the Office of Public Concerns, Social Security Administration.

Mr. William Daniels, Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation.

And then, the leader of the pack, Mr. James A. Kissko, who is the Executive Director of the Intra-Departmental Council on Indian Affairs for HEW.

So, at this time, I will turn it over to Jim.

Mr. James Kissko: Our purpose here today is to describe the new Indian Initiatives within HEW, the role of the Intra-Departmental Council on Indian Affairs, to seek your comments, suggestions and questions.

HEW is the largest of the federal departments. The budget is over a hundred sixty-five billion dollars this year. It's set to have a program that will take you from the cradle to the grave.

Out of that hundred and sixty-five billion dollars, however, only about five hundred million dollars is provided for Indian earmarked programs.

The Indian earmarked programs are the Indian Health Service, the Office of Indian Education, the Administration for Native Americans, the NIAAA Indian alcoholism program, the Indian and Migrant programs, Division of Headstart, and the New Vocational Education program within the Office of Education.

Since its creation over twenty years ago, HEW has been involved in Indian affairs, primarily with the transfer of the Indian Health Service to HEW. And then, over time, other programs were transferred from OEO, such as the ONAP programs, the Indian and Migrant Programs Division. Some new programs were legislated, like the Office of Indian Education and the Vocational Education Program. And some programs were initiated at the administrative discretion of agencies, such as the alcoholism program.

The department's acceptance of its role in Indian affairs has fluctuated from time to time. HEW was reluctant in the 1950s to assume responsibility for Indian health.

By 1968, another HEW initiative was undertaken to make the HEW more responsive to Indian needs and concerns.

Right after that initiative was started, administrations changed and that initiative never really bore any fruit.

It is fair to say that HEW traditionally has not known what to make of its role in Indian affairs. By and large, the Indian programs in HEW have been left to their own devices and they seldom did favor programs.

However, in 1965, Dr. George Blue Spruce persuaded then Secretary Weinberger that there was a real need for more consistent Indian policies in HEW, a need to improve communications with Indian people, a need for improved coordination within the department's programs, and a need for improved services to Indian people through those very large programs within HEW that are directed at meeting the general public's needs.

And it's those programs that have been the least responsive to Indian people for a variety of reasons.

The Secretary responded in 1975 by creating the Intra-Departmental Council on Indian Affairs to carry out the efforts addressing those needs. The council consisted of twenty-five members, most of whom represent key agencies in the department which do not have any special responsibility for Indian people.

The heads of the Indian set-aside programs constitute the executive committee of the council.

Up until very recently, Dr. George Blue Spruce was chairman of the Council. Soon, the new Commissioner of the Administration for Native Americans, David Lester, will be the new chairman.

In addition to the executive committee, the council consists of three working committees: The Barriers Identification Committee, the Resources Committee, and the Communications Committee. We have the chairman of each of those committees here with us today to talk with you.

Before introducing them, I wanted to go over some of the activities of the council over the past year, but I think I can summarize a couple very quickly, and we can move on to the new Indian initiatives.

We have been able to get the department to change its way of collecting data to include a category on American Indians and Alaska Natives.

We have found over the past several years that most programs had no idea to what extent Indian people were participating in their programs. They simply did not have the data category for American Indians and Alaska Natives.

We have been able to send out to the national Indian organizations, position papers, legislation, regulations, in advance so that word could be disseminated to their membership and constituencies and improved communications received back in HEW, after the congressional committees.

We have convened with national Indian groups for the purpose of showing an Indian perspective to the federal officials responsible for managing a number of programs, such as the Title XX programs and the Welfare Reform.

Our council members have been instrumental in working with different agencies, trying to correct misunderstandings that the agencies may have, and trying to temper some of the concerns, the considerations in HEW which frequently are not attuned to Indian needs or Indian concerns because the Indian people represent such a small part of the HEW constituency.

Our people have been very helpful in seeing to it that budget cuts have been restored and in undoing some of the things that have been done because no consideration was given to Indian people.

We have had our failures. The Office for Civil Rights no longer has an Indian focus. We have tried to convince them of the need for an Indian focal point within the office but have not been successful.

We have had many frustrations because HEW is a very massive agency. We have heard a lot said about it over the last couple of days. For those of us who are within the system, the system is very frustrating as well.

Our greatest efforts over the past year and a half, under Dr. Blue Spruce's guidance and leadership, have been directed to formulating and obtaining the Secretary's approval for departmental recognition that a special initiative needs to be undertaken to tune HEW agencies into the needs, problems, and concerns of Indian people, and to make those agencies more responsive.

The common theme in the different parts of the initiatives that you will be hearing is that the department and its agencies have a responsibility to Indian people other than what is manifested just in the Indian earmarked programs, and that the department and its agencies are not fulfilling those responsibilities.

Last summer, Secretary Califano met with a group of national Indian leaders. He acknowledged the fact that, in the past, frequently, Indian people have been shunted off to the Indian set-aside programs when they came to HEW looking for aid. He made a commitment at that time that would change during his term in office.

In October, Secretary Califano approved a series of recommendations based on council work over the last year and a half, which constitute the first part in what will be an ongoing departmental initiative, making HEW and its agencies more aware of Indian needs and more responsive to those needs.

The initiative consists of six facets. I will call on each of the committee chairmen to describe the initiatives for which they have a responsibility, summarize them, summarize what their basis is, and what the next year looks like in terms of accomplishments.

I would first like to call on Mr. William Fitch, who is Chairman of the Barriers Committee, who works in the Social Security Administration. His committee has the responsibility for the cornerstone of the whole initiative; and that is, the Secretary's directive to identify, in consultation with Indian people, needed actions by each HEW agency to improve the delivery of its services to Indian people.

Mr. William Fitch: What we are trying to do in the Barrier Subcommittee and with the improvement of the delivery services, we really need to relate to you and we have to have your input as we go along in this. Let me show you where.

At this point, it doesn't seem necessary to repeat the obvious, but, you know, our studies within the Department of Health, Education and Welfare have shown that there are two hundred and eleven programs in the department. One hundred and thirty-nine of those are programs in which Indians could be eligible. And yet, when we looked into these programs more carefully, we found that only forty-eight of those were being used, and only twelve of them were being utilized by more than one tribe.

I would have to say, and maybe it becomes obvious again, that probably no group within the country is either less informed or more underserved than the Indian community.

And so that, when we talk about improving the delivery of services, I think we can all say together that the time has come and it's long overdue.

I would like to say that we are sending out from the department to every one of the principal operating components, each one of these two hundred and eleven that I mentioned, and we are going to try to find out from each one of them, what they are doing, what their plan is going to be and some time frames in which they are going to get it done.

There are several areas in which we are going to ask for a report from every one of these two hundred and eleven components.

We want to know what the program is that's being effected. We want current data on the program services being delivered to Indians at the present time, and we don't think that's going to be very effective at the moment.

The third one is the quantifiable objective for each program to increase the program services to Indians. We don't want any vague generalities. We want quantifiable, measurable objectives that we know how to relate to and can monitor.

The next one is, we want specific activities planned for the implementation of each program at the headquarters and the regional offices, and I would say that has to go down below because nothing is more true than what was said this morning, that it has to work at the local level.

We want to know how the increased receipt of the services will be measured. This isn't going to be in generalities. We want it specific. We want to be able to see how it's improving from each report that we receive.

And we want the mechanism for Indian input. This is where we will probably have to come to you to see whether or not we can add to what we think we've got in the program.

And probably most important of all is the time frame for the accomplishment. That's a pretty big order, but it's long overdue and it's the only thing that seems will give us the working basis for the program that we think we need to implement and improve.

And by the end of this month, every one of these program operating components will be asked to designate an individual who will oversee the initiative and who will maintain liaison with the council.

In addition, we want the name of an individual who will be identified in each agency to the Bureau level, who will be responsible for his initiative.

We are not asking that this be done necessarily in a vacuum, because the council wants very much to work closely with those who are in the program to see whether it's something we can help, we can identify, because it goes beyond that.

When the plans are submitted, well, that's just the beginning, as far as we see it, because we of various subcommittees in the council will be looking at these plans to see whether or not they are complete, whether or not they meet the objectives that were set out.

We will be negotiating from time to time with some of those people, helping where we can. Then, after we have a plan that we think meets the criteria, it will be approved by the council and sent to the Secretary.

So, this program isn't something we're talking about in the future. From my own notes here, I said that at long last, we are converting our rhetoric into action. This program is already underway. By the end of the month, we will have the people who are going to be involved at all levels. We are going to be getting the plans in from each one of these components by the end of April. And by the end of the summer, we hope to have every one of these programs fully operative.

It wouldn't be fair at this point, as we certainly have learned this from you, when we've asked your reactions to some of our programs and policies in the past, we're not going to sit in judgment on some of

these plans and say, "We like them. We want you to like them, too."

So that, as we get some of these plans developed and we get the program ready to go, we're going to try to get them out to as many Bureau organizations as we can to see whether or not you can see something in them that we have overlooked. This is what we are talking about, Indian input. This has to be a two-way street. It hasn't been that way for all too long.

So that, as we get these plans, as we develop them, we'd like to have your reactions to them and see whether or not there is something that has been overlooked. And we would like to have you know the people who are being named in the components that are going to be monitoring this.

And I can tell you that, as far as the council is concerned, we're going to ride herd on them.

So I would like to think, as Jim said, that this is a cornerstone. There isn't anything that any of us believe in any more than trying to see that Indians get the services that they have long been entitled to.

Mr. Kissko: Next is Bill Forebush, who is Deputy Assistant Secretary for Budget for the Department and also Chairman of the Resources Committee. The Resource Committee is responsible for HEW to take an initiative in developing and better delegating its responsibilities from those other programs, other departments.

Mr. William Forebush: It's a common fact that one of the major problems in delivering services is that different agencies and programs either have the same responsibility or very similar and related responsibilities. And oftentimes, the interrelationships of these things get confused and delivery of services falls between the cracks.

What we have been trying to do in our new project here is to, first, identify critical areas that we might make a study of and try to resolve these kinds of overlapping or conflicting guidelines and rules.

Our major emphasis will be on administrative revisions, but if it turns out that the solution can only be arrived at through a change in law, we would explore that as well, but that would, of course, take a longer time.

Our procedure will be to, first, identify the issue, which we have done. We have chosen two areas that we are going to concentrate our efforts on for the next few months.

Having identified the issues, we would assemble a team to conduct a study. And we envision that team being composed of representatives from the agencies and programs involved, and perhaps some of the Indian organizations who have representatives in Washington who could work with us.

In any case, we would take the results and draft of the study that we do, and circulate them for comment among the Indian organizations.

Then, we would take the result of that study and propose it as a policy document with an implementation plan, and try to get approval of our

own Secretary and any other departmental secretary that might be involved in the initiative as well.

The two areas that we have chosen for initial focus are early childhood education programs, and welfare, particularly, cash assistance.

We have four major programs which are involved in the area of early childhood education. Headstart, I think, is the one that people would think of first, but we also have the BIA Kindergarten Program. We have Indian Education, a small part of which does go for early childhood education. We have a special initiative in the handicap program aimed at bringing services to pre-school children.

When we talk informally with our own people and with some Indian representatives, this is the one of greatest concern, the one that we got the most reaction to. So, we have chosen it as one of our initial areas for study.

Second, we have the question of welfare and cash assistance, and I'm talking about our existing programs. I think it's particularly important that we get our existing programs in order, so that when a major change, which we hope will come out of the Welfare Reform effort, comes along, we hope that we will be able to implement it smoothly. And I think a smooth operating existing program is a big help in doing that.

The programs here are mainly two, but they are quite large. The HEW cash assistance program works through the states. The federal government puts up some of the money and the states put up the rest.

The Indian services or the cash assistance to Indians who might be eligible, oftentimes are not properly claimed, or if claimed, not properly honored.

Second, is the BIA Cash Assistance Program which is designed to sort of backstop this larger effort. Based on the review of the barriers which Bill Fitch was talking about, it's pretty clear that a number of people who might be eligible for cash assistance are not receiving it. And we suspect that a major problem is the confusion of rules and what not, which, if cleared away, would get this assistance to the right place.

So, I think, that because of the major potential for effecting income and quality of living, we have chosen that one as a major focus of attention.

A number of others were reviewed, but not chosen for a study at this time. We may look at them at a later time. And perhaps, if you have suggestions of your own which I haven't mentioned here, if you would send them to us, we would consider them for later action.

One area, which I think we will get into some time later, is trying to rationalize our own programs of training and technical assistance. Almost every program in the department affecting Indians and non-Indians alike, has a component dealing with helping the group being served, using the assistance more effectively or, otherwise, improving performance.

These things are not well coordinated now. And we think that, if they were, we would get more mileage out of the money that we are putting into these programs.

Another candidate is one aspect of economic development, that which is caused by the difficulty of getting Indian construction companies bonded. Bonding is necessary for awarding of a contract. And the Department of Housing and Urban Development has identified this as a problem and we also perceive it as a problem. We might pursue that under HUD leadership rather than our own.

Two other areas are food nutrition and child welfare.

But in the initial studies we will focus our attention on early childhood education and welfare cash assistance.

Mr. Kissko: I would like to turn now to the third Bill, Bill Daniels, who represents the Office of the Assistant Secretary for Planning and Evaluation.

Mr. William Daniels: I'm Chairperson of the Communications Committee. And a theme that I've heard in this morning's presentations is that what we need is better communications. And it's apparent that, when it comes to communicating, we don't do it very well.

But we are attempting to take a look at the whole issue of communications within the department. The state of communications, to put it gently, is terrible.

The council, through the Communications Committee, is addressing that problem.

The information that we hope to communicate within the department and to state and local levels of government includes the current status of health, education and welfare of the Indian people, the basis of the special relationship between Indian people and the federal government, the federal policy of Indian self-determination and its implications, the legal relationships between Indian people and state and local governments, and a summary of the department's policies, progress and activities as they relate to Indian people.

Most decision-makers in HEW do not have this information. Most people that you come into contact with on a daily basis do not have this information. And yet, these people have to make decisions about your lives without the basic information about your special concerns.

At this point, we are in the process of developing an official departmental paper. This paper is going to be directed toward federal, state and county officials, outlining their responsibilities to Indians.

In the development of that paper, we are inviting a meeting with the national Indian organizations to help us identify the relevant topics. And then, when the paper goes into a stage of final development, it will come back to help us authenticate the paper to say, in fact, this is correct.

We are spending a great deal of time trying to figure out the best format for that paper because we don't want it to be just another paper sitting on somebody's shelf. We want it to be something useful; perhaps, it could be in a question and answer format that has been developed by the BIA of perhaps a hundred questions. And for each of the questions, there could be answers, and the process would be open to change and what have you.

We are also open to the best way of developing that paper.

At this particular point, in terms of our dissemination of information strategy, we are in the process of developing program descriptions. We now have a contract with NCAI to develop one hundred project descriptions. These will tell you where the programs are, who is eligible, the applications process, and the regulations and guidelines. It will be kept current and up to date.

Distribution of this will begin on or around May 1, 1978. It will go out to tribal chairmen, tribal councils, various Indian programs, and all other interested people.

The other area that we are working on is the establishment of the council as HEW's central, coordinating mechanism for Indian related legislation, regulations, policies and administrative procedures.

In the past, the way in which Indian concerns have been handled, at best, it's been haphazard and I'm sure you all have your stories. We have our stories, too. Letters are sent to the wrong office. Responses are not always accurate or helpful. The Congress gets many different responses from many different agencies on the same question. It's been recognized as a problem. We have to get our act together.

The council has been designated as the central coordinating point. To work toward that end, we are working closely with the office in HEW that receives Congressional requests, letters to the Secretary, circulates regulations, and we are working with the office that develops and circulates legislative proposals.

It is our desire to invite the representatives of national Indian organizations to meet with us on a regular basis, to bring an Indian perspective to our programs, strictly those that do not have a primary Indian focus.

We are also exploring various ways in which we can better communicate on a regular basis. Perhaps, it's a newsletter. However, the word newsletter doesn't strike us that well. Most government newsletters that I know of have information from two years ago when you receive it next year.

The other areas that we're working on -- Again, it's our desire to communicate to the department, to let it know that there is a council. And this council is made up of people that have some sort of effect on Indian programs, and also offices, as I mentioned earlier, that touch Indians, and also have some sort of contact with the national Indian organizations.

The role of the council, if we do our job, would be to provide a rationale and a greater consistency in the department in the way that we handle Indian affairs, because right now or in the past, we haven't handled it very well. And hopefully, through the combined effort and the commitment of Secretary Califano, we will be able to achieve this end.

Mr. Kissko: I really can't summarize much better than Bill did. I think we are well aware of initiatives that have begun in the past and

have died out through neglect and for other motivations. I think we have learned a lot by what has happened in the past, and I think we are at a particularly fortuitous time, when we have Secretary Califano as the head of HEW. He has made his commitments. He's a strong leader within HEW, and I think we have an excellent chance of fulfilling the promise that this initiative implies.

I hope to be able to come back next year and be able to tell you about the accomplishments that have been made over the past year.

I would like to open up the session to the floor and any questions that you might have, now or later.

Thank you for your attention, and thank you to the National Indian Health Board.

Any questions?

Jim McKay: I have a question for the second Bill.

Jim McKay is my name, and I'm from the State of Washington. I was interested in his remarks about bonding in connection with construction work that may be going on in Indian Health programs, for instance, in the Chemawa School, they will have a clinic built in connection with the rebuilding of the boarding school.

I know that some Indian tribes do have construction capabilities for doing construction within reservations. And I'm just wondering what, if any, difficulties we're going to have in connection with the bonding or bidding on jobs such as this school.

Mr. William Forebush: I think it is a problem that we have recognized. I believe, that from the point of view of the government, though, the best department takes a leadership in resolving it and that is HUD. So much of their activity is in the construction area.

They have contacted us and said that they are interested in trying to do something, and we will work with them in a supportive capacity.

Should that not be successful, we would try to address the bonding issue ourselves.

Mr. Kissko: I might add that this issue has come up frequently at meetings with various departments on Indian business and economic development. I have been hearing about it for the last three years. Everyone recognizes it as a problem, and yet, there has been no real effort made in those last three years to change the situation.

There have been suggestions made, a lot of discussion, but very little real work to resolve the problem. We feel that HEW has responsibility in economic development that derives from the Office of Native American Programs, which is now ANA. And while our stake is relatively small, it's important that this bonding issue be resolved.

And we are willing to help HUD in focusing on that issue. If we aren't able to help focus the issue with HUD, we will take some steps ourselves, at least within HEW, for HEW contracting and construction to resolve the bonding issue.

Mr. McKay: What is that again, 93-638?

Mr. Kissko: Oh, 638, yes. But there are other possibilities, too, because the construction under 638 would be a party to that, but there is other construction on or near reservations that the bonding problem has prevented from going to Indian construction companies.

The Indian construction companies, as I understand it right now, are not very healthy because they are having a great deal of difficulty getting work off the reservations, as well.

That's certainly under 638.

Any other questions or comments?

Ms. Emma Farrow: I'm Emma Farrow from Oregon.

I have a comment. I feel that in our Social Security Office in our little city that when our older people go into the office, the staff isn't very responsive. In fact, they are not very welcome. I mean, how much does it cost to smile?

And I think that you probably know that our older people, not only our older people, but a lot of time we don't ask the right questions. So, often we are told, "Well, we can't help you."

And I feel that they can. And they really need to bring somebody in with them to talk about their problem, especially dealing with social security,

And yet, I feel that the staff there is not responding. And I think that maybe one of the things is that they are not willing to deal with the paperwork.

So, what can you do to help us with this problem?

Mr. Kissko: Before I turn this over to Bill Fitch from the Social Security Administration, I would like to say that, in the past, the state and the local governments have been perpetrators of a lot of discriminatory programs that really come down from HEW.

And it's frequently difficult to deal with the states and to change their patterns of behavior.

Now, I think that the problem that you've pointed out is a very real one, and it's even closer to home to us because the people who run those local social security offices are feds, as ourselves, that should know better, and they should have a different attitude.

The Social Security Administration is making some efforts right now to improve that situation.

And I would like to ask Bill to briefly describe what's in those efforts.

Mr. Fitch: I'm very grateful for that expression, because it's the sort of thing that we're hearing all too often.

But I think you ought to know, first of all, within the Social Security Administration itself, because we know how widespread it is and how many people are programmed to be touched and benefit, we have now a Social

Security Coordinator right within our own headquarters office in Baltimore. What we are trying to do there is also develop an outreach program, find ways in which we can relate more closely with the Indian communities.

Just as you have said, we have many who feel that they have been rejected from the office, partly because their offices don't understand. They don't have an awareness of the background of the problem to know that some of your situations in developing claims are different than they are in many other situations when people have access to transportation and all the other things that are not always available on some of the reservations you come from.

So that we are taking this on from the standpoint of re-examining our whole process in dealing with special groups like yourselves.

And I would welcome, truly, any of you who know of situations in any office. And I don't mean from the standpoint of complaining necessarily, but giving us a chance to do something about better training some of those people who serve in those offices that do live in an Indian community that is not being properly served.

So, may I give an address? I wish that you would send any comments, suggestions, recommendations, that would be helpful in improving the quality of services to me. It's William Fitch, Director of the Office of Public Concerns, Social Security Administration, Altmeyer Building, 106, Baltimore, Maryland 21225.

My telephone number is (301) 594-2930 or 2929.

One of the other things that you ought to know is that we have just signed an agreement with the Community Services Administration, where we honestly believe we have not given Social Security and will contact many of those people who are entitled to supplemental income.

We know that many of the Indian people fall within the income categories and we cannot understand why they have not come in, why they are not receiving or why more are not receiving benefits. So that we have developed a cooperative program, now, with the Community Services Administration.

We are training some of their people to go out in the community on a one to one basis, in groups, however it is that they relate to the people at the local level. And among those areas, we are using our original demonstration. We are asking them specifically to include some of the Indian communities.

In doing that, we will identify whether or not there is a need for trained people to go out, whether it's the information we are not presenting properly, whatever it is, we are going to be working closely and finding out how our program information is being transferred to some of those people, and dealing more closely with you at the local level.

And again, if you have any suggestions and input, it is certainly more than welcome. Or if you have areas where you think we could have a good demonstration, we would welcome that. If it's not included in our immediate plans, we will make certain that it is included in later ones.

Mr. Kissko: Yes, sir?

Mr. Leo Haven: My name is Leo Haven, Navajo. My question is either directed to you or the gentleman at the far end. It pertains to contracts

Perhaps, one of your new initiatives could consider this. The problems we have are with processing of billing. You people are familiar with daily cost reimbursement, the contract with IHS, BIA. The delays in processing that billing to get out money to operate with is frustrating.

We submit our billing in Chinle, Arizona, They process it there a week later and take it to Window Rock, and they process it there and they double-check it. Then they wait and take it to Albuquerque. They process it there and double-check it and then it goes to Denver.

Now, all this processing takes anywhere from one month to two months. Now, how can that be speeded up?

BIA operates in the same fashion. IHS is a little ahead, but they are still too slow. With BIA, for example, our December billing is not even here yet. We are operating at a deficit or on a loan basis at Chinle. I have to pay for professional staff, necessary people, patient care and all the necessary things to take care of the extended care facility. It's being delayed by the poor processing by IHS and BIA.

How can that be improved?

Can any of you answer that?

Mr. Kissko: Well, I told you that those of us who are within the system frequently have the frustrations of dealing with HEW, dealing with the budget people, dealing with the people who process the papers, the payroll and the like.

I have to tell you frankly that I don't know. I think the possibility is to make something like that a project for the intra-departmental initiatives, but it's just something that has to be gone through step by step to see where unnecessary paperwork is being required, what kinds of short-cuts can be made. And quite frankly, the government has a history of not being concerned too much with unnecessary paperwork.

Mr. Haven: Now, wait a minute. We make improvements, and then we are back to the same old system, the slow processing of the monthly billings, that are necessary to maintain patient care and necessary requirements to operate a nursing home.

Mr. Forebush: Can I ask you a question about the particular contract you are talking about?

Mr. Haven: Chinle Extended Care Facility.

Mr. Forebush: Is this from Medicare or Medicaid money, or is this from the Indian Health Service money itself?

Mr. Haven: No Medicaid, no Medicare, BIA.

Mr. Forebush: In that case, that does not involve inter-agency confusion or problems. That could be handled by the Indian Health Service on its own.

I would suggest, and perhaps we could discuss or follow-up on this when we go back to Washington --

Mr. Haven: You kept saying new initiatives, and I thought this would be one of your issues.

Mr. Forebush: Well, let me just suggest a solution. In Medicare and Medicaid, the reimbursements are done in advance rather than after the fact.

In other words, the provider, once the basic agreement is worked out, is given a certain amount of money based on an estimate of the services to be provided during that month.

Then after the service period is concluded, a report on actual services delivered is submitted, and if a little more service was provided or a little less, an adjustment is made in subsequent advances.

It seems to me that that kind of a technique could be applied in this case, as it is in Medicare and Medicaid. It seems to me that that problem should have a solution.

Mr. Kissko: Could we ask you to come up right after this session and give us your name and we'll give you our names, and we will talk with IHS together and see if we can come up with a way that is shorter than that.

Unidentified Speaker: I think there are some problems when these things are established, wherever they are.

What I'm trying to say is maybe these should be established at the local level with Indian input. I think that tribes should have the chance to review these criteria before they are implemented.

I think that there could also be hearings at the local level, especially with your group. I think that some of these could possibly be clarified to establish a better working relationship with Indian tribes.

Another thing with tribal representation, it should be by the tribes themselves rather than by those people in Washington who are seeking Indian input.

And I would also like to ask why there is no Indian representation on our board?

Mr. Kissko: I will answer the last question first. There are Indian members of the Intra-Departmental Council on Indian Affairs, but by and large, the people who serve on the council come from offices and agencies that have a perspective of the responsibilities of them toward Indian people.

There are relatively few Indian people in other than the Indian set-aside programs. I think there has been some improvement over the last couple of years, but not that much, and it's regrettable. But as long as these other non-Indian people who are in key positions within the department are there, I think we have to involve them and make them as aware as possible of what the problems of Indian people are. We can't just turn our backs on them. They are there. They are decision-makers.

Mr. Neil Gregory: My name is Neil Gregory and I'm from Kingston, Washington. And I would like to make some comments on the tribal specific health planning process that we are all getting geared up to initiate.

And the comment I would like to make is that, first of all, I think you have some very good ideas. We are going to be planning for the years 1980 to '83, but we are instructed to use census figures which go back to 1970. In my particular circumstance, this is less than a third of the actual people we know are tribal members.

We are going to be planning for a long time in advance, and we are having to use these low population figures right from the beginning, which is going to put the tribes at a disadvantage.

The Indian Health Service people that we work with tell us that they have been mandated to use the '70 census figures. I would like to know whose policy this is and if all HEW programs use '70 census figures?

Mr. Kissko: I would say offhand that '70 census figures are used relatively little, particularly in 1978. I think there are updates provided for general population programs.

I don't know if the IHS requirement is discretionary or mandated in law. I would imagine it is discretionary. I could check with the IHS program management.

But what I would suggest, independent of this IHS mandate, if you know that it's just way off base, and if the system isn't responsible enough to recognize that, I think you owe it to the people who pay your salary who you are working for to provide two plans: one based on the accurate estimates of what the population is, and the one that is required by the bureaucracy, but I would hope that we could get a waiver or some change in that, particularly if you have some basis on which you are procuring estimates on the population.

But nothing should prevent you from being able to work out two conditions, one condition being the '70 inaccurate census base, and the other one being your accurate prediction of the population, but we will check with the IHS program managers and see the basis for that and whether it's waivable.

Mr. Kissko: This is the last question. It's yours.

Unidentified Speaker:

My main concern is our social security representative in Ketchikan. One lady works there four hours a day about one week -- the next week, she's somewhere else. And if you don't go in there and tell her, like my daughter who is eighteen, if you don't have time to tell her or report to her, she sends back a letter and, you know, you are really in Dutch. But when I go down there, she's closed, she's out of town. Almost every week you hear it on the radio, but when you are a working person, you're aware of what is going on but don't read the newspaper because you are tired and then you are at fault.

And what I'm wondering, are they that poor that they have to have just one representative there to cover all southeastern Alaska?

Mr. Fitch: What I was saying earlier, I think we have to take a look at our whole Social Security Program and the delivery of services. We have to take distances into consideration and we have to make sure that we have enough people to serve the people who have a right to be served. And so, this is one of the things that we are trying to do, identify where some of these areas are.

Unidentified Speaker: When you go to the office, it says to call a certain number. When I want to talk to somebody, I would like to straighten it out and get an answer and I don't like calling long distance all the time.

And when a person like me becomes a widow with fourteen children, you know, that's a lot of social security contacts to make. And there are a lot of people with the same problem and they don't complain to the government.

Who is the government? We are, all of us. We put you all in the positions you are in. We are eligible to vote.

Mr. Fitch: As a matter of fact, we do not think that is a complaint. This would be an opportunity to try to do something to improve the service.

Unidentified Speaker: Right. I can see that.

Mr. Fitch: Excuse me. This is one of the whole thrusts that we have within the Social Security at this particular point. It's part of the council in terms of Social Security itself as a program for outreach in trying to get the programs to the people and information to those like yourself and others who need it.

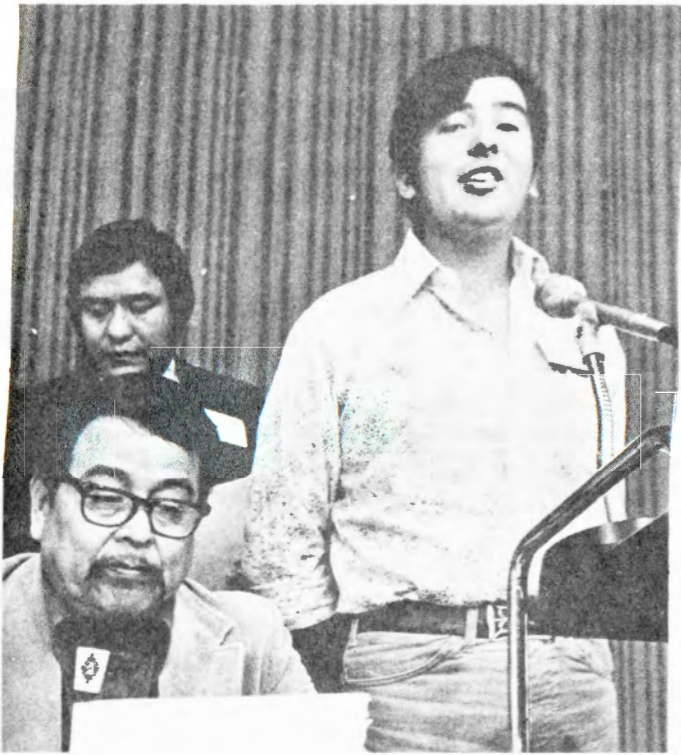
I think we are aware of it, and I think they are working on it, and the proof will be in seeing it happen.

Unidentified Speaker: We need more representatives out there that could take care of each community who don't keep jumping to another community each weekend.

Mr. Fitch: Someone mentioned CETA and there are possibilities with which we might be able to train other people to render assistance in doing some of that work. They don't have to be full time workers necessarily or even in the office, if they are there to assist the people, they are one of the kind of bases that we can work out.

Mr. Sampson: Thank you, gentlemen.

(A recess was taken.)



Speakers Address AISOM Luncheon

A NAVAJO MEDICAL student from the University of New Mexico told those who attended a luncheon in support of the American Indian School of Medicine of the need for such an institution. At left is Dr. Taylor McKenzie, president of the school proposed for construction on the Navajo reservation and pictured behind him is Dr. Thomas Atcitty, of the AISOM staff. (Photo courtesy of Melvin McKenzie, Navajo Division of Education.)



JOHN BELINDO, NIH Executive Director, addresses those who attended the February 14 AISOM banquet. Belindo served as chairman of the team of Indian and health education professionals who associated with the feasibility study on an Indian school of medicine mandated under Title VI of the Indian Health Care Improvement Act. (Photo courtesy of Melvin McKenzie, Navajo Division of Education.)

FOURTH GENERAL ASSEMBLY
February 14, 1978

The meeting of the Second National Indian/Alaska Native Health Conference was resumed on February 14, 1978, at 2:00 o'clock P.M., as follows:

Ms. Irene Wallace: We are going to start out with some announcements, some that you have heard, and others that will be new.

One of the most important ones is going to be a final announcement on the resolutions. To date, we do have thirty-five resolutions.

No more resolutions will be accepted after two o'clock.

This afternoon, we are going to be dealing with another law that happened about three years ago or so. And many people have a lot of problems with the law. There are so many different kinds of ways that this law has been handled throughout the country. There are many people who still don't know what it's about. There are many people who are trying to deal with it at their local level. There are those people who would like to see us participate in this law; and then there are those who don't want to participate.

One of the things that we are going to try to do this afternoon is give you an idea of, from the different levels, how this law is working.

We have people from the national level. We have people from the tribal level here. And each one will be talking about a different aspect of that piece of legislation.

After we have gone through the speakers, we are going to break up into workshop areas where we will give you an opportunity to talk about some



PAPAGO Executive Health Staff member, Irene Wallace chairs the Fourth General Assembly dealing with P.L. 93-641 (the National Health Planning and Resources Development Act). Wallace's tribe was a forerunner in knowledge of and involvement with the law. (Photo courtesy of the Papago Runner.)

of the things that will be presented this afternoon.

We are going to start out with Mr. Herb Semmel, who is a representative from the Consumer Coalition for Health from Washington, D.C., of which the National Indian Health Board is a member. And he's going to give you a very brief overview of the law and then talk about some of the duties that they have.

Mr. Herb Semmel: I particularly want to thank the National Indian Health Board for affiliating with the Consumer Coalition for Health, which has been a major activity of mine now for the past year.

We think that health planning does have a potential for improving the delivery of health care, for bringing about a fair distribution of resources for help and for reducing the runaway inflation in health care.

It is a potential which has not yet been realized, however, for some reasons that I will discuss in a minute.

Health planning also causes substantial dangers for many groups in American society. And the dangers it presents in the health care for Indians and tribal sovereignty are particularly serious.

On the other hand, I think, we all have to accept the fact of the law is here; health planning is taking shape. There are two hundred five HSA's, Health Systems Agencies, in operation in every part of the country. And these HSA's and state planning agencies are making decisions which affect every one of us in the health care we receive. So, like it or not, we must deal with the notion of health planning.

The Consumer Coalition was formed to fill a vacuum which we found existed at the national level, and also to encourage others to fill similar vacuums that exist at state and local levels.

When the planning law went into effect in 1975, and the process of implementing it began, the process went on with virtually no input from the public, from the consumers of health care, even though the law was passed for their benefit and even though the law specifically provides that the consumers are the ones who are supposed to control the basic health planning process.

That was going on, as is the usual case, with the federal bureaucracy trying to implement the new law, and with lobbying influenced by the interests in the health care industry, the AMA, American Hospital Association, and the various other groups of organized providers.

So, last summer, a conference was held by consumers in health planning, and out of that conference came the Consumer Coalition, which is a coalition of national, local groups, HSA's, and some individual members. On the national level, we have the AFL-CIO and other labor unions, groups representing minority groups, and rural organizations such as Rural America.

We are very proud that the National Indian Health Board was a charter member.

Despite the different interests in some areas, all of these groups in the coalition have one thing in common, and that is, they are all consumers of health care.

I've been asked to give you a very brief overview of the health planning law. I should start by apologizing to some of you who are already familiar with how the law operates and, with some great sophistication. I will be giving a rather broad, generalized view, but I hope some others will benefit from it.

Let me just start by, in some unsimple terms, saying, "What do we mean by health planning?"

es The basic idea of health planning is a good one, and is sorely needed in the health area where there hasn't been too much systematic planning in the past.

Planning means, first of all, that we examine the needs of our people for health care.

n Secondly, that we take an inventory of the existing, available services.

Third, we set some priorities for closing the gap between the needs and the available services.

And finally, we apply these priorities in allocating resources for future development in health services.

Of course, this is a very theoretical model. It's not yet in operation.

Most Health Systems Agencies have not yet completed the first three steps, determining needs, available resources, and priorities. Those three steps are supposed to be, or when they are completed, result in something called a Health Service Plan for each area and for each state.

Secondly, the legal tools, which are set out in the law to require allocation of resources in accordance with the plans, are not yet mandatory.

Third, and in many, and perhaps most cases, the planning process continues to be dominated by the medical establishment, despite the legal requirements for consumer control.

So that we haven't yet realized any of these potentials from health planning.

How does health planning work under the law known as P.L. 93-641?

The basic planning unit is the Health Systems Agency, which is a regional planning agency. There are two hundred and five of these agencies covering the entire country.

The usual geographical pattern for an agency is a metropolitan area, which usually furnishes the more expensive and complex services, and then, fanning out into the more rural areas of the suburbs surrounding the metropolitan base.

The populations of HSA areas generally range from a half million to three million, but there are a number of exceptions. For example, in a few states, particularly in the West, some HSA's are statewide. There is only one Indian HSA, which is for the Navajo Nation.

The HSA's have two major functions at present. The first is to provide a long-range plan for development of health services. And this involves, as I said earlier, the process of taking inventory of both needs and available facilities, and then translating that into a long-range development plan.

They are also, in the planning process, required to prepare annual plans which implement the long-range planning.

Now, these plans, themselves, are not legally binding on anyone else in terms of allocation of resources but they will have great influence on decisions for allocating resources. The plans will, undoubtedly, affect Indians as well as everyone else.

First of all, to the extent that Indians rely upon health services off the reservation, they are directly affected by the health plans, since the plans will influence what facilities are built, what services are offered, and the location where the services are offered.

Secondly, HSA's regard their function as developing a plan which takes into account the entire population and the entire geographic area covered by the HSA. And this will, undoubtedly, include reservations.

The second major function of the HSA's is to review and approve all federal grants for health services in the area covered by the HSA. Now, this is a very powerful weapon in health planning, a very powerful device. The total amount of these grants over which HSA's will have power is now running about six billion dollars a year, and, of course, that's going to get larger as inflation continues.

There is a special exemption in the act which affects Indians in two ways. First of all, the power of approval does not apply at all to services provided directly by the federal government. So that, the Indian Health Service is not affected by the HSA's.

By another exception, the approval power does not apply directly to grants to Indian tribes for health care, although the HSA's do have the power to comment on such grants. They don't have the power to approve or disapprove. But we can expect that the Department of Health, Education and Welfare will certainly give some serious consideration to the comments of HSA's on health care grants going directly to the tribes.

Finally, grants which are made to private, non-profit organizations operating health facilities on reservations, and all federal grants for specialized Indian health programs off the reservations are subject to review and approval by the HSA's. Now, even when the HSA's have approval power, which also, of course, means disapproval power, there is an out. That is HEW can overrule an HSA which turns down a proposed, federal grant, but the general expectation is that the cases in which the HSA's are overruled will be rare because part of the notion of the health planning act is to defer to the local planning decisions.

So, in both developing a plan and in its power to approve or at least comment on federal grants, the HSA will have some substantial input into the health services which are available to Indians.

The second basic planning agency in this system is the state agency, which is a branch of state government. I should go back and say that Health Systems Agencies usually are not directly a part of the state or local government. In the overwhelming number of cases they have set up as private, non-profit corporations, although in a few areas, they are agencies of either state or local government.

The state planning agency, in contrast, is part of state government. That agency has a number of functions, the most important and the most powerful of which is their power to grant or deny what is known as a Certificate of Need. The Certificate of Need is, in effect, a license which must be obtained from the state before most construction of health facilities can begin, and before most major purchases of health equipment can take place.

The purpose of the Certificate of Need is two-fold. First of all, the idea is to see to it that money is spent on health services of the kind and in the areas where needed.

And second, to contain cost. The Certificate of Need seeks to contain cost by avoiding excess capacity and unnecessary duplication of services. As you know, for example, an empty hospital bed costs somewhere between half and two-thirds of a full hospital bed. Of course, no revenue is being obtained from an empty bed.

Now, Certificate of Need decisions are supposed to take into account the plans and priorities developed by the HSA's, and the HSA's are given the opportunity to review and comment on all Certificate of Need applications, that is, all the ones in their particular area.

The Certificate of Need powers do not apply to programs operated directly by the federal government. So, again, Indian Health Service is not affected by it, but most other Indian health programs will require specific Certificate of Need approval if they want to engage in construction, purchase of equipment or other forms of capital expenditures for expansion or modernization.

There is a third agency which is called the Statewide Health Coordinating Council, which, in practice, I believe, will be largely an advisory board. And I'm not going to take the time to describe that because I think that most of the time, the key functions in the planning process are by regional HSA's and by the state agency.

As you can gather, from this oversimplified description of it, health planning is a very complicated matter. It is often very technical. It creates problems for consumers generally when they try to participate in the process. It creates particular problems for tribal sovereignty.

Despite all this, I think the greatest danger from health planning would come from trying to ignore it. As I stated earlier, it's here to stay and will increase in power, of course, if the legislation passes.

I suggest that you should undertake to develop strategies for dealing with the health planning process, for dealing with Congress on the subject, for dealing with HEW on the subject, and for dealing with the HSA's and the state agencies. Strategy might vary from area to area, or from tribe to tribe, depending on the local conditions, but what I think applies to everyone is that attention must be given to the health planning process.

Ms. Wallace: Our next speaker is going to be Mr. Ron Carlson, who is the Deputy Associate Administrator for Planning, Evaluation and Legislation of the HSA in Rockville, Maryland. He will give us a perspective on the national level and how things are going with this piece of legislation across the country.

Mr. Ron Carlson: As Herb was saying, perhaps one of the most complex, technically difficult pieces of legislation that has been passed in the health field of any recent date, is Public Law 93-641.

And what I'd like to do in the few minutes that I have with you this afternoon is take a look at that planning act in a couple of ways.

First, to look at the attitude of the department toward the planning act, that is, looking at the intent of the legislation against the need for change, and in so doing, give you a quick status report of what is happening with respect to the implementation of the act.

And then, secondly, the possible ramifications of the act on the planning activities that we see in general and the possible impact of Public Law 93-641 on Indian health care programs in particular.

With respect to the first, the views of the department, I think, are fairly clear. They were expressed yesterday by Dr. Lythcott in his keynote address. You will recall him saying that the Health Services Administration strongly endorses a balanced national health care program, one that incorporates both financing and resource development efforts.

He also said that the importance of 93-641 cannot be underestimated anywhere, including the Indian community, even though the act, as Herb was pointing out, doesn't necessarily change the relationship of the Indian Health Service and the Indian community.

As a matter of fact, he went on to say that 93-641 offers the Indians and Alaska Natives an opportunity to share in a larger planning effort which covers the entire United States.

Those of you who have been following, and I suspect that many of you have, the testimony given on the Hill, will recall that Hale Champion, the Under-Secretary in the Department of Health, Education and Welfare, said, before the Committee on Inter-State and Foreign Commerce, that, number one, comprehensive planning at local, regional and national levels is no longer a luxury in America; it is a necessity. It is a necessity if we are to implement a comprehensive, universal system for national care. It is necessary if we are ever to provide sufficient health care resources in areas which are underserved, while curbing unnecessary and expensive duplication in areas which are not. It is necessary if we are to ever fashion a flexible system responsive to all the health care needs of individuals.

In short, good planning is essential if we are ever to overcome defects and deficiencies brought by decades of haphazard growth, fragmentation, maldistribution and perverse economic incentives.

And while there has been that kind of thing with respect to health care planning, I think it's also safe to report that we are also getting some very rapid, accelerated, implementation of that act; that progress over the last year has been dramatic. For those of you who have been following what's been happening in the department, that hasn't necessarily been the history of the act but it has certainly been the case over the past several months.

At this time, all two hundred and five Health Systems Agencies, with staff totalling more than three thousand people, have been designated in funding. Even though only nine HSA's have been fully designated the department expects that by September of this year, a hundred and seventy-five HSA's will be fully designated. Over eight thousand people now serve on the two hundred and five HSA governing bodies.

Consumer and provider representation on these governing bodies is theoretically balanced, with fifty-three per cent being consumer, and forty-seven per cent providers and as Hale Champion pointed out to the committee, such a balance, again, is often more theoretical than real, and there is some concern about the effects on the health planning process in those cases.

Additionally, nearly five hundred advisory sub-area councils with thirteen thousand members have been organized by the many HSA's.

At the state level, all fifty-six state health planning and development agencies have been designated.

Forty-eight states have established their State-wide Health Coordinating Councils, which are to work with the State Health Planning Development Agencies. And some seventeen hundred individuals are there representing their state and local constituencies.

This first view of the planning act is relatively easy; that is, getting straight on the general intent, and getting the organization to work.

The next part, however, regarding where the act is going and what it really means is more difficult. I think that was expressed well in the Health and Welfare Policy Resolution adopted at the Thirty-Fourth Annual Convention of the National Congress of American Indians, which expressed concern about the direction health planning is actually taking.

You will recall that the National Indian Health Board advocates that health care services delivered to American Indians and Alaska Natives be of the highest quality, so that American Indians and Alaska Natives obtain an equal or better health condition than other American citizens.

But then, it goes on to say, too, that three years after the passage of 93-641, there are still many unresolved questions, and it identified some of those questions in Policy Resolution Number 2, specifically, does a health plan developed by an HSA supercede reservation health activities?

Could the Health Systems Agency review and comment authority over certain tribal funding proposals cause them not to be funded?

Are Indian reservations or tribal jurisdictions totally under the authority of HSA's?

Could HSA's close IHS hospitals or eliminate Indian health services because they duplicate services of a nearby non-Indian facility?

Each of these questions is really a single, hard-core question which asks about the extent or impact of the regulatory program on the Indian health program. In each case, too, the issue needs to be looked at in several different ways.

First, the development of the long-range Health Systems Plans, not only in terms of possible impact on the Indian health program, but in general. For now that the initial organizational and structural efforts are complete, most HSA's are hell bent on giving high priority to the development of their long-range Health Systems Plans.

Now, extremely important to our discussion is the fact that Section 1513 of the act provides that an HSA shall only review and comment on proposed use of federal funds which will -- and I'm quoting now -- "be located within or will specifically serve a federally recognized Indian reservation any land area in Oklahoma which is held in trust by the United States for Indians or which is a restricted Indian owned land area or a native village in Alaska."

The statute with respect to these programs is quite clear. What is not so clear is how the act will, in fact, be handled in a number of very important instances.

First, the exemption status of the tribes themselves. The preservation of Indian tribal exemption from HSA approval authority over use of federal funds must be insured. The issue is our foremost concern with respect to the impact of 93-641. Since only Indian tribes are exempt from HSA approval authority, urban Indian people must be a participant in planning for approval purposes, not sole review and comment.

Essentially, it is especially critical, therefore, that urban Indians participate in HSA planning and review activities since they are subject to HSA approval authority.

Secondly, while the Certificate of Need and 1122 are only indirectly related to P.L. 93-641, the review comment approval issue is directly related. Certificate of Need concerns the review of health facility expenditures funded by either public or private dollars.

The federal Certificate of Need regulations require that all non-federal health care facilities be subject to Certificate of Need review. Barring more stringent state Certificate of Need regulations, our position should be that IHS facilities, as federally owned services, are not subject to Certificate of Need review.

Thirdly, for reasons which are not yet fully clear, IHS facilities have not been subject to Section 1122 (of the Social Security Act) approval for capital expenditures. They must, of course, quite aside from the 1122 requirement, submit their plan for review and comment. The issue is unclear, particularly since Title IV of Public Law 94-437 mandates that Medicare and Medicaid reimbursement will be held in a special fund to upgrade IHS facilities.

Fourthly, regarding the long-range implications of the act's intent, in a January 30, 1978 statement to the House Sub-Committee GAO noted the lack of specific authority in the law for HSA's to regulate federal health facilities. They urged the Congress to consider amending the law to provide for local and state planning agencies review of proposed projects involving federal health facilities.

It has become increasingly important that there be the optimal level of Indian representation on agency governing bodies, State-wide Health Coordinating Councils and committees. The statute, of course, is specific in regard to the composition of the HSA governing bodies, in that they must be representative of social, economic, linguistic and racial populations within the health service areas.

Where is all of this headed?

Looking again at Hale Champion's statement before the Rodgers Committee, we see four major issues being dealt with, whether directly or indirectly.

The first is one of cost containment. Health care costs are escalating at a rate of fourteen per cent annually. Hospital costs are going up at a rate of fifteen per cent annually. And there are an estimated one hundred thousand unnecessary hospital beds nationally. That gives you some idea of the ramifications of the cost containment issue that's directly related to the health planning act.

The health planning act originally intended strong, state and local participation. The department now sees a need for an even stronger role for the states.

In recent years, states have been increasingly interested in both the health services they provide, and the health services they purchase.

Health planning in local governments: local government and local officials represent a valuable resource for health planning and the health planning program which can influence community support.

The department feels that a greater involvement of public officials at the local level promotes greater leadership for the unorganized members of the community.

The fourth is federal administration itself. Finally, in the effort to implement the original legislation, the department has run into several problems of a technical administrative nature. Local HSA's, state agencies, and central and regional office personnel have reported these problems. There is a greater need for flexibility in redesignating health service areas.

The ramifications of 93-641 are numerous. One thing is clear: Active involvement is critical, and while we may not get National Health Insurance this year or next year or the following year, I predict we will see significant changes in the Health Planning Act with the regulations getting out, goals being set, standards being issued, with greater and greater ramifications in the program on the Indian health program.

Ms. Wallace: Next, we have Theresa Carmody, who is with the National Congress of American Indians, the Health and Social Welfare Division.

One of the issues that was dealt with at their convention was Public Law 641. She will talk about some of the things that came up at that meeting and some of the things that they have been doing since that meeting.

Ms. Theresa Carmody: First of all, I would just like to say that copies of this policy statement that was passed at the NCAI Annual Convention are in the back row towards the middle, near the entrance. So, if you don't have a copy now, I urge you to pick one up on the way out because this will be used in discussion in the workshop sessions to follow this session.

I would just briefly like to go through some of the highlights of the policy statement that was passed by the member tribes of NCAI at our last annual convention in Dallas, which was held September '77.

There are basic unresolved questions in 641 regarding the relationships of the HSA's and the tribes. And highlighted in the policy statement are these unresolved questions.

The gentleman before me read these over, but I would like to read them again because I think they summarize very well some of the problems that have been occurring out in the field.

First of all, does the health plan developed by an HSA supercede reservation health activities?

This gets into the area of the development of Tribal Specific Health Plans under the Indian Health Care Improvement Act, and along with this, the development of health plans by the HSA's.

At this point, there seems to be little or no coordination between the development of these two sets of plans. HSA's have largely been ignoring the tribes in their development of these plans. And the tribes, who have been working very hard, you know, in the development of these plans, have been, in most instances, unsuccessful in working with the HSA's.

The second area is, could the HSAs' review and comment authority over certain tribal funding proposals cause them not to be funded?

The phrase "review and comment" has many different interpretations. And at this point, nobody really knows how it causes tribal programs to be funded or not to be funded. I believe there are some very negative comments made on some of the tribal proposals that do go into the agencies for review. I think that this kind of information should come out in the workshops and really needs to be documented.

And since we are part of these states, we made it clear that, although we will not be coordinating the planning with Utah and New Mexico, that our Health Systems Plan will be incorporated into all three states' State Health Plan.

In addition, we are also working with three HEW regions, Region Eight from Denver and Region Six from Dallas with the regional office in San Francisco, Region Nine being the office for us.

We had to coordinate our activities with the regional office, again, with respect to reviews, and also the 1122 review by the states.

Just communicating with the three state agencies and the HEW regions is one of the biggest problems facing the Navajo HSA at this time.

I would like to add that, now, since Navajo has its own HSA, given all these problems of reviews, Certificate of Need, in our situation, the whole thing is reversed because instead of the Navajo Tribe addressing or working with an HSA, it has to work with itself.

We have problems now, what kind of authority our HSA might exercise when a tribal, in this case, a Navajo health proposal is presented to us.

We feel that, because it's a Navajo HSA, will have review and approval authority as opposed to review and comment.

Right now, since under this legislation, we have to develop these plans, we are contending with the other major Indian health legislation, 94-437. As a means of coordinating our activities, we structured a rather unique planning approach, in that we focus on the guidelines that were developed in 437 and 641 in such a way that, as the Tribal Specific Health Plans and the Health Systems Plans are developed, they will be very similar in content and nature.

I would like to add one more comment. I think that this legislation, 93-641, although very controversial, is here to stay, and that in our situation, I think it's the first time that Navajo tribal government has had continuity. The whole Health Care Delivery System has been administered by the Indian Health Service, and I'm sure all of you are aware that most of the major decisions affecting Indian tribes come down from headquarters in Washington. And I think if our HSA is halfway successful, we can inspire the Navajo people to take a stronger and more aggressive stand when it comes to making health planning decisions.

The governing body of the Navajo HSA has been structured as mandated in the HEW regulations to reflect the area's population. There is a reason for this. I think the intent of the law was to get politics out of all health planning decisions but we just can't say that has happened with the way it's been designed with the majority consumers, minority providers and so on.

But I think it enables everybody to have input into these health planning decisions.

Ms. Wallace: The next speaker on the agenda is Mr. John Lewis, who is the Executive Director of the Inter-Tribal Council of Arizona in Phoenix. He has a project to work with Indian tribes to answer questions or to train people or to let them know what this is all about and I will let him explain that to you.

Mr. John Lewis: When I think of 641, I think of its enactment when there were groups like the Papago Tribe working hard to try to have some input into that particular act. Also, the National Congress of American Indians, for example, tried to get provisions that would provide some safeguards for Indian people's participation in that legislation.

Two pieces of legislation that come to mind, both enacted in January of 1975, are 641 and Title XX, which is part of the Social Security Act.

Now, those two particular acts really focus on human services. And I think that this is one area where many tribes are just beginning to bring their efforts together to develop tribal departments or merge health departments and social services.

Since 641's enactment 437 and 638 are really putting tribes in the position of being in the driver's seat to address human services, but at the time, these pieces of legislation, particularly Title XX and 641, brought in a host of concepts that were new to many groups including new concepts of planning. The legislation brought with it complex structures for dealing with it. It brought in the opportunity for innovative planning and coordination of federal programs to reduce fragmentation but at the same time, the necessary orientations and tribal input and participation were not done during its development; and thereby, 641 and Title XX have not been maximized by tribes.

But probably more importantly is that they really did not deal with the question of tribal sovereignty. And that particular area is, of course, something that tribes like to have recognized and they like legislation built from that. And I think the tribes are still in a position to do that, but I do feel that with Title XX and 641 as continuing issues, as have been identified by the previous speakers, there is still much work to be done.

The situation in Arizona regarding 641 is that we have a very diverse status of tribes regarding this act. We have the Navajo Tribe which has its own HSA, and we have tribes who have negotiated agreements only to have those agreements aborted by HSA's. We have tribes who have established agreements and are presently involved in the very complex process of maintaining the relationships and trying to build themselves into the structure. We have tribes who have not communicated at all with HSA's, who are drawing up legal documents taking positions regarding amendments to the legislation that would allow their participation on the basis they feel is right. We have tribes who have not begun to even meet with existing HSA's in any meaningful way, outside of having an HSA come and hand out information and not really giving them too much information about how to get involved.

So, in Arizona, we have a situation where there is much to be learned from each other; and, frankly, that is what our project is essentially about.

The Inter-Tribal Council of Arizona has received a contract from the Health Resources Administration and we are beginning to look at 641. The important part of it is that we are establishing a forum for the tribes to share their experiences, to share information, to share and identify a common basis in which to approach health or, in this case, maybe to approach human services, because one important point in regard to all the problems we identify here as a panel looking at 641, is that we are trying to develop services, we are trying to develop programs that are beneficial to the populations that we work with.

And when I think of Title XX, I think of 641. And the reason for that is that, ultimately, we are dealing with trying to get services to the same populations and certainly there is an overlap in these areas. One consideration that might be looked into is the behavior of health programs, such as in alcoholism. There are resources in that area and there are program resources that could come to Title XX of the Social Security Act which could be enhanced by going through the process of 641, but this is where it really comes together.

And when we consider human services, we have to think of the types of resources, the types of structures that are inherent in 641 and Title XX.

But the idea of our project is to begin providing this forum, beginning to look at 641 in a systematic way. We have requested representation from tribes and Indian organizations that are interested in health in the State of Arizona. We have a twenty-four-member advisory panel that will oversee the project and its contents. And we will be providing research and information materials to the groups.

And there will be a series of symposia that will address 641. The idea is that we look at 641, we look at the HSA's. We identify the responsibilities and the major functions that an HSA has. And at that point, I think that the different tribal experiences are really key and important to the process, because some tribes have worked out agreements regarding certain areas; some have not addressed these areas.

The HSAs' responsibilities and functions are contained in seven basic areas -- and I'll go over these quickly.

Number one is agency management and organization.

Number two is planned development.

Number three is data management and analysis.

Number four is planning implementation.

Number five is health systems development.

Number six is coordination.

Number seven is public involvement in education.

Now, the HSA's are gearing their staff and their activities around those seven areas. And within those areas, there are guidelines and standards

Eight: Are reservation health needs included in the HSA plans and do the tribes approve the plans?

Nine: Other documentation, for example, correspondence, memorandums of agreement or anything like that.

Ten: How do HSA's communicate with tribes? Is it effective?

We would like to divide into workshops after this session and go into a discussion of these papers because, you know, we have here, let's say, three or four hundred health experts and we really need the exchange of information to go on here today, because if we leave here without doing this, the problem will develop and the HSA's will just proceed as they have in the past.

So, we will encourage your attendance at these workshops. There will be a member of the National Indian Health Board attending each of those workshops as well as a facilitator from this panel.

Ms. Wallace: The next three speakers will address some of the experiences that the tribal groups have had with this Public Law.

The first one that I'm going to call is Mr. John Hubbard, who is the Executive Director of the Navajo Health Systems Agency at Window Rock, Arizona. They are the only tribe right now that has an HSA.

Mr. John Hubbard: Back in 1974, the Navajo Health Authority established one of the last planning agencies that were known as B Agencies. And I would like to start off with that, that planning legislation in this country is not really new because, before 93-641, there was very similar planning legislation which lasted approximately ten years.

And when that law expired, in its place, came 641 with a few changes and some very wide ranging authorities.

And because the Navajo Tribe already had this planning agency, it wasn't able to justify the establishment of a Health Systems Agency, as described in the new law.

About two years ago, the Navajo Tribe asked questions similar to those being talked about here today.

Number one is that: Will the states and the federal government exert a tremendous amount of authority over health planning activities?

And for that major reason, the Tribal Council decided to establish this Health Systems Agency as a unit of local government. By this mechanism, the HSA is directly linked into the Navajo Tribal Council. It is not a non-profit organization nor a regional planning commission as many of the other HSA's in the country are.

We feel that by this mechanism, the Navajo tribal government has some safeguards against unnecessary intrusion from the states and other planning agencies developed by legislation.

I would like to go over several very unique circumstances or conditions that we are working with.

Number one has already been mentioned. The Navajo HSA is the only Health Systems Agency in the country to be sponsored by an Indian tribe.

Secondly, because our health service area covers three states, portions of Utah and New Mexico with a majority being in Arizona, we have to coordinate our activities with the State Health Planning and Development Agencies. And that requirement is mandated in the law, not only with the State Health Planning Agencies, but, also, with the Statewide Health Coordinating Councils or the SHCC, as we call them.

As you can see right from the beginning, we were faced with a potential problem of developing three separate Health Systems Plans. And right, at that time, we knew that we had to work with one State Health Planning Development Agency or else there is no reason for this HSA to be established, because one of the reasons is to develop a single Health Systems Plan and an efficient plan.

We succeeded in negotiating an agreement, whereby the Navajo HSA will only relate to the Arizona State Health Planning and Development Agency. And that eliminated, for this year, the requirement to develop plans for Utah and New Mexico.

The whole thing about this is that these Health Systems Plans are pulled together by the state agencies to make the single State Health Plan.



SPEAKING of the Navajo Health Systems Agency, the only solely tribal HSA in the country, is John Hubbard, its director. At right is Theresa Carmody of the National Congress of American Indians, one of several other '641' panel members. (Photo courtesy of Melvin McKenzie, Navajo Division of Education.)

And then the third amendment: Each tribal health planning office shall have the right to review and approve or disapprove the proposed use within its reservation of federal funds appropriated for health services, including funds used for the direct delivery of health services by any federal agency.

And this would largely concern the tribal authority over the expenditure of IHS funds on the reservation.

The National Congress of American Indians along with the National Indian Health Board presented testimony to the House Sub-Committee on Health under the Inter-State Commerce Committee on January 31st. What we did was take the basic principles that were outlined in the policy statement passed at the annual convention and incorporate the ideas that were outlined in the amendments that I just read.

The staff of both the House and Senate Sub-Committees seemed to be very receptive to including Indian amendments in legislation of those four on 641. And this is going to happen very quickly. So, if you are having problems with the HSA's, if you present any good documentation or agreements that you have made with the HSA's or any letters that have been sent back and forth, this kind of documentation is what these committee staffs could use in pushing for these Indian amendments because, you know, they need some good backup data, data that shows them that the HSA's and 641, as it currently is written, is not working as far as tribes are concerned.

And then, in the areas where it is working, this needs to be strengthened.

The last piece of material that I would like to go over, and what we will really be working on in the workshops, also, is a guideline for development of this documentation. You know, there are many areas that you can document and there is a lot of information that can be collected, but a certain individual has come up with about ten guidelines that seem to be pretty adequate as far as developing the documentation that we need to put forth to the Congressional members and, also, that we need to present to HEW. I'll just read them.

Number one: Extent of tribal involvement in the formation of their Health Systems Agency.

Two: Describe HSA activity, if any, affecting tribal programs.

Three: Status of tribal proposals submitted for review and comment to HSA.

Four: Tribes formal position, if any, relating to participation with the HSA.

Five: The number of tribal representatives on the board of directors, governing bodies, sub-area councils, and area committees of the HSA's.

Six: IHS relationship with HSA.

Seven: Type of HSA: private, non-profit or public.

The third area is Indian reservations or tribal jurisdictions totally under the authority of HSA. In the Public Law as it exists, there is nothing defining the relationship of HSA's versus the tribes. At this point, it's basically been left largely to the tribes to define that relationship and also to push for representation on many of these boards. And the HSA's have largely ignored the tribes as far as trying to get their participation in health planning.

The fourth area is, could HSA's close IHS hospitals or eliminate Indian Health Service because they duplicate services or are near a non-Indian facility?

Once again, this brings in the development of the Tribal Specific Health Plans. If the HSA's in their development of health plans are largely ignoring what tribes feel are priorities on the reservation, whether it be a clinic, a hospital or whatever, if there is no coordination between the development of these two plans, then tribal health needs and priorities will be largely ignored.

Also, in the policy statement, it calls for NIHB to become a clearinghouse for tribal documentation of problems with 641. This whole process becomes very important because, at this time, tribes really haven't been able to exchange a lot of information in this area. So, in some states, you see tribes working rather successfully with HSA's; in other states, they are largely ignored; in other states, there has been very much difficulty working with the HSA's.

So, this kind of information really needs to be documented and sent in to the National Indian Health Board, so that when they propose recommendations for guidelines to HEW, that, the problems and concerns can be adequately expressed through this documentation.

Attached to the policy statement are three legislative amendments that have been drafted by the National Indian Health Board. So, if you don't have a copy now, please get one on the way out. I was really hoping to discuss this, before -- or after we finish with the panel discussion here.

I will just read them over briefly.

Amendment one: In carrying out their activities, HSA's shall respect the sovereign authority of Indian tribal governments in regard to health activities located within the exterior boundaries of the reservations. However, HSA's and tribal governments shall enter into agreements to promote planning and coordination on matters of mutual concern to both entities.

The Secretary of HEW shall promulgate regulations and guidelines for carrying out this section after consultation with Indian tribal governments, national Indian organizations, and HSA's affected by this provision.

Amendment number two: Of the funds provided for under section 1516 of this act, two per cent of such funds shall be set aside for grants to tribal health planning agencies under such conditions and allocation procedures as the Secretary determines is appropriate.

that HSA's must go through. And there are ways that a tribe may want to relate to each of these seven.

And, essentially, what we will be doing is looking at these areas in depth, looking at the HSA's, and producing information on how they are going about meeting these functions and responsibilities; and then beginning a dialogue with the tribes as to what sort of benefits they are receiving, the potential for benefits, the conflicts, the issues, and coming out with a plan, if you want to call it that, for tribes to address and to work with the HSA's, where possible.

The tribes will have that option, and all we do is provide the forum. And we provide, hopefully, a forum for tribes to exchange ideas.

I think that most of what comes out of our project can be beneficial to others. I listed seven, and they may not mean too much to you, but all the issues that we've been talking about and the complexities of trying to look at HSA's fit into those seven areas. And by approaching it in this manner we hope to at least come up with a series of statements and different positions that tribes in other areas may benefit from.

Because of the range of different types of relationships we have in Arizona, I feel that the usefulness of information that could come out of this will be increased.

I might mention one thing that has occurred, and this is something that you need to look at. Coordination is an area where the HSA's develop the plans, activities and strategies of how they are going to coordinate with other comprehensive planning that's going on.

And one of these, familiar to many of you, is the A95 process.

Well, in Arizona a couple of weeks ago, some of the tribal health departments received a letter saying that they needed to comply with the A95 process and have the state review their applications. Now, this is just another review process outside of the ones we have been talking about in P.L. 93-638 but this is one for which the state does have responsibility.

And many tribes have dealt with the A95 process before and have established that they need not go through having the state review their federal applications.

And the HSA's and the HRA regional office were requesting this from tribes, and the letter implied that tribes had to comply with this. But on checking on how the A95 process works with the OMB circular, tribes do not have to comply.

And this is the type of information that sometimes we lose sight of, that there are many precedents that already exist in trying to relate to some of the things that a new structure, such as the HSA and the state systems, try to impose upon tribes. This is a good time to begin questioning some of that and make them more consistent with the way tribes have been dealt with in other federal legislation and other federal and state agencies, because many times we have gone through this before, and it's a matter of reminding them and being in a position of documenting these statements.

But that is an example of the type of thing that, I think, can come out when tribes begin to share the types of information that are being requested of them from HSA's and from HRA regarding their health programs.

And this is the type of thing that I think we would like to see happening between us and in other states and, certainly, through the National Indian Health Board with whom we will be working and sharing the information that we receive from the project.

I might just say one other thing regarding the amendments that were presented. I think, each of those amendments are really good and they need to be looked at and supported. I think the important thing is to give tribes options. And I think that the amendments really speak to that, at least from our experience, that tribes are really at different places and approaching it a little bit differently.

Ms. Wallace: Our next speaker is Mr. Gordon Belcourt, who is the Director of the Tribal Health Department on the Blackfeet Indian Reservation. And he's going to give us a tribal perspective.

Mr. Gordon Belcourt: A couple of things that I would like to bring up. I realize that this is very technical stuff that we are talking about. And most of you, unless you are tribal health directors or tribal health administrators or tribal councilmen, may not have to deal with this, but I think it's important that you realize that this piece of legislation exists, and how it's going to affect you as an individual, how it's going to affect your family, how it's going to affect your tribe, and how it's going to affect us as a group of people.

The thing that Theresa mentioned, the guidelines for the development of testimony, is a very valuable piece of information for you to take back to your tribes and councils. And if you have any tribal health professional people, to make sure that they have access to this.

In the event that you do not have any tribal health directors or administrators, I think it's important that you convey this to the Indian Health Service so they can assist you in putting together some testimony on some of the things that we're talking about.

And the other handout you got is basically indicating who the representatives and senators are that are on the various committees. I think it's important that you know these people, not only the National Indian Health Board, and the NCAI and NTCA, know what their positions are on this very important piece of legislation, but that you contact your representatives and senators, also, and let them know basically what you are doing about this piece of legislation, or else, you know, somebody in your system of tribal government should take a very close look at this.

To try to bring to the meeting here a little bit of local perspective, I want to re-emphasize, coming from a local tribal health project and a local reservation, some of the concerns that the Board of the Blackfeet Tribal Health Department, some of the councilmen, and community people have related to me over the past three years.

Since 1974, we've been talking to a lot of people in the state and in Congress who we are having problems with this. And it's kind of hard for these people to effect any change in the legislation until we have a united voice.

And with that thought in mind, I consented to participate in this workshop.

Not only are we concerned about 641, but we are also concerned about many, many pieces of legislation out of the federal government and the accompanying regulations and we are also concerned about some of the legislation coming out of the state legislatures.

So, I think it's very important that we begin to focus on these, and that's the whole basis for my involvement here today, to focus on 641.

One of the immediate concerns that was expressed to us was the whole issue of tribal sovereignty in the 641 legislation, and we saw it as, basically, being unacceptable because the legislation did not speak to the autonomy of tribal governments.

And the other thing is that the legislation should speak to the rural Indian populations, the off reservation Indian groups.

About half of our rolls, which is about five or six thousand of my people, live off the reservation. Rather than referring to these people as urban Indians, our tribe refers to them as off reservation people. And I think there's a distinction there.

The other thing that has to be resolved because it affects Indian people is the whole attitude of, how does the legislation affect urban groups? And those urban Indians, if you prefer to call yourself an urban Indian, then this definition is going to affect you as an individual or those people whom you represent.

And then the last, and probably the most neglected aspect of our Indian people, are those groups that are unrecognized as of yet. And I think the legislation has to have provisions for ultimate inclusion of this group of people in any projects that they may initiate under 641.

We have problems with the section on review and comment. When we send our applications to the National Institute on Alcohol Abuse and Alcoholism in Washington, D.C. for direct funding, we find that the administration of the State Alcoholism Authority, for whatever purpose, had put some adverse comments on the application. Rather than being, you know, a very simple thing of evaluating and approving the grant, it became a very lengthy and drawn out period of responding to the charges or the negative review of the state people. And that went on for a long time.

So, we are concerned that the review and comment section of the legislation be spelled out very specifically as to how it applies to the reservations and to all Indian groups.

I think that's important, because from our point of view, review and comment is basically protocol.

Above all, we do not want to allow the HSA's or the State Planning Office to enter into any monitoring or evaluation of tribal projects, especially those that are directly funded out of the central office, and in certain instances, those that are funded out of the state formula programs.

Also mentioned was membership in HSA, national, regional, state planning

and the Health Systems Agency itself. In our case, in Montana, the entire state is an HSA.

About two years ago, the Billings Area Indian Health Board appointed me to the state HSA as a consumer. I was also appointed to the SHCC, State-wide Health Coordinating Council.

I was subsequently removed from both of these agencies because I received part of my salary from the tribe and part of it from the Indian Health Service. So, I was designated (arbitrarily I feel) as a provider, although, I guess, if you wanted to get down to it, I was both.

But the thing that I want to focus on, is what Erin brought up this morning about communications. It's fine and well to say that we, as Indian people, should rely on grass roots communication, that we have a certain way of expressing ourselves to each other, which is fine. But when you get into the situation with HSA's, in situations with state planning offices, with SHCC's, the level of communication is very, very high. It's very, very difficult, not only to communicate with these people, but to try to solicit any support or any kind of feeling for what reservation life is like.

And I think this is one of the hardest things that I tried to accomplish during the very short period of time that I was involved in a state HSA. And if you compound that by regional involvement and a regional planning board or council, this communication problem begins to amplify itself.

We feel that there are provisions within the legislation providing we can comment on the exchange of information clause, that staff people from the HSA's should provide technical assistance to the reservations and Indian groups.

And we went so far as to include the regional planning office in this. We feel that if we generally want 641 to succeed on the reservations and within the Indian communities, that we need to tie into the expertise of these state people, especially the planners.

So, we wanted some very distinct provisions for providing relevant staffing. It doesn't necessarily have to be Indian, but in our situation on the Blackfeet Indian Reservation, most of the people who have been able to provide us with relevant technical assistance and consultation just happened to be Indian.

We talked specifically about 437 and how it relates to 641. We are concerned that we are developing two primary products that are similar. We are developing the reservation plan for inclusion under 641, while we are also in the process of developing Tribal Specific Health Plans.

Now, the two are not mutually exclusive. And we feel that, for purposes of technical assistance and consultation both by the HSA's and by the Indian Health Service, ultimately, both products can come from the same level of technical assistance and the same time frames.

So, it's important for us that somehow 437 be tied into 641, and there has to be some dialogue initiated on that.

We feel strongly that a percentage of the money for 641 planning should be designated specifically for special projects and demonstration projects, to be utilized in Indian communities.

We feel that once legislation speaks to off-reservation Indians, reservation Indians, rural reservation Indians, and so forth, that this money, for a period of time, could be used for special projects and as demonstration monies to allow us to initiate some competent planning.

The section of the law concerned with information is very important to us, because at this point, the information exchanged by the HSA and the state and health planning offices has been zero. So, this has to be clarified and the state and the HSA's have to be mandated to share whatever information they have with the various Indian communities; otherwise, we will not be able to participate as effectively as we can.

We are concerned about how 641 ultimately is going to relate to some of the federal formula block programs received by the state. And we are thinking specifically about alcoholism and drug abuse money. We want this to be spelled out very effectively and specifically; otherwise, we feel that, because of the minimal amount of support and money coming from the state that this would be in jeopardy.

We also are concerned about what relationship 641 has to direct funding from the federal government to tribal governments and Indian communities.

Further, we are concerned that the HSA, at a national level, divide reservations into several HSA's. And this is something that John brought up and the Navajo Tribe has already recognized but I think this is going to be a problem for some of the other reservations as they get involved in 641.

We are concerned about the informational flow. Those of you who have remained here to participate in this 641 discussion, like Veronica said this morning, ultimately are the leaders. You will have to take this information or whatever information you can back to your tribal councils. It is very important that your tribal council, your governing board or whatever recognize and become informed about this piece of legislation.

The other problem we identified is clarification of Indian Health Service's role in 641 legislation. There is really no discussion on that.

We are concerned about outside people setting health goals for the tribes, and also setting national health goals without tribal involvement.

The other thing that the tribal people have asked me to relate is that the experiences of all tribes engaged actively in 641 have to be documented and submitted to a central focal point. And right now, I don't know what that focal point is.

You've heard discussions about the National Indian Health Board being a focal point, the possibility of NTCA being a focal point, NCAI being a focal point, setting up our own national planning office, of Indian Health Service being that focal point. That information has to be funneled into a central focal point and disseminated back to those reservations that haven't developed a level of expertise that some of the other reservations have.

These are some of the problems we have identified.

One of the benefits that we perceive is possibly increased communication and coordination with the various health providers surrounding a reservation and within a state.

We would also assume that through this legislation technical assistance and consultation would be provided to the tribes. Financial assistance in terms of grants for health planning and resource development could potentially be available as well.

And it was brought out that construction money may be available under 641. In order for us to tie into this money, we have to tie into 641 and the HSA's.

And I think these last two points are very important, a benefit of this kind of health planning. I think, with all the discussions we've had about Public Law 93-638 and Public Law 94-437, that the constant criticism I get from Indian Health Service people is the fact that we have to obtain the level of expertise or develop the capacity to administer 437 projects or to contract under 638.

I believe, with the development of Tribal Specific Health Plans and with the development of tribal health plans under 641, that this is going to increase our capacity to contract and to operate programs for our people.

I've got thirteen recommendations here which I've been asked to forward to the group.

Number one: Immediate designation of the National Indian Core Group to pursue all aspects of Public Law 93-641 and regulations, as well as to initiate change and clarification in the law and regulations that threaten tribal sovereignty and usage.

Two: Language clarification in the law to recognize tribal sovereignty and autonomy.

Three: Clarification of review and comment provision and access to information clause.

Four: Immediate Indian representation on all national, regional, state, HSA and sub-HSA's under Public Law 93-641.

Five: Immediate staffing of all HSA agencies with qualified Indian staff to provide technical assistance, consultation to local tribal groups in planning and resource development.

Six: Inclusion without change or deletions of all Tribal Specific *Health Plans in the HSA plans.*

Seven: Specific proportion of all 641 appropriations be set aside for tribal groups as special and/or demonstration projects.

Eight: All information on health planning and resource development be disseminated to local tribal groups.

Nine: Determination of major and sub-area Indian HSA's.

Ten: That tribal governing bodies have the sole responsibility for the determination of local goals, objectives and priorities as stated in the annual HSA implementation plan as related to specific Indian groups.

Eleven: That an equitable distribution formula be utilized to insure specific appropriations filtering down to the grass roots.

Twelve: That planning funds be given to tribal groups to initiate planning and resource development plans.

Thirteen: That the central office will be responsible for monitoring 641 activities and to maintain open lines of communication with local Indian groups.

And that's it. Thank you.



THOSE INTERESTED were able to learn more about the implications of P.L. 93-641 for their own tribes at workshops which followed the general assembly panel discussion on the law. (Photos courtesy of Melvin McKenzie, Navajo Division of Education.)



BANQUET
February 14, 1978

BE IT REMEMBERED that on the 14th day of February, 1978, at approximately six o'clock in the evening, the banquet of the Second National Indian/Alaska Native Health Conference began at the Albuquerque Convention Center, Albuquerque, New Mexico.

Mr. Jay Harwood: Welcome to this conference. We hope you are enjoying it, and it's really a pleasure to welcome you all to Albuquerque, New Mexico.

It is indeed a pleasure for me to shake hands with my very dear old friends like Perry. He has been a fine old buddy of mine for many, many years. I often thought he ought to have gone on with his education and become a doctor, and I'll tell you why, because Perry Sundust is one slick operator. I'll tell you. He'd make a good one.

Tonight, I would like to first open our program with the introduction of some very special guests that we have with us.

First off, under the direction and leadership of this man, the National Indian Health Board has accomplished much in this past year. And through their vision and the leadership that he has provided, I think great things are yet to come.

Ladies and gentlemen, Mr. Howard Tommie, the Seminole Tribal Chairman and Chairman of the National Indian Health Board.

Next, I would like to introduce to you another member of the National Indian Health Board. You see, this lady is a very special person to me. I've known her for many years, worked with her in the Billings area. She is a member of the Crow Tribe and a great leader of the Crow Nation. She is the President and Chairperson of the Billings Area Indian Health Board and serves as Vice-Chairman of the NIHB, Ada White.

No program is fitting without the introduction of old money bags. We've got one.

This man is very instrumental in health for Indian people in the Mid-western part of our country. He is a Keewanaw Chippewa. I hope that's right. And he comes from Michigan. He is the NIHB Secretary-Treasurer, Mr. Don LaPointe.

I would also like to introduce to you on my right the man whom I have held for many, many years in great esteem and have the greatest of respect for him and I think all of you do, too. Ladies and gentlemen, Dr. Emery Johnson, Director of Indian Health Service.

On my left, may I introduce to you the lady who is sort of boss around our house, my wife, Alice.

We have other special guests that we will introduce here momentarily.

Mr. and Mrs. Bobby George from the Navajo Nation. Bobby is here to delivery the Keynote Address tonight.

I was going to hold this next man for last and tell you something about him. Jose has devoted a lifetime to health and to the health of not only his people here in the Southwest, but also throughout much of the United States. He retired from the Indian Health Service, well over twenty years ago, but that hasn't stopped Jose because he went on to bigger and better things, like being a representative on the Indian Health Authority. He is a key figure in many of the legislative issues here in New Mexico. He's a very active man and, also, a prominent artist,

Ladies and gentlemen, he will open with our invocation. And before he actually leads us in prayer, he has something to tell us all in memory of the late, great Senator Hubert Humphrey.

Ladies and gentlemen, Jose Toledo.

Mr. Jose Toledo: Thank you, Mr. Harwood.

The National Indian Health Board proudly dedicates this health convention to the memory of the late and beloved Senator Hubert H. Humphrey, who for so many years, fought tirelessly to improve life for this nation's disadvantaged.

A true friend and supporter of the Indian people, Senator Humphrey fostered a time of hope for Indian affairs as he chaired the National Council on Indian Opportunity.

And, now, if we will all rise for the invocation.

(Prayer.)

Mr. Harwood: Thank you. Enjoy your dinner.

(A brief recess was taken.)

Mr. Harwood: We have another member of the Board from the Tucson area, a representative and friend. This is Ms. Irene Wallace.

I met this man many years ago. He's from Kayenta, Arizona, Elwood Saganey of the Navajo Tribe.

From California, welcome, Timm Williams.

Let's hear it for California.

How about Arizona. Here is Perry Sundust from the Phoenix area.

Perry is always getting a lot of applause and always running for something. I saw him running away from the cops, however, here in town.

There are others. Mel Sampson from the Portland area is here somewhere, I believe. I don't know exactly where he's seated, but I think the Portland area is well represented here this year.

Let me see. The Aberdeen area. Their representative is Mrs. Leona Claymore, and I don't know if she's here. Is she? She isn't.

I almost forgot. Oklahoma, where are you? Duane Pratt is the representative. Is Duane here? I don't know where he is. Oh, there you are. Okay.

Bobby George.

Mr. Bobby George: I would like to express appreciation on behalf of the Chairman of the Navajo Tribal Council, and also on behalf of the Navajo Area Indian Health Board of which I am a member, for the opportunity for us to present to you at this banquet our concerns with regard to Indian health throughout the country, and specifically, our concern for Indian health on the Navajo Reservation.

I would like to also express my appreciation on behalf of the chairman for the attendance of Senator Domenici here, and also for Dr. Emery Johnson, and the Honorable Chairman Howard Tommie, and other distinguished guests here this evening.

We have prepared a statement here on behalf of the Chairman of the Navajo Tribe, which I would like to present to you at this time.

It is clear that the health of the Indian people has improved radically since the creation of the Indian Health Service in 1955. Additionally, nutritional supplementation programs, increases in the general level of health awareness, and recent tribal economic developments have played significant roles in elevating the general health of our people. Although significant accomplishments have been realized, there still remains the everlasting dilemma of Indian Health Service being forever understaffed and underfunded.

And, although we are aware of our dilemma and accomplishments, we must continue to strive for more improvements and an increasing influence over our own internal affairs.

This motivation and awareness should continue to remind us that this is a long awaited and important time in our collective history as Native Americans. For, while many predicted and assumed the disappearance and assimilation of the American Indian into the ruling society during this decade, we are, in fact, emerging anew to preserve our unique heritage in a resilient, proud, and determined manner.

Thus, the time to discuss our rightful and meaningful roles in the planning, management, and evaluation of our own health programs is upon us.

We, even our medicinemen and native healers, have recognized the benefits of Western medicine. And, in turn, the non-Indian health professionals must recognize the benefits of many of our traditional healing arts.

Yet, we are far from achieving a state of balance and harmony in the process of self-determination, and we will attain such a balance only when we have trained more Native American health professionals and management experts. But already we can begin to see and taste the return of our pride and abilities in self-government, self-sufficiency, and the preservation of our cultural integrity.

These things are the essence of true self-determination.

Too often, however, the government has, with apparent good intentions, created programs for us which have encouraged laziness and dependency and other unworthy self-defeating attitudes rather than encouraging the emergence of new skills and self-sufficiency.

Public Law 93-638, the Indian Self-Determination and Education Assistance Act, has been viewed cautiously, and even suspiciously, by all of us. Used wisely, this act represents excellent options and directions.

However, it must be expanded upon, clarified, and more importantly, implemented.

Our opponents have twisted the concept of Indian sovereignty to appear to be an attempt to wrestle away power from state or federal government.

In actuality, we are struggling merely to achieve the self-governing rights accorded by treaties and those other promises largely conferred on us by the United States Government.

With this situation, undoubtedly very common to us all, it is very encouraging to address such a conference as this with so many highly skilled, articulate, aware, and fully qualified Indian health professionals *present*.

Collectively, we already possess the expertise to direct a healthy future for our people.

Though we are unique from one another as American Indian nations, we share common bonds which are far stronger than our differences. And, because we are collectively less than half of one per cent of the United States population, we must endeavor not to allow ourselves to be divided, and, thus, neutralized by our opponents.

The Indian Health Care Improvement Act, Public Law 94-437, is the most significant new hope for the health of Native Americans to be developed in two decades.

At this point, however, Public Law 94-437 is beginning to appear like another half-baked promise. The intent is admirable, to assist the Indian people to attain the same health status as the rest of the United States population, within the seven-year period from 1978 through 1985.

The first year of Public Law 94-437 has been relatively disappointing, especially in two areas.

One: Full funding as originally authorized by Congress upon passage of the law was not received.

And two: Not extending the concepts and principles of self-determination

into the implementation of Public Law 94-437.

Thus, even in areas where tribes are fully prepared and qualified to assume management of services, as in the administration of Title I, Health Manpower Development and Scholarships, the Indian Health Service has done little to release any control. Indian Health Service persists in its determination to direct our educational development.

For Fiscal Year 1979, the President has disallowed funding for Titles I and V. And still, in 1978, the General Accounting Office and Indian Health Service headquarters have not resolved their conflict over bed planning methodologies related to Title III, Hospital Facilities Construction.

With these facts in mind, the prospects for Fiscal Year 1979 Public Law 94-437 funding look grim indeed.

To further exemplify our concerns with this act and its implementation, we have found that the American Indian veterans, who served our country so bravely, are not yet eligible for adequate eligibility examinations.

And, on the Navajo Nation, there are available for only less than three per cent of the Navajo elderly, eyeglasses, hearing aids and dentures. The Indian elderly, the disabled veteran, the handicapped, and other special groups, need long awaited special attention from our Indian Health Service.

Congress must recognize that problems such as these are actually causing the Indian people to fall further and further behind the rapidly advancing health status of the United States at large.

To be specific once again, the total IHS 1977 budget for the Navajo Nation, including hospitals, ambulatory, environmental, dental, and absolutely everything provided, other than sanitation facilities construction, resulted in just slightly more than three hundred dollars per Navajo person.

This, compared with the U.S. 1977 estimate per capita health expenditure average of more than eight hundred dollars per person, demonstrates how we really measure up in this country.

As late as 1975, the mean age of death for Navajo males was only thirty-five years of age. The Navajo rate of death from alcoholism is over twelve times greater than the United States average.

Public Law 94-437, even if funded at twice the Congressional authorization levels, would not allow us to catch up to the U.S. general health status in terms of dollar expenditures for many years to come. And unless Congress increases its authorization for funding of urban Indians, the urban Indian will receive very limited health services.

A large percentage of Native American people live in rural, even ultra-rural areas. As an example, the population density in the Navajo Nation of five per square mile, is less than one-tenth the average density of the general United States. We always knew the rest of America was more dense than the Indian Nation.

Our people, historically, have always been poor.

These factors make it mandatory that approaches to Indian health care in the future be innovative, and such care will be very expensive.

Unless we inform our congressmen of the health situation among Native American people, Public Law 94-437 will not be funded.

For example, again, on the Navajo Nation, four contiguous service units in the heart of the Navajo Nation, namely, the Crownpoint, Chinle, Kayenta and Winslow Service Units, with a combined population of over forty thousand people, have no IHS hospital available for an average of one hundred miles from their homes. Other tribes experience similar problems.

With this in mind, it seems strange to hear of a hospital bed freeze for Indian people.

National Health Insurance is another very controversial subject to the Indian people in this country.

Some proponents of the various packages before Congress maintain that all Americans, including special groups like the American Indians, should be grouped into a unified national health mechanism. However, this is a dangerous notion.

If our health status was on a par with the rest of the country, this might seem appropriate at first glance. But as far behind as we are, National Health Insurance would offer us little assistance.

Most importantly, there is no proposed mechanism of including the principles of self-determination into National Health Insurance, like we have, potentially, with the Indian Health Service funding mechanism.

Thus, I am advising our health leaders to protect the IHS funding mechanism. However, should National Health Insurance be enacted, I would recommend incorporation of benefits not available from IHS through Title IV of the Indian Health Care Improvement Act.

Further, the entire Public Law 94-437 must incorporate the authorities and principles of Public Law 93-638, the Indian Self-Determination Act.

Without these or similar changes, and without preservation of the IHS funding mechanism, National Health Insurance cannot conceivably offer reservations and federally recognized tribes any advantages.

Public Law 93-641, the National Health Planning and Resources Development Act, has recently caused many tribes a great deal of concern through the creation of the nationwide network of HSA's, commonly known as Health Systems Agencies.

The Navajo Nation, despite its sprawling across the three states of New Mexico, Utah and Arizona, is unique among Indian tribes in having assigned to it a separate HSA. Although the Navajo HSA is developing in a cooperative manner with respect to the tribes, we must be cautious of potential conflicts over tribal sovereignty in the near future.

This will be of special importance when our HSA has been officially designated and develops its review and approval authority over non-IHS federal dollars spent on the Navajo Nation.

Furthermore, the HSA's and Public Law 93-641 must positively be brought around to address the issue of tribal sovereignty, including our right to self-government and to our unique cultural heritage.

The HSA's can provide assistance to tribes in offering a community oriented approach to health planning and health care delivery, rather than the mostly facility-oriented approach of the Indian Health Service.

At this point, these considerations are not occurring and the HSA's appear to be federal regulatory agencies which will most assuredly bypass our tribal councils and legitimate tribal governments to serve distant federal interests in Washington. One thing is certain. The HSA's are not going to disappear. We must work with them.

At present, on the Navajo, the tribe and our own HSA are communicating and cooperating, but the Navajo Nation and the other Indian nations must impress upon our congressmen the need to amend Public Law 93-641 to specifically and clearly address the role of tribal governments and the tribes' right of self-determination.

There are many specific recommendations which I could mention, and which must be elaborated upon by all of us in the future. But since time is short, I wish to continue my remarks with these observations.

There are many of us Indian people who have been spiritually discouraged and beaten down by those who have implied that we will never be capable of managing our own affairs. Yes, some of us have believed these kinds of criticisms, but fortunately, most of us have not.

This meeting exists here tonight because of the determination of the Indian people to achieve the degree of self-government and economic independence to which we are entitled, and toward which our true friends in Washington are assisting us.

It has been fear and lack of self-confidence and pride which has rendered many of us wary of self-determination.

Yes, I remember that many promises to us have been broken by the federal government, but we must not break our own promises to ourselves, to our children, and to those young new Indian health professionals here with us tonight. We must not forget that we are the proud, able and courageous First Americans.

And, we have laid the foundation for a new era for Native American involvement in our own affairs.

Therefore, we should continue to take advantage of the opportunities afforded us in the development of Tribal Specific Health Plans, water rights, land claims and energy resources.

If we do not attempt to develop our own plans for our own destiny, then the federal government and its agencies will do it for us, according to their own desires, as they have done in the past.

We are people with a heritage of self-sufficiency and of respect for man and nature. We taught the first white visitors to this land many tools of survival, and then we had to struggle to survive like never before.

We have survived and we will survive long enough to see Indian self-government and self-sufficiency come again, and perhaps long enough to help the non-Indians in their struggle to find some balance and harmony in their own lives as well.

Mr. Harwood: I think that those words which Mr. George blessed upon us bear much thought, as indeed, it was a very key message, I think, that all of us must think about.

I think, on a humorous side, I might pick up on it, also, in terms of speaking of hope. I want to tell you this story of hope, or whatever you want to call it.

Not too long ago, there were a couple of nuns who were motoring down from Santa Fe en route to Albuquerque on the interstate. And it seems as though they failed to stop at a station up there, and they ran out of gas.

So, they were only about halfway between here and Santa Fe. So, one of them said to the other, "Well, we must flag a vehicle down to see if we can get enough gas to get to the next station down the road a piece."

So, one of them got out of the car on the right side. And she went around there, and sure enough, she was out on the road, and it didn't take her long. This pickup came by and he pulled right up and he said, "Can I help you?"

And this sister said, "Yes, you certainly can. We've run out of gas and could you help us?"

He said, "Well, I'll tell you what." It just happened that this was a Santo Domingo and he had one of those Indian credit cards with him, a siphon hose, and he said, "I'll tell you, I can give you some gas, but I can't stay around here very long. I have a very important appointment in Albuquerque and I've got to move along." He said, "By the way, I guess I don't have anything or any kind of a container to put the gas in." He said, "You wouldn't happen to have something in your car, would you?"

So, they opened the trunk and they got to rummaging around, and they came up with a bedpan.

So, he went over there and he siphoned enough gas, and he took this gas in the bedpan, and he said, "Well, ladies, I've got to get on down the road."

And they said, "Go on. We'll get along all right."

So, these two sisters were there pouring this gas from this bedpan into the gas tank. And about that time, here come a couple of guys from Cochiti, and they were a little bit high. And one looked at the other and said, "My God, did you see that? You talk about faith."

That's how some of we Indians feel, Senator.

We have a very special guest tonight. Before we hear his remarks, we have the Laguna Pueblo Indian Dancers whom we have invited to perform a very special Eagle Dance.

Senator Domenici, the dance will be done in your honor.

(A brief recess was taken.)

Friends, tonight it is indeed an honor for me to introduce a man who is a great friend of our Indian people. He has served as a United States senator for the State of New Mexico. He was born and raised in this country, and he knows full well the needs and concerns of Indian people, not only in New Mexico, but, I think, throughout the United States as well.

In his term in the United States Senate, he has proven to be a strong supporter of many Indian causes, and one is, of course, the Indian Health Care Improvement Act. He was one of some five senators who was instrumental in bringing forth the phase funding concept for new construction of Indian Health Service hospitals throughout this country, which enabled the Indian Health Service to begin construction of five major facilities throughout the various areas.

He serves on the Energy and Natural Resources Committees, he is on the Budget Committee, he is on the Environment and Public Works Committee, and he is the Ranking Minority Member of the Special Committee on Aging.

Ladies and gentlemen, a nice, big welcome for our very special guest, the Honorable Senator Pete Domenici of New Mexico.

Senator Pete Domenici: You know, wouldn't it be something if people in my state and around this country, could not only have a view of the Laguna Indians that we saw tonight, and we want that to remain, but if Americans just understood how that group of Indian people implemented their sovereignty and their self-determination. It's amazing how little Americans know about what the Indian people are doing.

Having said that, let me ask you if you will bear with me and let me tell you three or four stories. I hope they are somewhat humorous. Three of them are kind of my own, and one has a bit of a message in it that someone told to me.

First, some of you out there might be wondering what nationality or what minority does a fellow named Domenici belong to. Well, let me clear it all up for you. It isn't Indian; it's Italian. And, if you were from New Mexico, you would know that there are very few Italians here, but when I went to Washington as, not only as Italian whose mother and father were born in Italy and came to this city, but also a Republican, you would really know that I know what it's like to be a minority.

In addition to that, I got a fancy invitation from a group in Washington and they said that they would like me to become the new, national, honorary chairman of a group that was called the Italian Republicans of America. Let me tell you, it would be very difficult to find very many.

But we looked it over and it seemed that it was right to do so, my wife, Nancy and I said, "Let's go ahead and accept."

I went to a little town outside of Washington named Silver Spring on a Sunday night, especially to find a little table, like, maybe yours, with six or eight people. When I walked in, there were about eight hundred, but I just say to you that they didn't believe I was me.

So, I identified myself with my New Mexico driver's license and they

finally sat me at the head table.

Shortly thereafter, a fellow from New Jersey came up and he hit me on the shoulder like this, and he said, "Senator Domenici, how many Italians do you have on your staff?"

Well, to tell you the truth, I never even thought of that and it never entered my mind. So, I said, "What?" And I said, under my voice, in my head, "Dear Lord, give me an answer to this fellow."

And as he repeated the question, the answer came. And I looked up and I said, "None, mister."

And he looked kind of like he was going to frown. And I said, "But let me tell you, there are so few Italians in New Mexico, we are substantially overrepresented by just me."

Before I finish in the next few minutes, maybe we will get a little thought of meaning to that humorous story.

Now, I want to tell you one more that, again, comes from my own household. Some of you who are New Mexicans know that my household is a very big household. There are eight children.

And, when I went to Washington, my last born, they are identical twin girls, were five and a half; and by the time this event occurred, they were reaching seven. I didn't see them so often in those first two years. So, I said, on this particular morning, maybe I will just stay home and cheat a bit instead of going down on that commuter train, I will go down at ten o'clock and I'll be with them.

Well, the funny thing was that I put on my robe and got a cup of coffee and sat in this chair in the front room, that was sort of my idea of senatorial splendor.

My daughters were on the floor there right in front of me, and the sad thing is, they didn't know I was there as they were watching television and totally oblivious that I had stayed to be with them.

So, I said their names, mildly at first, "Paula, Helen." It got a little louder, and intuitively I started to clap and say their names quite loudly. Finally, one of them stood up, Paula, looked over her shoulder and said, "Daddy, you is no king; you is just a senator."

I want to tell you, both of those are mine.

Now, I want to tell you one that we ought to all think about here tonight. Maybe you've heard some versions of it, but let me say that it's supposed to be a story that's true and that comes from Eastern European folklore.

And it starts out, one early spring morning when it's still quite chilly. And a big, strong, robust farmer is dressed to go to work in the woods with heavy boots and a heavy sweater, and he walks out the back door of his home. And he is instantly distracted by a little noise on the ground, and it's the noise of a chirping, little bird that fell out of the nest early.

And the farmer has some things to do, but being a generous, kindly fellow,

he wants to help that little chirping bird. So, he meanders over and he knows that if he plucks it, the warmth of his hand would cause the bird to feel good and react well, and he does, but then he has a problem because he has to go to work. And he doesn't know what to do, and his eyes are kind of looking around and he sees a rather large, fresh cow dropping.

And he immediately says, "That, too, is filled with energy and warmth." He walks over and makes a nest in it with his big boot and puts the bird down, steps back and is very content and happy because the bird reacts well. And he leaves to go to work thinking he has done a good job.

Now, you know what happens. The farmer's gone, the bird gets healthy and well and is chirping quite loudly, and the farmer is long gone. But the fox that frequents the corral approaches and hears and smells the bird, and he meanders over and sees it and plucks it out. And all the farmer's good works are gone.

Now, this folklore says we ought to learn three lessons from this story. And the first one is that it isn't always your enemies that get you into it.

And the second is, that it isn't always your friends that get you out of it.

And the third and most important is, when you are in it up to your neck, keep your mouth shut.

I'm afraid I'm taking so long that I shouldn't tell you the next story, but go on to the substance, but, nonetheless, there is a message in the next one, and let me tell it to you, and then we can talk seriously for a while.

Maybe there are already messages in the ones I just told you.

Let me tell you another true one, and I will preface it by saying to all of you, in all sincerity, I don't tell you this story in order to describe my views or prompt your views or anyone else's on the issue of the Panama Canal Treaty. It just happens that this event occurred and it centers around it. So, let me tell you.

The night of the President's fireside chat, for some reason, I was invited to the White House to be in attendance with some fifteen or twenty senators and other very distinguished guests, and so I went. But before I accepted, I told them, "I have one condition. I don't have a ride home." And I lived seventeen miles, and everyone is gone by then from my office, and my wife, I was just not going to ask her to do down. "Can you give me a ride home?"

And the answer was yes.

So, I went and the evening was splendid. You must understand that I felt sort of strange because I had already said that I didn't support them but the evening went on and we finished and had a very nice time. And I told the liaison man, "You know, I'd like to get home. Will you please see if I can have a ride?"

He said, "It's ready any time you would like."

So, I walked out into the hall, putting on an old, beat up overcoat, and a lady ran up to me, and she said, "Senator, are you Senator Domenici?"

"Yes, ma'am."

"You are wanted on the telephone."

And let me tell you, at ten o'clock on that night, I hadn't made a big issue of going there. I wondered who knew, and the response from me was not very nice.

It was something like, "Who in the hell found me here?" or something, but I went to the phone and I picked it up, and the voice on the other side said, "Are you my senator, Pete Domenici?"

And I said, "Yes, sir. And who are you?" And I won't tell you his name, but I will just say his name was Mr. Gruber.

And he said, "I am Mr. Gruber, and I live in Albuquerque, New Mexico."

Now, this was no more than twenty minutes after the big event, the fire-side chat.

And Mr. Gruber was on the phone. And I said to him, "Sir, before you tell me your problem, how did you find me?"

And he said, "Oh, it was very simple. I called your home in Rockville, Maryland, it's listed, and some very nice, young girl, perhaps your daughter, said, 'I'm sorry, sir, my father is not home, but if you want him, you can call him at the White House.'" Well, he said, "I did."

I said, "Well, now, what would you like to tell me?"

Well, he proceeded to tell me that he hoped I didn't agree with the President and that, "You didn't believe him, did you?"

And, you know, it was amazing as he went on and described his feelings. Here was a little man from Albuquerque who had caught me in the White House before I had left an event that our own President had called me to try to give me his views. And I had a citizen right here telling me the exact opposite.

So, I got in the car to drive home, and I told the driver. "Would you please turn on the light. I would like to read a little bit."

I read for a while, and soon, I said, "Okay, make it easy on yourself. Put off the light."

Now, I wanted to tell somebody this story, and it seemed like I couldn't wait until I got home. So, I said, "Mister," to the driver, "Could I tell you a secret?"

And he said, "If you like."

And I told him that story with a few more of the vulgarities that the man used. And I didn't know for a few seconds whether I did right, but when I finished, he stared straight ahead and for about thirty seconds said

nothing, and then he looked at me. And he said, "Senator, you don't have to worry about me telling your secret because I agree with Mr. Gruber."

Now, let me see if you will think back through what I have told you tonight, in these stories, and let me talk a bit about where we are.

It would be presumptuous of me to -- with people like our good doctor here, people like those of you who have been in Indian health for years, Indian people here in the audience, men and women, who have learned and struggled and understand the problem of Indian health from a professional standpoint.

So, it's much better that I not talk about that. And there is a much bigger issue brewing in America that you had better be worried about and we had better share tonight, and you had better begin to get concerned about it.

Now, first, let me say, if you are confused about the Indian health delivery system, don't think you are lonely. Those who participate in the veteran's program under VA are confused.

Those who think they are entitled to Medicare because they are old and paid Social Security are confused.

Those who have been in the military and are entitled to CHAMPUS are worried and don't know what's happening.

Those who were involved in private health insurance programs are concerned.

The medical schools are worried. They don't know the role of the doctor in the next twenty-five years.

So, it's perfectly logical that we can be disturbed and worried about the relationships of ourselves and all of the delivery systems, when it comes to that precious commodity called health, when they are so diverse, so different, so structured, and we don't quite understand where we are going.

But suffice it to say, that in the area of Indian health, talking about people, not about programs, talking about where we are and where we should be, your cause, in terms of need is the most legitimate of all because, indeed, we are years behind. So, we need not be worried about pushing the cause. We need not be worried about telling the facts.

And I hope that the good doctor who is in charge of Indian health in the program tonight talks about the strides we have made, the successes we have had, and equally talks about where we are going.

Now, having said that, let me say, you cannot separate your role as leaders in Indian health from the problem that is brewing in America that some people call the backlash. You can't separate yourself from the reality that, today in America somehow or another confrontation on almost every issue regarding Indians and non-Indians surfaces somewhere in America, and gets extreme notoriety, and causes fantastic concerns.

Do you remember? I talked about being a minority. Do you remember? I talked about representation.

Now, let me tell you what I think we must do and where we are. For years,

we pursued programs and ideas. And I think we have to stop, look, and listen a little bit and make some different kinds of decisions.

The first is, we must decide to educate the American people, who I truly believe, if they understood, would act differently. We must educate them as to what the treaties and trust relationships are. We must educate them and let them understand what self-government means today for the Indian people, the strides they have made, indeed, in my own state. Maybe we have to take some New Mexico leaders to some place like Zuni and let them look at the criminal code, look at the judges' training, look at the people who have committed crimes. You know, some of you are part of much better programs than that, that protect people, yet are under the control and sovereignty of Indian people.

But let me tell you, there are an awful lot of people who don't know what is going on, what you are doing, what your goals are. And unless they begin and you begin a program to help all of them understand, not indoctrinate, not confront, but understand, then I believe we have reached a plateau, and we'll be lucky if we don't slide backward; we'll be lucky if we just stay there for a while.

And I need not tell you what's happening in the Congress, for you must know. Some of you come from states where there are people who are even proposing that in one full swoop, we just get rid of the treaty relationships in total, because we don't know what else to do, apparently.

Now, let me also suggest that there is a genuine need for a spirit of cooperation among equals, bilateral or multilateral, but a true spirit of cooperation between state government and Indian government, not as one sovereign to another, but rather in a spirit of true cooperation.

And, last, but not least, is if we could set a model for that somewhere, and it requires so much of good people that I'm not sure we could legislate, those two things should end up in the not too distant future with negotiations between the Indian people and states and the federal government, where we sit down and decide what areas we can negotiate on. That's collection, criminal jurisdiction, whatever it may be.

Let me say, this is an amazing country, amazing, when Mr. Gruber can do what he did; when somebody working for the White House can drive you home and say he disagrees with his president.

This is an amazing country, and the people are predominately people of good faith who want to do what is right.

So, my message tonight is not a message about Indian health. You know enough about that and more than I. But let me suggest that rather the problem that our Indian people have today with their states, state governments, and national government, in this senator's opinion, will not be resolved properly if every issue goes to court and if every issue is permitted to fester and boil, and confrontation occurs because the facts of life are that you are a minority.

Nonetheless, you have substantial rights and you are right. And as long as you have those going with you, it appears to me that you will prevail, you will have successes, and there have been many already.

So, I close by saying to all of you, thank you so much for inviting me tonight, I am no king. And I think the problems are so difficult, so diverse, that I am glad I am not and I am glad we don't have them, but that will just make it harder to solve, if we are complicated, if we are filled with emotion, they are rather contradictory in one sense, yet very natural in another.

So, my urging to you tonight is that you pursue as a group, and individually as leaders, the idea of education, cooperation, which ends up moving toward negotiation and understanding. Without that, it appears to me that there is eminent danger because we could go backward, not forward.

Mr. Harwood: Thank you Senator.

On behalf of our Indian people and on behalf of our staff of Indian Health Service who are here tonight, we want to again express our appreciation and thanks to you for seeing fit to find a few hours in your very busy schedule to be here.

We will take your message advisedly, I am sure.

We are going to call upon Mrs. Eva Russell who is with the Indian Cultural Studies, who will give us now, God Bless America, and this will be done in Indian Sign language.

(The banquet was concluded at 9:30 o'clock p.m.)

CONCURRENT WORKSHOPS

February 15, 1978

We wish to acknowledge the assistance of those persons who helped with coverage of the following concurrent workshops; either by photography or taking notes: Evelina Zuni, Pueblo News; J. Schomisch, Gallup Independent; H. D. Timm Williams; Melvin R. Gardner; Vesta Starkey; Patti Carter; Ellen Whitekiller; Gene W. McElyea; Milton Johnson; Luz B. Kalaczik; Ruth Richards; Dr. Stanley Glenn; Helene C. Welsh; Carolyn WhiteCloud; Mary Collado; Shirley Zasadny; Charmaine Segundo; Diane Holman, R.N.; Evelyn Blanchard; Lupe Chinana; Edward Kennedy and Pat Lujan.

Tribal Specific Health Plans

Moderator: Mel Sampson, NIHB Representative
Portland Area

Facilitators: Tom Seidl, Chief; Evaluation and Special Projects
Portland Area Indian Health Service

Charles Erickson, Office of Research and Development
Tucson Area Indian Health Service

Sid Edleman, Assistant General Counsel for Public
Health, DHEW; Washington, D.C.

Erin Forrest, National Tribal Chairmen's Association

For more than half of this workshop's participants this provided their first introduction to the tribal specific health planning guidelines, even though the guidelines were originally distributed by Indian Health Service in October of 1977. This proved upsetting for the participants themselves as well as for those conducting the session.

Nevertheless, the workshop was able to continue and produce a number of recommendations which were formalized and presented to the conference general assembly on Wednesday afternoon.

Preceding discussion of the actual planning process, Erin Forrest gave a brief historical review of the origin of tribal specific health planning, noting that the concept is not specified "per se" in P.L. 94-437. According to Forrest, who helped in the formulation of the guidelines, tribal leaders and their health planners stand to benefit from using them as a mechanism to better understand their local health situations.

A crucial consideration in a tribe's development of its health plan is the size of its service population. Such a determination will be difficult, if not impossible, to make without knowledge of the IHS "on or near" policy currently being formulated for the delivery of health care to Indians and their dependents. DHEW Assistant General Counsel Sid Edleman told the group that the process of reaching concise interpretation to this end is a lengthy endeavor and informed the participants that at least another six weeks would be required before the proposed policy would be ready for printing in the Federal Register.

As the new policy is likely to increase reservation service populations, participants questioned Edleman about additional contract funds. He responded by saying that none have been requested, rather that expanded contract costs could be covered by anticipated funding under 94-437.

Making a presentation on use of the suggested guidelines, Seidl cautioned that Indian groups and their planners should not be overwhelmed by their complexity and detail and stated that a departure from the requested data would be acceptable. He explained that the format is structured to focus on "Resource Allocation Criteria,"

better known as the "RAC document" used annually by IHS to identify health needs and support budget requests.

All Tribal Specific Health Plans must be submitted to IHS by July 1, 1979, Seidl told the group. He said it is not clear at present what will happen if the level of funding in P.L. 94-437 is insufficient but commented that IHS Director Dr. Emery Johnson has agreed not to modify the scope or reduce the costs contained in any of the plans.

As the meeting came to a close it became apparent that technical assistance from all IHS Area Offices would be vital to the success of this entire effort.

(Specific recommendations developed out of this workshop can be found in the transcript of the Fifth General Assembly.)

Title VI of P.L. 94-437: The Need for and Feasibility of Establishing an American Indian School of Medicine

Moderator: James R. Smith, Director
Billings Area Indian Health Service

Facilitators: Taylor McKenzie, M.D., President
American Indian School of Medicine

George Blue Spruce, D.D.S., Indian Health Service
Rockville, Md.

Michael Lincoln, Executive Director, Navajo Health
Authority; Window Rock, Az.

Dr. Jasper McPhail, Dean of the American Indian
School of Medicine

Long-term federal funding is the only roadblock to establishment of an Indian School of Medicine, Dr. Taylor McKenzie, president of the proposed school in Shiprock, N.M., told those who attended this workshop.

Costs for the school are estimated to be between \$6 and \$15 million for construction and approximately \$18 million additionally before it becomes fully operational. Financial projections estimate it will cost \$5.5 million to operate the school in 1986-87 for 255 students with all but \$100,000 coming 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 accreditation is granted. All can be met, he said, except assurance of long-term financial support.

In addition to reporting on the school's current status, Dr. McKenzie gave some brief highlights of its development to date. In 1972, the Navajo Tribal Council established the Navajo Health Authority and commissioned it to improve the health care system on the Navajo Reservation and to establish an American Indian School

of Medicine to serve all Indian people.

An authorization for a one-year study to determine the feasibility and need for an Indian School of Medicine became part of P.L. 94-437, the Indian Health Care Improvement Act.

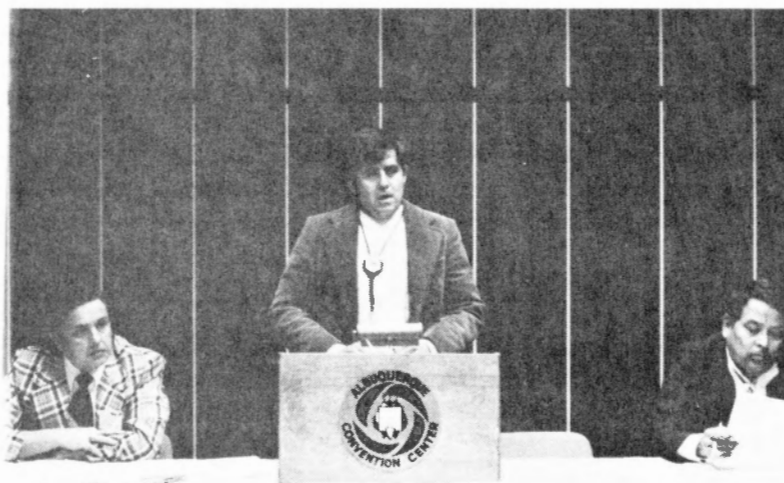
Meanwhile, in February 1977, the Navajo Tribal Council established and chartered the AISOM. Work continues to progress in securing academic and medical affiliations.

Dr. George Blue Spruce who heads the Indian Health Service's Office of Manpower Development and who served as a member of the feasibility study consultant group spoke of the severe shortage of Indian health professionals. He cited the ratio of 522 non-Indian physicians to 5 Indian physicians within IHS and predicted little improvement with the present system. He added that the turnover rate of non-Indian physicians on reservations is nearly 50 per cent annually.

But he cautioned the school's proponents that, "Congress is not looking favorably and is less likely to fund things which are separate and apart or something special."

In spite of this possible reluctance on the part of Congress, Dr. Jasper McPhail, dean of the proposed school said that the need for a separate school is real. "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," he maintained.

Michael Lincoln, Executive Director of the Navajo Health Authority, explained that Indian medical students would be able to keep their ties with Indian people and patients through the Indian



DR. GEORGE BLUE SPRUCE, IHS Indian Health Manpower Development Director, assessed the chances of federal funding for an Indian school of medicine, as one of the Title VI workshop facilitators. Other discussion leaders were Jim Smith, Billings Area IHS Director (left); Taylor McKenzie, M.D., President of the proposed American Indian School of Medicine on the Navajo reservation (right); Michael Lincoln, Executive Director of the Navajo Health Authority (not shown) and Dr. Jasper McPhail, Dean of the American Indian School of Medicine (also not pictured). (Photo courtesy of Evelina Zuni, Pueblo News.)

medical school.

The school would sponsor a summer work experience program where students would work "ideally with 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," he added.

The school would be unique in that it will also recognize native healing services, said Dr. McKenzie. "The utilization of native healing is resurgent and we want to make sure there are not confrontations between our students and native healing," he said.

It was explained that although the feasibility study was completed in August of 1977 it has since been tied up in review by the Department of Health, Education and Welfare.

In recommendations passed by the workshop and adopted in resolution form by the general assembly, it was decided that the Third National Indian/Alaska Native Health Conference will include the subject of the American Indian School of Medicine feasibility study as a main topic to be discussed by the general assembly and that the National Indian Health Board will encourage individuals, tribes, and organizations to write letters of support directly to congressmen, senators, and other appropriate officials in Washington in support of an Indian school of medicine.

Indian Preference

Moderator: Duane Pratt, NIHB Representative, Oklahoma Area

Facilitators: Sam Deloria, Director, American Indian Law Center
University of New Mexico; Albuquerque, N.M.

Ed Perkins, Liaison Officer, Navajo Health Authority
Window Rock, Az.

This workshop focused on the absolute Indian Preference policy applicable throughout IHS as the result of a 1977 court order. Participants included tribal representatives, IHS Equal Employment Opportunity officers, IHS training representatives and IHS Office of Research and Development representatives.

Among others, they heard from one facilitator who, viewing the policy in a positive light, suggested that it is a concept along the lines of Indian self-determination, whereby Indian people can assume the operation of those services the government provides to them.

In spite of the policy's good intentions, however, almost all of those present seemed to agree that many problems exist in its implementation.

One of these cited by the group was the case of Commission Corps appointments which fall outside the boundaries of Indian Preference and consequently give no control to tribal groups.

Viewing such a situation as inconsistent with the policy's intent, workshop participants stated that participation of tribal groups in such recruitment and appointments is essential in view of the changing and related programmatic structures of tribes and IHS.

Perhaps a more direct obstacle to Indian persons receiving the intended benefits of Indian Preference is the use of efficiency ratings to downgrade them. A number of reports and complaints have been received relating to such a practice, whereby an unfavorable performance rating results in a downgrade or an elimination of a position. Thereafter, such positions can be redesigned to accommodate IHS management through its "right to manage."

Another complaint was heard regarding the federal government's Affirmative Action plan which fails to reflect the intent of the Indian Preference policy as it relates to upward mobility, longterm career training and executive development training.

Participants voiced their concern that other inadequacies exist in the present reclassification and restructuring of IHS job descriptions. They stated that Indians have skills and abilities not necessarily reflected from or developed out of formal educational training.

In light of the above types of considerations, the group made several recommendations (although not as formal resolutions) which were presented and adopted by the General Assembly:

- 1) Training
 - a) University courses should be brought to reservations or Indian communities to upgrade academic skills.
 - b) The release time concept should be instituted to allow employees time for training.
- 2) Apply uniform standards relating to Indian Preference in both BIA and IHS.
- 3) Under P.L. 93-638, the Indian Self Determination and Education Assistance Act, Section 104, a tribe has the right to redesign Indian Preference in contracting.
- 4) Tribal groups give support to EEO officers in implementing Indian Preference.
- 5) Regarding Panel Determination: If one Indian person on a panel of applicants is deemed eligible, that person should be hired as prescribed by Indian Preference. The position should not be reannounced for lack of "qualified Indian applicants."
- 6) Eliminate "open and continuous" job announcements because they have a detrimental effect on Indians' opportunity for employment and program planning. All announcements should be channeled down to the area level and posted for advertisement.

Mental Health, Alcohol and Substance Abuse

Moderator: Perry Sundust, NIHB Representative, Phoenix Area

Facilitators: David Vallo, Director
California Indian Alcoholism Training Program
Sacramento, Ca.

Phyllis Cross, Special Assistant to LaDonna Harris
(Member of the President's Commission on Mental
Health)

Wanda Frogg, President, National Indian Board on
Alcoholism and Drug Abuse

Alcoholism remains the major health problem among Indian people, as pointed out in a number of presentations on the related subjects of alcoholism, drug abuse and mental health during this workshop.

The meeting room was packed as David Vallo outlined the problems of alcoholism and drug abuse among Indian people and as Wanda Frogg spoke of one oft-neglected sector of persons suffering from alcoholism, American Indian women.

Frogg said that since the beginning of most Indian alcoholism programs in 1971, the focus had been primarily on the male alcoholic. So, in 1975, a group of Indian women met to address the specific problems and needs of women and established the North American Indian Women's Council on Chemical Dependency.

Dealing with the broadest range of Indian alcoholism programs is Bud Mason, the new Alcoholism Director of Indian Health Service. His office is currently overseeing the transfer of alcoholism projects from NIAAA to IHS. He informed workshop participants that a committee to evaluate projects to be transferred has been established and is composed of Ernie Turner of Seattle and David Vallor of California for urban programs and Harold Redbird and Emmett White for those on reservations.

Alcoholism and mental health cannot be separated because of their close interrelationship, according to Phyllis Cross. Cross reported to the group on the work of the President's Commission on Mental Health, set up out of Rosalyn Carter's interest in and commitment to the mental health of the American people. Cross worked closely with Commissioner LaDonna Harris on focusing on Indian mental health issues and together they succeeded in involving 25 Indian people in the commission's various task forces.

The task forces found alcoholism to be the number one health, social and economic problem among the Indian populations. Eighty per cent of the visits made to IHS facilities are alcohol-related, stated Cross.

Related findings outlined by Cross varied from negative to positive. They included the need for more professional manpower to deal with the problem, the need for local Indian control of

mental health programs, a problem of programs claiming to provide services to the Indian population when such was not the case, separation of the subject of mental health from overall well-being as a concept alien to Indian people, and the fact that traditional community stability and natural support systems made Indian individuals "feel good about themselves."

Recommendations to the President's Commission formulated out of the work done on Indian mental health addressed several issues: tribal programs, i.e., third party payments; support of Indian people for their own mental health system; improved nutrition as a basic necessity for improved health; better services and opportunities for those Indian women "locked" into the tribal system; research to be "action-oriented" for Indians themselves and sanctioned by the group being studied and increased attention to the rights of Indian inmates.

A request for \$15 million in research and manpower funds for Indian mental health programs was made, as reported by Cross. What action is taken on this request and the entire Commission report was yet to be seen at the time of the conference, as Cross reported that a final report was due for presentation to President Carter on February 16.

Resolutions in support of the findings of the President's Commission on Mental Health and for Indian alcoholism programs were later presented and adopted by the National Indian Health Board.

Accident Prevention

Moderator: Donald LaPointe, NIHB Representative, Bemidji Area

Facilitators: Frank Clarke, M.D., Clinical Director
Albuquerque Service Unit, Indian Health Service

Orin Tonemah, Executive Director, National American
Indian Safety Council

Accidents are the leading cause of death in the Albuquerque Service Unit, the Albuquerque Area, and the Indian Health Service as a whole, Dr. Frank Clarke told those attending this workshop. This is in comparison to the total U.S. population, in which accidents rank fourth, he continued.

Among Indian people, accidents are second only to upper respiratory infections as the leading reason for ambulatory patient care.

Some of the statistics regarding accidents among the Indian population are all too predictable. Motor vehicle injuries, personal assaults, and falls are the major types of accidents reported with 39.5 per cent of motor vehicle accident injuries alcohol related, reported Dr. Clarke.

The highest death rate in accidents is in the 15-24 year age group followed by the 25 to 34 and 35-44 year olds, with male deaths predominating about 75-80 per cent.

Although perhaps predictable, such figures are nonetheless outrageous, yet as stated by Dr. Clarke, "there appears to be an apathy in attacking systematically and in force this preventable epidemic."

Solutions to each community's accident problem must be reached at a local level, according to Orin Tonemah. Achieving this must first be approached by orienting tribal councils to the magnitude of the problem. He suggested that they then be asked to adopt resolutions to establish tribal safety programs. Such programs, he said, can be an effective means for working to improve the safety status of a reservation, particularly once they have adopted safety codes and standards and located their areas' particular hazards and needs.

Tonemah has been working to "get some action into Indian country" related to the Occupational Safety and Health Act of 1970 and in particular has been cooperating with the Department of Labor, Occupational Safety and Health Administration (OSHA).

Also present at the meeting, a representative of OSHA, told participants of a preliminary study being conducted to assess the occupational safety and health needs of Native Americans. The project was currently underway and was to be completed by the end of March.

ORIN TONEMAH, Executive Director of the National American Indian Safety Council outlines a process for accident prevention. The first step is to orient people to the magnitude and significance of the problem, he suggests. (Photo courtesy of the Papago Runner.)



Sterilization and Abortion

Moderator: Violet Hillaire, Northwest Portland Area Indian Health Board

Facilitators: Jock Pribnow, M.D., Portland Area Indian Health Service
Patty Marks, Staff Member, Senate Select Committee on Indian Affairs; Washington, D.C.

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 during this workshop.

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 panel discussion at the workshop 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 the IHS policy regarding abortion, to date, is unaffected by Congressional restrictions on the use of HEW funds for abortions. That is, IHS, even though under HEW, receives its monies through the Department of Interior and is able to provide abortions for eligible Indian patients who go through normal IHS procedures.



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.)

Patty Marks, staff member of 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.

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.

She said that in talking to Indian people throughout the country, she has not found anyone who was hospitalized for a minor gynecological procedure and discharged sterilized.

But what she has found is women who had sterilizations or abortions because they did not know of federal benefits to support them or their children, or because they took the word of the physician simply because he was a doctor, or because they received biased counseling.

She also said, "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?" asked Felsen.

For the record, the report said that 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."

The most widely used consent form, the report said, did not indicate that the elements of the consent were presented orally to patients nor did it contain a statement at the top 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."

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

Pribnow responded by saying that 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 (and later adopted in resolution form by the General Assembly).

Jim West, an Indian medical student, said 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. James Felsen, deputy director for IHS' Division of Program Operations, 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 that physicians must sign consent forms.

Health Related Problems and Provision of Services to Indian and Alaska Native Elderly

Moderator: Andrea Fast Wolf, Executive Director, Four State Indian Health Board; Aberdeen, S.D.

Facilitators: Sophie Thompson, Board Member, National Indian Council on Aging

Juana Lyon, Director, National Indian Council on Aging; Albuquerque, N.M.

Two resolutions affecting this nation's Indian elderly grew out of this workshop attended by nearly 60 persons and were later adopted by the full General Assembly.

The first of them, titled "Advocacy for the Health Needs of the Indian Elderly," endorses statements of unmet needs of the Indian elderly and recommendations previously submitted to the Indian Health Service for remedial action. It further demands that IHS review these recommendations and take the initiative in acting on them "rather than awaiting action by other agencies," and that it do so in cooperation with NIHB and the National Indian Council on Aging.

It also makes the plea in the form of a resolve that health related concerns and services for the elderly be raised from their present "low priority" status to one which gives the elderly the services to which they are entitled and that all boards and individuals concerned with the well-being of the Indian and Alaska Native elderly unite in this effort.

The second resolution, based on the contention that emphasis has fallen "on institutional placement alone, resulting in failure to provide other necessary health services to patients needing long-term care," resolves that Indian tribes, IHS and the BIA, in planning long-term care, provide adequate support services and implement in-home health care and other alternatives in the care of the Indian elderly.



SUGGESTING measures to deal with the problems of the nation's Indian elderly is Juana Lyon (center), Director of the National Indian Council on Aging (NICOA). Also pictured are Bob Effman, NICOA Chairman and Andrea Fast Wolf, Director of the Four State Indian Health Board. (Photo courtesy of Evelina Zuni, Pueblo News.)

Patient Rights and Representation

Moderator: Elwood Saganey, Chairman, Navajo Area Indian Health Board and NIHB Representative

Facilitators: Gloria Keliiaa, Executive Director, National Indian Health Center; San Francisco, Ca.

Vernon Antone, Team Leader, Patient Representative Program, Phoenix Indian Medical Center

This workshop dealt with patients' rights, not necessarily a new concept, but one finally being guaranteed for Indian patients of IHS through programs such as the one at the Phoenix Indian Medical Center.

Gloria Keliiaa, one of the developers of the Phoenix Service Unit Patient Representative Program and Vernon Antone, one of three patient representatives, told the group of the program which began two years ago.

Operated by the Phoenix Service Unit Indian Health Advisory Board, which contracts for program funding with the IHS area office, the program is available to serve patients of the Phoenix Indian Medical Center, a 200-bed hospital offering comprehensive health services.

The program has several objectives. Philosophically, the patient representatives are the enforcers of the Patients Bill of Rights, which aims to ensure patients of the highest level of health care available, adopted as official policy of the Phoenix Area in December, 1973.

The patient representatives are present to reinforce physician-patient relationships.

They function to recognize problems in the delivery of health care throughout the service unit.

And they are to provide the linkage mechanism and communication channel between patients, Phoenix Indian Medical Center staff, and related health care personnel and organizations.

In April, 1975 three persons were selected as representatives and began intensive training in human relations, sensitization to patient needs, hospital procedures, first aid and medical terminology.

Familiarity with the hospital organization and its day-to-day workings enabled them to recommend action for change, when they saw the need. This ability, and responsibility, of the representatives made for a problem of staff acceptance when they first began.

The initial difficulty arose mainly from a lack of understanding by the staff of the representatives' responsibilities.

Since that time, however, the representatives have gained broad acceptance and as intended, the program has served as a "two-way

street," for medical staff and administration as well as patients.

With their ability to spot problems within the whole health delivery system and bring them to the attention of the medical center staff and the Phoenix Service Unit Indian Health Board, as a result of the representatives' efforts, changes both small and large have been made in the system.

Changes are also taking place among the patients themselves. They are less reluctant to speak out for their rights as fear of retaliation had prevented them from doing in the past. And their acceptance of hospital operations has grown with increased knowledge.

Being constantly responsive to and aware of patient, staff and administration needs is not an easy job. According to Keliaa, not everyone could be a patient representative. "There are no educational requirements; education means nothing. No amount of education can help you do your job which is loving people," she explained.

Once selected, representatives must undergo intensive training for six months and continue with additional training for another six.

With the Phoenix program regarded as a success, patient representatives are now employed at Indian facilities in both San Francisco and Alaska. Proponents believe that the concept is adaptable to other IHS situations as well and the Phoenix Indian Health Advisory Board has asked IHS for money to train additional representatives from throughout the country.

(The workshop produced two resolutions, a record of which can be found in the General Assembly proceedings from the final afternoon of the conference.)

Serving the Mentally and Physically Handicapped

Moderator: Ethel Gonzales, NIHB Representative, Alaska Area

Facilitators: Theodore Marrs, M.D., Chief, Albuquerque Area Maternal, Child and Health Branch, IHS

Arthur L. Thomas, Special Assistant to the Director,
Indian Health Service

Movie Presentation: "Waiting for the Dawn," A School
for Me, Inc.; Tohatchi, N.M.

This workshop attended by some 35 people was primarily an informational one designed to cover two laws affecting the handicapped: P.L. 94-142 (the Education for All Handicapped Children Act of 1975) and Section 504 of the Rehabilitation Act of 1973.

Art Thomas, Special Assistant to IHS Director Dr. Emery Johnson, informed the participants that IHS is being pressured to employ handicapped Indian persons and that as a matter of policy, any program utilizing federal funds may not discriminate against the

handicapped. Regulations governing IHS in this matter will be enforced by the Civil Rights Office of HEW, he said.

The remainder of the workshop was devoted to consideration of two efforts on behalf of handicapped Indian children. The first, commonly known as the Indian Children's Village, is being developed by the Laguna Pueblo in cooperation with IHS. It will serve handicapped children of all tribes. Dr. Ted Marrs showed the group a slide presentation on efforts to make the village a reality.

Already established and doing a seemingly impressive job is A School for Me, Inc. in Tohatchi, N.M. on the Navajo reservation. A film presentation on the school evoked comments such as "The wonderful results these people are getting were unbelievable. It made me realize that our greatest resource is our children and our main aim should be to assist them in obtaining their greatest potential."

The project is titled A School for Me, participants were told, because in visiting the project, one of the little children was asked, what were these buildings. He said, "It's a school for me." Thus, the interpretation in use for "me" is: Any child with a mental or physical handicap that keeps him/her out of the standard classroom."

Due to the length of the presentations there was no time for formulation of policy recommendations or resolutions but according to moderator Ethel Gonzales, "participants seemed to feel that they did get the information they came looking for."

Urban Specific Health Plans

Moderator: H.D. Timm Williams, NIHB Representative, California Area

Facilitators: Jo-Anne E. Lutz, President, American Indian Health Care Association

Wes Halsey, P.L. 94-437 Title V Coordinator, Indian Health Service

Luana Reyes, Director, Seattle Indian Health Board

Karen Neary, Milwaukee Indian Health Board

Rusty Tahsuda, Salt Lake Indian Health Center

In December of 1979, the Secretary of Health, Education and Welfare will report to Congress on progress under the Indian Health Care Improvement Act (P.L. 94-437) and regarding additional authorizations for Fiscal Years 1981-84. It is the hope of the Indian Health Service that the Secretary's report will be based on a composite plan from Indian tribal and urban groups.

Participants of this workshop reviewed a rough draft of Urban Specific Health Planning Guidelines developed by IHS and discussed several related issues which have arisen since their distribution three months prior to the conference here. One primary question concerned the availability of IHS technical assistance to urban

projects in developing their plans. Dr. Robert Birch, IHS 437 Manager, responded from the audience saying that Director Dr. Emery Johnson had recommended that each area provide technical assistance to urban as well as tribal groups within their jurisdiction. (Since the workshop, IHS has designated a specific urban technical assistance person within each area with the exception of Alaska and Navajo, which are presently without urban Indian health projects.)

Karen Neary of the Milwaukee Indian Health Board suggested that it would be helpful for urban projects to work closely with the tribal groups in their areas looking ahead to the time when the service unit tribal and urban plans will be consolidated.

Also discussed was the process for funding review of urban projects under P.L. 94-437 and for allocation of the \$3.25 million appropriated to urban projects this fiscal year. It was explained that a review committee of urban people would consider proposals for new projects.

Approximately 50 persons attended the workshop which produced no formal recommendations or resolutions.



JO-ANNE E. LUTZ, President of the American Indian Health Care Association addresses participants of the workshop dealing with development of specific health plans by urban Indian organizations. (Photo courtesy of Melvin McKenzie, Navajo Division of Education.)

Indirect Cost Principles for Federal Grants and Contracts

Facilitators: Edward Kennedy, Comptroller, Northern Cheyenne Tribe;
Lame Deer, Mt.

Allan Keaton, Negotiator, Division of Cost Allocation,
DHEW Regional Office; Dallas, Texas

For a tribe administering federal grants and contracts, indirect costs are those it incurs which are not readily identifiable with a particular project or activity but nevertheless necessary to its general operation. The costs of operating and maintaining buildings, grounds, and equipment, depreciation, administrative salaries, general telephone expenses, general travel, and supplies expenses are types of expenses usually considered as indirect costs.

In theory, all such costs might be charged directly; practical difficulties, however, preclude such an approach. Therefore, they are usually grouped into a common pool(s) and distributed to those tribal activities benefited through a cost allocation process. The end product of this allocation process is an indirect cost rate(s) which is then applied to individual grant and contract awards to determine the amount of indirect costs chargeable to the awards.

An indirect cost rate, then, is a device for determining that portion of a tribe's indirect costs each of its projects or activities, including grants and contracts, should bear. Its object is to make sure that each function of a program bears its fair share of administrative costs.

More technically speaking, the indirect cost rate is the ratio, expressed as a percentage, between the indirect costs and a direct cost base, commonly either direct salaries and wages or total direct costs exclusive of capital expenditures and other distorting base costs. A tribe is reimbursed for its indirect costs based on its established rate, subject to administrative and legislative limitations, as part of the costs of individual grants and contracts awarded.

Heretofore, according to Edward Kennedy, Comptroller for the Northern Cheyenne Tribe, "tribes have lost money operating federal contract and grant programs." While establishment of an indirect cost rate for a tribe remains optional, it is generally viewed to be a wise move for it enables them to save their own resources formerly spent on administration and management costs.

But while the procedure may be advantageous, it has proven absolutely baffling at worst and confusing at best for tribes which have adopted it. They are not properly informed about the distinctions between direct and indirect costs and must deal with numerous federal agencies, all with separate regulations, said Kennedy.

Among these, the Department of Interior's Audit and Investigation Division's policy guidelines are the most beneficial to Indian tribal governments and structures, he pointed out to workshop participants. The division has been sensitized to the peculiar needs of tribal governments and their corresponding costs, he said.

Although not all federal employees involved are aware of it, Kennedy added, inter-agency agreements between all agencies (with the exception of the Department of Labor) have been issued recognizing the Department of Interior as the lead agency for negotiating indirect cost agreements with Indian entities.

There are several methods for determining a tribe's indirect cost rate based on which is the most advantageous, and each was discussed here including, the simplified method, the fixed-carried forward method, the provisional method and the step-down method.

The participants made three recommendations to the conference general assembly:

- That all federal departments establish inter-agency agreements whereby one set of regulations and procedural guidelines be used for the formalization of indirect cost rates.
- That the Department of Interior's regulation procedures and cost acceptance policies be recognized and accepted by all funding agencies.
- And that once acceptable uniform regulations and procedures are established, regional work sessions be held giving tribes and Indian organizations an opportunity to revise and recommend changes.

(Note: Tribal persons with further questions on the indirect cost rate or costing procedures discussed at this workshop or regarding indirect cost rates generally may contact: Edward Kennedy; Comptroller, Northern Cheyenne Tribe; Box 128; Lame Deer, Mt. 59043.)

Title XX: Social Services Amendment to the Social Security Act
(P.L. 93-647)

Moderator: Elloise DeGroat, Tribal Affairs Liaison, Navajo Area Indian Health Service; Window Rock, Az.

Facilitators: Bobby George, Director, Division of Social Welfare, The Navajo Tribe; Window Rock, Az.

Donna Bissell, Director, Great Lakes Inter-Tribal Council Food Stamp, Nutrition and Advocacy Program

This workshop centered around Title XX of the Social Security Act which is designed to provide social services to residents of all states through state funding and with its failure to do so in any kind of adequate manner for the nation's Indian population. The discussion categorized Indian people's dissatisfaction into three areas: exclusion from benefits, interference with tribal sovereignty and administrative problems.

In the first category, 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.

Tribes have been frustrated even when they have attempted to secure Title XX benefits with their own resources. Bobby George of the Navajo Tribe told workshop participants that his tribe submitted a request for a social services program to the State of New Mexico six years ago. The tribe paid the 25 per cent match out of its own funds as state officials neglected to inform them that an in-kind match (of non-monetary resources) was possible. The tribe ended up spending nearly \$5 million within two years to initiate the program and was only able to recover \$2 million of that amount due to lack of state cooperation. According to George, the tribe had to go through the state as its advocate for recovery of the money from the Federal government and "since there was no money in it for them they weren't interested."

The Navajos encountered similar difficulties with the State of Arizona under Title XX and finally cancelled their contract and continued the program with tribal funds.

Perhaps an even more serious deterrent to tribal participation is that in states which do provide benefits, programs often result in what tribal members perceive 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 area in which tribes feel the states have definitely overstepped their bounds is that of child placements. It was mentioned here that two pieces of legislation which would affect adoption and foster care of Indian children are under consideration by Congress. While one, the Indian Child Welfare Act was introduced by Sen. James Abourezk (D.-S.D.) with the intent of returning child welfare matters to tribes themselves, the other, S. 1928 is favored by the administration and would give such responsibility to state service agencies and courts. Such legislation would have implications extending as far as Title XX, according to persons here.

Indian people are moving to change all this and participants were informed that Indian groups met with the executive director of the DHEW Intra-Departmental Council on Indian Affairs in May of 1977. The director plans to seek the approval of Secretary Califano for some of their recommendations, primary of which is direct federal funding for tribes to operate their own social service programs, if they so wish.

Several recommendations came out of the workshop and can be found in the record of the Fifth General Assembly of the conference.

1980 Census: Supplemental American Indian Questionnaire

Moderator: John W. Davis, Director, Oklahoma City Area Indian Health Service

Facilitator: Edna Paisano, Statistician, U.S. Bureau of Census Washington, D.C.

Funding for all federal programs is based in part on figures provided by the U.S. Census Bureau. These include, of course, not only those programs exclusively for the benefit of Indians, but general programs such as revenue sharing and manpower programs as well. Thus, in order for Indians to get a fair share of federal funds, the 1980 census must reflect their true population.

Persons who attended this workshop heard of encouraging actions being taken by the Bureau of Census to assure that a more accurate count of Native Americans is taken than in previous census years. Tribal officials have been requested to review and update reservation maps. Reservation boundaries have been delineated as accurately as possible. Advice from tribal groups regarding many aspects of the 1980 census is being solicited. And, meeting with strong endorsement from the group assembled here, more enumerators and supervisors, who live in the enumeration districts where they will be working, will be employed. The reasoning behind the last of these is that these persons will have a more complete knowledge of the location of other persons living there.

Reservation residents identifying themselves as Indian will be asked to answer questions contained on a supplemental questionnaire during the upcoming census. A tribal questionnaire has been developed and will be sent to tribal organizations for review and comment (also meeting with strong endorsement from the workshop participants). At the time of the conference here, a "dress rehearsal" making use of that questionnaire was soon to be conducted on two Colorado reservations.

Workshop participants were also pleased to learn that the initial census count of each tribe in 1980 will be reviewed with that tribe before it is considered final. A tribe may also request that a special census be conducted but it must pay for the count.

Following the 1980 census, census data by reservation will be available for the use of tribal groups. The number of publications of Indian population data will be considerably increased and tribal organizations will be consulted about the kinds and arrangements of data that would be most useful to them.

Census officials here also announced that in a marked change from the previous 10 year intervals, after 1980 the census will be taken every five years.

Recommendations of the workshop may be found in the General Assembly proceedings for the afternoon of February 15.

FIFTH GENERAL ASSEMBLY
February 15, 1978

BE IT REMEMBERED that on the 15th day of February, 1978, at approximately two o'clock in the afternoon, the Meeting of the Second National Indian/Alaska Native Health Conference was resumed at the Albuquerque Convention Center, Albuquerque, New Mexico.

Mr. Elwood Saganey: We have come to the last leg of our meeting, and hopefully this is the fun part, where we take action on some of the things that we have been talking about since Monday.

My name is Elwood Saganey. I'm a member of the Navajo Tribe, and representative to the National Indian Health Board for the Navajo area.

I would like to, at this time, give the floor to the Chairman of the National Indian Health Board, Howard Tommie, for announcements.

Mr. Howard Tommie: I think we promised everybody that we would have the transcript of the speeches made by Dr. Johnson and Dr. Lythcott when they were here in the First General Assembly. We understand that they are limited at this time, but you can pick them up in the press room.

And we also want to respond to the California group or the off-reservation groups that are interested in the resolution that was enacted at our Palm Springs meeting, about a year and a half ago. We had indicated to them that we would share this with them, and after going back in our minutes of the meeting when we took action on this found that the full Board designated a committee, and the committee brought their findings back to the Board in our meeting in June, I think it was, and we acted upon it. Our apologies that we could not get this information to you sooner. If you desire to take any further action on the Board's position regarding urban representation on the National Indian Health Board, we have copies of that in the press room also.

So, I would just like to say that if there are people who are interested in receiving the decision on representation on the National Indian Health Board from the urban group (and the decision has been made) you have addresses on your program booklet, and your letters will be received, if you would care to state your objections or your approval, we will anticipate this procedure. And then, maybe we will get the NIHB committee on this back together and look into it a little bit further. But at this particular time, the only thing that I can share with you right now is the document of the proceedings of our regular Board meeting and the decision that was made, and also the report of the committee that was set up.

So, know that the reason I elaborate on this is that people are interested in what action has been taken. We also have some previous resolutions, from the last conference, which are also available, so if there is anyone interested, not to make a bunch of excuses, we were very limited on staff and the transcripts of all the meetings, proceedings, were handled by one staff, and then transferred to another staff.

So, if anyone is interested, I think we have a record of the Board action taken. You have our address on your program booklet, and if you will write to the National Indian Health Board headquarters in Denver, we will share with you copies of the response to the resolutions that were handled at the Palm Springs conference.

The gentleman over here.

Unidentified Speaker: Elmer is my name.

The reason I attended this conference was because of the Palm Springs conference. And I feel that our people that were not represented on the national level, somewhere or another there should have been someone representing the people at large, and that's your urban and rural people throughout the United States and Alaska.

And I haven't seen a report yet. So, if we have one, I haven't had the chance to study it. And if I feel there should be some input from our part of the country, California, why we will write to you.

Mr. Tommie: We appreciate that, and we have one in the press room, if you will make your way up there. Put it in your own words in a letter, and I think we can get your ideas and input into it.

We will go ahead and continue.

Mr. Saganey: We will allow the reports that come in from the different workshops from yesterday and this morning.

I will first call on Howard Bad Hand, NHI coordinator of the NIHB headquarters staff to give the report on the National Health Insurance position from the NHI Core Group.

Mr. Howard Bad Hand: On Monday, we presented some issues and concerns concerning the national Indian position on National Health Insurance. At that time, also, the panel gave some briefing on what the National Health Insurance Core Group of the National Indian Health Board did.

I would like to reiterate just a couple of those activities that the National Health Insurance Core Group has been involved in for the past year. I only joined the staff of the National Indian Health Board as of June 1, 1977, so I wasn't aware of who the Core Group was when I joined, but I attended their meeting in June, which was held in Phoenix. At that time, we officially met with Mr. Cecil Williams who was picked by Secretary Califano to be on the National Advisory Committee on National Health Insurance issues.

There, the national Indian position was reviewed for Mr. Williams' benefit and we established some type of future direction for the Core Group.

So that we went on to November 3 and 4, 1977, when the National Advisory Committee on National Health Insurance held its first set of major discussions on National Health Insurance issues. And since I took the role of coordinator for the National Health Insurance Core Group, I attended the meeting and began to accumulate some of the discussion papers of the National Advisory Committee on National Health Insurance. And as an aside, I would like to say that I do have copies of all discussion papers that the National Advisory Committee worked with, and if you would like copies, we will send them to you upon request, by letter, from your boards or by you individually. And you can send your request to our Denver office.

So, at any rate, after the first set of meetings, we gathered together the discussion papers and informed the Core Group members as to the direction that seemed to be taking place with the National Health Insurance Advisory Committee.

On November 17, 1977, the Core Group again convened a meeting in Phoenix. Its primary purpose was to give the Core Group members an update on National Health Insurance issues and to give attention to activities related to Public Law 93-641, the National Health Planning and Resources Development Act.

Now, many of you attended the NCAI Convention in Dallas in September. At that time, the Health and Welfare Concerns Committee passed a resolution on involvement of the National Indian Health Board with Public Law 93-641. We stated that the Core Group would be involved to insure that any positions developed with the 93-641 issues concurred or were in line with the position developed for National Health Insurance by Indian people.

So, at that meeting, we went into depth on 641 issues, giving credence to that resolution passed by NCAI in September of 1977.

Also, at that meeting, the Core Group reviewed the consensus position with a member of the Kennedy staff in which we covered Kennedy's objections to certain portions of the National Health Insurance position as adopted by Indian people.

Now, going on to what happened on Monday, originally the Indian consensus position was developed to address certain Indian issues within the concept of National Health Insurance. It was felt that Indian rights, sovereignty and health delivery were the areas that any NHI program could affect drastically. Thus, the Indian position was developed, which stated that Indians should not be included in the basic National Health Insurance program so that the present Indian health programs could be built upon and improved upon.

Recognizing that any National Health Insurance program will have an impact on Indians, the position further states that any National Health Insurance program must specifically address Indian concerns by: one, affirming the Indian people's right to their special Indian programs.

Two, defining the relationship between National Health Insurance and the Indian health programs.

And, three, strengthening the Indian Health Service so as to achieve

equity between Indian health programs and those available to all other Americans. In particular, the NHI legislation should amend the Indian Health Service legislation to provide a guarantee within IHS comparable to the one that will be offered other Americans through NHI.

National Health Insurance legislation, furthermore, must recognize and preserve the principles of tribal sovereignty and self-determination. It must also define the relationship between non-reservation Indian health programs and National Health Insurance.

So, that is a review of the Indian position that we have to date.

Now, on Monday, we presented to you, more specifically, the concerns and issues of that Indian position. The Core Group itself at the Washington, D.C. meeting, of January 12th through the 13th of this year, met again with members of the Kennedy and HEW staffs to go over the Indian position, and also to exchange information as to how your Core Group could best aid in the information process between Indian people and HEW and Congressional staffs.

So, at that time, the Core Group decided that they really did not have the authority to change the position in any way, but rather to present the options, recommend options, recommend changes, or to just leave the position as it is. The Core Group decided to leave the position as is and bring it before you and let you decide if that position needed to be reaffirmed or changed in any manner.

So, we have now come to that point.

On Monday, we broke up into groups. Now, each group, I am sure, has a representative that will either reaffirm the position or recommend changes, and I refer that procedure to Mr. Tommie.

So, I think it's now time for that to occur, either reaffirm the position or you decide to make the changes.

Ms. Ethel Gonzales: I'm Ethel Gonzales from Alaska, and I'm speaking on behalf of our Alaska delegation.

We met in our caucus on Monday and reviewed the position paper given to us, page by page, and reached a consensus that we could support the position paper with these proposed revisions. I will outline them briefly for you.

Page one, sentence one: It says that American Indians belong with other citizens. We felt that that had to be clarified since other pieces of legislation always include Alaskan Natives as a separate entity, to the American Indians and Alaskan Natives. It was decided that, with other citizens, we would like that insertion.

Page two, number two, statement of position. We have no problem with the three outlined positions as given.

We would like stricken from that first paragraph, the last five lines. So, it would read, beginning with position number three, strengthening the IHS by incorporating several of the basic elements of NHI into the

IHS system, period. The reason for that is we felt that there should be no reference to a substitute type of legislation, rather supplemental, and that should be followed through on all other references through this position paper, that substitute be stricken and that we retain supplemental.

Page three, section three, principle one, there is some revision and I am going to read: 'The NHI legislation must specifically support the continuation of the IHS tribal/urban Indian Health System as a special federal mechanism for the financing and delivery of health services to Indians and, as such, NHI must become a supplement for this financing mechanism to this delivery system.' We deleted a number of words from that sentence.

Page four, starting at the top of the page, there is no problem with the first sentence that we see.

The second sentence, starting: 'NHI must be used as a total supplement to this direct financing method,' striking the words, 'or partial substitute for, nor must NHI contain any provision which directly or indirectly could lead to a dismantling of the IHS direct delivery system.'

We would propose that the following paragraph be deleted entirely.

The only other revisions are the follow through with the terms substitute and supplemental. Then, the rest of the position paper.

We would request that there be an Alaskan representative on the Core Group, also.

These are the recommendations of our Alaskan delegation, Mr. Chairman. I would move for their adoption.

Mr. Saganey: I would like to hear from each one of the caucuses, all of the reports, first, before we take any type of action.

There were six caucuses. Is there anybody here from another one?

Mr. Mel Sampson: Mr. Chairman?

Mr. Saganey: Mr. Mel Sampson.

Mr. Sampson: My name is Mel Sampson, and I'm a member of the Yakima Tribal Council and Chairman of the Northwest Portland Area Indian Health Board.

We, from the Northwest caucus met and reviewed the exact same things that the Alaska caucus did. So, we support all the modifications that were introduced by the Alaskan Natives.

Mr. Sundust: Mr. Chairman?

Mr. Saganey: Mr. Sundust?

Mr. Sundust: We took the position of the Core Group and there was much discussion on that. We didn't make any change on the position itself.

Mr. Saganey: Go ahead, Irene.

Ms. Irene Wallace: We, in our group, have reaffirmed the basic principles that were in the basic NHI position. However, we would like to retain the option of waiting until there is a bill out and have the right to redo some of those principles where they are going to be needed.

Ms. Luana Reyes: Mr. Chairman, my name is Luana Reyes. I'm from the urban caucus.

There was a lot of discussion about principle number six during the urban caucus. We did not take the time to rephrase the position itself, but there were several suggestions made and I would just like to list those for the record. And I think that perhaps the Core Group would have to do some work on them.

The first question that was asked was as to how would National Health Insurance be paid for to support urban Indian programs. That question dealt directly with the kinds of monies that would be used to pay for the NHI premiums, whether it would come from general taxes, that kind of thing.

And I think the feeling of our group was that something should appear in the principle that would discuss the nature of that.

The second suggestion was that urban Indian programs should be strengthened because of the special services they now provide that would not be provided by National Health Insurance.

The third suggestion was that Indian Health Service should pick up the cost of health care for Indians residing off reservation. The assumption was that IHS would remain intact, regardless of what kind of NHI legislation was passed.

The fourth suggestion was that something should appear in the principle that would increase the influence of the Indian Health Service to continue and expand what is being done now for urban projects; in other words, strengthening IHS.

The fifth suggestion was that, within the principle, the kinds of services that would be covered by NHI should be delineated.

Number six, there was a strong statement to encourage the National Indian Health Board to identify someone from the rural non-federally recognized tribes, or identify someone from the Core Group.

Mr. Saganey: Timm Williams?

Mr. Timm Williams: Mr. Chairman, my name is Timm Williams, Chairman of the California Rural Indian Health Board, a National Indian Health Board representative.

I would like to state that California did not caucus on this issue. And we feel right now that we would like to follow Irene Wallace's position, that we would like to reserve the right when the bill comes up to give our input from California, and that we are in a unified effort.

Mr. Ron Laverdere: My name is Ron Laverdere. I'm Chairman of the Four-State Area Indian Health Board. And we would like to go on record that we do support the position paper and the recommendations of the Core Group.

Ms. Ann Poitres: Mr. Chairman, my name is Ann Poitres. I'm a member of the Board of Directors of the California Urban Indian Health Council. And I would like to emphasize Mr. Williams' statement, that California, in both the Rural Indian Health Board and the Urban Indian Health Council, is becoming increasingly concerned about the plan in California, and it is directing us more and more toward developing positions that both urban and rural reservation people can support. And certainly, we will be providing additional information to you through Mr. Williams as well as through the American Indian Health Care Association.

Mr. Ed Kennedy: Mr. Chairman, my name is Ed Kennedy, and I was in one of the caucuses. We discussed conflicting regulations and came up with a recommendation that all of the procedural guidelines be aggregated and accept the cost principle procedures of the Department of the Interior.

We couldn't get into the contracting portion of it because the facilitators didn't want to talk about that. So we dealt only with the issues that we were mandated to deal with.

They also recommended that regional training workshops in direct costs and procedures be conducted, once these are established.

Mr. Saganey: We are talking about National Health Insurance, and I would like to say at this time that if any of the caucuses has a resolution or a motion to make, I would like to ask you to give it to the Resolution Committee. Mr. Don LaPointe is the chairman of that committee and will be presenting all of the resolutions that come out of these workshops.

Mr. Press?

Mr. Dan Press: There is one last workshop that hasn't reported. I was the facilitator of the Oklahoma workshop. The participants took a middle ground between two positions that have been discussed just previously.

They said they support the basic position, that National Health Insurance should not be a supplement to Indian Health Service. However, they realize that people like Senator Kennedy and Dr. Lythcott are under a lot of pressure, and they want to enforce that kind of position. The Core Group should not feel like they are locked into the basic position when it is required to negotiate. They feel the Core Group has the authority to negotiate and back off the basic position as it now stands.

Mr. Saganey: Now, you have heard the reports on the National Health Insurance issues and position.

We would like to continue and go on to the other workshops that took place yesterday on Public Law 93-641, and make a report.

Mr. Press?

Mr. Press: My name is Dan Press. I'm the general counsel to the National Indian Health Board.

Several consensus positions came out of the workshops and I would call upon the facilitators for the other workshops to come up after me and raise any issues that I may have left out.

First, there was the general consensus that there should be a resolution from this group supporting amendments to Public Law 93-641, which would, first, require HSA's and other entities created by Public Law 93-641 to recognize the sovereign rights of Indian tribes and to prohibit HSA's from infringing at all on those rights.

Secondly, the amendments should provide for funding through the 641 legislation for tribal health planning activities.

Secondly, there was consensus that HEW must do a lot more than it has been in the past to address the issue of the relationship between Indians and HSA's. And there was a call first, that HEW begin immediately to seek consultation with all Indian tribes and organizations on their problems with 641, and then to begin to address those problems.

Secondly, that HEW should issue regulations immediately defining the term 'review and comment' in a way that makes it clear that HSA's have authority to comment only on that part of a tribal proposal which may affect the non-Indian health system. The HSA's have no right to comment on any part of a tribal proposal which is just intrinsic to the tribe, only if there is any overlap or ripple effect that may affect non-Indian health services, the HSA's could comment on that part of it. But they cannot comment on anything that is basically a tribal matter.

Thirdly, the groups expressed some anger that Indian Health Service has done almost nothing on the 641 issue and has provided very little assistance to tribes, and called for Indian Health Service to carry out its often proclaimed role as advocate to the Indian people on health in HEW, to actually do what they proclaim that they do, and to begin to work inside HEW to help resolve some of these problems tribes have had with HSA's.

Fourth, the groups called for the National Indian Health Board to take the lead in doing two things: First, working with HEW to make sure there are adequate guidelines and protection for tribes in 641; and secondly, to take the lead in providing assistance to tribes in learning about 641 and in negotiating arrangements with their HSA's.

In other words, NIHB should become the lead agency within the Indian community for providing information and technical assistance to Indian tribes on the whole 641 issue.

Lastly, it was recommended that there be a Core Group to be integrated with the National Health Insurance Core Group, or a new Core Group that would serve as the advisory group within the NIHB framework to do the development of proposals, policies, issue statements and some of the technical assistance work to tribes on 641.

A resolution has been prepared that basically states those various points.

Should I read the resolution? Do you want to call it to a vote?

(A brief discussion was held off the record.)

The consensus of the people up here is that I should read the resolution and it should be called to a vote immediately.

Whereas, the lack of clear definition of the relationship between Indians and Public Law 93-641 created entities, such as HSA's and SHCC's, has posed a threat to Indian rights and made it difficult for tribes to participate in the health planning process established by Public Law 93-641; and

Whereas, tribes need monies to fund tribal health planning activities; and

Whereas, Public Law 93-641 is now being reviewed for amendments by the Congress; and

Whereas, HEW, in conjunction with maximum Indian input needs to develop guidelines on the relationship between HSA's and tribes and HSA's and urban Indian health organizations; and

Whereas, tribes and urban Indian health organizations need information on Public Law 93-641 and assistance in developing viable relationships with their HSA's.

Now, therefore, be it resolved that, one:

Congress is requested to amend Public Law 93-641 to

- (a) require HSA's, SHCC's and other entities established or empowered by Public Law 93-641 to respect the special rights and sovereign authority of Indian tribes and
- (b) to provide funding for tribal health planning activities; and

Two: HEW should take immediate steps to address the special situation of Indians and Public Law 93-641 created entities, beginning with consultation with Indian tribes and organizations. HEW shall also issue a definition of the term "review and comment" that assures that HSA's do not use that phrase to infringe on the sovereign rights of Indian tribes; and

Three: The Indian Health Service shall implement its often proclaimed role as advocate of Indians on health by working inside HEW to promote Indian interests and concerns on Public Law 93-641; and

Four: The National Indian Health Board is requested to assume the leadership role in working with HEW in the special needs of Indians under Public Law 93-641 and in providing assistance to tribes on dealing with that Act.

Before it's called to a vote, anyone who is interested in working with NIHB and serving on the Core Group on 641 and feel they have had some experience with HSA's and want to be involved in trying to correct some of the problems that have been created by this Act, should give their names to Howard Bad Hand or anyone else from NIHB. There is no specialized wisdom on this. The only wisdom on Indians and HSA's is what your

own experiences have taught you out in the field. So, the wisdom has got to come from out in the field.

So, there is a need for people who have had experiences at the tribal level to serve on this Core Group and develop these policies.

Mr. Frank Cook: My name is Frank Cook, and I'm with the California Rural Indian Health Board. I haven't heard any rural. All I've heard is tribes and urban. Where is the rural?

Mr. Press: Was that issue raised in your workshop?

(No audible response.)

Mr. Press: The resolution will be amended to refer to tribes, urban Indian health organizations, and rural Indian health organizations.

I stand corrected.

Ms. Ann Poitres: This issue of HSA's has been discussed repeatedly. I hope that the resolution, which I feel confident that the urban people would support, can be expanded slightly.

The situation in California is that we are, by practice, not by policy, but by practice, consistently excluded from participation in committees. And it goes this way: We submit names for appointment to the HSA committees. We have support from other Indian organizations within the HSA's.

What happens, however, is that we are informed that we are consumers, but when you are a consumer, who serves on the consumer board from the health project? Then, we become providers and we've got plenty of providers on our committees.

So, by practice, we are consistently excluded.

I hope that NIHB can amend the resolution to express that concern and to recommend that the practice be stopped.

Mr. Press: Various people from California have expressed the special problems they have had, and I would encourage the California organizations to appoint their representative to serve on whatever working group is established to follow up after this conference on 641.

Unidentified Speaker: I have a little problem with the census figures on the last page of the position paper because we have no accepted figures in Indian country as to how many Indians there really are.

So, I would be uncomfortable in putting down in a position paper figures that are current estimates, because we have to live under the proposal, and I think they want facts.

So, I just wanted to take issue with this and, also, a point of order, that there was a motion on the floor by the Alaskan delegation. And I just feel kind of uncomfortable that it could get shoved aside so easily and not be acted upon.

Ms. Lydia Free: Mr. Chairman, I make a motion that we accept the resolution as amended.

Ms. Nicky Solomon: Second.

Mr. Press: Is there any further discussion?

Ms. Ethel Gonzales: Mr. Chairman, I would like you to read the resolution, please, and state that I find it very difficult to act on the resolution without having a copy so that I have a chance to review it prior to action.

I feel that this is the proper way to handle it. So, would you restate your resolution, please?

Mr. Press: We will have a second reading of the resolution.

Whereas, the lack of clear definition of the relationship between Indians and Public Law 93-641 created entities, such as HSA's and State Health Coordinating Councils, has posed a threat to Indian rights and made it difficult for tribes to participate in the health planning process established by Public Law 93-641; and

Whereas, tribes need monies to fund tribal health planning activities; and

Whereas, Public Law 93-641 is now being reviewed for amendments by the Congress; and

Whereas, HEW, in consultation with Indian tribes and organizations, needs to develop guidelines on the relationship between HSA's and tribes and HSA's and urban Indian health organizations; and

Whereas, tribes and urban Indian health organizations need information on Public Law 93-641 and assistance in developing viable relationships with their HSA's.

Therefore, be it resolved that:

One: Congress is requested to amend Public Law 93-641 to

(a) require HSA's, State-wide Health Coordinating Councils and other entities established or empowered by Public Law 93-641 to respect the special rights and sovereign authority of Indian tribes and

(b) to provide funding for tribal health planning activities; and

Two: HEW should take immediate steps to address the special situation of Indians and Public Law 93-641 created entities, beginning with maximum consultation with Indian tribes and organizations. HEW shall also issue a definition of "review and comment" that assures that the HSA's do not use that phrase to infringe on the sovereign rights of Indian tribes; and

Three: The Indian Health Service shall implement its often proclaimed role of advocate of Indians on health by working inside HEW to promote Indian interests and concerns on Public Law 93-641.

Four: The National Indian Health Board is requested to assume the leadership role in working with HEW on the special needs of Indians under P.L. 93-641 and in providing information and assistance to tribes on dealing with that Act.

Is there any further discussion?

Ms. Gonzales: In the first amendment that you proposed, the Alaskan delegation is having difficulty in that there is no reference to the unique tribal organizations that exist in our State of Alaska, as it refers to reservations only.

Mr. Press: That same issue was raised by the people from Oklahoma, and we have a number of suggestions for specific, technical language changes to meet the unique needs of particular groups. In fact, somebody from Alaska submitted some language to us to make sure that Alaska's needs are addressed.

Ms. Gonzales: I know that was submitted to you, but it was not addressed by your resolution.

Mr. Press: Well, the resolution doesn't provide specific legislative language. And when the legislative language is drawn up in light of these principles, it will have the Alaskan needs dealt with in it.

Ms. Gonzales: Thank you.

Mr. Tommy Murino: Delegate from California, Tommy Murino.

I feel the same as the lady from Alaska. I don't feel it would be proper to vote on something that we cannot see the input in. I feel it should be written out so we will know what we are voting on. I mean, once you vote on something, you can change it any way you see fit. It's happened

If you are going to read the resolution, I think you should put the input in there, as it was requested from Alaska.

Mr. Press: I would be glad to amend it. In the "therefore, be it resolved" section of the resolution, number five, any amendment language presented to Congress shall specifically provide for the unique needs of Alaskan Natives, Indians living in Oklahoma, California, and other parts of the country which present unique circumstances and need to be addressed specifically.

Does that meet your requirement?

Mr. Murino: Yes.

Mr. Press: As far as getting printed copies of it, I can't address that issue. There are about forty or fifty resolutions; to print up five or six hundred copies of each would just be physically impossible in the time that was available.

Ms. Ada White: My name is Ada White, Chairman of the Planning Committee.

The Chairman of the Resolutions Committee, Donald LaPointe, is not here with us right now. However, on his behalf, I will make the following

statement to clarify why some resolutions have not been prepared in advance.

First of all, the resolutions that were submitted in advance are currently being retyped with changes and modifications, and are being reproduced. When they are reproduced ten copies per area will be distributed. The area representative to NIHB will be given copies of eighteen resolutions. It will be incumbent upon them to distribute those copies to their delegates who are representatives from your areas.

The second very important thing is the fact that we are receiving resolutions from the workshops this morning that have not yet been reviewed nor screened by the Resolutions Committee. They are coming directly from the floor. They have not been reproduced, but, be assured, you will receive copies of those resolutions with particular clarification.

Mr. Saganey: Are there any comments on the resolution?

I would like to call for action on the resolution.

Unidentified Speaker: Mr. Chairman, I call for the question.

Mr. Saganey: Question.

All those approving the resolution as read with amendments. The first amendment was made, and the amendment for Alaska and Oklahoma. We requested that these be included.

All those approving this resolution, please do so by raising your hands.

Thank you.

Opposed, same sign. One.

By majority vote the resolution as read by Mr. Dan Press is hereby approved. It will be referred to the NIHB for distribution.

There was a motion entertained by the Alaskan delegation. I would like to give the floor back to them if they still think they should make a motion on the floor.

d Ms. Gonzales: Mr. Chairman, the motion was to support the national Indian position paper on National Health Insurance with the proposed revisions, and I outlined them to you.

Mr. Saganey: Did you make a motion?

Ms. Gonzales: Yes.

Ms. Lucille Brenwick: I second it.

Mr. Saganey: The motion is on the floor made by Ms. Gonzales from Alaska. Second.

Is there any discussion?

Mr. Mel Sampson?

Mr. Mel Sampson: Mr. Chairman, as indicated in our report, the Portland area supports the changes that were made. Our changes were the same as those of the Alaska Natives. I think it gives the position paper a little more clout and a little more zest.

And I would urge that the people vote for it. I think it gives us a more positive position rather than some of the language that was stricken.

Mr. Saganey: Thank you, Mr. Sampson.

The question has been called for.

All those approving the motion for NHI, raise your hands.

Thank you.

Opposed, same sign. One opposed that I see back there.

Mr. Sampson: Mr. Chairman?

Mr. Saganey: Yes, Mr. Sampson?

Mr. Sampson: Did you get all of the changes up there as they are read?

Ms. White: Yes. I think I've made notation. However, if Ethel has a specific copy, she can read it to the reporter. But I did make notation of the pages and the parts to be changed. But, Ethel, I think it would be best if you just brought the changes and read them to the reporter.

Mr. Saganey: Thank you.

By your vote, a majority vote, the position on NHI, with changes, is hereby approved.

I would like, before we go on with our reports from the workshops this morning, to give special recognition to the Resolutions Committee who worked so hard, and have been working every day since the conference started. I would like to have them if they are here, as I name them, please stand up.

Chairman of the Resolutions Committee is Don LaPointe. Donald?

Tom Leubben, staff attorney. He's around somewhere.

Dabney Altaffer, attorney for the Papago Tribe.

Lorna Patricio, representative from the Papago Tribe.

Ada White, representative from the Billings area.

And Duane Silverstein, NIHB staff member.

Last, but not least, the person who is still typing up some of the resolutions, Ruth Richards.

Now, we will start with reports from the workshops and the decisions and recommendations that were made. Some of the workshops also made resolu-

tions or acted on resolutions, and if you have those after your report, please read the resolutions, and we'll call for action.

I would like to start with Tribal Specific Health Plans, which was moderated by Mel Sampson.

Mr. Sampson: The Tribal Specific Health Plans workshop also included the on or near regulations. I was the moderator and the facilitators were Tom Seidl, who is the Chief Evaluation and Special Projects Officer from the Portland area office and Mr. Charles Erickson from ORD, Indian Health Service, out of Tucson, and Mr. Sid Edleman, the Assistant General Counsel for Public Health, HEW, Washington, D.C. We also had Erin Forrest, who is on the NCAI and NTCA Health Committees.

First of all, we did not develop our recommendations and concerns into a resolution form.

What we want to do, though, is enter our concerns, needs, desires and recommendations, and I suppose I should add frustrations, into the record for positive consideration.

We also want a definite follow-up process to all of which I shall report with the follow-up to be coordinated by the Indian Health Board mechanism.

Point number one: There is a considerable amount of dissension and uncertainty about the Tribal Specific Health Plans that indicate a definite lack of communication at the Indian Health Service area levels.

Therefore, the respective IHS area offices should and must start communicating with the tribes in reference to Tribal Specific Health Plans.

Just a little supportive information on that. We must have had, at times, fifty to seventy-five people in the workshop. As the discussion went on, the confusion on the people's faces seemed to get worse and worse, as the majority of them did not receive the information; at least, they said they did not receive the information in reference to the guidelines that had been processed and all of the staff that's been developed thus far in reference to the Tribal Specific Health Plans.

So, I felt that, at that particular time, I was thrown in with the lions because I shared their frustrations. So, that was the zest in developing that first recommendation.

Point number two: We request written and documented assurance that the entirety of all Tribal Specific Health Plans will be maintained, which includes, but is not limited to, total funding of the plans. The discussion generated around this was, when we are out at the tribal level and work with the kinds of resources that they have and put a lot of time into formulating our specific health plan as it meets our specific reservation's needs, who is going to keep us assured that by the time the figures we provide to the area office reach the central level office and by the time they get to budget appropriations, that they are still going to be contained.

So, we need feedback on a scheduled monitored basis that our plans are not being changed or misdirected.

Point number three: We have a dire concern over the population figures which will be utilized in the health planning processes, and which will be utilized in the Resource Allocation Criteria, which is referred to as RAC.

We are definitely against being forced to utilize the 1976 figures on Indians. We are all aware that these figures are grossly inadequate. The consensus there was that the service population figures that we are currently addressing at the service unit levels far exceed the 1970 census figures that they are attempting to force us to utilize in developing these plans.

So, therefore, it really would be, at least in my opinion, a wasted effort.

In the Tribal Specific Health Planning process, some tribes do not know who the technical assistance people are within their respective Indian Health Service area offices.

Therefore, the area offices should and must make all the tribes within their respective areas aware of the technical assistance people that they have available.

Now, in the event that the area office does not have this kind of assistance available, they should see to it that the TA is provided.

Item number five: In utilizing the Resource Allocation Criteria, RAC, there is no assurance that quality in health delivery service will be attained. The RAC process directs itself totally to quantity, in reference to numbers of people, doctors, and the kinds of things that are going to deliver the services.

So, the assumption is made by Indian Health Service that a larger number of people is indicative of quality, and it is not.

Item number six: We request that the National Indian Health Board develop and implement a proposal that should be funded by the Indian Health Service to assure that all tribal planners, tribal health planners, tribal council representatives, and other people who are directly concerned or involved with this process have access to the same TA materials and capabilities, whether it be by a joint workshop concept or by a professional technical assistance team, that should be provided by the Indian Health Service.

Item number seven: We were verbally made aware, by Mr. Sid Edleman, that the on or near regulations will be published and out in about two or three weeks. I don't know how many of you are familiar with the length of time that we've been hassling and inputting and I don't know what all with these on or near regulations. The first draft of them came out, I think, one and a half years ago. And it's going to be hard to formulate a specific health plan on a reservation without having knowledge of what is contained in those regs.

So we, therefore, request that these be distributed to all people in Indian related fields that are dealing with health.

Point number eight: The revised planning model will be released on February 28, 1978.

We also urge that this model be distributed to all tribes immediately upon its release.

The last point is that the uncertainty of the population status has generated the recommendation by the guidelines that tribes develop two specific health plans, meaning that you would utilize the 1970 census figures, and meaning that you would utilize the other figures that you would be able to substantiate as being the true figure for your particular area.

We are not desirous of having to develop two health plans. We feel that we should only have to develop one, and that would be the one using our figures, and not the one utilizing the 1970 census figures.

Mr. Saganey: We will move on.

Mr. Dan Bragobra: My name is Dan Bragobra. I am from Washington State.

Mel was touching on some very specific points that are of interest to all of us in establishing our tribal health plans. If we can rectify the population problem with Indian Health Service, another real danger is that



TAKING a moment out to chat were: (l-r) Stephen LaBoueff, Jr., IHS, Tucson, Ariz.; Patricia Roberts, IHS, Window Rock, Ariz.; Susie LaFromboise, Health Planner, Sisseton Wahpeton Sioux Tribe; Steve LaBuff, Sr., Chemawa Indian Alcoholism Program and Martha Rose Paquin, Zuni Alcoholism Program, Zuni, N.M. (Photo courtesy of Melvin McKenzie, Navajo Division of Education.)

our plans lose their integrity, inasmuch as our area office has told us that no matter what type of population figure we use, if we send in two separate data figures, that the service unit's plan will provide ours.

And in the planning model that they gave us, they have a chart showing where the tribes' specific health plans will be going on the way through the bureaucratic system.

And on the other side, it shows where the service unit plans will constantly override those. And it ends up that the service unit plans and the area office plans are modified, and the headquarters plan modifies that, and then they go to Congress. It's always IHS' plan. With the tribal plan, it stays over here and it winds up for reference and is filed.

So, that's another concern that we should be aware of. Even if we can get them to accept our figures, they still can override them.

We have to do something about changing that, also.

Mr. Sampson: That's an excellent point. That kind of justification came out in reference to the feedback -- when the specific health plans are submitted, that we are kept abreast, you know, as a close monitoring process, as to where they are, and if there are any complications, what they are and this kind of thing.

One other point that I neglected to state, that came out of the workshop, also, was that there is going to be a floor resolution in reference to the population figures. And the workshop urged that the body support that resolution that will be introduced.

Dr. Stitt: I'm the director for the Portland area.

There is something that needs to be clarified. First of all, I don't know where he was told that the service unit figures were going to supersede the figures that are used in putting together their plans.

Actually, we are talking about two separate processes. This has been a continuing, ongoing effort and requirement that the Indian Health Service come up with plans each year. Now, that's one process. That's mandated from the Department of Health, Education and Welfare down through the various levels to the Indian Health Service.

There are certain rules that guide or control that planning process. Among the rules, is a mandate from Congress that Indian Health Service planning be according to U.S. census population figures. Now, that's one thing.

But the thing that I think needs to be straightened out, that's one planning process. The thing they are addressing here are Tribal Specific Health Plans, which represent a different process.

I hope there is some relationship and I hope there is some coordination, but, at this point, there is no mandate that there be such.

These two processes need to be kept separate. The Tribal Specific Health

Planning process is what has been devised to meet the requirements of the legislation which says that the Secretary must report after the first three years of experience with Public Law 94-437, to advise Congress as to what is necessary for the remaining years of the seven-year process.

So we are talking two separate processes. Admittedly, population figures represent a real difficulty. They are not actual; they are not accurate.

The point was raised over here just a little bit ago, there's quite a bit of difference between resident census population and service population.

Now, at this point, it seems to me what you should be dealing with is service population and that's what you are going to have to be interested in and what you should be interested in when drafting your Tribal Specific Health Plan.

You have to be concerned with people who are actually being treated or that the system has a responsibility for extending services to at this point.

So, keep these two things separate.

Patty Marks: Mr. Chairman, can I ask a question for clarification? My name is Patty Marks and I'm with the Senate Indian Affairs Committee.

Dr. Stitt, could you tell us whereabouts in the law they refer to the census statistics. We were reading it through very quickly, and we couldn't find it.

And I was just concerned as to whether or not this was actually in the law or whether this was in the regulations, so that we can make an accurate recommendation.

Dr. Stitt: It does not appear in the law itself. It does appear in the report of the testimony that is related to the law, and it comes specifically as a mandate from Congress to the Indian Health Service to plan and examine it. I think it's worth examining.

Ms. Marks: I did not realize this.

Dr. Stitt: I've got some questions about it, and I could talk on this a long time. They talk to some rather narrow issues, I think. They talk about the planning of hospital beds, and they talk about the planning for the service requirements.

And, since I'm up here, I'll give you something that is a personal opinion that might be worthwhile, I don't know.

I think what Congress said is that we cannot go on planning illogically. We must plan according to some standards.

Now, the only standards that occurred to them were the U.S. Census population figures, but, in the same sentence, they address four other standards.

Mr. Saganey: We will go to Title VI, Public Law 94-437, the Need for

and Feasibility of Establishing an American Indian School of Medicine.
Will the reporter please come up?

Ms. White: My name is Ada White, and I'm reporting for the workshop on Title VI of Public Law 94-437.

First, I was not a participant of the workshop.

The second thing, I don't know who was present there.

The third thing, I do have submitted to me three resolutions that I was asked to present. I will present the resolutions and it will depend upon those people in the crowd who were present at the workshop, or who believe in the resolutions to move for adoption and a second.

The first resolution.

Title: Indian Health Manpower as an Agenda Item for the Third National Indian/Alaska Native Health Conference.

Whereas, the Congress of the United States enacted Public Law 94-437, the Indian Health Care Improvement Act; and

Whereas, Title VI of Public Law 94-437 mandated the study of the "need for and feasibility of the establishment of an American Indian School of Medicine" and

Whereas, the feasibility study report has documented the need for and feasibility of an American Indian School of Medicine; and

Whereas, the feasibility study was discussed and endorsed at the American Indian School of Medicine Workshop.

Be it resolved, that the National Indian Health Board include in the Third National Indian/Alaska Native Health Conference agenda a report/panel to the full conference on Indian Health Manpower Development; and

Be it further resolved, that a subsection of this report include the status of the feasibility study for an American Indian School of Medicine.

I need a motion to adopt the resolution as read.

Mr. Dennis Tiepelman: My name is Dennis Tiepelman, a representative from Alaska. I was at that workshop. I move for adoption of the resolution.

Ms. White: Is there a second?

Mr. Ben Hogue: Second.

Mr. Tiepelman: To offer some discussion on the proposed resolution. The presentation there was to about twenty people, and it was very important and very interesting how this feasibility study and proposed American Indian School of Medicine is moving along. So it was suggested that at the next conference, there be a full panel at the beginning so that the

participants could really see the impact and help this kind of stuff to go through, including legislators and other people that could affect the establishment of this kind of facility.

So that was the reason why the resolution was adopted.

Mr. Saganey: The motion is on the floor to approve the resolution that was just read.

Are there further comments?

Questions?

All of you who approve this resolution as read, please raise your hands.

Opposed, same sign.

By your vote, a majority vote, the resolution is hereby approved, and will be referred to the National Indian Health Board for distribution.

Ms. White: Second resolution, Supporting the Feasibility Study of the American Indian School of Medicine.

Be it resolved, that the National Indian Health Board supports the feasibility study as presented; and

Be it resolved, that the Secretary of HEW, Joseph Califano, immediately submit the report, as submitted, to Congress; and

Be it further resolved, that the Congress make every effort to provide immediate and long-term funding for the American Indian School of Medicine.

A motion for adoption?

Ms. Patricia Maracano: I move for its adoption.

Ms. White: Is there a second to the motion?

Mr. Frank Willetto: Second.

Mr. Saganey: The motion has been made and seconded.

Discussion?

All those approving the resolution as read, please raise your hands.

Opposed, same sign.

No opposition. The resolution is hereby approved.

Ms. White: There is a third resolution here, and I would like to take the opportunity to refer this to the National Indian Health Board for their action. I will read it for the record.

Resolution title: Letters of Support from Individuals and Tribes.

Whereas, the Congress of the United States enacted Public Law 94-437, the Indian Health Care Improvement Act; and

Whereas, Title VI of Public Law 94-437 mandated the study of the "need for and feasibility of, establishing an American Indian School of Medicine"; and

Whereas, the feasibility study report has documented the need for and feasibility of an American Indian School of Medicine; and

Whereas, such a feasibility study was discussed and endorsed at the American Indian School of Medicine Workshop.

Be it resolved, that the National Indian Health Board encourages individuals and tribes to write letters of support for the feasibility study to their congressmen.

I would like to submit this to the National Indian Health Board for follow through in terms of contacting individuals and groups throughout the country for the letters of support.

Mr. Saganey: We will move on to the next workshop that took place this morning, on Indian Preference. Will the reporter for this particular workshop please come up?

Ms. Evelyn Blanchard: I didn't attend this particular workshop, but I'm a substitute for Mr. Duane Pratt and will give his report.

It seems important that tribal groups and organizations form a task force to look at problems related to the Indian Preference law. One of the problems involves becoming acquainted with the mechanisms that are used in implementing Indian Preference.

The group delineated the following problems: There are basic questions regarding the validity of the Commissioner's appointments. There is no control over these appointments by the Indian people.

Inappropriate procedures are utilized in the efficiency ratings that tend to downgrade Indians in their employment, rather than upgrading them. And this seems to be a very serious problem because it results in Indians not being allowed the opportunity to advance in those organizations that provide services to them.

A third problem was that the affirmative action plans do not reflect, as they are practiced, the intent of the Indian Preference law as it relates to other mobility, long-term career training, and executive development training.

The fourth area is that inadequacies at present, reclassification and restructuring of job descriptions need to be illuminated and investigated. Indian people have many skills and abilities, but may not meet the educational requirements. And the restructuring and classification must be done in a way to allow Indians who are qualified, by virtue of their skills and ability, to fill these positions.

The fifth problem presented is that there are many questions regarding

the review of panels and procedures, with specific attention to the determination of eligibility factors. The group was interested to know by whom these factors are determined and from what.

It is also known that in addition to being qualified as an applicant for a position, specifically with Indian Health Service, an Indian must also be determined suitable.

Now, this is an important question because who is it who determines one's suitability? Is this the area director? Is it the personnel panel that is set up by the particular agency, or whom? Something must be done about this particular part of this process.

I'm sorry. I don't understand this real well. I hope there is someone here from the workshop who can answer questions, if there is a question raised about it, but the question was raised: Who validated 77-2, was this a judicial validation or was it a departmental one?

The discussion group recommended that, number one, training that is universally sanctioned and courses that give credit be brought to the reservations or Indian communities to upgrade the academic skills of Indian people, so that they can have the opportunity to begin to meet some of the educational requirements of the various jobs.

Two, that the release time concept be introduced into the employment picture to allow employees to have time for training. Many employees are not able to take additional time, oftentimes, many people are required to travel long distances and, because of this, are not able to become trained or to upgrade their skills.

Three, it is recommended that the standards be applied uniformly, relating to Indian Preference in both BIA and Indian Health Service.

Number four, under the authority of Public Law 93-638, section 104, a tribe has the right to redesign Indian Preference in its contracting relationships.

Five, tribal groups need to give support to the employment opportunity officers in the various organizations to assist them in implementing Indian Preference.

Number six is a recommendation concerning a panel determination. If one Indian appears on the panel as eligible, that eligible Indian should be hired as prescribed by Indian preference, and the position should not be reannounced because that particular person was not selected, and a reannouncement should not occur as a device to keep that particular Indian person from getting that position.

The group considered that practice as a subtle form of discrimination.

Let me read number seven the way it is: Do away with open and closing announcements because of their detrimental effect on Indians.

And further, that all announcements be channeled down from the area level and posted for advertisement.

Ms. Carmen Chasteen: I would move that the recommendations be adopted in resolution form.

Mr. Saganey: Motion made to adopt the recommendations, coming from the Indian Preference workshop.

Do I hear a second?

Mr. David Harding: Second.

Mr. Saganey: Discussion?

Mr. David Harding: Just to comment on Indian preference, I think that, in the future as we look toward realizing some of our goals, it's going to play a big role in determining whether we get to realize some of the self-determination issues.

We are stuck with the Bureau of Indian Affairs as the agency of the federal government, but yet, we don't have as many Indians in those high level executive jobs as we could have. From talking with different people, I have asked about Indian Preference and got the feedback that there weren't qualified Indians out there.

So, the resolution or the statement that was just made, I think, needs to be looked at closely and needs to be addressed by letters to the Bureau, to your Congressional people, whomever you think may help out, because it will be very crucial in the future.

There are qualified Indians out there. There are more educated Indians today than there have ever been in the history of this country.

So, we need to think about Indian Preference. It is a law of the land.

Mr. Saganey: Yes, your name?

Mr. Edgar Monetatchi: Ed Monetatchi.

Just a point of clarification on the last statement that was read by the speaker. She said that open and closing announcements should be discontinued.

I think what the statement in the workshop was, is not that open and continuous announcements should be continued, but rather all vacancies should be advertised separately with each occurrence.

By having an open and continuous announcement, they are technically complying with announcing the vacancies, but many people do not know that the open and continuous announcement is in effect at all times. So, they do not see these announcements.

Ms. Emma Farrow: Personally, I am very uncomfortable about Indian Preference because I feel that tribal people and organizations don't understand its implications.

And I agree with the man who said that there are qualified Indians who can accept these higher positions. I also know of qualified people who

will not apply for positions because of Indian Preference.

And, granted, we have a lot of potential Indian people who could fill these positions, but I feel it is the direct responsibility of tribal people in their education departments to concentrate on making education a priority on the reservation, and to follow through with a good, sound career program. I feel that we have too many young Indian people in colleges and universities without a goal.

So, therefore, I feel that it is up to the tribes to be more discriminating and to ask more of Indian people in colleges and universities, and to give them the knowledge of the positions available on reservations in Indian Health Service and in other federal agencies. They need this career development badly, and it needs to be started early, concentrated upon, and followed through in the career, or in the education, on whatever levels the children are on.

I also feel that tribal education boards with the support of the Indian people, should look at their education programs to see that the children are staying in school, and to let the students know that it is valuable to graduate from high school. And then, to encourage them to go to college but with some goals in mind.

Mr. Saganey: Thank you. I call for action on the motion.

All those approving the motion, please raise your hands.

Thank you. Opposed?

One, two. Two opposed.

By your vote, a majority vote, two opposed, the recommendation as presented is hereby approved.

We will now move on to Mental Health, Alcohol and Substance Abuse. Will the reporter from that workshop please come up?

Mr. Perry Sundust: I haven't got too long a report to make, but I would say, it's on one of the outstanding workshops of the conference.

The resolutions from the alcoholism workshop:

Number one, that money resulting from the transfer of Indian projects to IHS from the NIAAA be used to start up new Indian programs.

Number two requests the Indian Health Service to include additional money in their appropriation request for the projects, and also, that IHS administer the cost.

Number three, special hearings in the Senate and House appropriations committees on requests for projects listed.

Other recommendations: Number one, upgrade the position of chief Indian task NIAAA to the higher position making level.

Number two, that the NIAAA funds from Public Law 94-437 transfer programs

become earmarked especially for new Indian start-up and expansion of successful ongoing programs to meet the needs due to inflationary cost.

Number three, to meet the need to cover IHS administration and inflation costs of transferring projects by providing additional appropriations.

Number four, that special appropriation be made for training programs in the field of alcoholism and substance abuse.

The other recommendations -- I don't have them with me -- were on the President's Commission on Mental Health.

Mr. Saganey: Are there any questions? If not, we'll move on.

I would like to call on the workshop on sterilization and abortion.

Will the reporter please come up here?

Ms. Myrtle Nievel: My name is Myrtle Nievel. I'm a tribal council member from Washington State, and a Portland Area Indian Health Board delegate.

The following major issues and concerns were addressed by many concerned Indian people. Their discussions are summarized in these recommendations.

One, that all tribal governments become aware of this major, social health problem and become active participants in the policies that are made by Indian Health Service and DHEW affecting the tribal communities' future survival.

Two, that IHS immediately delegate authority to local levels for determining use of contract health monies for abortion and sterilization.

Three, that NIHB should be provided current drafts of all IHS operation and policy manual changes to allow sufficient time for tribal and community reaction.

Four, that IHS elective -- that is, eyeglasses, dentures, hearing devices -- services should be carefully defined at all area levels, and IHS and boards should review and update these services.

Five, that IHS should establish a national health educational component that would address the locally defined health conditions affecting the quality of life of the Indian family which would reduce the incidence of unwanted Indian children.

Ms. Patricia Marks: My name is Patricia Marks and I sat in on the workshop. A resolution emerged and I would like to read it for the floor at this time.

Whereas, the 1975 GAO report and other reports submitted to Indian tribes and organizations have revealed serious problems within the Indian Health Service sterilization and abortion counselling procedures; and

Whereas, sterilization and abortion are serious procedures affecting the lives of Indian people.

Therefore be it resolved, that the Second National Conference on Indian and Alaska Native Health hereby officially demands that the Indian Health Service provide trained Indian counsellors, versed in the native languages, and sensitive to Indian culture, concerns and needs who can discuss the nature and the importance of the medical procedure and what alternatives are available; and

Be it further resolved, that the Indian Health Service immediately initiate an investigation into any and all allegations of abortion or sterilization procedures performed by Indian Health Service personnel without the informed consent of the patients involved; and

Be it further resolved, that all tribes and Indian organizations be encouraged to provide testimony and comments to the Secretary of the Department of Health, Education and Welfare on the newly proposed sterilization regulations prior to March 13, 1978.

Mr. Saganey: You heard the resolution from the sterilization and abortion workshop.

Unidentified Speaker: I would like to move for the adoption of this resolution and also to say that this resolution should be sent to the President.

Ms. Kelly Cusnick: Kelly Cusnick from Alaska. I second the motion.

Mr. Saganey: Moved and seconded that we adopt this resolution as read.

Questions?

All those approving this resolution, raise your hands.

Opposed, same sign.

None opposed.

By your vote, a majority vote, the resolution is hereby adopted.

We will go on to Health Related Problems and Provision of Services to Indian and Alaska Native Elderly.

Will the reporter from that workshop please come up?

That reporter is not here yet, so we'll hear the report from Accident Prevention.

Donald LaPointe?

Mr. Donald LaPointe: The accident prevention workshop submits this report. The facilitators for the workshop were Messrs. LaPointe, Tonemah, Harvey and Clarke.

Frank Clarke made the point that fifty-six per cent of fatal accidents occur in the fifteen to twenty-five-year old age group. Accidents are considered to be a major cause of death on many reservations.

Mr. Tonemah gave a report on how the problem should be approached. The first step in the process is to orient people to the magnitude and significance of the problem. This orientation process should be directed toward the tribal council. Their consent is vital in the establishment of a tribal safety program. The overall goal of a project such as this is to effect a change in the health status of the reservation residents.

OSHA was at the meeting. They gave an orientation on a project in progress that is to do an analysis and assessment on how the OSHA Act of 1970 has impacted on the reservations.

The types of things they would be looking for would be the following:

Number one, the nature of work activities.

Number two, the equipment used.

Number three, types of products manufactured.

Number four, the process used.

Number five, the environmental setting.

The duration of the project is through March of 1978. OSHA is seeking input from the tribes as to contact persons and possible site visitations. Anyone wishing to assist with the project should contact OSHA, the Office of Policy Analysis and Administration, Washington, D.C.

Mr. Saganey: Are there any questions, comments?

If not, we will continue.

We will continue to the next workshop, Patient Rights and Representation. Would the reporter please come up?

Ms. Gloria Keliaa: Patients rights is patient advocacy. And if there was ever a group of people who needed advocacy, it is the Indian people.

Whenever an Indian person has sat for hours and hours waiting to see a physician, whenever an Indian person has never had access to a physician or to any component of the health care delivery system, there is a need for advocacy. Whenever an Indian person has died because of distance, unavailability, or any other facet, there is a need for advocacy.

Patient advocacy is not new to the health world. It has been around for about twenty, twenty-five, thirty years.

There are hospitals up and down the East Coast, West Coast, who have patient representatives who essentially collect the bills, and if you don't have the money to pay for them, you are referred to the county hospital.

The concept that we wish to give to you here now is true patient advocacy, and that is one of helping Indian patients receive top quality medical care, and to provide a liaison and a change mechanism to make the system respond to the patient's needs, and this is an Indian patient in Indian

Health Service.

Approximately three years ago, in conjunction with the Administration of the Phoenix Indian Medical Center and the Phoenix Service Unit Indian Health Advisory Board, three patient representatives were selected and trained.

These people have effected change within that system. They have gotten unresponsive staff people out of their jobs and moved into positions where they were responsive. They have changed policies and procedures. They are the most knowledgeable people about that health care system because they have read every policy and procedure for that medical center. There is not one other person in the Phoenix area who can say that. And I really doubt that there is any person within Indian Health Service who ever took on the responsibility of reading from front to back the policies and procedures.

They read them, not to memorize them or remember them totally, but so that they could more effectively do their jobs; and that is, when an Indian patient approaches them with a problem or a question, they may not know the answer, but they damn sure know where to go to get the answer.

There are three reps out at the Phoenix Indian Medical Center, and they recently hired two additional patient representatives. One of those patient representatives accompanies a physician to visit the Indian elderly in rest homes.

Another patient representative has been designated to the contract health service hospitals in the City of Phoenix and the surrounding area to visit patients and to advocate for them, especially where Indian patients do not speak English or prefer to speak their own language.

Recently, the San Francisco Public Health Service Hospital which serves as a referral hospital for reservation people residing within the Phoenix area, and also acts as a referral source for Indian people receiving care at the American Indian Health Centers in San Francisco and Oakland, hired a patient advocate for Indian people through money provided by Indian Health Service.

So, now, we are up to five patient representatives. I understand that there is also a patient representative type at Anchorage Medical Center. So, that's six.

Papago recently hired a patient representative so that's seven.

Mel Sampson tells me that Florida is now in the process of developing a patient representative program for their Indian people. That's nine.

Do you know how many we need? About four hundred.

The concept has been pretty well received by Indian Health Service, except when it comes to funding. Approximately five years ago, Emery Johnson issued a policy statement directing all Indian Health Service areas to develop, write and implement a Patients' Bill of Rights.

It was interesting today. There is only one area, really, that has a Patients' Bill of Rights. There are a couple of others who have them who patterned them off the one that was written within the Phoenix area.

Now, we had pamphlets with us. The Service Unit Board then took that pamphlet and put it in words that were easily understood and meaningful for their service population. That was about two years ago. It has never been approved for printing and adoption.

One of the rights of Indian people listed in there was to legal recourse and to general counsel. And they said, "We'd better not print that."

I want to tell you something. Indian patients have rights anyway. They don't have to be written. They are there. And Indian people need to be informed of that.

We discussed sterilization. We discussed many things, and we bring you two resolutions that we would like to present for adoption.

The first one is with regard to providing money to train patient advocates patient representatives for any tribal group or Indian organization who wishes to have them. Now, the principle behind this is that Indian Health Service cannot train patient representatives because, if they do, they will not be patient advocates. No system can train somebody to advocate against them.

Now, that sounds negative. I don't mean it to be negative because it can be very constructive. When you find something wrong with their system, then you deal with it and you change it and you make it responsive to the patients.

The Phoenix Service Unit Board recently submitted a proposal wherein they are asking for money from the Indian Health Service to train Indian people for any Indian group who wants to have a patient advocate, to have them come to Phoenix for six months, and then to hold them back for an additional six months at their facility, designing and structuring a system that would meet that area or tribe's particular needs. One system will not work for everybody. They will all have to be modified.

The resolution reads as follows:

Whereas, the Phoenix Service Unit Indian Health Advisory Board has submitted a proposal to Indian Health Service in an effort to obtain funding to train patient representatives.

Be it resolved, that IHS provide funds to be used for the development of patient representatives to any tribal entity or Indian organization which would wish to implement such a program.

The group felt very strongly about this next statement, and that is: IHS is not to train patient representatives. The group felt that Indian people have to select and train our own patient representatives in order to best represent us.

Be it resolved, that IHS make funds available for those tribes or Indian health boards needing and requesting technical assistance in developing their own Patient Bill of Rights.

Be it further resolved, that IHS, in its own program planning procedure, provide sufficient funds in Fiscal Year '79 to enact the above.

What we are saying by this is, five years ago, Indian Health Service area offices were mandated to write a Patients' Bill of Rights and to post them and to inform Indian people that they did have rights. This has not been completely done.

What we are saying here is, we really don't want you to write a Patients' Bill of Rights for us. We want to write our own. Now, we want the money to do that. I would like to make that a motion.

Mr. Saganey: We have a motion from the floor.

Ms. Emma Farrow: Second by Emma Farrow.

Mr. Saganey: Question?

All approving this resolution, please raise your hands.

Thank you. Opposed, same sign.

None.

The resolution is hereby approved.

Ms. Gloria Keliiaa: I have a second resolution.

The group was very concerned about the lack of contract medical care money.

Now, the question was asked, you know, isn't that a patient's right?

And my response to that is, that Indian people do have a right to quality health care. Now, when anything interferes with that, then IHS has a commitment to respond and resolve the problem.

The resolution reads this way:

Whereas, there is a shortage of contract money resulting in unpaid bills creating inconveniences and/or poor quality health care delivery in many IHS service units and health programs where provision of quality health care for Indian people is a commitment of the Indian Health Service and U.S. Government;

Therefore, be it resolved, that the Indian Health Service provide the basic health right of patients by providing sufficient funds to cover present and past bills generated through contract medical care services so that no patient is ever denied access to quality medical care.

Be it further resolved, that the IHS set aside sufficient monies for unexpected emergencies occurring within any given program.

Be it further resolved, that these funds should be made available to Indian contractors to provide basic health care should the cost of health care exceed their present contract budget.

By that, we mean, many tribal organizations contract with Indian Health Service to provide contract medical care to Indian people. And if you get short within your given quarter or within the end of the year, and you have a patient come in with a very expensive medical problem, you have no choice but to respond to that health need. You have no choice but to make sure that that patient is treated, because in many instances, it can mean life and death, and in many instances, it has meant exactly that.

So, we want Indian Health Service to respond. We want them to set aside a portion of money and to be prepared, because we know that the structure is able to do that.

And that's our motion.

Mr. Francis Abeita: I second it.

Mr. Saganey: Motion made and seconded.

Any discussion?

Ms. Lucille Brenwick: My name is Lucille Brenwick, and I'm from Alaska. I'm a member of the Service Unit Board in Anchorage connected with the service hospital there.

We contract with other hospitals, for instance, the big one in Glenemma.

Last month, the contract funds for that hospital ran out, and patients were turned away. We've tried to convince other people that a certain amount is only set aside for each hospital that contracts with BIA, and they must work within that boundary.

Now, we also are to make people aware that if you have other means, such as, insurance, union insurance, other health insurance, to use it when you can, so that when someone is brought to the hospital that is terminally ill or seriously hurt, that will require quite a bit of funding, that person will have access to those funds.

So, we ask people to use any other source of health insurance that they can.

Ms. Emma Farrow: I would support the resolution just read. However, I do have a question.

I think all the tribes received the directive from Dr. Johnson that our Indian Health Services are now to include the husband non-Indian spouses; whereas, before, also eligible were non-Indian wives and their dependents. And I think this is going to cause additional problems for Indian people within their clinics, hospitals and their overall IHS health services.

I just wanted to mention this, and maybe it's going to be brought up in one of the resolutions. I don't know.

Ms. Gloria Keliiaa: I would like to respond.

Ms. Ada White: There have been two resolutions on that specific issue given to the Resolutions Committee and they will be coming up later. It's pointing out two options on how to address it.

Ms. Gloria Keliiaa: I just wanted to say, I was talking with Patty Marks the other day, too. You see, I had a question here.

Sure, that was discrimintaion against Indian women.

I want to know, as an Indian person from Indian Health Service, if they did any study of the impact of that type of decision.

I want to know, how come, all of the sudden they want to do this. Now, there were two alternatives, as I saw it. One was, that you stop providing care to non-Indian wives of Indian men, or you begin to provide care for non-Indian men plus Indian women.

But when you begin to provide that care, you dilute the amount of money that is there. And I want Indian Health Service to show me in writing their study on how they came to that kind of a decision. I am looking forward to hearing these resolutions.

Are we still on this one resolution?

Unidentified Speaker: I'm from the Portland Area Indian Health Board. I have a comment on the resolution.

I think it should say something in terms of directing Indian Health Service to let Congress know that we do not have enough money in the contract health budget for any area in the nation.

Ms. Keliiaa: Ada says that there is a resolution addressing that. It will be a separate one. There is a request for a supplemental appropriation.

Mr. Saganey: We will take action on this resolution.

All those approving this resolution, please raise your hands.

Thank you. Opposed, same sign.

None.

The resolution is hereby adopted.

Mr. Saganey: Would the reporter from the elderly workshop come up here?

Mr. George Effman: Our workshop was dealing with health related problems and provision of services to Indian/Alaska Native elderly.

There were two facilitators, Sophie Thompson, a member of the National Indian Council on Aging and Juana Lyon, director of that organization in Albuquerque, New Mexico.

And I want to say that it was very exciting and challenging in the three hours that we had. I was really happy with the turnout of about sixty people.

We had two resolutions, the first of which I will now read:

Title: Advocacy for the Health Needs of the Indian Elderly.

Whereas, specific health related needs of the American Indian and Alaska Native elderly were expressed in the workshops on Physical Well Being and Environment at the First National Indian Conference on Aging sponsored in June of 1976 by the National Tribal Chairmen's Association; and

Whereas, these statements of unmet needs were submitted to the Indian Health Service and no remedial action is evident and the promise of improved health services under Public Law 93-641, Public Law 94-437, and Public Law 93-638, does not seem to extend to the elderly; and

Whereas, a workshop on the Health Related Problems and Provision of Services to the Indian and Alaska Native Elderly at the Second National Indian/Alaska Native Health Conference has reviewed and endorsed the statement of unmet needs and expanded the recommendations for remedial action;

Now, therefore, be it resolved, that the Second National Indian/Alaska Native Health Conference hereby endorses said statements of unmet needs and recommendations for remedial action; and

Be it further resolved, that this assembly demands Indian Health Service to review the said recommendations and take the initiative in acting upon them rather than awaiting action by other agencies, and do so in cooperation with the National Indian Health Board and the National Indian Council on Aging; and

Be it further resolved, that all members of the National Indian Health Board, the area health boards, tribal or service unit health boards and advisory councils and committees as well as all individuals concerned with the well-being of the Indian and Alaska Native elderly are urged to unite their efforts to raise health related concerns and services for the elderly from their present low priority status to one which gives the elderly the services to which they are entitled as human beings, as Indian people entitled to equal services, and as the preservers of the Indian and Alaska Native heritage and traditions.

Mr. Joe Braswell: Mr. Chairman, I move for the adoption of the resolution.

Mr. Jim Burns: I second the motion.

Ms. Lucille Brenwick: Question.

Mr. Saganey: All those approving the resolution, please raise your hands.

Opposed, same sign.

None.

The resolution is hereby adopted and approved.

Mr. Effman: And we have another resolution. The title is Long-Term Care Planning.

Whereas, as has been stated by concerned people, planning for long-term care must embrace the full range of health care services -- prevention, hospital care, discharge planning, follow-up and outreach; and

Whereas, emphasis has fallen on institutional placement alone, resulting in failure to provide other necessary health services to patients needing long-term care; and

Whereas, the majority of such patients are in the "elderly" age category; and

Whereas, in planning for long term care, Indian Health Service must be conscientiously cognizant of the desires of the elderly -- as recorded in the Summary Report of the 1976 National Indian Conference on Aging; and

Whereas, health screening clinics and other community-based services, such as home health care, day care and other alternatives to nursing home placement, need to be developed for the elderly; and

Whereas, the practice of placing elderly in institutions far from their homes is alien and unacceptable to Indian people, although necessitated by the family's inability to cope with demands created by advancing years; and

Whereas, the national trend is away from institutionalization to other methods of long term care;

Now, therefore be it resolved, that Indian tribes, the Indian Health Service and the Bureau of Indian Affairs, in planning long term care, provide adequate support services and implement in-home health care and other alternatives in the care of the Indian elderly.

There was other discussion, but we were told that it would be added to later.

Mr. Joe Braswell: Mr. Chairman, Joe Braswell from Nevada. I move for the adoption of the resolution.

Unidentified Speaker: I second the motion.

Mr. Saganey: The motion has been made and seconded.

Call for question.

All those approving this resolution, please raise your hands.

Thank you. Opposed, same sign.

The majority approves. None opposed.

The resolution is hereby adopted.

We will move on to the next workshop, Serving the Mentally and Physically

Handicapped. Will the reporter please come up?

Ms. Ethel Gonzales: Ladies and gentlemen, they do have packets of the resolutions which will be coming up right after the workshop reports. They are very limited in number and, therefore, we have arranged packets by each area. I would hope the representative from the area will come up and pick up the packet when it is called and distribute them within your group. We have about ten copies of each which, hopefully, will serve everybody. If you do have extras of a particular resolution, please let us know and bring them back up here so that we can redistribute them to those groups who don't.

(A brief discussion was held off the record.)

Ms. Ethel Gonzales: First of all, I would like to commend you on your perserverence in sitting through this very trying afternoon. I think that shows dedication to the learning process, trying to learn something that will be helpful in your communities and your reservations when you go back. And I just can't help but commend those few of you who are still here.

My report will be very brief. Our workshop on the mentally and physically handicapped was attended by about thirty-five persons. I served as moderator. The facilitators were Dr. Ted Marrs, Chief of the Albuquerque Area Maternal and Child Health Branch and Arthur L. Thomas, Special Assistant to the Director of Indian Health Service.

The workshop was designed to cover two pieces of legislation affecting handicapped people, Public Law 94-142, which is the Education for All Handicapped Children Act of 1975 and section 504 of the Rehabilitation Act of 1973.

Our workshop was mainly an informational one. Art Thomas spoke to us very briefly, informing us that they are being pressured in Indian Health Service for the employment of Indian handicapped people, and that any program utilizing federal funds could not discriminate against handicapped persons.

These regulations governing us will be enforced by the Civil Rights Office of HEW.

Following the presentation by Art Thomas, a slide presentation was given by Dr. Ted Marrs on a Laguna tribal project to serve the handicapped children of all tribes, commonly known as the Indian Children's Village. This was a very informative presentation on the effort Dr. Marrs is making to make this become a reality in this area. An information packet was distributed to those people present.

Following that, a movie presentation was shown entitled "Waiting for the Dawn." This was information on A School For Me, Incorporated. This was developed by the Navajo people, and I must admit, I was very impressed with the work they are doing with handicapped children.

The project is titled A School For Me, we were told, because in visiting the project, one of the little children was asked, what were these buildings. He said, "It's a school for me." So the interpretation in use for me is: Any child who has a mental or physical handicap that keeps

him out of the standard classroom, those were the things that were addressed. It was somewhat unfortunate that these films took so long leaving no time for exchange of dialogue or questions and answers.

We ran past noon, so there was little feedback from the workshop participants. They seemed to feel that they did get the information they came looking for, but there were no policy recommendations or resolutions submitted.

Mr. Saganey: If there are no questions, we will move on.

The next workshop group is Urban Specific Health Plans. Will the reporter please come up?

Ms. Jo-Anne Lutz: My name is Jo-Anne Lutz, Chairperson of the American Indian Health Care Association.

In our workshop on Urban Specific Health Plans, we reviewed the guidelines that were distributed with regard to development of these plans.

Our discussion centered around several issues. One was, was there a clear definition of IHS involvement at the area levels with regard to providing technical assistance on the development of Urban Specific Health Plans.

We were informed that there is in each area, a representative that has been designated to assist with these plans.

A subsequent question that arose was, suppose that people in the areas do not have the expertise to develop or work with Urban Specific Health programs, since the involvement up to this time has not been that great. And the recommendation was that, should that expertise not be available, that those urban programs would have the availability of outside sources, perhaps, the national organizations or consulting firms, to assist in development of these plans, keeping in mind that they must be submitted to the Secretary by December of 1979.

There were no resolutions and with that, I would like to conclude my report.

Mr. Saganey: We will move on and hear the report from the workshop on Indirect Cost Principles for Federal Grants and Contracts. Will the reporter please come up?

Ms. Ada White: Again, I was not a participant of the workshop, but I have been asked to present a very brief report on some of the workshop discussion. I do not know how many people participated, but I will go on.

The workshop discussed grant development and conflicting regulations pertaining thereto.

It is recommended that all departments of the federal government establish inter-agency agreements, whereby one set of regulations and procedural guidelines be used for the formulation of indirect cost rates.

It is recommended that the Department of Interior's regulations, procedures and cost acceptance policies be recognized and accepted by all funding agencies.

Also, once uniform, acceptable regulations and procedures are established, regional work sessions be instituted, giving the tribes and Indian organizations an opportunity to revise and recommend changes.

There was no suggestion, or no resolution attached, so I present your report as is.

Mr. Saganey: We will continue with the next workshop. Title XX Social Services Amendment to the Social Security Act. Will the reporter please come up?

Ms. Elloise DeGroat: My name is Elloise DeGroat, and I was the moderator for the Title XX workshop. We met with approximately thirty-five participants from about seven states.

Some of the problems that we have had for the last three years were outlined. The biggest three cited were, that under Title XX, Indian people were excluded from benefits; number two, interference with Indian sovereignty; and number three, was administrative problems.

Mr. Bobby George was one of the facilitators in the workshop and he illustrated some of these problems as experienced by the Navajo Tribe in getting benefits under Title XX for the past six years.

The two specific child welfare bills now being considered were also discussed. Interference with Indian self-determination was cited by the introduction of these two bills, Senate Bill 1214 and Senate Bill 1928. Senators are favoring the latter which would give the responsibility for child welfare to state service agencies and state courts.

This would have implications for other bills, such as Title XX, for continuing funding through the state agencies. And as far as the Indian efforts toward some changes in Title XX, Senator James Abourezk is trying to get Senate Bill 1214 passed which would work directly with Indian funding under Title XX.

Indian groups met with James Kissko of HEW in May of 1977. Mr. Kissko has a summary of all Indian recommendations regarding Title XX and other legislation.

I think the biggest recommendation from tribes throughout Indian country has been for direct funding to the Indian people, rather than going through the state.

Mr. Kissko is planning to meet with Secretary Califano to discuss and get his approval on some of these recommendations. Many people will be receiving a copy of some of these recommendations for their review before they are passed on to Congress.

Correspondence with Mr. Kissko with regard to Indian concerns and problems was encouraged. His mailing address appears in the agenda.

The consensus recommendations from the group are:

- Indian groups should not be required to provide matching funds to obtain Title XX grants.
- Title XX, whether administered by a tribe or state, should not reduce existing federal programs serving Indians.
- Indian Title XX programs, to the extent possible, should be operated by Indians for Indians.
- Title XX funds should be channeled to Indian programs in the form of direct payment, rather than through many channels.
- Title XX funds available to Indians should be based on a formula, such as the one used to allocate CETA grants.
- Population figures should not be used as a base for Title XX funds. The needs of the people provide a better basis.

We have submitted a resolution to the staff of the National Indian Health Board for the board's action.

Mr. Saganey: Thank you.

We will move on to the next workshop. The 1980 Census: Supplemental American Indian Questionnaire. Will the reporter please come up?

Mr. Jeff McKenna: My name is Jeff McKenna, and I'm the Health Planner for the Nuksak Tribe of Washington State.

We attended the 1980 Census workshop this morning. And I would like to say there were about twenty people who stayed throughout the workshop, and various other people came in and out to ask a few questions and left again.

We spent most of the time agreeing that the 1970 census was a disaster for Indians in terms of accuracy. And the rest of the time was spent explaining what programs the Census Bureau has started in the last few years to try to make the 1980 census more accurate.

Our group decided that they wanted their workshop report to be in the form of resolutions that could be voted on by the General Assembly. So, we discussed five resolutions in the beginning, and voted on three of them, which I would like to present to you now.

We decided that it would be possible to preface all three resolutions with the same introductory paragraphs. So, for the sake of time, I will read the introductory paragraphs just once.

Whereas, the American Indian and Alaska Native population in the 1970 census was substantially undercounted by the Bureau of Census' own admission; and

Whereas, Indian and Alaska Native people are concerned that the same gross errors not reappear during the 1980 census count; and

Whereas, Indian and Alaskan Native people realize that an accurate and undisputed population count is fundamental to adequate Congressional funding of Indian and Alaskan Native programs;

Now, therefore, be it resolved, that the Census Bureau establish an Indian and Alaskan Native staffed special emphasis program to insure the most accurate possible enumeration of American Indian and Alaskan Natives during the 1980 census.

And that's your first resolution.

Mr. Saganey: You heard the resolution. Is there any motion?

A Voice: I move for adoption of the resolution.

Mr. Frank Willetto: Mr. Chairman, my name is Frank Chee Willetto, Navajo. I second that motion.

Mr. Saganey: Motion made and seconded.

All those approving this resolution as read, please raise your hands.

Thank you. Opposed, same sign.

The majority approving, none opposed, the resolution is hereby adopted.

Next resolution.

Mr. McKenna: Now, therefore, be it resolved, that the National Indian Health Board urges the Census Bureau to use local Indian and Alaskan Native residents as enumerators during the 1980 census count.

Mr. Saganey: You heard the resolution.

Motion for adoption?

A Voice: I move for the adoption of this resolution.

Mr. Saganey: Is there a second?

Mr. Burns: I second the motion.

Mr. Saganey: Thank you. All those approving this resolution, please raise your hands.

Thank you. Opposed.

By your vote, a majority voting, none opposed, the resolution is hereby adopted.

Mr. McKenna: Our third resolution reads as follows:

Now, therefore, be it resolved, that the Census Bureau's Supplementary Questionnaire for American Indians be administered to all Indian and Alaskan Native people, and not only to those residing on trust land, as apparently planned.

Ms. Lucille Brenwick: Lucille Brenwick, Alaska. I move for adoption of this resolution.

A Voice: Second.

Mr. Saganey: Motion made and seconded.

All those approving the resolution raise your hands.

Thank you. Opposed, same sign.

The majority voting, approved; none opposed. The resolution is hereby adopted.

Mr. Saganey: Thank you very much.

We will now move on to the resolutions, and I call on the Resolutions Committee Chairman, Donald LaPointe.

Mr. Donald La Pointe: There were a large number of resolutions turned in, fifty-eight. A lot of these issues could have been answered in a workshop, so we did turn some of the resolutions back to the workshop to be acted upon.

We also reviewed the resolutions that were submitted. And those issues that were considered local will be acted upon tomorrow at the National Indian Health Board meeting.

The issues that were considered national, you do have copies of those resolutions, and we will start with resolution number two. It's a resolution that was submitted by the South Dakota United Indian Association. The resolution title is: Nation-Wide Policy on Abortion.

Whereas, a recent notice T.N.-AA-77.6 has been released. Material transmitted is supplemental to part 3-9.2.6 of the Indian Health Manual;

Whereas, the material transmitted provides clarification of policy on termination of pregnancy (abortion) consistent with Public Health and Indian Health Service policies and the recent U.S. Supreme Court decision:

Be it resolved, that no abortion services be made available at any time by the Indian Health Service;

Be it further resolved, that the adoption of this resolution will assure the Indian people that Indian Health Service is working in coordination with the culture and traditions of all native people in the U.S.

Ms. Marks: Mr. Chairman?

Mr. La Pointe: Yes?

Ms. Marks: My name is Patty Marks, and I would like to speak in opposition to this resolution.

I feel right now that, while there are some very serious problems with the abortion and sterilization issue in Indian Health Service, to simply stop these services immediately, without any plan of action or any plan for further implementation or improvement of services, is wrong and will lead us to very detrimental infringements on the rights of Indian women who do, after informed consent, desire such services and cannot afford to go other places for them.

I think that there is a need for change, a need for alternatives, but I think that an absolute stopping of services at this point is not the best plan of action. And I would like to encourage those people voting to vote against this motion.

Mr. Sampson: Mr. Chairman?

Mr. Saganey: Mr. Sampson?

Mr. Sampson: Can I call a point of order, to put the resolution on the floor first before you enter into discussion?

Mr. Saganey: The resolution was read to you for motion from the floor. Is there any action from the floor?

Mr. Cusnik: I make a motion to adopt that resolution as read.

Mr. Saganey: The motion is made to adopt the resolution as read. Is there a second?

Ms. Brenwick: I will second it. Lucille Brenwick, Alaska.

Mr. Saganey: The motion is made and seconded.

Discussion?

Mr. Willeto: Mr. Chairman?

Mr. Saganey: Mr. Frank Willeto?

Mr. Willeto: My name is Frank Willeto.

I believe we should have an amendment to this. We do have emergencies where it would be either the baby or the mother. For such cases, I believe the resolution should state that in case of emergency, abortions may be performed with the consent of those involved. Maybe we should just go ahead and pass it with this amendment.

Mr. Saganey: Mr. Sampson?

Mr. Sampson: Mr. Chairman, was there a motion made for an amendment, or was that just a recommendation?

Mr. Saganey: I did not hear a motion for amendment, but I heard a recommendation or suggestion for an amendment.

Mr. Willeto: Mr. Chairman, my name is Frank Willeto.

I asked for an amendment, and that's a motion.

The amendment I asked for, in a short version, is that in case of emergency, this can be done.

Mr. Sampson: Mr. Chairman, I would second that because I realize that the situations are different, you know, in all different reservations, but to totally stop it, I think, takes away, I think, some consideration where sometimes things could be dire, where life could be dependent upon these types of things. To totally stop it, I think, is not being realistic.

So, I would second that amendment, and I would call for the question.

Ms. Lorna Keliacul: My name is Lorna Keliacul. I'm a community health representative and also a tribal council member, and also, I'm on the Women's Commission.

I cannot see anything like this being passed denying our women. You cannot impose your culture or traditions on every Indian, regardless of where we live. I am not, myself, for abortion, but if it is needed and it is going to affect a person's life, then it should be available to Indians because Indians do not have the money to go and pay for some backwards doctor at some other place. So, they may try to induce labor themselves or try any other way where they would harm themselves, and we want to keep our people alive and let them try again when the time is right for them.

I believe, also, that any kind of abortion thing like this should also have family planning added to it. This way, we can avoid the abortions.

Thank you.

Mr. Saganey: The motion is on the floor to amend this resolution, but I will wait for more discussion.

Ms. Joan LeBeau: My name is Joan LeBeau. I'm a field supervisor with the CHR program in Cheyenne River.

I would like to say this: I don't think this has been discussed at the reservation levels, yet, and I think it should start from there before anything comes before this board.

And I would like to make a motion to table it, and refer it back out to the reservations, down to the grass root people.

Mr. LaPointe: There is an amendment asked for in this case. In case of emergency, abortions can be done.

Is there a second? There should be a second.

Mr. Saganey: We will act on the amendment.

Ms. White: I'm speaking to the main motion and not to the amendment.

Mr. Saganey: We will act on the amendment first. The discussion is closed on the amendment.

We will call for action on the amendment.

Mr. Willetto: Mr. Chairman, my name is Frank Willetto again.

I would like to withdraw the amendment so we can table it.

Mr. Saganey: Mr. Frank Willetto withdrew the amendment.

The motion to table is on the floor, made by Frank Willetto.

Mr. Sampson: And I will second that motion.

Mr. Saganey: Thank you, second by Mel Sampson, to table the resolution as read.

Question called for.

All those approving the motion to table this resolution, please raise your hands.

Thank you. Opposed? None opposed. I pass it on the tabled motion.

Mr. La Pointe: There has been some concern over who will sign these resolutions.

The signature of the authorized representative will be that of Howard Tommie, the Chairman of the National Indian Health Board.

It has been suggested that we look at resolution number 13.

Violet Hillaire: Mr. Chairman, I would like to give my opinion. I think we have passed all the major concern resolutions anyway, and I don't see any controversial ones here. So, why can't the board take action on them. They represent all the tribes in the nation anyway.

Mr. La Pointe: We need a motion to that effect, but before we do that, it has been requested that we at least take a look at this resolution number thirteen.

The following resolution is hereby submitted by the Navajo Area Indian Health Board for consideration at the Second National Indian/Alaska Native Health Conference.

The resolution is requesting the Secretary of Health, Education and Welfare and the U.S. Congress to appropriate all authorized positions and dollars under Public Law 94-437, Title II, to improve health services to Native Americans to the level of the rest of the United States.

Whereas, on September 30, 1976, President Gerald R. Ford signed into law Public Law 94-437, the Indian Health Care Improvement Act, which recognized for the first time that the health of Indian people was below the level of the rest of the United States, and

Whereas, during fiscal year '78, the Indian Health Service as a whole, received two hundred and ninety of the four hundred and twenty-five authorized personnel positions under Title II of Public Law 94-437; and

Whereas, because of insufficient staff in IHS facilities, Indian people must wait long hours to be seen in overcrowded clinics or be told that they cannot be admitted to a hospital despite bonafide illness; and

Whereas, in sections 2 and 3 of Public Law 94-437, the Congress has acknowledged a trust relationship between the federal government and Indian people with respect to Indian health; and

Whereas, the United States District Court has found, in *White versus Califano*, that the fiduciary obligations of the United States to the Indian people extends to the provision of health care as a particular result of Public Law 94-437, and

Whereas, continued funding under Public Law 94-437, at less than the levels of the funding authorized in the act, constitutes a failure by the U.S. to fulfill its recognized fiduciary duties to Indian people in the health area;

Be it resolved, that the National Indian Health Board requests that the Department of Health, Education and Welfare, and the United States Congress appropriate all authorized Title II Public Law 94-437 positions and dollars.

Be it further resolved, that the Department of Health, Education and Welfare, and the United States acknowledge their responsibility to Indian people and add into the fiscal year '79 budget the authorized personnel and dollars under Title II, Public Law 94-437.

The Resolutions Committee recommends that this resolution be adopted.

Mr. Harry Benson: Harry Benson, from Alaska.

Mr. Chairman, I move for its adoption.

Mr. Saganey: The motion is made to adopt this resolution as read.

Mr. Willeto: Mr. Chairman, my name is Frank Willeto.

I would like to second the motion for adoption because this concerns each and every one of us, the Indians in the United States as well as Alaska.

Mr. Saganey: Motion made to adopt, and seconded.

Question.

All those approving this resolution, please raise your hands.

Opposed, same sign.

The majority approving, none opposed, the resolution is hereby adopted.

Mr. La Pointe: There has been a motion by Violet Hillaire of the Portland area that --

Mr. Francis Abeita: Francis Abeita.

I second the motion.

Mr. Saganey: Motion made and seconded, that we refer the resolutions to the National Indian Health Board for action.

Question.

All those approving the motion, please raise your hands.

Thank you. Opposed?

Four opposing.

The majority approving, the motion as made to refer the rest of these documents to the National Indian Health Board is approved.

I would like now to call on Mr. Howard Tommie, the Chairman of the National Indian Health Board, to come up here, for closing remarks.

Mr. Tommie: We're down to the last comments, and I won't keep you any longer than necessary. One of the things that I really want to say to the National Indian Health Conference, this has been really a good turn-out for us and we are real proud that you have been able to see fit to come and join us.

As I indicated before we started the conference, we could put together a real good agenda as well as activities, but if the participants were not here, we have not accomplished what we intended to accomplish.

And by the showing of the people who have come, it is a clear indication that people are concerned, not just on these specific items which we have concentrated on, 638, 437, 641. As I look at it, I think we just hit the surface of the concern of the American Indian people throughout the United States.

We have worked diligently with our staff, and I cannot say enough about our staff, to accomplish this conference, and I think we have, in many ways, got out the information necessary to make the Indian people aware of some of the major issues that are confronting them and will continue to do so.

And by giving you these types of information about your concerns in order for you to take action on these particular issues, I think we can call all kinds of conferences, all kinds of discussions, but as I indicated before, you are going back to your area, you are going back to your tribal council, and making a specific request to be on your tribal council's agenda on health issues.

As the senator said last night, and I think, one of the major things he was concerned with as I was talking to him, is that the politicians are going to react to the wishes of the voting population, namely, the non-Indian people, in their state or their district.

Therefore, a great majority of the people who do not understand the relationship between the Indian people and the non-Indian people greatly burden these people because they have to run for reelection.

Therefore, they call upon us to try to educate the non-Indian public in your district and in your state, and he made that recommendation.

However you took it, I think it's a valid request on his part.

I would also like to extend our great appreciation for this conference to the senator who appeared before us last night, to the Indian Health Service Area Director, Jay Harwood, and also to the representatives from the Albuquerque area who have worked diligently to try to get this type of input into our conference. I cannot thank Jay Harwood enough because he has provided his staff and, also, all the other area directors who worked with the National Indian Health Board to try to make this a successful conference.

We have impressed upon the area directors to encourage, and even to go as far as financing individuals to attend this conference, and I'm pretty sure that they have responded to it.

Therefore, I believe that many of the people who are here are really interested in working with their own areas, and in bringing issues raised back to their areas. And I think that for all of the issues brought up there are unique situations in each area.

So, to summarize what has come out of this conference, I think we have a task to do, and that is to go home to our local areas and try to make corrections in those things which we are not happy with.

Meeting together here we have made recommendations, and have directed many of the comments toward the agencies that we are trying to work with, but we must also realize that we have to do our share. We have to set up working systems within ourselves which we are comfortable with, and I think that this is what Indian Health Service is looking for us to do when they ask that tribes draw up Tribal Specific Health Plans with the hope that they will be implemented.

In other words, we have to do our share. And I think that we have the capabilities within our own areas to do that.

So, at this time, when we are requesting many different things from them, they are also requesting us to set up some sort of plan; and I think that we have the capabilities to do that, and I think that we will do it.

As I have already indicated a while ago, there are many people that have worked with us to accomplish this conference, namely, John Belindo,

our Executive Director. Planning for this conference has been going on for at least four or five months back, and I think the NIHB staff has done a very commendable job, and I think that the board members feel the same way.

Let's give John Belindo and his staff a round of applause.

As I was walking around, talking to different people, a lot of good comments were made by people indicating that they appreciate a conference such as this. And I have nobody else to thank but the planning committee of the board, with Ada White chairing that committee and also, George Platero, our Albuquerque area representative.

And, of course, Irene Wallace has also worked on the Planning Committee. They have really done a real commendable job, and I want to thank them personally. And I'm sure most of the conferees are happy that we have capable people such as these who have planned this conference.

And, of course, the panel members and facilitators, and, also, the moderators who displayed enough interest to come in and help us. The names are too numerous for me to mention, but they have helped and the IHS people have helped, and I can go on and name a bunch of people, but I don't think that you want to sit here any longer.

And until such time as we feel like another conference is needed and the board decides to have it, I would like to close the conference.

And so, at this time, -- sorry.

The lady from Alaska.

Ms. Gonzales: Ethel Gonzlaes from Alaska.

Before you adjourn, Mr. Chairman, I just wanted to take this opportunity, on behalf of our Alaska delegation, to express our thanks to the National Indian Health Board and the National Indian Health Board staff for all of your efforts in making this conference available to all of the native peoples.

We feel that we have learned some good things and certainly we will be going home and putting these together for a better system of health service for our people.

Thank you.

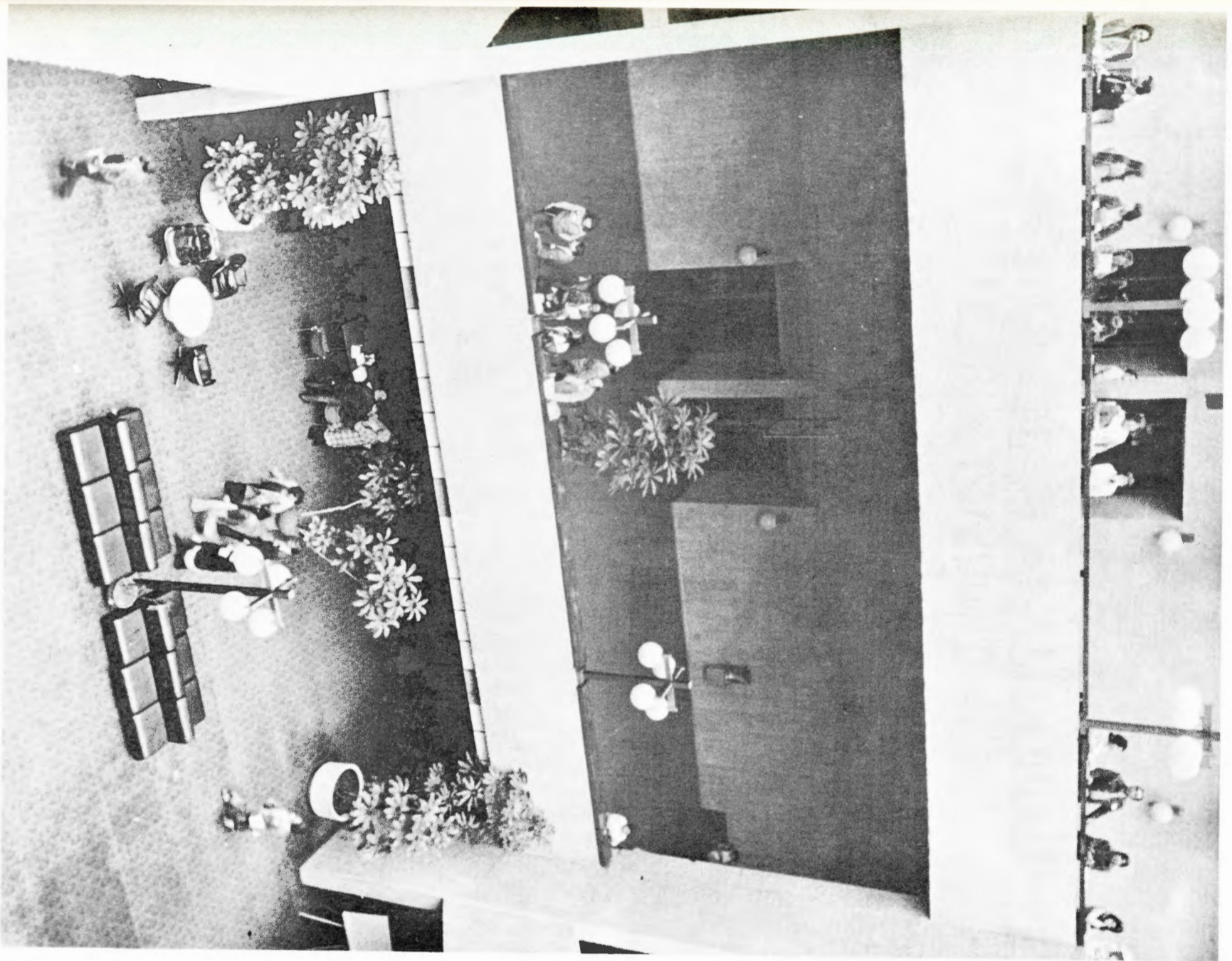
Mr. Tommie: Thank you a lot.

At this time, we thank you for your participation and your patience.

So, I will close the session until the National Indian Health Board decides to schedule another one.

I will close the session with the benediction from Elwood Saganey.

* * * * *



RESOLUTIONS ADOPTED IN CONJUNCTION WITH THE SECOND NATIONAL INDIAN ALASKA/NATIVE HEALTH CONFERENCE



RESOLUTIONS Committee hard at work. (Photo courtesy of Melvin McKenzie, Navajo Division of Education).

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

ENCOURAGING LETTERS OF SUPPORT REGARDING THE STUDY TO
DETERMINE THE NEED FOR AND FEASIBILITY OF ESTABLISHING AN
AMERICAN INDIAN/ALASKA NATIVE MEDICAL SCHOOL

- WHEREAS, The Congress of the United States enacted P.L. 94-437, the "Indian Health Care Improvement Act"; and
- WHEREAS, Title VI of P.L. 94-437 mandated the study of the "need for, and feasibility of, establishing a school of medicine to train Indians to provide health services for Indians"; and
- WHEREAS, A Study to Determine the Need for and Feasibility of Establishing an American Indian/Alaska Native Medical School, (Cresap, McCormick and Paget, Inc., July 22, 1977) has documented the need for and feasibility of an American Indian School of Medicine; and
- WHEREAS, Such a feasibility study was discussed and endorsed at the American Indian School of Medicine Workshop, Second National Indian/Alaska Native Health Conference, February 12-15, 1978.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board encourages individuals and tribes to write letters of support regarding A Study to Determine the Need for and Feasibility of Establishing an American Indian/Alaska Native Medical School, (Cresap, McCormick and Paget, Inc., July 22, 1977).

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

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

- WHEREAS, Indian people and Alaska Natives have long been subject to medical experimentation and research and statistical studies; and
- WHEREAS, such experimentation and studies have often been conducted without the informed consent of the Indian participants; and
- WHEREAS, such medical experimentation involving Indian people has often been unnecessary, not in the best interests of the participants, or performed on Indian people as a captive experimental population; and
- WHEREAS, research studies and statistical analyses of medical and health data relating to Indian people have not always been conducted for the benefit of Indian people, and the results of such studies have often been misused or abused; and
- WHEREAS, Indian populations have sometimes been utilized by the Indian Health Service for the training of medical personnel.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board shall continue to work with the National Commission for the Protection of Human Subjects to study the possible abuses of medical research involving Indian and Alaska Native people and to draft recommendations for comprehensive guidelines or regulations governing the conduct of medical experimentation involving subjects and the use of Indian and Alaska Native populations for the training of medical personnel; and

BE IT FURTHER RESOLVED, that the Indian Health Service institute an absolute moratorium upon any form of medical experimentation involving Indian subjects pending a national Indian Health Service policy, together with appropriate amendments to 45CFR46, the Protection of Human Subjects, governing such, experimentation.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

RECOMMENDING AMENDMENT OF THE REHABILITATION ACT OF 1973 TO
PROVIDE FOR DIRECT FUNDING TO INDIAN TRIBES AND TRIBAL
ORGANIZATIONS THAT WOULD PERMIT THEM TO PLAN, DESIGN OR
ADMINISTER VOCATIONAL REHABILITATION SERVICES

- WHEREAS, the Navajo Vocational Rehabilitation Project was initiated on July 1, 1975 through an Innovation and Expansion grant to improve and expand services to Navajo rehabilitation clients and to formulate a comprehensive plan for the development of resources and services within the Navajo Nation; and
- WHEREAS, Public Law 93-112, the Rehabilitation Act of 1973 is now being considered for renewal before the United States Congress; and
- WHEREAS, there is currently no mechanism within the law to provide direct funding to Indian tribes and tribal organizations to plan, design, administer or provide vocational rehabilitation services to Indian clients; and
- WHEREAS, the states have not been providing adequate or culturally/linguistically relevant rehabilitation services to Indian clients; and
- WHEREAS, there exist legislative precedents for the direct funding of federal programs to Indian tribes and tribal organizations.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board recommends that the Rehabilitation Act of 1973 be amended to provide a mechanism for direct funding to Indian tribes and tribal organizations that would permit tribes to plan, design, or administer vocational rehabilitation services to eligible Indian clients should the tribe so choose.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

REQUESTING THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
AND THE U.S. CONGRESS TO APPROPRIATE ALL AUTHORIZED POSITIONS
AND DOLLARS UNDER PUBLIC LAW 94-437, TITLE II, TO IMPROVE
HEALTH SERVICES TO NATIVE AMERICANS TO THE LEVEL OF THE REST
OF THE UNITED STATES

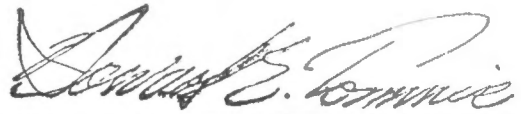
- WHEREAS, on September 30, 1976, President Gerald R. Ford signed into law Public Law 94-437, the Indian Health Care Improvement Act, which recognized for the first time that the health of Indian people was below the level of the rest of the United States; and
- WHEREAS, during FY 78 the Indian Health Service, as a whole, received 290 of the 425 authorized personnel positions under Title II of P.L. 94-437; and
- WHEREAS, because of insufficient staff in Indian Health Service facilities, Indian people must wait long hours to be seen in overcrowded clinics or be told they cannot be admitted to a hospital despite bonafide illness; and
- WHEREAS, in Sections 2 and 3 of P.L. 94-437 the Congress has acknowledged a trust relationship between the federal government and Indian people with respect to Indian health; and
- WHEREAS, the United States District Court has found in White vs. Califano that the fiduciary obligations of the United States to Indian people extends to the provision of health care as a particular result of P.L. 94-437; and
- WHEREAS, continued funding under P.L. 94-437 at less than the levels of funding authorized in the act constitutes a failure by the U.S. to fulfill its recognized fiduciary duties to Indian people in the health area.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board requests that the Department of Health, Education and Welfare, and the United States Congress appropriate all authorized Title II P.L. 94-437 positions and dollars; and

BE IT FURTHER RESOLVED, that the Department of Health, Education and Welfare, and the United States Congress acknowledge their responsibility to Indian people and add into the FY 79 Budget the authorized personnel and dollars under Title II, P.L. 94-437.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority of the National Indian Health Board of Directors present.

A handwritten signature in cursive script, reading "Howard E. Tommie".

Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

SUPPORTING THE AMENDMENT OF TITLE XX OF THE SOCIAL SECURITY
ACT TO DEAL PROPERLY WITH SOCIAL SERVICES GRANTS FOR AMERICAN
INDIANS AND ALASKA NATIVES

- WHEREAS, Title XX, which deals with grants for social services, has resulted in dissatisfaction among American Indians and Alaska Natives; and
- WHEREAS, in the past Indian people have been excluded from benefits in some states, the states generally reluctant to allocate resources under their control to Indian people; and
- WHEREAS, some states prefer to fund existing programs rather than start up new programs which would benefit Indian people; and
- WHEREAS, Indian tribal councils and Indian organizations are concerned that Indian Self-Determination, P.L. 93-638 efforts are being hampered as a result of operation of current Title XX.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board support the request of American Indians and Alaska Natives to amend Title XX in accordance with the following principles:

- 1) American Indian/Alaska Native groups should not be required to provide matching funds to obtain Title XX grants;
- 2) Title XX, whether administered by a tribe or state, should not supplant or reduce an existing federal program servicing American Indians/Alaska Natives;
- 3) Indian Title XX programs should be operated by American Indian/Alaska Natives to the greatest extent possible;
- 4) Title XX funds should be channeled to programs in the form of direct payment rather than by reimbursement.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

ASKING THAT INDIAN HEALTH MANPOWER BE PLACED ON THE AGENDA
OF THE THIRD NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE

WHEREAS, the Congress of the United States enacted P.L. 94-437, the "Indian Health Care Improvement Act: and

WHEREAS, Title III of P.L. 94-437 mandated the study of the "need for and feasibility of the establishment of an American Indian School of Medicine"; and

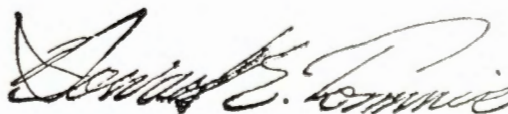
WHEREAS, the feasibility study was discussed and endorsed at the American Indian School of Medicine Workshop.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board include on the Third National Indian/Alaska Native Health Conference agenda a report/panel to the full conference on Indian Health Manpower Development; and

BE IT FURTHER RESOLVED, that a subsection of this report include the status of the feasibility study for an American Indian School of Medicine.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

ASKING THE RELEASE OF PLANNING MONEY FOR THE CHINLE
SERVICE UNIT HOSPITAL

- WHEREAS, the Navajo Area Indian Health Board has placed the planning and construction of the Chinle Service Unit Hospital as number one priority for the Navajo Nation; and
- WHEREAS, the Chinle Service Unit Health Board supports the Chinle Hospital Steering Committee and has representatives on that committee in its effort to expedite the planning and construction of a hospital within the Chinle service unit area; and
- WHEREAS, the Chinle service unit (IHS) presently offers only out-patient care to approximately 22,000 plus residents; and
- WHEREAS, the residents of the Chinle service unit area must travel from 70 to 145 miles to secure inpatient care; and
- WHEREAS, patients requiring hospitalization must travel a 7,700 foot pass; and
- WHEREAS, the IHS O.P.D. facility in the Chinle service unit area had over 75,000 plus out patient visits in 1977; and
- WHEREAS, the Indian Health Service had allocated \$650,000 planning money for a hospital in Chinle; and
- WHEREAS, the \$650,000 has been frozen pending the release and approval of the GAO report on Indian hospital bed needs; and
- WHEREAS, the freeze has created problems for many other Indian tribes in their efforts to obtain funding for the planning of new IHS hospitals.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board calls for immediate release of all planning funds presently being held by IHS for planning of new facilities.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

URGING THE BUREAU OF CENSUS TO EMPLOY AMERICAN INDIANS
AND ALASKA NATIVES AS ENUMERATORS DURING THE 1980 CENSUS COUNT

WHEREAS, the American Indian and Alaska Native population in the 1970 Census was substantially undercounted by the Bureau of Census' own admission; and

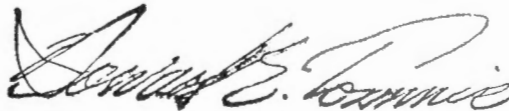
WHEREAS, Indian and Alaska Native people are concerned that the same gross errors should not reoccur during the 1980 census count; and

WHEREAS, Indian and Alaska Native people realize that an accurate and undisputed population count is fundamental to adequate congressional funding of Indian and Alaska Native programs.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board urges the Bureau of Census to employ American Indians and Alaska Natives as enumerators during the 1980 Census count.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

REQUESTING IHS FUNDS FOR THE TRAINING OF TRIBAL PATIENT
REPRESENTATIVES

WHEREAS,


the Phoenix Indian Health Advisory Board submitted a proposal to Indian Health Service to obtain funding to train Patient Representatives, that Indian Health Service provide funds to develop training programs for any tribal entity or program that wishes to implement such a program.

NOW, THEREFORE BE IT RESOLVED, that Indian Health Service make funds available for those tribes or Indian Health Boards that need technical assistance in developing their own Patient Bill of Rights; and

BE IT FURTHER RESOLVED, that Indian Health Service in its own program procedure provide sufficient funds in FY 79 to enact the above.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

REQUESTING THE AMENDMENT OF P.L. 93-641 TO INCLUDE INDIAN CONCERNS AND REQUESTING NIHB TO ASSUME THE LEADERSHIP ROLE IN WORKING WITH DHEW FOR THE SPECIAL NEEDS OF INDIANS UNDER P.L. 93-641 AND IN PROVIDING ASSISTANCE TO TRIBES UNDER THE ACT

- WHEREAS, the lack of clear definition of the relationship between Indians and P.L. 93-641 created entities, such as HSA's and SHCC's, has posed a threat to Indian rights and made it difficult for tribes to participate in the health planning process established by P.L. 93-641; and
- WHEREAS, tribes need monies to fund tribal health planning activities; and
- WHEREAS, P.L. 93-641 is now being reviewed for amendments by the Congress; and
- WHEREAS, HEW, in conjunction with maximum Indian input, needs to develop guidelines on the relationship between HSA's and tribes and HSA's and urban Indian health organizations; and
- WHEREAS, tribes and urban Indian health organizations need information on P.L. 93-641 and assistance in developing viable relationships with their HSA's.

NOW, THEREFORE BE IT RESOLVED, that Congress is requested to amend P.L. 93-641 to a) require HSA's, SHCC's and other entities established or empowered by P.L. 93-641 to respect the special rights and sovereign authority of Indian tribes and (b) to provide funding for tribal health planning activities; and

BE IT FURTHER RESOLVED, that HEW should take immediate steps to address the special situation of Indians and P.L. 93-641 created entities, beginning with consultation with Indian tribes and organizations. HEW shall also issue a definition of "review and comment" that assures that the HSA's do not use that phrase to infringe on the sovereign rights of Indian tribes; and

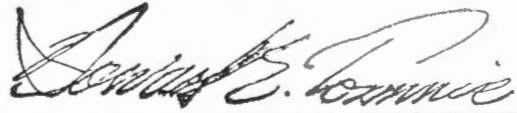
BE IT FURTHER RESOLVED, that the National Indian Health Board is requested to assume the leadership role in working with HEW in the special needs of Indians under P.L. 93-641 and in providing assistance to tribes under the Act; and

BE IT FURTHER RESOLVED, that Indian Health Service shall implement its claimed role as advocate of Indians in health working inside HEW to promote Indian interests and concerns on P.L. 93-641; and

BE IT FINALLY RESOLVED, that amendments shall address the unique needs of Alaska Natives, Indians living in Oklahoma, California and other areas of the country that have unique situations.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.

A handwritten signature in dark ink, appearing to read "Howard E. Tommie", written in a cursive style.

Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

REQUEST FOR CONGRESSIONAL REVIEW AND RESOLUTION OF THE HOSPITAL
BED FREEZE SITUATION FOR HOSPITAL PLANNING, CONSTRUCTION, AND
RENOVATION SO THE NEEDS OF INDIAN PEOPLE CAN BE MET IN
ACCORDANCE WITH THE AUTHORIZATION OF TITLE III OF P.L. 94-437

- HEREAS, during Fiscal Year 1978 no new hospital construction funds were awarded to the Navajo Nation because of a hospital bed freeze imposed by Congress, due to a controversy between IHS and U.S. General Accounting Office over planning methodology; and
- HEREAS, The U.S. General Accounting Office report covering hospital bed projections for the Navajo Nation did not consider the fact that Navajo land is an "ultra-rural" area with a population density of about five people per square mile, which represents less than 1/10 of the average population density of the U.S., which is 57 people per square mile; and
- HEREAS, planning monies for construction of Chinle, Winslow, and Shiprock Hospitals authorized under P.L. 94-437 and appropriated in the FY-1978 appropriation hearings have also been held up by Health, Education, and Welfare until the IHS bed planning methodology and national bed planning methodology is resolved; and
- HEREAS, the Navajo Nation lacks public transportation services of any kind and has very few developed paved highway systems; and
- HEREAS, three service units of the NAIHS, namely Kayenta, Winslow and Chinle, have no IHS hospital beds at all, and the Crownpoint Hospital is an unaccredited out-dated facility which needs replacement; and
- HEREAS, under Title III, Public Law 94-437, the Congress of the United States authorized quality-assured hospital bed facilities to be completed during the seven-year authorization of the Indian Health Care Improvement Act, yet the existing freeze is causing the Indian people to fall further and further behind the rest of the United States; and
- HEREAS, more and more Navajos are trying to seek services at non-IHS facilities off the reservation because of the unavailability of hospital beds within 100 miles of their homes and because of lack of humanistic quality and of quality-assured care at underfunded, inadequately-staffed IHS facilities.

NOW, THEREFORE BE IT RESOLVED, that despite the superficial statistics about the present hospital beds on the Navajo Nation prepared by the U.S. General Accounting Office, the Navajo Nation is in obvious dire need of new, improved, and renovated hospital bed facilities immediately at several locations; and

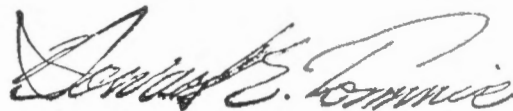
BE IT FURTHER RESOLVED, that the Chinle, Winslow, and Kayenta Service Units, representing over 40,000 Navajos located more than 100 miles from an IHS hospital, require construction of new or replacement facilities to meet their needs; and

BE IT FURTHER RESOLVED, that the Shiprock Hospital is in serious need of renovation and expansion, and Crownpoint Hospital needs replacement; and

BE IT FURTHER RESOLVED, that the Congress of the United States is hereby requested to review and resolve the hospital bed freeze situation for hospital planning, construction, and renovation needs of the Indian people which can be met in accordance with the authorization of Title III, Public Law 94-437.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

URGING NIHB AND THE DHEW INTRA-DEPARTMENTAL COUNCIL TO
LOBBY FOR INCREASED APPROPRIATIONS FOR BOTH P.L. 94-437 AND
P.L. 93-638

- WHEREAS, the Indian Health Care Improvement Act states it is the policy of the Nation to fulfill its special responsibility for Health Services to American Indian people; and
- WHEREAS, the Indian Health Care Improvement Act further states that it is a national goal to strive toward provision of the highest possible health status to Indians; and
- WHEREAS, the Indian Self-Determination Act is the mechanism for American Indian tribes to realize the maximum determination and control of Indian health planning and programming; and
- WHEREAS, the appropriations under P.L. 93-638, the Indian Self-Determination Act were not adequately increased for FY 78 to provide tribes with the necessary resources to plan health needs.

NOW, THEREFORE BE IT RESOLVED, that the Second National Indian/Alaska Native Health Conference delegates urge the National Indian Health Board and the Intra-departmental Council of HEW to fully advocate and address the U.S. Congress to increase appropriations under P.L. 93-638 and P.L. 94-437, to implement the stated national policy of highest possible health and self-determination for Indian people; and

BE IT FURTHER RESOLVED, that a report be made to American Indian tribes on the actions taken pursuant to this resolution and the results thereof.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

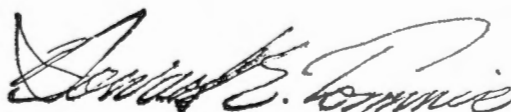
RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

REQUIRING IHS TO ENGAGE IN MORE EFFECTIVE AND CONSISTENT
CONTRACTING AND GRANT PROCEDURES

- WHEREAS, the Billings Area Indian Health Board has been organized to represent, develop, plan and evaluate health programs being provided to Indian citizens in the States of Montana and Wyoming; and
- WHEREAS, consistency and uniformity in practices and procedures are essential for the effectiveness of Indian Health Service programs for Indians; and
- WHEREAS, it has been the experience of Indians in the Billings Area Office's jurisdiction that considerable and unwarranted vacillating in contracts and grants have needlessly disrupted such programs for Indians; and
- WHEREAS, such continuing vacillations lends the contract program areas of Indian Health Service to chaos, misunderstandings and confusion, all of which frustrate program efforts by Indian and Indian Health Service personnel alike.
- NOW, THEREFORE BE IT RESOLVED, that the Second National Indian/Alaska Native Health Conference hereby recommends to the National Indian Health Board that appropriate measures and steps are immediately taken to have the activities, practices and attitudes of persons in the Contracting Office investigated, reviewed and evaluated as to whether or not they are consistent with the provisions of 25 CFR, 21 CFR, 41 CFR; and
- BE IT FURTHER RESOLVED, that the Health Services Administration, Rockville, Maryland, be requested and informed by these present deep concerns and frustrations for Indians of the Billings Area because of persons in the Contracting Office unwarranted and continual vacillations; and
- BE IT FURTHER RESOLVED, that the Health Services Administration be requested to immediately take measures with persons in the Contracting Office as to effect consistent and stable delivery of contracts in the Billings Area jurisdiction of the Indian Health Service.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

RECOGNITION OF HEALTH MANPOWER DEVELOPMENT AS A PRIORITY ISSUE
AND LENDING SUPPORT TO THE HEALTH CAREERS AWARENESS PROGRAMS
AND ACCESS AND RETENTION OF AMERICAN INDIANS AND ALASKA
NATIVES IN THE HEALTH AND ALLIED HEALTH FIELDS

- WHEREAS, Indian Self-Determination is a mandate of Congress for the Indian people; and
- WHEREAS, health is a basic human right of all people and a necessary ingredient for Indian self-determination; and
- WHEREAS, the number of American Indians and Alaska Natives at the professional level in health and allied health fields is documented to be one of the lowest in the nation; and
- WHEREAS, there is a lack of an identifiable American Indian and Alaska Native health manpower pool; and
- WHEREAS, increased access to quality education and vocational training is the only long range absolute assurance of entry to professional levels of health career programs for Indian students.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board recognizes health manpower development as a priority issue and lends full support to the Health Careers Awareness Programs and access and retention of American Indians and Alaska Natives in the health and allied health fields; and

BE IT FURTHER RESOLVED, that the National Indian Health Board in the future provide separately from general assembly an increased number of workshops concerning education for health and vocational training including all phases of access and retention such as direct care providers, allied health, health care administration, and public health.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

REQUIRING IHS TO ACCEPT UPDATED SERVICE UNIT POPULATION
FIGURES IN LIEU OF THE 1970 BUREAU OF CENSUS FIGURES FOR
TRIBAL SPECIFIC HEALTH PLANS

WHEREAS, P.L. 94-437, the Indian Health Care Improvement Act allows for the formulation of Tribal Specific Health Plans; and

WHEREAS, these Tribal Specific Health Plans must be based on a 1970 Bureau of the Census population count within each tribe and service unit; and

WHEREAS, the Indian Health Service has repeatedly said that it recognizes that American Indians are undercounted and that tribes may submit two plans using Indian Health Service or the Census count, or the respective tribal population count.

NOW, THEREFORE BE IT RESOLVED, that the Indian Health Service accept updated service unit eligible population in lieu of the Bureau of Census figures as reported in 1970.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

REQUIRING 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 STERILIZATIONS BEING PERFORMED BY IHS PERSONNEL
WITHOUT THE INFORMED CONSENT OF THE PATIENTS INVOLVED

WHEREAS, the 1975 GAO report and reports submitted to Indian tribes and organizations have revealed serious problems within the I.H.S. sterilization and abortion counselling procedures; and

WHEREAS, sterilization and abortion are serious procedures affecting the lives of Indian people.

NOW, THEREFORE BE IT RESOLVED, that the Second National Indian/Alaska Native Health Conference hereby officially requests that Indian Health Service provide trained Indian counselors versed in the native Indian language and who are sensitive to Indian culture, concerns and needs and who can discuss the nature and importance of the medical procedure and the alternatives available; and

BE IT FURTHER RESOLVED, that Indian Health Service immediately initiate an investigation of all allegations of abortions or sterilizations being performed by Indian Health Service personnel without the consent of the patients involved; and

BE IT FURTHER RESOLVED, that all tribes and Indian organizations provide testimony and/or comments to the Secretary of DHEW on the newly proposed sterilization regulations prior to March 13, 1978.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD


REQUESTING CONGRESS TO MAKE SUPPLEMENTAL APPROPRIATIONS
TO CONTRACT MEDICAL CARE PROGRAMS

- WHEREAS, Contract Medical Care (CMC) programs under Indian Health Service rules and regulations do not make provisions for payment of vendor services provided in a fiscal year (FY) prior to the current contract year; and
- WHEREAS, Indian tribes and organizations under contract medical care programs in cooperation with Indian Health Service face a deficit, due to unusual unexpected expenditures during the last several days of FY 1977 contracts; and
- WHEREAS, cost overrun is due mainly to inflationary conditions and the cost overrun is incurred during the last 15 days of the contract year; and
- WHEREAS, the rules and regulations governing the expenditures of CMC programs with Indian Health Service provide for vendor services payment within the FY contract without provision being made for carryover of excess funding; and
- WHEREAS, due to unusual circumstances, namely the inflationary cost of health care services experienced on a national level.

NOW, THEREFORE BE IT RESOLVED, that the Second National Indian/Alaska Native Health Conference requests Congress to appropriate supplemental funding to CMC programs allowing those communities to pay their vendors thus preventing further cutbacks from necessary health services.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

SUPPORT OF INDIAN POSITION ON NATIONAL HEALTH
INSURANCE DEVELOPED BY NIHB'S NHI CORE GROUP

- WHEREAS, the Iowa, Absentee Shawnee, Sac & Fox Merger or Health Board of Oklahoma fully understands the National Administration's move toward National Health Insurance, which is to provide health services coverage for the entire population including Native Americans; and
- WHEREAS, the Iowa, Absentee Shawnee, Sac & Fox Merger Health Board of Oklahoma does support efforts for all Indians concerned, that Indian Health Service continue as a definite health provider, to provide comprehensive health services to all Native Americans regardless of the initiation of the Administration's National Health Insurance proposal which should allow Indians their choice of health provider services; and
- WHEREAS, the Merger Board of Oklahoma is in total support of Indian Health Service's continuation and improvement under regulations of P.L. 93-638, the Indian Self-Determination Act, P.L. 94-437, the Indian Health Care Improvement Act and the Indian Health Service Act of August 5, 1954, (68 stat. 674), P.L. 568.
- NOW, THEREFORE BE IT RESOLVED, that the Iowa, Absentee Shawnee, Sac & Fox Merger Health Board of Oklahoma does present this resolution to the National Indian Health Board for acceptance; and
- BE IT FURTHER RESOLVED, that the Merger Board of Oklahoma accepts responsibility of this resolution as documentation and support to the Indian Health Service, support for the efforts of the Indian people nationally, and support to the National Indian Health Board.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

ADVOCACY FOR THE HEALTH NEEDS OF THE INDIAN
ELDERLY BY NIHB AND ALL LEVELS OF IHS

WHEREAS, specific health related needs of the American Indian and Alaska Native elderly were expressed in the workshops on Physical Well-Being and Environment at the First National Indian Conference on Aging sponsored in June of 1976 by the National Tribal Chairmen's Association; and

WHEREAS, these statements of unmet needs, Summary Report, National Indian Conference on Aging, Phoenix, Arizona, June 15 -17, 1976, were submitted to the Indian Health Service and no remedial action is evident and the promise of improved health services under P.L. 93-641, P.L. 94-437, and P.L. 93-638 does not seem to extend to the elderly; and

WHEREAS, a Workshop on the Health Related Problems and Provision of Services to Indian and Alaska Native Elderly at the Second National Indian/Alaska Native Health Conference has reviewed and endorsed the statements of unmet needs and endorsed and expanded the recommendations for remedial action.

NOW, THEREFORE, BE IT RESOLVED, that the Second National Indian/Alaska Native Health Conference hereby endorses the said statements of unmet needs and recommendations for remedial action; and

BE IT FURTHER RESOLVED, that the Second National Indian/Alaska Native Health Conference requests the Indian Health Service to review the said recommendations and take the initiative in acting upon them, rather than awaiting action by other agencies, and do so in cooperation with the National Indian Health Board and the National Indian Council on Aging; and

BE IT FURTHER RESOLVED, that all members of the National Indian Health Board, the Area Health Boards, Tribal or Service Unit Health Boards and Advisory Councils and Committees, as well as all individuals concerned with the well-being of the Indian/Alaska Native elderly are urged to unite their efforts to raise health related concerns and services for the elderly from their present low priority status to one which gives the elderly the services to which they are entitled as human beings, as Indian people entitled to equal services, and as the preservers of the Indian and Alaska Native heritage and traditions.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.

A handwritten signature in dark ink, appearing to read "Howard E. Tommie", written in a cursive style.

Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

ENDORSING THE FINDINGS OF THE AMERICAN INDIAN
AND ALASKA NATIVE TASK FORCE OF THE PRESIDENT'S
COMMISSION ON MENTAL HEALTH AND URGING THE
COMMISSION'S ADOPTION OF THE SAME

- WHEREAS, President Carter has established the President's Commission on Mental Health; and
- WHEREAS, LaDonna Harris, a Comanche Indian, has been appointed by President Carter to serve on the Commission; and
- WHEREAS, an American Indian and Alaska Native Task Force was appointed to study and make recommendations regarding the Mental Health needs of American Indians and Alaska Natives; and
- WHEREAS, this Task Force and LaDonna Harris have presented a report to the President's Commission with specific recommendations.

NOW, THEREFORE BE IT RESOLVED, that the Second National Indian/Alaska Native Health Conference endorses the findings and recommendations of the Task Force; and

BE IT FURTHER RESOLVED, that the National Indian Health Board should urge the President's Commission on Mental Health to adopt the recommendations of the American Indian and Alaska Native Task Force.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

SUPPORTING THE ALL INDIAN ADVISORY BOARD TO THE
SECRETARY OF AGRICULTURE IN ITS APPLICATION TO
ENTER INTO A WORKING ARRANGEMENT WITH NIHB

- WHEREAS, American Indians and Alaska Natives have expressed a desire for an upgrading of their nutritional status and well-being; and
- WHEREAS, American Indians and Alaska Natives have requested the formation of an all Indian Advisory Board to the Secretary of Agriculture to further such goals; and
- WHEREAS, an all Indian Advisory Board has been selected from the various American Indian and Alaska Native areas; and
- WHEREAS, the members of the All Indian Advisory Board have submitted a proposal to the Community Services Administration to fund its proposed activities; and
- WHEREAS, the All Indian Advisory Board proposes to reach an agreement with the National Indian Health Board in order for it to receive, and disburse to the All Indian Advisory Board any federal or other funds allocated to it for the purposes of advising and acting on all matters affecting American Indian and Alaska Native food and nutrition matters.

NOW, THEREFORE BE IT RESOLVED, that the Second National Indian/Alaska Native Health Conference hereby supports the All Indian Advisory Board in its request to enter into such agreement with the National Indian Health Board; and

BE IT FURTHER RESOLVED, that the All Indian Advisory Board shall correlate the food and nutrition activities of American Indians and Alaska Natives, shall advise the Secretary of Agriculture of the needs and wishes of American Indians and Alaska Natives, and shall advise, represent, and act as advocate for American Indians and Alaska Natives on all matters affecting their food and nutrition program and activities.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.

A handwritten signature in cursive script, appearing to read "Howard E. Tommie", written in dark ink.

Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

PROTECTION OF THE RIGHTS AND RESOURCES OF THE
INDIAN EDLERLY IN LONG TERM CARE PLANNING

- WHEREAS, concerned people have stated that planning for long term care must embrace the full range of health care services--prevention, hospital care, discharge planning, follow-up and outreach; and
- WHEREAS, emphasis has fallen on institutional placement alone, resulting in failure to provide other necessary health services to patients needing long term care; and
- WHEREAS, the majority of such patients are in the "elderly" age category; and
- WHEREAS, in planning for long term care, Indian Health Service must be conscientiously cognizant of the desires of the elderly as recorded in Summary Report, National Indian Conference on Aging, Phoenix, Arizona, June 15 - 17, 1976; and
- WHEREAS, health screening clinics and other community-based services such as home health care, day care, and other alternatives to nursing home placement need to be developed for the elderly; and
- WHEREAS, the practice of placing elderly in institutions far from their homes is alien and unacceptable to Indian people, although necessitated by a family's inability to cope with demands created by advancing years; and
- WHEREAS, the national trend is away from institutionalization to other methods of long term care.

NOW, THEREFORE BE IT RESOLVED, that the Indian tribes, the Indian Health Service and the Bureau of Indian Affairs, in planning long term care with the family, including foster home care, provide funding for continuing adequate support services, especially, housing, and implement total in-home services, home maintenance, Home Health Care and other alternatives, in the care of the Indian elderly; and

BE IT FURTHER RESOLVED, that the rights and resources of the individual elderly person be protected; and

BE IT FURTHER RESOLVED, that the elderly be given the opportunity to teach tribal culture values in these programs.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.

A handwritten signature in dark ink, appearing to read "Howard E. Tommie", written over a horizontal line.

Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

SUPPORT OF INDIAN ENROLLMENT INTO A MEDICINE
PROGRAM AND MASTER OF PUBLIC HEALTH DEGREE
PROGRAM

- WHEREAS, the National Indian Health Board represents the health interests of Indian Americans and Alaska Natives and concerns of Indian Americans and Alaska Natives; and
- WHEREAS, the Indian Medical Program at the University of North Dakota in Grand Forks, North Dakota is programmed and designed to improve medical care for Indian people by training Indian people in medical and health professions; and
- WHEREAS, the MPH Program at the School of Public Health, University of California, Berkeley has been by far the major source of trained Indian Americans and Alaska Natives in such public health programs as health and hospital administration, health education, environmental health; and
- WHEREAS, a new Indian related Masters Degree Program in Alcoholism Studies and Community Mental Health has been developed through the efforts of the MPH Program; and
- WHEREAS, the Master of Public Health Degree Program for American Indians and Alaska Natives has been in existence for seven years and has enrolled 104 Indian students in graduate programs; and
- WHEREAS, 90% of the Indian graduates have returned to work directly with Indian urban, reservation and rural communities; and
- WHEREAS, the implementation of P.L. 93-638, the Indian Self-Determination Act and P.L. 94-437, the Indian Health Care Improvement Act require the skills of trained Indian professionals particularly in the health field.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board duly recognizes the need for Indian medical professionals and requests that Indian students be given the opportunity to enter the medical professions; and

BE IT FURTHER RESOLVED, that the National Indian Health Board urge that adequate financial support be made available to the above programs as they are essential for the development of Indian health professional manpower which would enhance the implementation of P.L. 93-638 and P.L. 94-437 and the improved health status of Indian people; and

BE IT FURTHER RESOLVED, that in the future adequate financial support is specifically earmarked for the INMED and MPH Programs within annual Indian Health Service budget appropriations.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.

A handwritten signature in dark ink, appearing to read "Howard E. Tommie", written over a horizontal line.

Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

PROVIDING FOR TRAINING OF INDIAN HEALTH BOARDS
ON IHS HIRING PRACTICES AND INCLUSION OF INDIAN
HEALTH BOARDS IN ALL PHASES OF THAT HIRING

WHEREAS, Indian Health Service hiring practices are of vital importance to the delivery of beneficial and efficient services in terms of the attitudes and abilities of health care providers; and

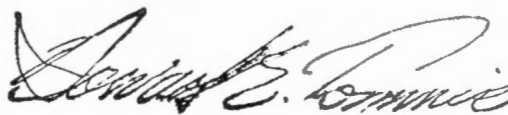
WHEREAS, tribal people must be assured that they can communicate with the personnel which requires participation of all levels, from initial recruitment to selection of IHS personnel.

NOW, THEREFORE BE IT RESOLVED, that health boards be trained in the process used by Indian Health Service in its hiring practices in order to be able to participate as contributing participants; and

BE IT FURTHER RESOLVED, that in order to assure better health care to Indian tribes and Alaska Natives that their participation and input be guaranteed in all phases of planning, selection of personnel and implementation of activities needed to provide better health care and programs.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

SUPPORTING THE OVERTURN OF THE BAKKE DECISION

- WHEREAS, in 1976, the California Supreme Court ruled in favor of Allen Bakke charging reverse discrimination concerning affirmative action programs for minorities; and
- WHEREAS, the Congress supported the passage of P.L. 94-437 - "Indian Health Care Improvement Act", Title I - Indian Health Manpower Development, to alleviate all social and cultural barriers to better Indian health for American Indians and Alaska Natives; and
- WHEREAS, if the Bakke Decision is upheld by the United States Supreme Court, possibly eliminating Affirmative Action Programs, then the status of Indian Health Manpower Development may be jeopardized causing difficulty for potential American Indian and Alaska Native individuals wishing to enter the health professions.
- NOW, THEREFORE BE IT RESOLVED, that the Second National Indian/Alaska Native Health Conference supports the National Committee to Overturn the Bakke Decision, thus supporting affirmative action for minority programs.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

REQUESTING IHS DOCUMENTATION INDIAN HEALTH BOARDS
TO ITS EXPENDITURES FOR SPECIAL PROGRAMS

- WHEREAS, The Northwest Portland Area Indian Health Board is a recognized body of twenty-four (24) tribal representatives representing thirty-four (34) tribes in the states of Washington, Oregon and Idaho, dedicated to assist and promote the health needs, concerns and services to Indian people; and
- WHEREAS, the Indian Health Service has been funding tribal health programs through several funding allocations, some of which are Tribal Employee/Tribal Leadership Training, CHR, MCH, WIC, Community Development and P.L. 93-638; and
- WHEREAS, Indian Health Service has funded each Area Office for tribal projects funded by IHS headquarters; and
- WHEREAS, each area of the Indian Health Service maintains documentation of the expenditure of these special projects; and
- WHEREAS, the Indian Health Service headquarters has not provided documentation of this information to account for the expenditures other than their own local areas; and
- WHEREAS, the Freedom of Information Act provides that individuals and groups can request specific information related to these tribal projects; and
- WHEREAS, the information being requested does not violate the Privacy Act regulations.

NOW, THEREFORE BE IT RESOLVED, that the Indian Health Service in Rockville, Maryland provide to the Northwest Portland Area Indian Health Board and other IHS Area Indian Health Boards upon their request the following items of interest:

1. Total appropriation funds for FY 1976, 1977 and 1978;
2. Each Area project:
 - a. Name of specific tribe or tribes and/or;
 - b. Name of project and of present director;
 - c. Project scope and objectives;
 - d. Date project first funded;
 - e. Initial funding level;
 - f. Date and amount of any contract funding modification or scope revision;
 - g. Date of expiration of each project, proposal, grant and/or contract for each contract;

- h. Name of each Project Officer for each contract;
- i. Sub-total allocation tabulation by each specific funding source;
- j. Total allocation tabulation of all sources of tribal contracts/grants;

BE IT FURTHER RESOLVED, that identical information be provided by headquarters as to:

- 1. Allocation of funds for specific tribal Indian organization contracts or grants;
- 2. Accountability of P.L. 93-638 funds utilized directly for Indian Health Service;
- 3. Sub-total by each specialized allocation or expenditure of P.L. 93-638 funds for grants, contracts or Indian Health Service personnel; and

in the addition to the above, a recapitulation of all sub-totals of each area and Indian Health Service headquarters to funds appropriated by Congress for FY 1976, 1977 and 1978; and

BE IT FURTHER RESOLVED, that Dr. Emery Johnson provide this information within forty-five (45) days of receipt of this resolution and prior to redistribution of any funds allocated to the Portland Area Office of Indian Health Service; and

BE IT FINALLY RESOLVED, that the National Indian Health Board supports the Northwest Portland Area Indian Health Board in its request to Indian Health Service.

CERTIFICATION

It is hereby certified that at the Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, the foregoing resolution was presented and approved by a majority vote of the National Indian Health Board of Directors present.



Howard E. Tommie, Chairman

APPENDIX

NATIONAL INDIAN POSITION
ON
NATIONAL HEALTH INSURANCE

(as previously adopted
by the National Indian
Health Board and National
Congress of American
Indians)

I. Introduction

American Indians, along with other citizens have been concerned about the planned adoption of a National Health Insurance Program in this country. On the basis of their unique legal, historical and moral relationship with the Federal government, Indians receive their health care from the Indian Health Service (HEW) and more recently from tribally run health programs as well. NHI, as the largest health program ever adopted by the Federal government, promises to have a major impact on the Indian health programs. NHI could be of great benefit to Indian people, helping them to improve their level of health, which is now the lowest of any population group in the country. On the other hand, NHI could result in great harm to the Indian people, destroying the existing Indian health system, which they wish to retain and to which they are entitled. These issues must be resolved before NHI legislation is adopted.

Indian tribes, health boards and organizations have spent more than a year analyzing the various NHI proposals and discussing their possible impact on the Indian health system. Out of this effort, the Indian community has developed a consensus Indian position on NHI. The position, which is presented herein, is in the form of certain basic principles that the Indian community believes must be incorporated into any NHI legislation to insure that it benefits Indian health and does not diminish the level of health service now available to Indian people. Whatever NHI approach is adopted by the Federal government, it must, in the legislation, recognize and build on the

dual rights and status that Indians hold.

II. Statement of Position

The core of the Indian consensus position is that Indians should not be included in the basic NHI program, so that Indians can continue to build their own unique Indian health programs. However, a section of the NHI legislation must specifically address Indian concerns by (1) reaffirming Indian people's right to their special Indian program; (2) defining the relationship between NHI and Indian health program; and (3) strengthening the IHS by incorporating several of the basic elements of NHI into the IHS system so as to achieve equity between Indian health programs and those available to all other Americans. In particular, the NHI legislation should amend the IHS legislation to provide a guaranteed benefit package within IHS comparable to the one that will be offered other Americans through NHI.

NHI legislation must also recognize and preserve the principles of tribal sovereignty and tribal self-determination. It must also define the relationship between non-reservation Indian health programs and NHI.

Because the Indian health system is unique, the principles set out will not fit precisely into NHI legislation; instead it will require a separate section dealing specifically with Indians. However, because of the significant impact NHI could have on the existing Indian health care system, we believe that this separate section is justifiable, and in order to protect Indian rights,

the Indian community considers it essential. Since the final shape of the NHI legislation has not yet been determined, it was not possible to provide specific legislative language. However, when the final form of NHI is determined, representatives of the Indian community will be pleased to work with the Federal government to transform the basic principles contained in their position into concrete statutory language.

III. The Indian Position on NHI

Principle # 1: The NHI legislation must specifically support the continuation of the IHS-tribal-urban Indian health system as the special Federal mechanism for financing and delivering health services to Indians; and as such, NHI must not, in any way, become a substitute or supplement for this financing mechanism or be used to replace or weaken this delivery system.

The NHI legislation must reaffirm the legal, historical, and moral Federal responsibility for health care to Indians through the IHS-tribal-urban financing and delivery system. In the Indian Health Care Improvement Act, the Congress once again recognized the special legal and historical relationship that has existed between Indians and the Federal government for over 160 years. The Act states: Sec. 2 The Congress finds that:

- (a) " Federal Indian health services to maintain and improve the health of Indians are consonant with and required by the Federal government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."

This responsibility has been carried out through the direct financing of Indian health programs by Congress to IHS and the direct delivery of health services to Indians by IHS and tribal health programs. NHI must not be used as a total or partial substitute for or supplement to this direct financing method. Nor must NHI contain any provision which directly or indirectly, could lead to a dismantling of the direct delivery system.

There have been recommendations that NHI become a source of funding to IHS and tribal programs, e.g., that NHI reimbursement to IHS could become a partial substitute or even supplement, for the direct appropriation IHS now receives from Congress. There have also been suggestions that if Indians were given NHI "credit cards", they could purchase health care through the private provider system and there would no longer be a need for a direct Indian delivery system. It is the Indian consensus position that any step in either of these directions is totally unacceptable.

The need for the continuation of the existing delivery and financing system is explained below:

A. The Direct Delivery System

The IHS-tribal delivery system of hospitals, clinics, staff, outreach and preventive programs, etc. must be continued because;

- (1) It is the only health system available to the majority of Indian people and no NHI proposal provides for the establishment of a delivery

system that could replace IHS. If NHI was used as the basis for dismantling the IHS delivery system, Indians would be required to depend on the private medical system which has demonstrated that it is neither willing nor able to serve the remote areas where most reservations are located and to provide culturally sensitive services to Indian people.

- (2) The Federal policy of Indian Self-Determination offers tribes the option of assuming policy and/or operational control of the IHS programs serving their people--if the tribe wants to assume the responsibility and at a pace determined solely by the tribe. Dismantling the IHS delivery system would leave no program over which tribes could exercise their right to Self-Determination.

B. The Existing Financing Mechanism

The existing financing mechanism must be maintained because:

- (1) Direct Federal financing of health services to Indians, from Congress to IHS, is the clear and visible manifestation of the special Federal commitment to Indians on health. Our history has shown us that as soon as a separate appropriation for Indians

is eliminated, all of the rights and obligations that accompany that appropriation are quickly forgotten. The Indian situation is a unique one, and a separate appropriation is the only mechanism that has ever guaranteed proper consideration of our special situation. Since there is no intrinsic merit in switching appropriation sources and since any perceived collateral benefit cannot sufficiently compensate for the dangers such a switch poses to the Indian people, it is the consensus Indian position that NHI should not, in any way or amount, become a financing substitute or supplement for direct appropriations to IHS and tribal health programs.

- (2) The Indian health financing and the delivery systems must be kept unified if there is to be proper accountability--to the Congress, and to the Indian people. Since the source of funding is ultimately the same, it makes little sense to develop a complicated and confusing series of channels and levels in order to "involve" IHS and Indians in NHI. Such a system would be administratively

awkward, would impose additional administrative costs, and by separating delivery and financing, would make accountability that much more difficult.

- (3) IHS provides a range of services that are not covered under any NHI proposal--environmental and sanitation services, community involvement, special outreach services, etc. If the IHS financing system was replaced by NHI, Indians would end up receiving fewer services than are now available to them--thereby adding to the serious health problems which Indians are already facing.

Principle # 2: Indian people should be exempted from any compulsory NHI financing charge. Indians do not have to pay now for their use of IHS and tribal health services. As stated by the Director of IHS, "IHS is like an HMO, in that Indians have prepaid for their services many times over--with their land, water, and resources". Since Indians will be continuing to use IHS-tribal services, it would be unjust to suddenly begin to charge them for the health services that they have always received at no cost. It would also be in violation of the special Federal obligation to Indians.

Indians are presently required to pay the Medicare payroll tax and many elderly Indians also, unknowingly, pay the monthly Medicare premium. Yet, because they have IHS, their utilization

of Medicare is extremely low. As a result they end up subsidizing the Medicare program. This situation must not be repeated under NHI.

Therefore, the legislation should specifically provide an exemption from compulsory financing charges for Indians who use IHS-tribal services. However, voluntary participation in NHI should be left open to those Indians who would prefer to use non-IHS-tribal services or for whom IHS facilities may not be convenient.

Principle # 3: Certain elements of the NHI approach, the guaranteed benefit package, the individual's entitlement to that package, and prospective funding to implement that guarantee should be incorporated into the IHS system in conjunction with the adoption of NHI.

IHS is the Indians' own health system and we want it to be continued; but we also want it strengthened. IHS, which assumed the Federal responsibility for health care to Indians in 1955, is severely underfunded at the present time. Its own internal review found that its existing appropriation allows it to provide only 53% of the services it is supposed to be providing to Indian people. This severe underfunding means that many Indians who need surgical procedures get put on waiting lists and must wait 2-3 years to receive them (the infamous IHS surgery backlog). In the outpatient clinics, it means long waiting lines, overworked staff, rushed examinations, and insufficient equipment to perform necessary tests and diagnoses. The end result is an inadequate health delivery system which causes

unnecessary death, deterioration of health, and suffering among the Indian people.

Statistics show that the rate of tuberculosis for Indians and Alaska Natives is 6.5 times higher than the rate for all other U.S. citizens; the rate for diabetes is at least three times higher than all other U.S. citizens; and while respiratory and gall bladder illness statistics are not reported in the general population, Indian Health Service officials state emphatically that the rates for these diseases among Indians and Alaska Natives are significantly higher than that of the general population. Otitis Media, an infection of the inner ear, continues to be a leading cause of disability among Indians and Alaska Natives. Although surgical treatment can generally prevent the long-term and serious disabilities of deafness and learning disabilities resulting from Otitis Media, only a fraction of this essential surgery is now being provided. The infant mortality rate among Indians is 1.1 times the national average, while the Indian birth rate continues at a rate twice that of other Americans.

Indian communities have an extremely high incidence of mental illness, alcoholism, accidents, homicide, and suicide. The suicide rate within Indian communities is approximately twice as high as the total U.S. population and the Indian and Alaska Native have an average life span of 65.1 years, while every other American can expect to live to the age of at least 70.8 years.

The underlying cause of this situation can be traced to certain

inadequacies in the IHS authorizing statute and appropriation system. The IHS authorizing legislation does not contain a guaranteed health benefit package--the specified list of covered basic health services that is found in all NHI proposals. Instead, it simply authorizes services "for the relief of distress and conservation of health" (42 USC 13, The Snyder Act).

More importantly, the IHS appropriation process is not structured in a manner that insures IHS the funding necessary to provide a basic benefit package to all Indians who need basic medical services. IHS does not have the open-ended funding that is available to Medicaid. Nor is its appropriation determined through the prospective funding method recommended in many NHI approaches--where a facility's funding from NHI funds would be directly tied to its projection of expected utilization by its client population. Rather, IHS is funded on an "historical budget", which has no rational relationship to the actual rate of utilization of IHS services by the Indian population. The "historical budget" consists of the arbitrary base amount IHS was allocated in 1955, (when it was established in HEW) plus the annual increases it has been given since then. While at times the increases have been generous (in a relative sense), they too have been arbitrary in that they were based on the previous year's budget which was arbitrary to begin with and never on a determination of actual utilization rates and the actual cost of providing those utilized services.

The result of this "historical budget" is IHS' present situation

in which it is trying to "squeeze" all needed services into a budget that realistically can pay for only 53% of them; with the long backlog of needed surgery, overcrowded and underequipped facilities, unnecessary deaths and disabilities, etc.

This situation is in conflict with the principles behind and the mechanics of most NHI approaches. One of the motivating principles behind NHI is that every American should have financial access to at least the basic kinds of health services; e.g., no American should have to wait 2-3 years for needed surgery. NHI guarantees that funds will be available to pay for the services specified in the benefit package whenever a person needs those services. Many of the NHI approaches recommend that hospitals and other health facilities be reimbursed through a prospective funding mechanism; a facility will project its expected utilization for the coming year for NHI covered services, estimate the cost of providing those services, and then be given that amount by NHI (with adjustments to be made at the end of the year). This is in direct contrast to the way IHS is funded; it is given an arbitrary amount and then required to provide all need services--whether demand is for one, a hundred, or a thousand of those services . To permit IHS to continue to operate under this system, while all other Americans have a guaranteed benefit package, is truly to relegate Indians to a second class status in health because of their desire to retain their special relationship with the Federal government.

It is therefore, the consensus Indian position that the benefit package contained in the NHI Act should also be guaranteed to Indians through IHS. The special Indian section of the NHI legislation should amend the IHS authorizing legislation to 1) incorporate a benefit package into the IHS program comparable to that provided by NHI to all other Americans; and 2) establish an appropriation mechanism that guarantees IHS the funding needed to provide the services in the benefit package to all covered Indians. That is, the legislation should require IHS to project the number of NHI covered services it will have to provide in the forthcoming year and the cost of providing those services. IHS would then automatically be entitled to have that amount appropriated to it by Congress through IHS' existing appropriation channels, (the Subcommittees on Interior and Insular Affairs of the House and Senate Appropriations Committees). Funds for services which IHS provides but which are not covered in the NHI benefit package would continue to be appropriated in the same manner as they are now. The legislation should also define eligibility for the IHS benefit package to include all federally-recognized Indians.

Principle # 4: Indian tribal governments must be recognized as the appropriate governmental entities for administration of health programs on their reservations. The NHI legislation must not give State governments authority or jurisdiction over Indians or Indian health programs.

Various NHI approaches propose to rationalize the health system in this country through increased governmental regulation. Many of these proposals would give state and local governments a significant role in this increased regulation--planning, institutional certification, monitoring, fee-setting, etc. None of these proposals recognize the sovereign status of Indian tribes or prohibit state and local governments from exercising these regulatory powers on Indian reservations. Thus the regulatory portion of NHI promises to erode the sovereignty of Indian tribal governments. These provisions must be changed to reflect the sovereign status of Indian tribes.

An unbroken line of court cases over a period of 150 years has recognized the sovereign status of Indian tribal governments over Indian reservations, and the complete exclusion of state governments. The cases have ruled that states cannot exercise civil or criminal jurisdiction over Indians on reservations, cannot tax Indians, and generally cannot exercise any other authority over Indians living on Indian lands.

The Federal government has recognized the importance of tribal sovereignty to the future of Indian people. In recent statutes, Congress has included specific language to protect tribal sovereignty and to prevent state erosion of it. For example, in the National Health Planning and Resources Development Act, tribal health programs were specifically exempted from the authority of Health Systems Agencies to review and approve proposals for Federal health funding.

Therefore, it is the consensus Indian position that Indian tribal governments be given the sole authority for regulating health programs, funds, and resources, and carrying out any other governmental function on their reservations; and that State governments be given no authority under NHI to carry out governmental functions on Indian reservations.

Principle # 5: The principles of Indian tribal Self-Determination must be incorporated in NHI legislation.

The Federal government has formally adopted the policy of Self-Determination for Indian tribes. As established by the Indian Self-Determination Act of 1975 (P.L. 93-638), Indian tribes, not the Federal government, are to make determinations regarding the needs and priorities of their tribal members; the Federal government will respect those determinations and will assist tribes in developing the capability to implement tribal goals and objectives. The principles must be incorporated into NHI, in so far as NHI affects health care to Indians, in the following manner:

The Self-Determination Act gives the tribes the option of taking over BIA and IHS programs and running them as tribal programs. The Act and the Regulations specifically state that the Federal government will not require tribes

to take over Federal programs; it is a function of the tribe to decide if it wants to do so and how and when it wants to do so. NHI must not be used to compel tribes to assume responsibility for IHS health programs at a pace different or faster than that determined by the tribe. NHI must not be structured to reward tribes that take over IHS programs and to punish tribes that do not. Health benefits to Indians must flow equally to them, whether the health program on their reservation is administered by the tribe or by IHS.

Tribes must also be given authority to revise or adapt IHS standards for the delivery of health care in order to make that delivery more responsive to the tribe's values and traditional methods of providing for the health of its people.

Resources must be made available to tribes so they will have capabilities to carry out these functions. Under the National Health Planning Act, the Federal government authorized the creation of Health Systems Agencies throughout the country to carry out health planning for their areas. The Act set the minimum level of staff and staff competency required to perform these planning tasks and then provided the HSA's with the funding needed to obtain this competency. The Act also established Health Planning Centers to provide backup to the HSA's. No comparable program has been

established to enable tribes to obtain an equivalent level of competency. Most tribal health boards have no full-time staff; tribal health departments have no steady and adequate source of funding to permit them to meet their Self-Determination responsibilities. It is the Indian consensus position that Congress must provide Indian tribes with resources and backup support comparable to that provided HSA's so that tribes will have the capability to carry out their responsibilities under NHI, responsibilities which appropriately should reside in the tribe under the principles of Indian Self-Determination.

Principle # 6: Urban Indian Health Programs must be designated as eligible providers for the purpose of receiving reimbursement from both IHS and NHI when those clinics provide covered services to eligible persons.

Non-reservation Indian people usually have little direct access to Indian Health Service and are largely dependent on the non-Indian health care system. In some urban areas there are Indian health programs that provide some health services to Indians. At present urban Indian health programs do not have sufficient funds to deliver the quantity and range of services required. Hence, National Health Insurance is regarded by many non-reservation Indians as a means by which they can obtain greater access to care. Similarly urban Indian health programs are generally looking to National Health Insurance as an additional source of funds.

According to the 1970 U.S. Census report. 48% of the total Indian population resided in urban areas. Current estimates indicate the total population now residing in urban areas exceeds 50% of the total Indian population. The current IHS budget is only sufficient to serve 53% of the health needs of reservation based people. This means that up to 75% of the total Indian population does not receive adequate health care and could not if needed.

Indian people residing in urban areas have relocated mainly because of economic reasons. However, the move to the city has not always led to an improved standard of living. In many cases it has represented a diminished standard of living from that which they experienced prior to moving to urban areas. Poverty among Indian people in cities ranges from 30% to over 50%.

The fact that there is a high degree of poverty among Indians directly affects their ability to obtain health care. Accessibility to health care in cities is primarily based on ability to pay. Most hospitals in cities require proof of ability to pay prior to admittance. This fact alone prohibits many urban Indian people from seeking health care from local health providers, i.e., state, city, county, or PHS hospitals or clinics. This lack of low cost health providers oftentimes forces Indian people to do without health care rather than face the embarrassment of being denied health care by the existing systems. In some areas Indian

people can use existing IHS facilities if they present themselves. But to make use of these facilities requires time off, loss of pay, travel ranging from 40 to 140 miles, and the added expense of that travel.

Congress, during recent years has recognized the need to provide some form of health care for Indians in urban areas and has begun appropriating limited funds supporting urban Indian health programs in a number of cities across the country. These programs, which have been delivering primary health care services to Indian people since 1970, are non-profit private organizations, directed by Indian consumers and providers. Also, some of the urban Indian health programs serve as contract providers for the IHS and are reimbursed for care provided to IHS eligible Indians. NHI legislation must not change this already established relationship as it concerns Indians eligible to receive care under the IHS financed benefit package.

Recognizing the fact that IHS funding is inadequate, the lack of low cost health providers, and that urban Indian people are denied accessibility to the existing systems because of inability to pay, the existing demand for health care is great. The creation of NHI will increase demands for health care which the existing health delivery systems will be inadequate to meet. For this reason, urban Indian health programs must be continued to assure Indian people in cities of the availability and accessibility of health care.

NATIONAL INDIAN POSITION
ON
NATIONAL HEALTH INSURANCE

(as amended at the
Second National
Indian/Alaska Native
Health Conference)

I. Introduction

American Indians and Alaska Natives, along with other citizens have been concerned about the planned adoption of a National Health Insurance Program in this country. On the basis of their unique legal, historical and moral relationship with the Federal government, Indians receive their health care from the Indian Health Service (HEW) and more recently from tribally run health programs as well. NHI, as the largest health program ever adopted by the Federal government, promises to have a major impact on Indian health programs. NHI could be of great benefit to Indian people, helping them to improve their level of health, which is now the lowest of any population group in the country. On the other hand, NHI could result in great harm to the Indian people, destroying the existing Indian health system, which they wish to retain and to which they are entitled. These issues must be resolved before NHI legislation is adopted.

Indian tribes, health boards, and organizations have spent more than a year analyzing the various NHI proposals and discussing their possible impact on the Indian health system. Out of this effort, the Indian community has developed a consensus Indian position on NHI. The position, which is presented herein, is in the form of certain basic principles that the Indian community believes must be incorporated into any NHI legislation to insure that it benefits Indian health and does not diminish the level of health services now available to Indian people. Whatever NHI approach is adopted by the Federal government, it must, in the legislation, recognize and build on the

dual rights and status that Indians hold.

II. Statement of Position

The core of the Indian consensus position is that Indians should not be included in the basic NHI program, so that Indians can continue to build their own unique Indian health programs. However, a section of the NHI legislation must specifically address Indian concerns by (1) reaffirming Indian people's right to their special Indian program; (2) defining the relationship between NHI and Indian health program; and (3) strengthening the IHS by incorporating several of the basic elements of NHI into the IHS system.

NHI legislation must also recognize and preserve the principles of tribal sovereignty and tribal self-determination. It must also define the relationship between non-reservation Indian health programs and NHI.

Because the Indian health system is unique, the principles set out will not fit precisely into NHI legislation; instead it will require a separate section dealing specifically with Indians. However, because of the significant impact NHI could have on the existing Indian health care system, we believe that this separate section is justifiable, and in order to protect Indian rights, the Indian community considers it essential. Since the final shape of the NHI legislation has not yet been determined, it was not possible to provide specific legislative language. However, when the final form of NHI is determined, representatives of the Indian community will be pleased to work with the Federal government to transform the basic principles contained in their position into concrete statutory language.

III. The Indian Position on NHI

Principle # 1: The NHI legislation must specifically support the continuation of the IHS-tribal-urban Indian health system as the special Federal mechanism for financing and delivering health services to Indians; and as such, NHI must become a supplement for this financing mechanism to the delivery system.

The NHI legislation must reaffirm the legal, historical, and moral Federal responsibility for health care to Indians through the IHS-tribal-urban financing and delivery system. In the Indian Health Care Improvement Act, the Congress once again recognized the special legal and historical relationship that has existed between Indians and the Federal government for over 160 years. The Act states: Sec. 2 The Congress finds that:

- (a) "Federal Indian health services to maintain and improve the health of Indians are consonant with and required by the Federal government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."

This responsibility has been carried out through the direct financing of Indian health programs by Congress to IHS and the direct delivery of health services to Indians by IHS and tribal health programs. NHI must be used as a total supplement to this direct financing method. NHI must not contain any provision which directly or indirectly, leads to a dismantling of the IHS direct delivery system.

The need for the continuation of the existing delivery and financing system is explained below:

A. The Direct Delivery System

The IHS-tribal delivery system of hospitals, clinics, staff, outreach and preventive programs, etc. must be continued because:

- (1) It is the only health system available to the majority of Indian people and no NHI proposal provides for the establishment of a delivery system that could replace IHS. If NHI was used as the basis for dismantling the IHS delivery system, Indians would be required to depend on the private medical system which has demonstrated that it is neither willing nor able to serve the remote areas where most reservations are located and to provide culturally sensitive services to Indian people.
- (2) The Federal policy of Indian Self-Determination offers tribes the option of assuming policy and/or operational control of the IHS programs serving their people--if the tribe wants to assume the responsibility and at a pace determined solely by the tribe. Dismantling the IHS delivery system would leave no program over which tribes could exercise their right to Self-Determination.

B. The Existing Financing Mechanism

The existing financing mechanism must be maintained because:

- (1) Direct Federal financing of health services to Indians, from Congress to IHS, is the clear and visible manifestation of the special Federal commitment to Indians on health. Our history has shown us that as

soon as a separate appropriation for Indians is eliminated, all of the rights and obligations that accompany that appropriation are quickly forgotten. The Indian situation is a unique one, and a separate appropriation is the only mechanism that has ever guaranteed proper consideration of our special situation. Since there is no intrinsic merit in switching appropriation sources and since any perceived collateral benefit cannot sufficiently compensate for the dangers such a switch poses to the Indian people, it is the consensus Indian position that NHI should become a financing supplement for direct appropriations to IHS and tribal health programs.

- (2) The Indian health financing and the delivery systems must be kept unified if there is to be proper accountability--to the Congress, and to the Indian people. Since the source of funding is ultimately the same, it makes little sense to develop a complicated and confusing series of channels and levels in order to "involve" IHS and Indians in NHI. Such a system would be administratively awkward, would impose additional administrative costs, and by separating delivery and financing, would make accountability that much more difficult.
- (3) *IHS provides a range of services that are not*

covered under any NHI proposal--environmental and sanitation services, community involvement, special outreach services, etc. If the IHS financing system was replaced by NHI, Indians would end up receiving fewer services than are now available to them--thereby adding to the serious health problems which Indians are already facing.

Principle # 2: Indian people should be exempted from any compulsory NHI financing charge. Indians do not have to pay now for their use of IHS and tribal health services. As stated by the Director of IHS, "IHS is like an HMO, in that Indians have prepaid for thier services many times over--with their land, water, and resources". Since Indians will be continuing to use IHS-tribal services, it would be unjust to suddenly begin to charge them for the health services that they have always received at no cost. It would also be in violation of the special Federal obligation to Indians.

Indians are presently required to pay the Medicare payroll tax and many elderly Indians also, unknowingly, pay the monthly Medicare premium. Yet, because they have IHS, their utilization of Medicare is extremely low. As a result they end up subsidizing the Medicare program. This situation must not be repeated under NHI.

Therefore, the legislation should specifically provide an exemption from compulsory financing charges for Indians who use IHS-tribal services. However, voluntary participation in NHI should be left open to those Indians who would prefer to use non-IHS-tribal services or for whom IHS facilities may not be convenient.

Principle # 3: Certain elements of the NHI approach, the guaranteed benefit package, the individual's entitlement to that package, and prospective funding to implement that guarantee should be incorporated into the IHS system in conjunction with the adoption of NHI.

IHS is the Indians' own health system and we want it to be continued; but we also want it strengthened. IHS, which assumed the Federal responsibility for health care to Indians in 1955, is severely underfunded at the present time. Its own internal review found that its existing appropriation allows it to provide only 53% of the services it is supposed to be providing to Indian people. This severe underfunding means that many Indians who need surgical procedures are placed on waiting lists and must wait 2-3 years to receive them (the infamous IHS surgery backlog). In the outpatient clinics, it means long waiting lines, overworked staff, rushed examinations, and insufficient equipment to perform necessary tests and diagnoses. The end result is an inadequate health delivery system which causes unnecessary death, deterioration of health, and suffering among the Indian people.

Statistics show that the rate of tuberculosis for Indians and Alaska Natives is 6.5 times higher than the rate for all other U.S. citizens; the rate for diabetes is at least three times higher than all other U.S. citizens; and while respiratory and gall bladder illness statistics are not reported in the general population, Indian Health Service officials state emphatically that the rates for these diseases among Indians and Alaska Natives are significantly higher than that of the general population. Otitis Media, an infec-

tion of the inner ear, continues to be a leading cause of disability among Indians and Alaska Natives. Although surgical treatment can generally prevent the long-term and serious disabilities of deafness and learning disabilities resulting from Otitis Media, only a fraction of this essential surgery is now being provided. The infant mortality rate among Indians is 1.1 times the national average, while the Indian birth rate continues at a rate twice that of other Americans.

Indian communities have an extremely high incidence of mental illness, alcoholism, accidents, homicide, and suicide. The suicide rate within Indian communities is approximately twice as high as the total U.S. population and the Indian and Alaska Native have an average life span of 65.1 years, while every other American can expect to live to the age of at least 70.8 years.

The underlying cause of this situation can be traced to certain inadequacies in the IHS authorizing statute and appropriation system. The IHS authorizing legislation does not contain a guaranteed health benefit package--the specified list of covered basic health services that is found in all NHI proposals. Instead, it simply authorizes services "for the relief of distress and conservation of health" (42 USC 13, The Snyder Act).

More importantly, the IHS appropriation process is not structured in a manner that insures IHS the funding necessary to provide a basic benefit package to all Indians who need basic medical services. IHS does not have the open-ended funding that is available to Medicaid. Nor is its appropriation determined through the prospective funding method recommended in many NHI approaches--where a facility's funding

from NHI funds would be directly tied to its projection of expected utilization by its client population. Rather, IHS is funded on an "historical budget" which has no rational relationship to the actual rate of utilization of IHS services by the Indian population. The "historical budget" consists of the arbitrary base amount IHS was allocated in 1955, (when it was established in HEW) plus the annual increases it has been given since then. While at times the increases have been generous (in a relative sense), they too have been arbitrary in that they were based on the previous year's budget which was arbitrary to begin with and never on a determination of actual utilization rates and the actual cost of providing those utilized services.

The result of this "historical budget" is IHS' present situation, in which it is trying to "squeeze" all needed services into a budget that realistically can pay for only 53% of them; with the long backlog of needed surgery, overcrowded and underequipped facilities, unnecessary deaths and disabilities, etc.

This situation is in conflict with the principles behind and the mechanics of most NHI approaches. One of the motivating principles behind NHI is that every American should have financial access to at least the basic kinds of health services; e.g., no American should have to wait 2-3 years for needed surgery. NHI guarantees that funds will be available to pay for the services specified in the benefit package whenever a person needs those services. Many of the NHI approaches recommend that hospitals and other health facilities be reimbursed through a prospective funding mechanism; a facility will project its expected utilization for the coming year for NHI covered services, estimate the cost of providing those services, and then be given that amount by NHI (with adjustments to be made at the end of the

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NOTE: THE NATIONAL INDIAN POSITION ON NATIONAL HEALTH INSURANCE WAS FURTHER AMENDED AT THE 35TH ANNUAL CONVENTION OF THE NATIONAL CONGRESS OF AMERICAN INDIANS, SEPTEMBER 21, 1978. COPIES MAY BE OBTAINED FROM NCAI.

ADDENDUM

NIHB: Working for Improved Indian Health

Since its formation in 1972, the major programs and activities of the National Indian Health Board, Inc. (NIHB) have advocated that "health care services delivered to Indian Americans and Alaska Natives should be of the highest quality and of sufficient quantity so that Indian Americans and Alaska Natives attain an equal or better health condition than other American citizens."

As a means of achieving this, NIHB is organized to "review and comment on all national policies proposed by the Indian Health Service and other federal agencies which serve or should be serving American Indians and Alaska Natives, and to recommend services provided by those agencies to American Indians and Alaska Natives."

Thus, the primary thrust of NIHB activities in the past has been interest in developing projects related to Indian health programs and provision of advisory, consultative and guidance functions for the Indian Health Service.

Advisory functions include advising the Director of Indian Health Service on all matters impacting on the relationship of IHS and American Indians and Alaska Natives relating to health affairs, National Health Insurance, the interrelationship of P.L. 94-437 with P.L. 93-638 (the Indian Self-Determination and Education Assistance Act), and the National Health Planning and Resource Development Act (P.L. 93-641).

NIHB also provides a liaison system between area health boards and the Indian Health Service.

It also functions to review Indian health budget materials, implementation activities of the Indian Health Care Improvement Act, policies and procedures of Indian Health Service and complaints of Indian consumers and beneficiaries.

NIHB performs its review and advisory functions through quarterly board of directors meetings. Board resolutions on health and health-related matters later form a guide for IHS-Indian relationships in health affairs.

Composed of 12 members, the Board of Directors represents all geographically-defined regional IHS areas, with representatives selected by their area health boards.

In addition to continuing such work, with its staff capabilities expanded over the past year, the focus of NIHB efforts has shifted toward increased involvement with legislation impacting on Indian health and social welfare and on increased dissemination of information and assistance to tribal people and their health boards.

More specifically, NIHB staff continue to closely monitor National Health Insurance developments and, working closely with the NHI Core Group (composed of tribal and national Indian organization represent-

atives), are seeking to insure that the Indian viewpoint is included in whatever plan is finally adopted. NIHB staff presented testimony before a national hearing on the NHI issue, have attended meetings of HEW Secretary Califano's task force (along with securing an Indian representative on the same) and have actively participated in HEW hearings soliciting the views of Indian people locally around the country.

NIHB has also made its position known, appearing either before commission or congressional committee hearings, on full funding for the Indian Health Care Improvement Act, S. 1214: the Indian Child Welfare Act of 1977, and protection of human subjects in health care programs delivered under DHEW.

Through numerous mailings and through its recently - developed monthly newsletter, the NIHB Health Reporter, the organization has attempted to advise Indian people of significant health-related hearings on their own areas and keep them informed about the implications of the subjects involved. NIHB staff persons have remained available to provide additional information or assistance as requested by tribal groups, health departments and boards.

In the future, NIHB will stress the continuation of cooperation and interaction, not only with IHS, but with tribal organizations and Indian health organizations which share the mutual concern of improving the health status of American Indians and Alaska Natives. To this end, specific NIHB planning objectives include:

--Advocate the continuance of IHS health care services as a federal obligation based on treaties and laws which have been reaffirmed by congressional and executive action.

--Promote Native American participation in implementation of the Indian Health Care Improvement Act.

--Serve as the primary advocate for health board training and technical assistance.

--Promote close coordination with area health boards, service unit boards, the National Tribal Chairmen's Association, the National Congress of American Indians, the American Indian Health Care Association and other groups and organizations concerned with improvement of the health status of Indian Americans and Alaska Natives. Offer sponsorship of joint meetings with these groups and organizations on health matters of mutual interest and concern.

--Implement a communications system for providing all health boards with information on new health developments and serve as the source of health information for Indians. Provide a clearinghouse of information on the national Indian position on National Health Insurance. Provide ongoing consultation with IHS and Indian communities regarding pending NHI legislation.

--Serve as a clearinghouse for information on P.L. 93-641: the National Health Planning and Resources Development Act.

--Sustain an organized voice and active participation in decisions, developments, and implementation of IHS policies. Improve existing methods, programs and efforts through which NIHB and IHS continue to identify health gaps.

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