Calendar No. 128

94TH CONGRESS
1st Session

SENATE

REPORT
No. 94-133

INDIAN HEALTH CARE IMPROVEMENT ACT

REPORT

OF THE

COMMITTEE ON INTERIOR AND INSULAR AFFAIRS UNITED STATES SENATE

together with

ADDITIONAL VIEWS

TO ACCOMPANY

S. 522

MAY 13 (legislative day, APRIL 21), 1975.—Ordered to be printed

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94TH CONGRESS
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REPORT
No. 94-133

INDIAN HEALTH CARE IMPROVEMENT ACT

MAY 13 (legislative day), APRIL 21.—Ordered to be printed

Mr. JACKSON, from the Committee on Interior and Insular Affairs, submitted the following

REPORT

together with additional views

[To accompany S. 522]

The Committee on Interior and Insular Affairs, to which was referred the bill (S. 522) to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill, as amended, do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert the following language:

That this Act may be cited as the "Indian Health Care Improvement Act".

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FINDINGS

SEC. 2. The Congress finds that—

(a) Federal health services to maintain and improve the health of the 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.

(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

(c) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

(d) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States. For example, for Indians compared to all Americans in 1971, the tuberculosis death rate was over four and one-half times greater, the influenza and pneumonia death rate over one and one-half times greater, and the infant death rate approximately 20 per centum greater.

(e) All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.

(f) Further improvement in Indian health is imperiled by—

(1) inadequate, outdated, inefficient, and undermanned facilities. For example, only twenty-four of fifty-one Indian Health Service hospitals are accredited by the Joint Commission on Accreditation of Hospitals; only thirty-one meet national fire and safety codes; and fifty-two locations with Indian populations have been identified as requiring either new or replacement health centers and stations, or clinics remodeled for improved or additional service;

(2) shortage of personnel. For example, about one-half of the Service hospitals, four-fifths of the Service hospital outpatient clinics, and one-half of the Service health clinics meet only 80 per centum of staffing standards for their respective services;

(3) insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and mental health services, and services available through contracts with private physicians, clinics, and agencies. For example, about 90 per centum of the surgical operations needed for otitis media have not been performed, over 57 per centum of required dental services remain to be provided, and about 98 per centum of hearing aid requirements are unmet;

(4) related support factors. For example, over seven hundred housing units are needed for staff at remote Service facilities;

(5) lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climatic conditions; and

(6) lack of safe water and sanitary waste disposal services. For example, over thirty-seven thousand four hundred existing, and forty-eight thousand nine hundred and sixty planned replacement and renovated Indian housing units need new or upgraded water and sanitation facilities.

(g) The Indian people's growth of confidence in Federal Indian health services is revealed by their increasingly heavy use of such services. Progress toward the goal of better Indian health is dependent on this continued growth of confidence. Both such progress and such confidence are dependent on improved Federal Indian health services.

DECLARATION OF POLICY

SEC. 3. The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

DEFINITIONS

SEC. 4. For purposes of this Act—

(a) "Secretary", unless otherwise designated, means the Secretary of Health, Education, and Welfare.

(b) "Service" means the Indian Health Service.

(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 102, 103, 104(b)(1)(i), and 201(c)(5), such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group as defined in the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection (c) (1) through (4) of this section.

(g) "Urban center" means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, composed of urban Indians, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

TITLE I—INDIAN HEALTH MANPOWER

PURPOSE

SEC. 101. The purpose of this title is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the Service and private practice among Indians.

HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 102. (a) The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities or Indian tribes or tribal organizations to assist such entities in meeting the costs of—

(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them (A) to enroll in schools of medicine, osteopathy, denistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions; or (B), if they are not qualified to enroll in any such school, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

(2) publicizing existing sources of financial aid available to Indians enrolled in any school referred to in clause (1) (A) of this subsection or who are undertaking training necessary to qualify them to enroll in any such school; or

(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians, and the subsequent pursuit and completion by them of courses of study, in any school referred to in clause (1) (A) of this subsection.

(b) (1) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(2) The amount of any grant under this section shall be determined by the Secretary. Payments pursuant to grants under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

(c) For the purpose of making payments pursuant to grants under this section, there are authorized to be appropriated $1,500,000 for fiscal year 1977, $2,500,000 for fiscal year 1978, $3,000,000 for fiscal year 1979, $4,000,000 for fiscal year 1980, $4,500,000 for fiscal year 1981, $5,000,000 for fiscal year 1982, and $4,500,000 for fiscal year 1983.

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS

SEC. 103. (a) The Secretary, acting through the Service, shall make scholarship grants to Indians who—

(1) have successfully completed their high school education or high school equivalency; and

(2) have demonstrated the capability to successfully complete courses of study in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions.

(b) Each scholarship grant made under this section shall be for a period not to exceed two academic years, which years shall be the final two years of the preprofessional education of any grantee.

(c) Scholarship grants made under this section may cover costs of tuition, books, transportation, board, and other necessary related expenses.

(d) There are authorized to be appropriated for the purpose of this section: $2,000,000 for fiscal year 1977, $2,500,000 for fiscal year 1978, $3,000,000 for fiscal year 1979, $3,500,000 for fiscal year 1980, $4,000,000 for fiscal year 1981, $4,500,000 for fiscal year 1982, and $4,500,000 for fiscal year 1983.

HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

SEC. 104. (a) The Secretary, acting through the Service, shall make scholarship grants to individuals (i) who are enrolled in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions (including schools certified by the Secretary as capable of training individuals in Indian traditional medicine), and (ii) who agree to provide their professional services to Indians after the completion of their professional training.

(b) (1) The Secretary, acting through the Service. (i) shall accord priority for scholarship grants under this section to applicants who are Indians, and (ii) may determine distribution of scholarship grants on the basis of the relative needs of Indians for additional service in specific health professions.

(2) Each scholarship grant under this section shall (i) fully cover the costs of tuition, and (ii), when taken together with the financial resources of the grantee, fully cover the costs of books, transportation, board, and other necessary related expenses: *Provided,* That the amount of grant funds available annually to each grantee under clause (ii) shall not exceed $8,000, except where the scholarship grant is extended to cover the period between academic years pursuant to paragraph (3) of this subsection.

(3) Scholarship grants under this section shall be made with respect to academic years, except that any such grant may be extended and increased for the period between academic years if the grantee is engaged in clinical or other practical experience related to his or her course of study and if further grant assistance during such period is required by the grantee because of his or her financial need.

(c)(1) As a condition for any scholarship grants under this section, each grantee shall be obligated to provide professional service to Indians for a period of years equal to the number of years during which he or she receives such grants.

(2) For the purpose of clause (1) of this subsection, "professional service to Indians" shall mean employment in the Service or in private practice where, in the judgment of the Secretary in accordance with guidelines promulgated by him, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians. Periods of internship or residency, except residency served in a facility of the Service, shall not constitute fulfillment of this service obligation.

(3)(A) A service obligation of any individual pursuant to this section shall be canceled upon the death of such individual.

(B) The Secretary shall by regulation provide for the waiver or suspension of a service obligation of any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.

(d) Individuals receiving scholarship grants under this section shall not be counted against any employment ceiling affecting the Service or the Department of Health, Education, and Welfare.

(e) There are authorized to be appropriated for the purpose of this section: $6,000,000 for fiscal year 1977, $7,500,000 for fiscal year 1978, $9,000,000 for fiscal year 1979, $12,500,000 for fiscal year 1980, $19,000,000 for fiscal year 1981, $26,000,000 for fiscal year 1982, $30,000,000 for fiscal year 1983, and, for each succeeding fiscal year, such sums as may be necessary to continue to make scholarship grants under this section to individuals who have received such grants prior to the end of fiscal year 1983 and who are eligible for such grants during each such succeeding fiscal year.

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 105. (a) Any individual who receives a scholarship grant pursuant to section 104 shall be entitled to employment in the Service during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship grant.

(b) Any individual enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions (including schools certified by the Secretary as capable of training individuals in Indian traditional medicine) may be employed by the Service during any nonacademic period of the year. Any such employment shall not exceed one hundred and twenty days during any calendar year.

(c) Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department of Health, Education, and Welfare.

(d) There are authorized to be appropriated for the purpose of this section: $800,000 for fiscal year 1977, $1,200,000 for fiscal year 1978, $1,600,000 for fiscal year 1979, $2,200,000 for fiscal year 1980, $2,800,000 for fiscal year 1981, $3,200,000 for fiscal year 1982, and $3,550,000 for fiscal year 1983.

EDUCATIONAL AND TRAINING PROGRAMS IN ENVIRONMENTAL HEALTH, HEALTH EDUCATION, AND NUTRITION

SEC. 106. (a) The Secretary, acting through the Service, shall make grants to individuals, nonprofit entities, appropriate public or private agencies, educational institutions, or Indian tribes and tribal organizations to enable the recipients of such grants to establish and carry out programs to train individuals so as to enable them to provide their services to Indians in the following areas:

(1) environmental health, including proper waste disposal, reduced pesticide inhalation, proper sanitation, and vector control;

(2) health education, including advising and training Indians with respect to personal hygiene, the essentials of first aid, the care of critically ill in the home and entitlements of Indians to, and the availability of, health care services and assistance; providing adequate health information to schools; and establishing health courses in secondary schools encouraging entry by Indians into health-related professions; and

(3) nutrition, including advising and training Indians with respect to child nutrition, availability if nutrition programs (such as hot school lunch programs), nutrition in prenatal care, and nutrition education for the total population, particularly for those found to have or to be susceptible to, diabetes, hypertension, and heart disease.

(b) Grants pursuant to this section shall be made in such manner and in such amounts and subject to such conditions as the Secretary shall by regulation prescribe.

(c) There are authorized to be appropriated to carry out the provisions of this section: $500,000 for fiscal year 1977, $600,000 for fiscal year 1978, $700,000 for fiscal year 1979, $800,000 for fiscal year 1980, $900,000 for fiscal year 1981, $900,000 for fiscal year 1982, and $600,000 for fiscal year 1983.

CONTINUING EDUCATION ALLOWANCES

SEC. 107. (a) In order to encourage physicians and other health professionals to join the Service and to provide their services in the rural and remote areas where a significant portion of the Indian people resides, the Secretary, acting through the Service, may provide allowances to health professionals employed in the Service to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

(b) There are authorized to be appropriated for the purpose of this section: $100,000 for fiscal year 1977, $200,000 for fiscal year 1978, $250,000 for fiscal year 1979, $300,000 for fiscal year 1980, $350,000 for fiscal year 1981, $350,000 for fiscal year 1982, and $325,00 for fiscal year 1983.

TITLE II—HEALTH SERVICES

SEC. 201. (a) For the purpose of eliminating backlogs in Indian health care services and to supply known, unmet medical, surgical, dental, and other Indian health needs, the Secretary is authorized to expend $491,975,000 through the Service, over a seven-fiscal-year period in accordance with the schedule provided in subsection (c). Funds appropriated pursuant to this section each fiscal year shall not be used to offset or limit the appropriations required by the Service to continue to serve the health needs of Indians during and subsequent to such seven-fiscal-year period, but shall be in addition to the level of appropriations provided to the Service in fiscal year 1976 required to continue the programs of the Service thereafter.

(b) The Secretary, acting through the Service, is authorized to employ persons to implement the provisions of this section during the seven-fiscal-year period in accordance with the schedule provided in subsection (c). Such positions authorized each fiscal year pursuant to this section shall not be considered as offsetting or limiting the personnel required by the Service to serve the health needs of Indians during and subsequent to such seven-fiscal-year period but shall be in

addition to the positions authorized in the previous fiscal year and to the annual personnel levels required to continue the programs of the Service.

(c) The following amounts and positions are authorized, in accordance with the provisions of subsections (a) and (b), for the specific purposes noted:

(1) Patient care (direct and indirect): $4,000,000 and one hundred and fifty positions for fiscal year 1977, $10,000,000 and two hundred and twenty-five positions for fiscal year 1978, $18,000,000 and three hundred positions for fiscal year 1979, $26,500,000 and three hundred and twenty positions for fiscal year 1980, $36,000,000, and three hundred and sixty positions for fiscal year 1981, $46,000,000, and three hundred and seventy-five positions for fiscal year 1982, and $58,000,000 and four hundred and fifty positions for fiscal year 1983.

(2) Field health, excluding dental care (direct and indirect): $3,000,000 and ninety positions for fiscal year 1977, $6,000,000 and ninety positions for fiscal year 1978, $9,000,000 and ninety positions for fiscal year 1979, $13,000,000 and one hundred and twenty positions for fiscal year 1980, $18,000,000 and one hundred and fifty positions for fiscal year 1981, $23,000,000 and one hundred and fifty positions for fiscal year 1982, and $28,500,000 and one hundred and sixty-five positions for fiscal year 1983.

(3) Dental care (direct and indirect): $800,000 and eighty positions for fiscal year 1977, $1,500,000 and seventy positions for fiscal year 1978, $2,000,000 and fifty positions for fiscal year 1979, $2,500,000 and fifty positions for fiscal year 1980, $2,900,000 and forty positions for fiscal year 1981, $3,200,000 and thirty positions for fiscal year 1982, and $3,500,000 and twenty-five positions for fiscal year 1983.

(4) Mental health: (A) Community mental health services: $900,000 and forty positions for fiscal year 1977, $1,700,000 and thirty positions for fiscal year 1978, $2,400,000 and thirty positions for fiscal year 1979, $3,000,000 and twenty-five positions for fiscal year 1980, $3,500,000 and twenty positions for fiscal year 1981, $3,800,000 and ten positions for fiscal year 1982, and $4,100,000 and fifteen positions for fiscal year 1983.

(B) Inpatient mental health services: $200,000 and fifteen positions for fiscal year 1977, $400,000 and fifteen positions for fiscal year 1978, $600,000 and fifteen positions for fiscal year 1979, $800,000 and fifteen positions for fiscal year 1980, $1,000,000 and fifteen positions for fiscal year 1981, $1,300,000 and twenty positions for fiscal year 1982, and $1,600,000 and twenty-five positions for fiscal year 1983.

(C) Model dormitory mental health services: $625,000 and fifty positions for fiscal year 1977, $1,250,000 and fifty positions for fiscal year 1978, $1,875,000 and fifty positions for fiscal year 1979, and $2,500,000 and fifty positions for fiscal year 1980.

(D) Therapeutic and residential treatment centers: $150,000 and ten positions for fiscal year 1977, $300,000 and ten positions for fiscal year 1978, $400,000 and five positions for fiscal year 1979, $500,000 and five positions for fiscal year 1980, $600,000 and ten positions for fiscal year 1981, $700,000 and five positions for fiscal year 1982, and $800,000 and five positions for fiscal year 1983.

(E) Training of traditional Indian practitioners in mental health: $75,000 for fiscal year 1977, $150,000 for fiscal year 1978, $200,000 for fiscal year 1979, $250,000 for fiscal year 1980, $300,000 for fiscal year 1981, $300,000 for fiscal year 1982, and $300,000 for fiscal year 1983.

(5) Treatment and control of alcoholism among Indians: $8,000,000 for fiscal year 1977, $10,500,000 for fiscal year 1978, $13,000,000 for fiscal year 1979, $15,000,000 for fiscal year 1980, $17,000,000 for fiscal year 1981, $18,500,000 for fiscal year 1982, and $20,000,000 for fiscal year 1983.

(6) Provision of health care personnel in primary and secondary Bureau of Indian Affairs schools: $600,000 and thirty-three positions for fiscal year 1977, $1,000,000 and twenty-two positions for fiscal year 1978, $1,300,000 and sixteen positions for fiscal year 1979, $1,700,000 and twenty-two positions for fiscal year 1980, $2,500,000 and forty-four positions for fiscal year 1981, $3,900,000 and seventy-six positions for fiscal year 1982, and $6,000,000 and one hundred and fifteen positions for fiscal year 1983.

(7) Maintenance and repair (direct and indirect): $3,000,000 and twenty positions for fiscal year 1977, $3,000,000 and twenty positions for fiscal year 1978, $4,000,000 and thirty positions for fiscal year 1979, $4,000,000 and thirty

positions for fiscal year 1980, $4,000,000 and thirty positions for fiscal year 1981, $2,000,000 and fifteen positions for fiscal year 1982, and $1,000,000 and five positions for fiscal year 1983.

(d) The Secretary, acting through the Service, shall expend directly or by contract not less than 1 per centum of the funds appropriated under the authorizations in each of the clauses (1) through (5) of subsection (c) for research in each of the areas of Indian health care for which such funds are authorized to be appropriated.

TITLE III—HEALTH FACILITIES

CONSTRUCTION AND RENOVATION OF SERVICE FACILITIES

SEC. 301. (a) For the purpose of eliminating inadequate, outdated, and otherwise unsatisfactory Service hospitals, health centers, health stations, and other Service facilities, the Secretary, acting through the Service, is authorized to expend $528,637,000 over a seven-fiscal-year period in accordance with the following schedule:

(1) Hospitals: $123,880,000 for fiscal year 1977, $55,171,000 for fiscal year 1978, $24,703,000 for fiscal year 1979, $70,810,000 for fiscal year 1980, $45,652,000 for fiscal year 1981, $29,675,000 for fiscal year 1982, and $33,779,000 for fiscal year 1983.

(2) Health centers and health stations: $6,960,000 for fiscal year 1977, $6,226,000 for fiscal year 1978, $3,720,000 for fiscal year 1979, $4,440,000 for fiscal year 1980, $2,335,000 for fiscal year 1981, $1,760,000 for fiscal year 1982, and $2,360,000 for fiscal year 1983.

(3) Staff housing: $2,484,000 for fiscal year 1977, $43,450,000 for fiscal year 1978, $8,231,000 for fiscal year 1979, $9,390,000 for fiscal year 1980, $20,140,000 for fiscal year 1981, $12,267,000 for fiscal year 1982, and $13,704,000 for fiscal year 1983.

(4) Health facilities for primary and secondary Bureau of Indian Affairs schools: $1,500,000 for fiscal year 1977, $1,000,000 for fiscal year 1978, $1,000,000 for fiscal year 1979, $1,000,000 for fiscal year 1980, $1,000,000 for fiscal year 1981, $1,000,000 for fiscal year 1982, and $1,000,000 for fiscal year 1983.

(b) The Secretary, acting through the Service, is authorized to equip and staff such Service facilities at levels commensurate with their operation at optimum levels of effectiveness.

(c) Prior to the expenditure of, or the making of any firm commitment to expend, any funds authorized in subsection (a), the Secretary, acting through the Service, shall—

(1) consult with any Indian tribe to be significantly affected by any such expenditure for the purpose of determining and, wherever practicable, honoring tribal preferences concerning the size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

(2) be assured that, wherever practicable, such facility, not later than five years after its construction or renovation, shall meet the standards of the Joint Commission on Accreditation of Hospitals.

CONSTRUCTION OF SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 302. (a) The Secretary is authorized to expend, pursuant to the Act of July 31, 1959 (73 Stat. 267), $378,000,000 within a seven-fiscal-year period following the enactment of this Act, in accordance with the schedule provided in subsection (b), to supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.

(b) To effect the purpose of subsection (a), there are authorized to be appropriated: $60,000,000 for fiscal year 1977, $60,000,000 for fiscal year 1978, $60,000,000 for fiscal year 1979, $60,000,000 for fiscal year 1980, $60,000,000 for fiscal year 1981, $52,000,000 for fiscal year 1982, and $26,000,000 for fiscal year 1983.

(c) The Secretary is authorized and directed to develop a plan, together with the Secretaries of the Interior and of Housing and Urban Development and upon consultation with Indian tribes, to assure that the schedule provided for in subsection (b) will be met. Such plan shall be submitted to the Congress no later than ninety days from the date of enactment of this Act.

PREFERENCE TO INDIANS AND INDIAN FIRMS

SEC. 303. (a) The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (36 Stat. 861), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians (hereinafter referred to as an "Indian firm") in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless he finds, pursuant to rules and regulations promulgated by him, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at his finding, shall consider whether the Indian or Indian firm will be deficient with respect to (1) ownership and control by Indians, (2) equipment, (3) bookkeeping and accounting procedures, (4) substantive knowledge of the project or function to be contracted for, (5) adequately trained personnel, or (6) other necessary components of contract performance.

(b) For the purpose of implementing the provisions of this title, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1921 (46 Stat. 1491), as amended.

TITLE IV—ACCESS TO HEALTH SERVICES

SERVICES PROVIDED TO MEDICARE ELIGIBLE INDIANS

SEC. 401. (a) Notwithstanding any other provision of law, for the purpose of title XVIII of the Social Security Act, as amended, a Service facility (including a hospital or skilled nursing facility), whether operated by the Service or by any Indian tribe or tribal organization, shall hereby be deemed to be a facility eligible for reimbursement under said title XVIII: *Provided*, That the requirements of subsection (b) are met.

(b) Prior to the provision of any care or service for which reimbursement may be made, the Secretary shall certify that the facility meets the standards applicable to other hospitals and skilled nursing facilities eligible for reimbursement under title XVIII of the Social Security Act, as amended, or, in the case of any facility existing at the time of enactment of this Act, that the Service has provided an acceptable written plan for bringing the facility into full compliance with such standards within two years from the date of acceptance of the plan by the Secretary. The Service facilities shall not be required to be licensed by any State or locality in which they are located: *Provided, however*, That the Secretary shall include in his certifications appropriate assurances that such facilities will meet standards equivalent to licensure requirements.

(c) Any payments received for services provided to beneficiaries hereunder shall not be considered in determining appropriations for health care and services to Indians.

(d) Nothing herein authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

SERVICES PROVIDED TO MEDICAID ELIGIBLE INDIANS

SEC. 402. (a) Notwithstanding any other provision of law, for the purpose of title XIX of the Social Security Act, as amended, a Service facility (including a hospital, skilled nursing facility, or intermediate care facility), whether operated by the Service or by an Indian tribe or tribal organization, shall hereby be deemed to be a facility eligible for reimbursement under said title XIX: *Provided*, That the requirements of subsection (c) are met.

(b) The Secretary is authorized to enter into agreements with the appropriate State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are beneficiaries under title XIX of the Social Security Act, as amended.

(c) Prior to the provision of any care or service for which reimbursement may be made, the Secretary shall certify that the facility meets the standards applicable to other hospitals, skilled nursing facilities, and intermediate care facilities eligible for reimbursement under title XIX of the Social Security Act, as amended, or, in the case of any facility existing at the time of enactment of this Act, that the Service has provided an acceptable written plan for bringing the facility into full compliance with such standards within two years from the date of acceptance of the plan by the Secretary. The Service facilities shall not be required to be licensed by any State or locality in which they are located: *Provided, however,* That the Secretary shall include in his certifications appropriate assurances that such facilities will meet standards equivalent to licensure requirements.

(d) Any payments received for services provided recipients hereunder shall not be considered in determining appropriations for the provision of health care and services to Indians.

(e) Notwithstanding any other provision of law, with respect to amounts expended during any quarter as medical assistance under title XIX of the Social Security Act, as amended, for services which are included in the State plan and are received through a Service facility, whether operated by the Service or by an Indian tribe or tribal organization, to individuals who are (i) eligible under the plan of the State under said title XIX and (ii) eligible for comprehensive health services under the Service program, the Federal medical assistance percentage under said title XIX shall be increased to 100 per centum.

(f) Nothing in this section shall authorize the Secretary to provide services to an Indian beneficiary with coverage under title XIX of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

REPORT

SEC. 403. The Secretary shall include in his annual report required by subsection (a) of section 601 an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements through titles XVIII and XIX of the Social Security Act, as amended.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

PURPOSE

SEC. 501. The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population.

CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

SEC. 502. The Secretary, acting through the Service, shall enter into contracts with urban Indian organizations to assist such organizations to establish and administer, in the urban centers in which such organizations are situated, programs which meet the requirements set forth in sections 503 and 504.

CONTRACT ELIGIBILITY

SEC. 503. (a) The Secretary, acting through the Service, shall place such conditions as he deems necessary to effect the purpose of this title in any contract which he makes with any urban Indian organization pursuant to this title. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake the following activities:

(1) determine the population of urban Indians which are or could be recipients of health referral or care services;

(2) identify all public and private health service resources within the urban center in which the organization is situated which are or may be available to urban Indians;

(3) assist such resources in providing service to such urban Indians;

(4) assist such urban Indians in becoming familiar with and utilizing such resources;

(5) provide basic health education to such urban Indians;

(6) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (3) through (5) of this subsection;

(7) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

(8) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

(9) where necessary, provide or contract for health care services to urban Indians.

(b) The Secretary, acting through the Service, shall by regulation prescribe the criteria for selecting urban Indian organizations with which to contract pursuant to this title. Such criteria shall, among other factors, take into consideration:

(1) the extent of the unmet health care needs of urban Indians in the urban center involved;

(2) the size of the urban Indian population which is to receive assistance;

(3) the relative accessibility which such population has to health care services in such urban center;

(4) the extent, if any, to which the project would duplicate any previous or current public or private health services project funded by another source in such urban center;

(5) the appropriateness and likely effectiveness of a project assisted purusant to this title in such surban center;

(6) the existence of an urban Indian organization capable of performing the activities set forth in subsection (a) and of entering into a contract with the Secretary pursuant to this title; and

(7) the extent of existing or likely future participation in such activities by appropriate health and health-related Federal, State, local, and other resource agencies.

OTHER CONTRACT REQUIREMENTS

SEC. 504. (a) Contracts with urban Indian organizations pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (48 Stat. 793), as amended.

(b) Payments under any contracts pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract made by him with such organization pursuant to this title as necessary to carry out the purposes of this title: *Provided, however,* That, whenever an urban Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.

(d) Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts by such organizations.

REPORTS AND RECORDS

SEC. 505. For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, such organization shall submit to the Secretary a report including information gathered pursuant to section 503(a) (7) and (8), information on activities conducted by the organization pursuant to the contract, an accounting of the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of the urban Indian organization with respect to such contract shall be subject to audit by the Secretary and the Comptroller General of the United States.

AUTHORIZATIONS

SEC. 506. There are authorized to be appropriated for the purpose of this title: $5,000,000 for fiscal year 1977, $10,000,000 for fiscal year 1978, and $15,000,000 for fiscal year 1979.

REVIEW OF PROGRAM

SEC. 507. Within six months after the end of fiscal year 1978, the Secretary, acting through the Service and with the assistance of the urban Indian organizations which have entered into contracts pursuant to this title, shall review the program established under this title and submit to the Congress his or her assessment thereof and recommendations for any further legislative efforts he or she deems necessary to meet the purpose of this title.

TITLE VI—MISCELLANEOUS

REPORTS

SEC. 601. (a) The Secretary shall report annually to the President and the Congress on progress made in effecting the purposes of this Act. Within three months after the end of fiscal year 1979, the Secretary shall review expenditures and levels of authorizations under this Act and make recommendations to Congress concerning any increases or decreases in the authorizations for fiscal years 1981 through 1983 under this Act which he deems appropriate. Within three months after the end of fiscal year 1982, the Secretary shall review the programs established or assisted pursuant to this Act and shall submit to the Congress his assessment thereof and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and insure a health status for Indians, which are at a parity with the health services available to, and the health status of, the general population.

(b) There is hereby authorized to be appropriated to the Secretary $150,000 to support a one-year study by the National Indian Health Board of mental health problems, including alcoholism and related problems, among Indians. The study, together with any recommendations the Board may have for legislative or administrative actions to remedy such problems, shall be submitted to the Congress by the Secretary no later than thirty days after the study's completion.

REGULATIONS

SEC. 602. (a)(1) Within three months from the date of enactment of this Act, the Secretary shall, to the extent practicable, consult with national and regional Indian organizations to consider and formulate appropriate rules and regulations to implement the provisions of this Act.

(2) Within four months from the date of enactment of this Act, the Secretary shall publish proposed rules and regulations in the Federal Register for the purpose of receiving comments from interested parties.

(3) Within six months from the date of enactment of this Act, the Secretary shall promulgate rules and regulations to implement the provisions of this Act.

(b) The Secretary is authorized to revise and amend any rules or regulations promulgated pursuant to this Act: *Provided*, That, prior to any revision of or amendment to such rules or regulations, the Secretary shall, to the extent practicable, consult with appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.

LEASES WITH INDIAN TRIBES

SEC. 603. Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes for periods not in excess of twenty years.

AVAILABILITY OF FUNDS

SEC. 604. The funds appropriated pursuant to this Act shall remain available until expended.

I. OVERVIEW OF S. 522, AS AMENDED

A. Purpose of S. 522

The purpose of S. 522, the Indian Health Care Improvement Act, is to assure the highest possible health status for the American Indian people. To meet this purpose, S. 522 would provide the direction and financial resources to overcome the inadequacies in the existing Federal Indian health care program and invite the greatest possible participation of Indians and Alaska Natives in the direction and management of that program.

Through the various titles, the bill proposes to achieve the following objectives:

To assure an adequate health manpower base to provide proper health services to Indians and a sufficient cadre of trained Indian professionals and other health workers to permit Indian communities to have a maximum voice in shaping those services (title I);

To assure the elimination of the enormous backlog among Indians of unmet health needs and essential patient care (title II);

To construct modern, efficient hospitals and other health care facilities serving Indians where none exist and renovate the existing facilities, most of which are in a state of general deterioration (title III);

To overcome the adverse effects of unsafe water supplies and insanitary waste disposal systems in Indian communities and homes (title III);

To enable Indian people to exercise their citizenship rights to a broader range of national health resources (title IV); and

To assist urban Indians both to gain access to those community health resources available to them as citizens and to provide primary health care services where those resources are inadequate or inaccessible (title V).

The six inter-related titles of S. 522, if enacted into law, would authorize a sustained and coordinated Federal health effort addressed to the excessive backlog in the treatment of diseases and illnesses affecting Indian people in both reservation and urban settings; to the physical shortcomings and staffing deficiencies in Indian Health Service facilities; to the inadequate water and waste disposal systems which serve as the source of numerous communicable diseases in Indian communities; and to the several legal constraints which preclude reservation and urban Indians from making use of national health resources on the same basis as all other citizens.

This effort would be sustained by incremental increases over a 7 fiscal year period to the current Indian Health Service budget base. The incremental approach is chosen in lieu of mounting a "crash" program, because the latter, with its too sudden infusion of funds,

inevitably proves to be uneconomical and unmanageable. It is anticipated that the incremental increases in financial resources would serve to eliminate the documented excessive backlogs in health care requirements and establish a firm foundation upon which a continuous program capable of meeting the total health needs of the Indian and Alaska Native people could be maintained after the end of the seven fiscal year period.

Title II—Health Services—and title III—Health Facilities—are based on a forward plan developed by the Indian Health Service personnel through several years of careful and intelligent health planning activities. Throughout the formulation of this plan, the Indian people have fully participated in its development. Moreover, professional medical and public health organizations have expressed their endorsement of the forward plan and consider it to be a realistic approach when measured against the known health needs of the Indian people.

B. Legislative History and Committee Amendments

S. 522's predecessor in the 93d Congress, S. 2938, was introduced by Senator Jackson on February 2, 1974.

Hearings on S. 2938 were held before the Committee on April 3 and 5, 1974. The bill was substantially amended and ordered reported by unanimous voice vote in open markup session on July 23, 1974. S. 2938 was passed by the Senate on November 25, 1974. The House did not consider the bill.

S. 522 was reintroduced in the Senate on February 3, 1975, and is virtually identical to S. 2938 as it was approved by the Senate in the last Congress.

The Chairman and Ranking Minority Member of the Committee agreed to move S. 522 directly to full Committee for markup in the belief that this measure has been thoroughly justified through hearings on S. 2938 and as reflected in the Committee Report (S. Rept. No. 93–1283) on S. 2938 filed with the Senate on November 25, 1974.

As approved by the Senate on November 25, 1974, the authorizations for the various titles in S. 2938 amounted to $1,640,800,000. S. 522, as introduced in this Congress, contained the same authorizations and proposed that the funds, for most activities, would be spent over a five fiscal year period following date of enactment.

In response to the serious state of the economy and the President's announced moratorium on new spending authorities, Majority and Minority staff discussed various alternatives which would reduce S. 522's impact on the overall federal budget. These discussions led to the following revisions in S. 522 suggested by staff and unanimously approved by the committee in markup session on April 16, 1975:

1. That the expenditure of appropriations authorized in the bill should begin in fiscal year 1977, instead of the first fiscal year following date of enactment as provided in S. 522, as introduced;
2. That the authorizations, in most instances, should be extended from 5 to 7 years;
3. That the Secretarial reporting requirements in S. 522 be changed to assist Congress in undertaking a thorough review of

all expenditures at the end of the third fiscal year in order to revise authorization levels should this action be deemed appropriate; and

4. That the grand total of the authorizations be revised to reflect a $39 million decrease brought about by various adjustments to S. 522.

S. 522, as amended, was ordered reported by unanimous voice vote in open markup session on April 16, 1975.

C. Major Provisions

Title I—Indian Health Manpower

Title I establishes the Indian Health Manpower program consisting of a recruitment and counseling program, a preparatory scholarship program, a professional scholarship program, an extern program, and continuing education. This health manpower program should be viewed as a "package" designed to strengthen and expand the capacity of the Indian Health Service to obtain sufficient health professionals to meet the health care needs of Indians. More specifically, Title I is justified on the basis of the following points:

First, Title I is designed as an *Indian-oriented* health manpower program. By designing a separate Indian health manpower program, there is a greater chance of obtaining sufficient personnel to serve in the Indian Health Service and to produce greater numbers of Indian health professionals.

Second, the administration of an Indian Health Manpower program has been assigned to the IHS. By assigning the administration of the program to IHS, the chances for success are greater because it is in the interest of IHS to assure that the program works.

Third, the health professional scholarship program is designed to provide enough financial support to attract, and to support adequately Indian students.

Fourth, the programs in Title I are related to each other and form a coordinated effort to meet Indian health manpower needs under one administrative entity.

Section 102. Health Professions Recruitment Program for Indians

Provisions.—This section establishes a grant program to facilitate the recruitment of Indians into health profession careers.

Purpose.—Since a basic purpose of S. 522 is to increase the number of Indians in health profession careers it was felt that a specified program should be established to encourage Indians to choose a health career.

Expected Results.—In the seven fiscal years for which authorizations are provided in S. 522 it should be possible to contact 250,000 students from 300 tribal groups to determine their potential for training in the health professions.

Cost.—For the seven fiscal year period there is authorized a total of $25 million.

Section 103. Health Professions Preparatory Scholarship Program for Indians

Provisions.—Under this section scholarships are to be provided to qualified Indians, regardless of whether or not they are reservation

Indians, for two academic years which shall be the final two years of any pre-professional health education curriculum. The scholarship shall cover costs of tuition, books, transportation, board, and other necessary related expenses.

Purpose.—Section 103 is designed to support Indian students interested in health careers and to encourage completion of pre-professional studies.

Expected Results.—Approximately 4,000 Indian youngsters will receive training during their final two years of academic work.

Cost.—For the seven fiscal year period there is authorized a total of $24 million.

Section 104. Health Professions Scholarship Program

Provisions.—Under this section scholarship grants are to be made available to any qualified individual, but with Indians as priority recipients. In return for the scholarship the recipients must agree to provide their professional services to Indians, either through the IHS or private practice.

The IHS is authorized to establish scholarship priorities according to existing health professional needs.

Each scholarship would fully cover the cost of tuition. In addition, an amount would be provided to cover the costs of books, transportation, board and other necessary related expenses. The amount of the grant to cover expenses would be based on the financial resources of the grantee and would not exceed $8,000.

As a condition for the scholarship each grantee would be obligated to serve in the Indian Health Service for a period of years equal to the number of years the grantee received scholarship support. Under certain conditions, private practice would be permitted as a pay-back for scholarship support if that private practice involves serving a substantial number of Indians.

Purpose.—The primary objective of the health professional scholarship is to increase the number of health professionals, especially Indians, serving in the Indian Health Service. The Indian Health Service has always found it difficult to meet its manpower needs, but with the end of the draft and the increasing demand being placed on IHS services the pressures are growing. A scholarship program which requires service as a pay-back is seen as a primary tool to meet such pressures.

The justification for a large scholarship grant is based on a recent GAO study which made it very clear that to overcome the resistance of most medical students to serving in rural areas, especially reservation, it would take a generous scholarship. In addition, available evidence would indicate that without sufficient financial resources many Indian students would be unable to remain in school since existing programs are inadequate.

Expected Results.—An estimated 10,000 students would be provided scholarship assistance at approximately $10,000 per student. This would include tuition payments and expenses.

Cost.—For the seven fiscal year period there is authorized a total of $110 million.

Section 105. Indian Health Service Extern Programs

Provisions.—Under this section, the Indian Health Service is authorized to employ either individuals receiving scholarship grants under Section 104 or other individuals engaged in health professional training during any non-academic period of the year.

Purpose.—The purpose of this section is to facilitate employment opportunities for medical students and to provide a further opportunity to recruit medical care personnel.

Expected Results.—Approximately 6,400 students could be exposed to actual work situations in the IHS.

Cost.—For the seven fiscal year period there is authorized a total of $15,350,000.

Section 106. Education and Training Programs in Environmental Health, Health Education and Nutrition

Provisions.—Under section 106, the IHS would be authorized to make grants to individuals, non-profit entities, appropriate public or private agencies, educational institutions or Indian tribes or tribal organizations to implement educational or training programs on behalf of Indians in the following areas: environmental health, health education, and nutrition.

Purpose.—As a result of the President's Special Indian Message of July 8, 1970, the Department of Labor provided funding for training of residents of Indian communities to serve as special assistants to health professionals in the fields of environmental health, health education and nutrition. Funding under this program was to end on June 30, 1974. This provision will extend and expand this program.

Expected Results.—Under the programs funded through the Department of Labor more than 2,700 tribal leaders, technicians, and other community health workers were trained in a two-year period at a cost of slightly more than $4.8 million.

Cost.—For the seven fiscal year period there is authorized a total of $5 million.

Section 107. Continuing Education Allowances

Provisions.—This section authorizes funding for continuing education programs for health professionals employed by the Indian Health Service.

Purpose.—A recent GAO report indicated that one of the major reasons why health professionals resisted serving in rural areas was the lack of professional contact and continuing education programs. This section is designed to assist in meeting that need. This program will also facilitate recruitment.

Expected Results.—It is expected that 3,750 health professionals in the Indian Health Service would be afforded continuing education opportunities in the seven fiscal year period.

Cost.—For the seven year period there is authorized a total of $1,875,000.

Total Cost.—Title I authorizes an expenditure of $181,225,000 over a seven year period.

Title II—Health Services

Purpose.—To authorize adequate appropriations over a seven fiscal year period to eliminate the backlogs identified in the areas of patient care, field health, dental care, mental health, alcoholism, and maintenance and repair of service facilities.

There exists today among the Indian population a backlog of needed curative and preventive services as well as essential maintenance and repair requirements for Indian health facilities.

These needs would be addressed through the following provisions, reflecting the seven fiscal year total:

Section 201(c)(1). Patient Care

To remove the backlogs in direct patient care, this section authorizes $198,500,000.

Section 201(c)(2). Field Health

To provide field health services—which include environmental health, public health nursing, health education, and field medical services—this section authorizes $100,500,000.

Section 201(c)(3). Dental Care

To reduce the tremendous backlog in dental needs and services, this section authorizes $16,400,000.

Section 201(c)(4). Mental Health

A. Community mental health services—$19,400,000.
B. Inpatient mental health services—$5,900,000.
C. Model dormitory mental health services—$6,250,000.
D. Therapeutic and residential treatment centers for Indian children—$3,450,000.
E. Training of traditional Indian practitioners in mental health—$1,575,000.

Section 201(c)(5). Treatment and Control of Alcoholism

$102,000,000.

Section 201(c)(6). Provisions of Health Care Personnel in Bureau of Indian Affairs' Primary and Secondary Schools

$17,000,000.

Section 201(c)(7). Maintenance and Repair of Indian Health Service Facilities

$21,000,000.

Expected Results.—The phased approach recommended in Title II will not only result in a reduction of the major illnesses and diseases which prevent Indians from enjoying optimum physical and mental health, but also the establishment of a firm program base which will enable IHS to provide the levels of health services beyond the life span of S. 522.

Cost.—Provides an authorization of $491,975,000 over a 7-fiscal-year period.

Title III—Health Facilities

Construction and Renovation of Service Facilities

Purpose.—To authorize sufficient appropriations over a seven fiscal year period to provide for the elimination of inadequate, outdated,

and unsatisfactory Indian Health Service hospitals, health centers, and health stations; to provide for the construction of new and replacement housing to accommodate the health staff assigned to remote stations; and to provide for the construction of primary and secondary BIA school health facilities.

The Indian Health Service operates 51 hospitals to serve the health needs of Indians. Of these 51 hospitals, approximately one-third would never be capable of meeting national fire and safety code standards, and less than half are accredited under the standards of the Joint Commission for Accreditation of Hospitals. The average age of these hospitals is about 21 years.

The IHS provides staff housing facilities at remote locations where adequate housing is unavailable in the private market. Rentals are charged employees for the use of these facilities, or, in the case of Commissioned Officers, they do not receive their rental allowance. There is a current existing shortage of 700 staff housing units. Assuming full staffing of the Indian health care program as proposed by S. 522, there is an additional staff housing need of 800 units.

These construction needs would be addressed in the following provisions, reflecting the seven fiscal year authorizations:

Section 301(a)(1). Hospitals

$383,670,000.

Section 301(a)(2). Health Centers and Health Stations

$27,801,000.

Section 301(a)(3). Staff Housing

$109,666,000.

Section 301(a)(4). Health Facilities for Primary and Secondary BIA Schools

$7,500,000.

Expected Results.—These sections would provide for the construction of 20 replacement hospitals; construction of 3 new hospitals; and modernization of 14 hospitals. They provide also for construction of 52 new, replacement or expanded health centers and construction of several hundred staff quarters. And, they provide for 120 improved health facilities in Bureau of Indian Affairs schools.

Cost.—Provides an authorization for appropriations of $528,637,000 over a seven fiscal year period.

Section 302. Construction of Safe Water and Sanitary Waste Disposal Facilities

Purpose.—To authorize sufficient appropriations over a seven fiscal year period to provide for the construction of safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.

The lack of safe water, adequate waste disposal facilities and other sanitation facilities in many Indian and Alaska Native homes and communities materially contributes to the high incidence of certain environmentally related diseases on Indian reservations and in Alaska Native Villages.

Even after the completion of sanitation facilities projects authorized and requested through fiscal year 1976, there will still remain an

estimated 21,000 existing Indian and Alaska Native homes which lack running water and/or an adequate means of waste disposal. There will also remain nearly 17,000 homes which require upgrading or other improvements to the water and/or waste disposal facilities to meet with current standards.

Work is also required to provide capital improvements to community water and sewer systems (e.g. new wells, storage, treatment) and to establish and equip tribal operation and maintenance organizations and solid waste collection and disposal systems.

These needs would be addressed through the following provision, reflecting the seven fiscal year total:

Section 302(a). Water and Sanitation Facilities

$378,000,000.

Expected Results.—This section would provide for services to 48,960 of 54,400 new and improved homes for Indians and Alaska Natives; serve some 10,000 existing homes which have not yet participated in the program and some 6,000 existing homes needing upgrading of their water and/or waste facilities. These projections assume that approximately 10 percent of the needed 54,400 new and improved homes will be located in communities now requiring additional sanitation facilities construction and that a portion of the needs of existing homes will be accomplished as part of serving new and improved homes. This section would also provide for needed capital improvements to existing community water and sewer systems as well as the equipping, training and support of approximately 300 needed tribal organizations to operate, maintain and manage utility systems and provide solid waste collection and disposal services.

Section 303. Preference to Indians and Indian Firms

Purpose.—Provides that, where possible, the Secretary of Health, Education, and Welfare must give preference to any Indian firm in awarding contracts for the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. This provision recognizes the need for economic development on the reservations and attempts to stimulate that development through the awarding of construction and renovation contracts.

Title IV—Access to Health Services

Section 401. Services Provided to Medicare Eligible Indians

Provisions.—This section makes eligible for reimbursement under the Medicare Program services rendered to Indian patients in service facilities, whether operated by IHS or an Indian tribe. In addition, this section provides that payments received by such facilities are to be credited to the facility itself and such payments shall not be considered as a basis for changing the level of appropriations.

Purpose.—The purpose of this section is to remove a current prohibition against Medicare reimbursement for services performed in IHS facilities. By removing this limitation, the IHS will be able to

service Medicare Indian patients who previously had only been able to use their benefits in hospitals far removed from the reservation.

Section 402. Services Provided to Medicaid Eligible Indians

Provisions.—This section is similar to section 401 except that it relates to Medicaid and authorizes agreements between the IHS and the State concerning reimbursement. This section also contains language providing for the crediting of payments to the facility performing the service and prohibiting the use of payments as a basis for changing the level of appropriations.

Purpose.—The purpose is the same as for Section 401.

Expected Results.—The anticipated results of this title are necessarily unknown since it is nearly impossible to predict the number of Indians who would qualify for Medicare and/or Medicaid. It can be expected however that some increase in the amount of money available to the Indian Health Service facilities will result from passage of this Title.

Title V—Access to Health Services for Urban Indians

Provisions.—Under this title, the IHS is authorized to enter into contracts with urban Indian organizations to provide assistance for establishing and administering:

1. Referral programs to make urban Indians knowledgeable of available urban health services.
2. Direct health care programs for urban Indians.

The provisions also include the following:

1. The contractual conditions which the IHS may impose.
2. The criteria for selecting urban Indian organizations for the purpose of contracting.
3. General contracting provisions relating to Indians, most of which are similar to those contained in P.L. 93–638, the Indian Self-Determination and Education Assistance Act.
4. An annual report requirement.
5. A requirement that the IHS review and submit to Congress (6 months following the end of the 1978 fiscal year) a report with legislative recommendations.

Purpose.—The need for expanded contractual authority is justified on the basis that existing pilot programs administered by IHS have shown that Indian referral programs in urban areas have increased urban Indians awareness of existing health services. Support of direct care programs is justified on the basis that some urban Indian health care programs are already providing direct care services and it would be inappropriate to restrict Federal funds to support of referral programs only.

Expected Results.—The passage of this provision of S. 522 would result in the establishment of comprehensive medical health facilities in 26 urban areas serving more than 200,000 American Indians.

Cost.—Title V authorizes an expenditure of $30 million over three fiscal years.

Title VI—Miscellaneous

Provisions.—(1) The Secretary of Health, Education, and Welfare is required to file an annual report on the implementation of this Act. In addition, the Secretary shall review the programs established under this Act and submit to Congress recommendations for additional assistance at the end of fiscal year 1979. Finally, the Secretary is required to assess the future course of programs authorized under S. 522 following the end of fiscal year 1982.

(2) $150,000 is authorized to support a 1-year study by the National Indian Health Board, a private nonprofit orgarization, on mental health problems of Indians.

(3) A mandated schedule for publication of regulations.

(4) Authorization for the IHS to enter into leases with Indian tribes not in excess of 20 years.

(5) Funds appropriated under this Act shall remain available until expended.

II. INTRODUCTION: HISTORY OF, AND NEED FOR, INDIAN HEALTH CARE

S. 522, the Indian Health Care Improvement Act, addresses one of the most critical and deplorable situations in the United States; the health status of, and the provision of basic health services to, the American Indian people.

Recent Indian Legislation and the Importance of S. 522

The 93d Congress passed the Indian Financing Act (S. 1341, PL 93–262) to provide Indian organizations and individuals with capital in the form of loans and grants for the purpose of assisting the establishment and operation of Indian enterprises.

The 93d Congress passed and the President approved the Indian Self-Determination and Education Assistance Act (P.L. 93–638). The purpose of Public Law 93–638 is to implement the policy of Indian self-determination by authorizing the Bureau of Indian Affairs of the Department of the Interior and the Indian Health Service of the Department of Health, Education, and Welfare to enter into contracts with Indian tribes to provide for a greater measure of tribal control over those agencies' programs. In addition, the legislation would provide an authorization for and greater parental control of the Johnson-O'Malley program and would establish several new education programs to benefit Indian children and the schools which they attend.

The 1st session of the 93d Congress also passed, and the President approved, the Comprehensive Employment and Training Act of 1973 (PL 93–203). This Act contained a major Indian manpower program to increase Indian training opportunities.

All of these measures reaffirm the policy of this body that the Indian people must decide their own future and that the Federal Government must provide them with the educational and economic tools to implement the decisions they reach. These measures are clearly important; yet, this Committee believes none of them is as critical as this Indian Health Care Improvement Act.

The most basic human right must be the right to enjoy decent health. Certainly, any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians. Without a proper health status, the Indian people will be unable to fully avail themselves of the many economic, educational, and social programs already directed to them or which this Congress and future Congresses will provide them.

Early History of Indian Health Care

In the early history of this country, the only Federal health services available to Indians were those provided by military physicians assigned to frontier forts and reservations. At times, these services were rendered to fulfill treaty promises. However, the primary concern of these physicians was the prevention of the spread of smallpox and other contagious diseases—diseases which were virtually unknown to Indians before their contact with the white man.

In 1849, Indian health policy shifted from military to civilian administration with the transfer of the Bureau of Indian Affairs (BIA) from the War Department to the Department of the Interior. Although some limited progress occurred under this new administrative arrangement, by 1875 there were still only about half as many doctors as there were Indian agencies, and by 1900 the physicians serving Indians numbered only 83.

During this time, Indian health services were financed out of miscellaneous funds appropriated to the Bureau of Indian Affairs. Appropriations earmarked specifically for health services to Indians began with $40,000 in 1911. The Snyder Act (Act of November 2, 1921, 42 Stat. 208) provided the formal legislative authorization for Federal health care for Indians. It authorized the Secretary of the Interior to expend funds for the "relief of distress and conservation of the health of Indians." This short phrase of the Snyder Act continues to be the basic legislative statement of the Federal Government's obligation to provide health services to Indians.

In the mid-1920's a more concerted effort was made to assist the health needs of Indian communities. This effort was facilitated by the assignment of commissioned officers of the Public Health Service to Indian health care services. While these highly trained medical and public health officers strengthened the overall direction of the Federal Indian health program, other shortcomings in that program frustrated success in overcoming the numerous serious health problems of Indians. The program was continually plagued with outdated facilities, severe understaffing and inadequate appropriations.

By the mid-1940's, health services and the level of Indian health had deteriorated so severely that pressure began to mount for the transfer of the Indian health program to the Public Health Service in the Department of Health, Education, and Welfare. The initial impetus for the transfer came from several studies done of the BIA health program, including a 1948 Bureau of the Budget study, the 1949 report of the Hoover Commission, and a 1949 study by the American Medical Association, all of which found the need for a new approach to Indian health problems. The results of these studies and the nature of that need were presented to the Congress, in this Committee's "Report on the Transfer Act", June 1954. The contents of that report and subsequent legislative history suggest the ironic fact that many Congressmen who advocated termination may have supported the transfer as an action compatible with their effort to repeal laws which they felt unwisely set Indians apart from other citizens.

Thus, in 1954, the Congress enacted the Transfer Act (71 Stat. 370) which resulted in the 1955 transfer of the Federal responsibility for health services to Indians from the Bureau of Indian Affairs in the Department of the Interior to the newly created Division of Indian Health, under the U.S. Surgeon General in the Public Health Service, Department of Health, Education, and Welfare (HEW). In 1968, the Division of Indian Health was retitled the Indian Health Service (IHS). The functions of the Surgeon General have now been abolished, and the health service programs in HEW have gone through several administrative reorganizations. The IHS is now a division of the Public Health Service in the Health Services Administration of HEW. Despite its inception in a termination atmosphere, The IHS has grown rapidly since 1955. From a budget of $24.5 million and a staff of 3574 in 1955, it now has an authorized staff of 8108 and an annual budget of approximately $226 million.

The program of the IHS has been officially described as follows:

> To carry out its mission and to attain its goal, the Indian Health Service: (1) assists Indian tribes in developing their capacity to man and manage their health programs through activities including health and management training, technical assistance, and human resource development; (2) facilitates and assists Indian tribes in coordinating health planning, in obtaining and utilizing health resources available through Federal, State and local programs, in operation of comprehensive health programs, and in health program evaluation; (3) provides comprehensive health care services, including hospital and ambulatory medical care, preventive and rehabilitative services, and development of community sanitation facilities; (4) serves as the principal Federal advocate for Indians in the health field to assure comprehensive health services for American Indians and Alaska Natives.[1]

To carry out its program, the Indian Health Service has established three administrative levels: Headquarters, Area Offices, and Service Units. Headquarters is located in Rockville, Maryland. The eight Area Offices, correspond roughly, in function, to HEW Regional Offices; however, to be closer to the IHS service population, their locations most nearly correspond to the BIA Area Offices (out of which they emerged in 1955). The 88 Service Units are the primary health delivery units in the IHS. They are located on Indian reservations, in cities in which the IHS has regional medical centers, and in nonreservation areas, particularly in Oklahoma and Alaska, where concentrations of Indians who are part of the IHS service population reside.

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[1] Federal Register, vol. 36, No. 51, Tuesday, Mar. 16, 1971, p. 5003.

Some 498,000 American Indians, belonging to more than 250 tribes, and Alaska Natives are eligible to participate in the health care program of the Indian Health Service. Generally, in language, religion, social organization, and values, these Indians and Alaska Natives have maintained their traditional cultures—cultures which often conflict with the predominate non-Indian society. The majority of these Indians live on isolated Federal Indian Reservations or in rural Indian communities. Alaska Natives live primarily in remote villages. The isolation of these peoples is heightened by their cultural differences and by the inability of many of them to speak English. Their median income is $4,884 annually per family, which places them in the lowest income group in the United States. In short, they are among the most impoverished and isolated of any U.S. peoples, and often are deprived of the basic life-serving necessities such as good nutrition and a sanitary environment.

Major transportation and communication problems pose additional barriers to the implementation of health programs. Many patients must travel long distances over primitive roads and difficult terrain to reach hospitals, health centers, or other health facilities. On many reservations public transportation facilities are lacking or inaccessible, and telephones and automobiles are scarce. The very ill or those needing emergency treatment must be transported by ambulance or airplane, sometimes hundreds of miles. In Alaska, there are virtually no roads in the areas where Natives live and only one railroad in the State. Transportation is further hampered by extremes of climate and topography.

The health problems of the Indian people are directly related to their geographic and socio-economic conditions, cultural beliefs, and educational level. To meet basic health needs in this unique and difficult environment, the Indian Health Service has attempted to devise a health care program which will be responsive, flexible, and comprehensive. The IHS health services program, through its various delivery systems, provides a full range of curative, preventive, rehabilitative, and environmental services. The program is carried out in 88 strategically located Service Units, with a facilities systems of 51 hospitals, each with an ambulatory care department, 86 health centers, and over 300 health stations and satellite clinics. To maintain its program, the Indian Health Service employs about 8,100 full-time health workers, more than half of whom are of Indian descent.

The employees at the community level comprise a health team called a Service Unit which is responsible for providing health care as well as conducting preventive health activities. The Service Unit is composed of two major components. One is responsible for patient care, including hospital services, hospital maintenance and repair, and contract health services; the other for field health services.

The field health services are provided to Indians and Alaska Natives in their homes and communities and consist of sanitation and dental programs, as well as programs in public health nursing, health education, and field medical services. Health centers and stations are situated so as to provide as complete and convenient a range of health services as possible to Indian communities. These clinic based services are supplemented by visits to homes where preventive

and curative health services are provided in combination with education in good health care and practice.

To provide supplemental, specialty, and emergency services to complement the basic services available through the Service Unit programs and to deliver health services on many smaller reservations where Indian Health Service professionals are not available, the IHS conducts a contract health services program. Under the program, the Indian Health Service purchases at a reasonable rate from non-IHS sources professional services it would otherwise be unable to provide its patients. Health services contracts are made with hospitals, clinics, private medical practitioners, university medical centers, counties, tribes, and other Indian organizations. Areas of emphasis within the program include acute hospital and medical care, preventive health services, services for psychiatric patients and improved mental health, transportation, prescription drugs, eye care, and dental services.

The Indian Health Service, as the principal Federal advocate for Indians and Alaska Natives in the health field, encourages other Federal, State and local agencies to participate in the over all effort to improve the health of these people. Presently involved are the Departments of Agriculture, Interior, and Housing and Urban Development, in addition to a number of Department of Health, Education, and Welfare components such as Medicare, Medicaid and others. The Center for Disease Control, for example, assists the Indian Health Service in efforts to improve the quality of clinical laboratory services and the control of infectious diseases. Resources provided by the National Institute of Mental Health and National Institute on Alcohol Abuse and Alcoholism are directed to the prevention and treatment of mental illness, emotional disturbances, alcoholism, drug abuse, and suicide.

As citizens of the United States, Indians are also eligible to participate in all general population-oriented public and private health programs on the same basis as any other citizen. The Indian Health Service encourages Indians to become fully aware of, and active participants in, those health programs. It also attempts to stimulate the efforts of other health programs to provide greater outreach to Indians.

Indian and Alaska Native Participation in the Indian Health Service Program

The role of Indian and Alaska Native people has expanded greatly within the Indian Health Service as a result of training programs conducted by the Service. As previously stated, Indians and Alaska Natives make up more than half (at latest count 52 percent) of the total Indian Health Service work force. Trained in a wide variety of health skills, they are working as community health medics, licensed practical nurses, dental assistants, mental health aides, sanitarians, medical social work associates, food service supervisors, nutrition aides, laboratory technicians, radiology technicians and specialists in fields associated with environmental control. The following table shows the various professional and administrative positions in the IHS held by Indians:

Summary of professional and administrative positions held by Indians in the Indian Health Service

(Civil Service and Commissioned Officers)

Positions	*Number*
Hospital directors	4
Medical officers	2
Community development specialists	21
Area directors	3
Area deputy directors	2
Social workers	7
Administrative officers	10
Nursing	13
Public health educators	4
Public health advisors	3
Human resources development specialists	4
EEO officers	8
Personnel management	3
Construction personnel	7
Program analysts	2
General services personnel	7
Indian health advisors	1
Tribal affairs officers	10
Budget analysts	6
Service unit directors	15
Staff assistants	5
Medical technology consultants	1
Hospital administrators	2
Illustrator	1
Sanitarians	15
Contract health care officers	2
Sanitary engineers	5
Total	163

Source: House hearings, fiscal year 1974, p. 16. Information provided by IHS; no grade levels or comparable data for non-Indians were provided. Printed in Urban Associates, Inc., "A Study of the Indian Health Service and Indian Tribal Involvement in Health," August 1974.

The Indian Health Service has developed a new outreach approach in the Community Health Medic Program. Central to this approach is the provision of an entry point in the health care system for patients living in severely isolated Indian and Alaska Native communities. Community Health Medics, who are Indians or Alaska Natives, are trained by the IHS to function independently in field stations or in conjunction with doctors in outpatient clinics in these remote communities. Their principal duties are to provide primary health services and to arrange referral of those patients requiring more complicated health care to the appropriate health facilities. The 25 Indians and Alaska Natives in the first group to be trained under this program completed the two year course in 1973 and have been assigned as physician assistants at Indian Health Service hospitals and field clinics. Twenty others are presently undergoing the academic phase of training. All have had extensive medical experience in civilian or military life.

More recently, emphasis has been placed on professional training for Indian people in health administration, public health nursing, sanitary science, health education, nursing specialties, and medicine. The number of college work-study programs in which Indians can increase their experience in health vocations while obtaining a formal professional education is also increasing.

Indian and Alaska Native employees of the Indian Health Service have also availed themselves of the IHS's two upward mobility programs which train personnel in skills needed for advancement in their chosen occupations and also provide opportunities for horizontal movement to positions offering greater skills utilization or job enrichment. The Upward Mobility Program provides training for IHS personnel at the GS 1–7 grade levels and wage grade equivalents; the START program, now being developed, focuses on the GS 1–5 grade levels and is to serve as a feeder into the Upward Mobility Program.

There is a distinct difference, however, between employment in the Indian Health Service and participation in shaping the IHS program. Success in the latter objective has been more difficult. Although 52% of the 7,430 IHS employees, as of April 1973, were Indians, only 4.6% were at the GS 13–15 or equivalent commissioned officer level. As the table below indicates, the overwhelming majority of the 3,858 Indian employees then in the IHS were to be found in low GS and Wage Board levels.

ALL IHS EMPLOYEES, NUMBER AND PERCENT INDIAN BY EMPLOYMENT CLASSIFICATION ALL GS LEVELS AND COMMISSIONED OFFICERS

	GS level					
	1 to 5	6 to 7	8 to 10	11 to 12	13 to 15	Total
Non-Medical:						
Professional:						
Number of Indians	51	38	23	31	11	154
Number of non-Indians	4	10	16	62	61	153
Total	55	48	39	93	72	307
Percent of Indians	92.7	79.2	59.0	33.3	15.3	50.2
Technical:						
Number of Indians	109	79	53	16	1	258
Number of non-Indians	31	33	53	48	10	176
Total	140	112	106	64	11	434
Percent of Indians	77.9	70.5	50.0	25.0	9.1	59.4
Clerical:						
Number of Indians	757	67	20	39	5	888
Number of non-Indians	205	78	16	17	40	356
Total	962	145	36	56	45	1,244
Percent of Indians	78.7	46.2	55.6	69.6	11.1	71.4
Service:						
Number of Indians	775	82	23	47	12	939
Number of non-Indians	213	85	25	50	72	445
Total	988	167	48	97	84	1,384
Percent of Indians	78.4	49.1	47.9	48.5	14.3	67.8
Summary:						
Number of Indians	1,692	266	199	133	29	2,239
Number of non-Indians	453	206	110	177	183	1,129
Total	2,145	472	229	310	212	3,368
Percent of Indians	79.0	56.0	52.0	43.0	14.0	66.0
Medical:						
Professional:						
Number of Indians	12	94	73	19	6	204
Number of non-Indians	35	461	283	108	65	952
Total	47	555	356	127	71	1,156
Percent of Indians	25.5	16.9	20.5	15.0	8.5	17.6

ALL IHS EMPLOYEES, NUMBER AND PERCENT INDIAN BY EMPLOYMENT CLASSIFICATION ALL GS LEVELS AND COMMISSIONED OFFICERS—Continued

	GS level					
	1 to 5	6 to 7	8 to 10	11 to 12	13 to 15	Total
Medical—Continued						
Technical:						
Number of Indians	379	71	12	3		465
Number of non-Indians	44	105	58	33	16	256
Total	423	176	70	36	16	721
Percent of Indians	89.6	40.3	17.1	8.3		64.5
Service:						
Number of Indians	938	1				939
Number of non-Indians	85	1				86
Total	1,023	2				1,025
Percent of Indians	91.7	50.0				91.6
Summary:						
Number of Indians	1,329	166	85	22	6	1,608
Number of non-Indians	164	567	341	141	81	1,294
Total	1,493	733	426	163	87	2,902
Percent of Indians	89.0	23.0	20.0	13.0	7.0	55.0
Commissioned Officers:						
Number of Indians						11
Number of non-Indians						1,149
Total						1,160
Percent of Indians						0.9
Medical and commissioned officers:						
Number of Indians	1,329	166	85	28	11	1,619
Number of non-Indians	164	567	341	715	656	2,443
Total	1,493	733	426	743	667	4,062
Percent of Indians	89.0	23.0	20.0	3.8	1.7	39.9
Total IHS employees:						
Number of Indians	3,021	423	204	161	40	3,858
Number of non-Indians	617	773	451	892	839	3,572
Total	3,638	1,205	655	1,053	879	7,430
Percent of Indians	88.0	35.9	31.1	15.3	4.6	51.9

Source: IHS Computer Run—April 1973. Printed in Urban Associates, Inc., "A Study of the Indian Health Service and Indian Tribal Involvement in Health", August 1974.

Fifty-one percent of the 375 employees at IHS headquarters in Rockville, Maryland, are Indians; but of the 77 GS–13's or above, only 13 (17%) are Indians. According to a report by Urban Associates, Inc., entitled *A Study of the Indian Health Service and Indian Tribal Involvement in Health*, none of those 13 are key decision-making positions.[2] The report also noted:

> It might be expected that, proportionally, more Indians would be found in key positions in Area Offices than at Headquarters, on the assumption that Indians are starting to work their way up the ladder. However, six Area Offices have a lower overall percentage of Indians in GS 11 and 12 positions than does Headquarters. All Area Offices have a lower percentage of Indians in GS 13–15 positions than at Headquarters . . .
>
> Of 40 persons employed as Area personnel officers, only eight are Indians and only one is at the GS 11–12 level, compared to 32 non-Indians, of whom 27 are at that level.

[2] The Indian Health Service disputes this conclusion and states that at least 5 of the 13 are in "key decision-making positions." The IHS also has, on several occasions before this Committee, spoken of the difficulties in employing Indian decisionmakers posed by the limited pool of skilled Indians from which to recruit.

Only in the Oklahoma City Area, where there was an Indian Area Director until his retirement last year, is there evidence of a commitment to Indian employment, not only at the service and para-professional level, where 78% of the Area employees are Indian, but also in decision-making positions, where there are 47% Indians at the GS 11–15 level. The Director established a rule that no non-Indian could be hired until IHS had made every effort to recruit an Indian. In this case at least, an Indian in a key staff position resulted in increased Indian employment....

Some indications of change are beginning to be evident at the Service Unit level. Exceptional efforts are being made to place Indians as Service Unit Directors (SUD's), with 15 of the 84 SU's now having Indian Directors. By far the best record of Indian employment can be seen in the SU's in the Oklahoma City Area and in the United Southeastern Tribes (USET) sub-region, where a relationship to the tribes through contracting has made IHS staff positions clearly dependent upon tribal approval.

Indians are absent or nearly so in the upper grade levels of some other SU's. The Phoenix Area has three SU's with no Indians at the GS 11–15 level; Aberdeen and Albuquerque each have one SU that has no Indians at this level; the Tucson SU records only one Indian.[3]

The following tables show the present status of Indian employment in the Indian Health Service.

HEADQUARTERS, AREA OFFICES, AND SERVICE UNITS[1]—NUMBER AND PERCENT EMPLOYED, INDIANS AND NONINDIANS[2] AT THE GS11–15 LEVEL

	Employed	Employed Indians	Percent Indians
Headquarters	122	26	21
Area offices:			
Aberdeen	31	3	10
Service units	44	13	30
Bemidji	14	3	21
Service unit	6	0	0
Anchorage	50	7	14
Service units	48	5	10
Albuquerque	26	7	27
Service units	17	3	18
Billings	23	0	0
Service units	28	8	29
Navajo	22	7	32
Service units	53	11	21
Oklahoma	34	16	47
Service units	34	16	47
USET PO[3]	4	3	75
Service unit	8	5	63
Phoenix	29	3	10
Service units	44	7	16
Portland	12	1	8
Service units	19	8	42
Tucson PO	45	4	9
Service units	17	1	6
Total	608	131	

[1] Based on 69 reported service units.
[2] Exclusive of the 1,160 commissioned officers.
[3] Program office.

Sources: HEW computer run—January 1974, and Tucson IHS computer run—April 1973. Printed in Urban Associates Inc. "A Study of the Indian Health Service and Indian Tribal Involvement in Health, August," 1974.

[3] Urban Associates, Inc., "A Study of the Indian Health Service and Indian Tribal Involvement in Health," August 1974, pp. 45–47.

SERVICE UNITS (69) [1]—PERCENT OF ALL EMPLOYEES WHO ARE INDIAN [2]

Area offices	Percent							
	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 to 99
Aberdeen					5	5		
(Bemidji)				1	1	1	1	
Alaska			2	1	1	4		
Albuquerque				1	1	3	1	
Billings				1	3	1	1	
Navajo					1	4	3	1
Oklahoma					1	6	1	
(USET) [3]				1	1	1	1	
Phoenix			1		2	5	1	
Portland	1				2	1		
Tucson [3 4]		1						
Total	1	1	3	5	18	31	9	1

[1] 69 of the largest among the 84 service units.
[2] Exclusive of the 1,160 commissioned officers.
[3] Program office.
[4] IHS computer run, April 1973.

Source: HEW computer run—January 1974. Printed in Urban Associates, Inc., "A Study of the Indian Health Service and Indian Tribal Involvement in Health", August 1974.

Fortunately, participation by Indian people in their health program is not limited to employment by the Indian Health Service. Tribal governments and community institutions are taking increasingly active roles in health program management. Their involvement variously extends to guiding health programs and to coordinating and blending together multiple health resources in the Indian Health Service delivery system. Indian tribes are a major employer of health services workers within the geographical service unit areas of the Indian Health Service. These tribal employees, most of whom were hired as a result of contracts with the Indian Health Service, represents approximately one-fifth of the Service Unit health workers.

Indian Health Boards are one method of providing direct Indian participation in Indian health care, other than by Indian employment in the IHS. These boards have been developed at all three IHS levels: Service Unit, Area Office, and national. The Service Unit Boards, composed of tribal members elected or selected by the tribe or tribes in the area served by the Service Unit, are agencies of the tribal government. The Area Boards are composed of representatives of each of the Service Units in the Area; however, Area Board members are usually chosen by the tribal chairmen or councils rather than by the Service Unit Boards. The National Indian Health Board consists of representatives of the Area Boards.

The Indian Health Service views these boards as a primary source of Indian participation in IHS policymaking and invites the Boards to work with its three levels in policy development. Although the IHS provides some training for members of the Board, and in some cases provides staff support to Boards which do not have their own full-time staffs, it strives not to exert control over Board decisionmaking. In recognition of this attempt to protect the independence of these Boards, the IHS has contracted with the National Indian Health Board and several Area Boards to evaluate IHS activities from the consumers' perspective. (The IHS also solicits tribal views by the more direct method of continuous consultations with the National Tribal Chairmen's Association.)

Contracting is the principal method by which the tribes participate directly in IHS programs. Under contracting, program responsibility for health programs is transferred from the Indian Health Service to the tribes. Through a formal contracting procedure a tribe agrees to provide particular services and the IHS agrees to pay the tribe to perform those services. There are two basic types of contracts. The first type, contracts for basic—other than health—services, does not provide a policymaking role to the contracting tribes. It includes such services as laundry services, garbage disposal, and construction. The primary role of this type of contract would appear to be to assist economic development in Indian country by providing employment to Indian workers and profit to Indian-owned businesses. The second type of contract, which calls for delivery by the tribes themselves of health services which often were formerly provided by the IHS, does provide the tribes with the opportunity to manage health care programs.

Unfortunately, this authority of the Indian Health Service to enter into contracts is based on a number of old statutes, particularly the Buy Indian Act (25 U.S.C. 47). The provisions of these statutes inhibit the ability of the IHS to insert in its contracts innovative or flexible provisions providing the tribes with more Federal support and relieving them of certain restrictive requirements applicable to all Federal contracting. Public Law 93–638, the Indian Self-Determination and Education Assistance Act provides the IHS new contracting authority tailored to meet Indian needs and to further the goal of Indian self-determination.

The Community Health Representative program is the largest program contracted to the tribes in dollars, in number of people involved, and in number of tribes holding contracts. Contracts are held by 131 tribes and 15 Alaska Native Health Corporations and Native villages serving 156 Alaska Native villages which employ 1,153 Community Health Representatives and Alaska Native Community Health Aides. A Community Health Aide Program was begun by the Office of Economic Opportunity in 1967; but, by 1972, the last portion of the OEO program was transferred to the IHS. In many instances, and often in extremely remote areas, the tribally-employed Representatives and Aides are the only providers of health services in residence. Their function is to act as liaison between community residents and existing health resources and community health activities, promote local participation in health programs, locate new health resources, devise innovative and more effective ways to utilize available resources, and carry out other tribally-defined, high priority health functions.

Other tribally-managed health efforts under IHS contracts include the operation of such community health services activities as alcoholism projects, family planning programs, maternal and child health programs, and health screening and nutrition programs. A number of community development activities, training, and manpower recruitment programs have also been established. A variety of funding sources and mechanisms are being used to support these activities.

Another method to further Indian involvement in health care is indicated in the development of a broad range of tribal or intertribal

executive-type health structures. Although these structures possess varying names, staffs, authorities, etc., they share a common purpose: to provide a tribe with an administrative office the sole responsibility of which is health. The benefits provided by these structures are summarized in the Urban Associates study:

> Most tribes do not have the funds to afford their own administrative staff and specialists. Instead, three or four tribal officers act for the tribe on numerous matters including health, without having the time or technical knowledge to do a thorough job in any area. The Health Boards can only do so much on a volunteer basis without staff support. A health department gives the tribe the staff to give direction to the tribal health effort. Such a staffing arrangement need not be established by each tribe. An intertribal arrangement can either supplement or support tribal health departments by providing a central pool of technical assistance that a group of small tribes could tap, or it could go further and act as an intertribal health department exercising central authority on health matters for a group of closely related small tribes.[4]

There are about 10 to 15 tribal health structures in operation or in the planning stages. Perhaps, foremost among these tribal structures is the Navajo Health Authority. The Authority's Board of Commissioners, selected by the Tribal Council, is, by its plan of operations, to be composed of persons (one half of whom must be tribal members and one-half of whom must have ten years of health education or practice) possessing the following qualifications: membership in the business community; an American Indian not of Navajo heritage; membership in the legal profession; a president of a university or college within the boundaries of the four adjacent states; a present or former professor of medicine at a recognized school of medicine; a practicing physician; a registered nurse; a member of the Navajo Area Health Advisory Board; a hospital administrator; and a Navajo practitioner of the healing arts.

The aggressive plan of operation of the Authority calls upon it to undertake the following tasks:

> Establish and operate a Center for Health Professions Education that will develop and implement the establishment of an American Indian Medical School and training programs for all health professions and allied health professions.
>
> Provide long-range comprehensive planning, evaluation, and development appropriate to the full development of an exemplary health system for the Navajo Nation.
>
> Coordinate, develop and/or cause to be developed to their maximum potential and utilization, all appropriate and available resources of the Navajo Nation, the federal government, the various states and other agencies, groups or individuals meaningful to the improved health education of the Navajo people; and develop and promote the full utilization, preservation, education

[4] Urban Associates, Inc., "A Study of the Indian Health Service and Indian Tribal Involvement in Health," August 1974, p. 64.

and practice of the Navajo healing sciences appropriate to the future health education of the People.

Interpret and distribute data, which accurately describe the health status and needs of the Navajo people, and establish and maintain an American Indian Health Library.

The best-known intertribal health structure is the California Rural ndian Health Board. Its programs are indicative of the growth of In- ian organizations under contract with the IHS area of success is its ugmenting the Federal contract resources with services and funds rovided by State, local, private and voluntary sources. With hese added resources CRIHB has been able to extend a variety of ublic and private health services to approximately 40,000 Indians iving in 32 rural counties and on some 50 Indian reservations.

All told, the growth of Indian participation in the management of ndian Health Service programs is indicative of the growth of Indian articipation in the self-determination process. This growth is mani- esting itself in the greater number of Indian employees who have ac- uired sophisticated skills, in the increasing and increasingly vocal lesire of tribes to be instrumental in the delivery of specific health ervices, and in the expanding tribal capability for managing local, omprehensive health services in lieu of Federal direction.

Progress Under the Indian Health Service

The Federal Government's historic commitment to and long-term nvestment in the future of the Indian people and Alaska Natives have egun to bear fruit. Since 1955, the infant death rate has declined 69 ercent; the death rate from gastritis and related diseases has declined 6 percent; the tuberculosis death rate is down 89 percent, the influenza nd pneumonia death rate has decreased 54 percent; and the death rate rom certain diseases of early infancy has declined 71 percent.

New facilities constructed in the last twenty years since the transfer f the Indian health programs to the IHS include 13 hospitals, 21 health centers, and 51 field stations. Major alterations were made at 14 standing facilities; and many other hospitals and health centers were modified to serve as comprehensive community health facilities.

Over the same period, physicians assigned to the program increased from 125 to 495; dentists, from 40 to 187; and registered nurses, from 780 to 1,145.

A significant trend in the Indian health program has been the increased acceptance by Indians and Alaska Natives of health care services, and especially use of the ambulatory services. Hospital admissions have more than doubled, outpatient visits have increased five times, and dental services have increased five times.

Since passage of Public Law 86–121, enabling construction of sanitation facilities for Indians, over 78,000 Indian and Alaska Native homes have been provided with running water and waste disposal systems. A continuing consulting and service program has also been made available to Indian and Alaska Native families and communities to assist them in implementing comprehensive environmental health programs.

In summary, changes from the circumstances of 1955, together with a new input of consumer involvement and the development of more effective health service delivery methods, account for the significant progress made to date in elevating the health status of Indian people and Alaska Natives.

The Deplorable Status of Indian Health: The Base From Which Future Progress Must Be Measured

Statistics can be highly misleading, however. The sad facts are that, despite of this laudatory progress, the vast majority of Indians still live in an environment characterized by inadequate and understaffed health facilities, improper or nonexistent waste disposal and water supply systems, and continuing dangers of deadly or disabling diseases. These circumstances, in combination, cause Indians and Alaska Natives to suffer a health status far below that of the general population and plague Indian communities and Native villages with Health concerns other American communities have forgotten as long as 25 years ago.

Health statistics provide a measure of not only the progress in, but also the continuing plight of, Indian health: the incidence of tuberculosis for Indians and Alaska Natives is 7.3 times higher than the rate for all citizens of the United States; 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 which affects most commonly children under the age of 2 years, continues to be a leading cause of disability in Indians and Alaska Natives, and, although surgical treatment is possible which can generally prevent the long-term and serious disabilities of deafness and learning deficiencies, 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 all Americans.

The prevalence of disease among Indians cannot help but have a significant adverse impact on the social and cultural fiber of their communities, contributing to general societal disintegration and the attendant problems of mental illness, alcoholism, accidents, homicide and suicide. For example, the suicide rate for Indians and Alaska Natives is approximately twice as high as in the total U.S. population.

These health statistics relate a deplorable tale, a tale which has a tragic ending—while every other American can expect to live to the age of at least 70.8 years, the Indian and Alaska Native can expect to live only to age 65.1.

All efforts to alter these woeful health conditions among Indians are met with the initial and fundamental impediment of outdated or inadequate health facilities. Of existing Indian Health Service facilities, some 38 hospitals, 66 health centers, and 240 other health stations are at least 20 years old. Many of them are old one-story, wooden buildings with inadequate electricity, ventilation, insulation, and fire protection systems, and of such insufficient size as to jeopardize the

health and safety of their occupants. To meet the needs of some 498,000 Indians, IHS and contract facilities provide some 3,700 hospital beds. Compared with a national average of 1 hospital bed per 125 persons, IHS and contract facilities combined provide 1 bed per 135 persons, a shortage of more than 200 beds under existing standards of service and demand.

The Joint Committee on Accreditation of Hospitals (JCAH) has investigated the condition of Indian Health Service facilities. It is their conclusion that only 24 of the 51 existing IHS hospitals meet JCAH standards of accreditation (either because of insufficient staffing or poor physical plants), that two-thirds of the hospitals are obsolete, and that 22 need complete replacement.

In order to overcome the gross deficiencies in the quantity and quality of existing facilities, more money must be allocated. Per capita expenditures for Indian health purposes are 25 percent below per capita expenditures for health care in the average American community. The greater incidence of disease among Indians renders this deficiency all the more acute. It is further compounded by the fact that many of our national health programs, designed to assist the general population, are difficult or impossible to apply to Indians. Medicare, Medicaid, and social security programs afford little relief because, given the unique social situation of most Indians, very few know they are eligible for Medicare or have worked long enough for social security eligibility.

S. 522 would provide the necessary funds and direction to eliminate the deficiencies in facilities and would improve access to Medicare, Medicaid, and other similar programs.

Central to the Indian health tragedy is the manpower shortage among physicians and related health personnel—probably the most pressing and serious problem facing the Indian Health Service. At present, there are 495 physicians in the IHS. Simply translated this represents a ratio of one physician for every 988 Indians as against a national average of slightly under 600 persons per physician. This shortage is complicated by the highly dispersed and remote locations of many Indian tribes, vast distances between settled areas on reservations, and the lack of adequate roads and emergency transportation and communication systems.

Leading medical officials have given truly dire warnings that any further decline in manpower could have critical implications for the health of Indians. Yet, despite these warnings, the severe manpower shortages which are now being experienced by the Indian Health Service are likely to become even more acute in the coming years. For approximately two decades, the Indian Health Service drew on the Doctor Draft Act as the main source for its supply of needed physicians and dentists. Under that Act, physicians and dentists upon completion of their training were permitted to serve two years in the Public Health Service in lieu of their military commitment. Consequently, a large number of such health professionals were assigned to the Indian Health Service in fulfillment of their 2-year military requirement. However, the expiration of the Doctor Draft Act anthority on June 30, 1974, has had the practical effect of eliminating

this stable source of health professionals for assignment to the Indian Health Service. An absence of adequate housing facilities and the remoteness and cultural isolation of IHS assignments have added to the problem of recruiting professional staff.

Unfortunately, the Indian people cannot look to their own tribal members for relief from the health manpower shortage. There are only 50 known physicians of Indian descent currently engaged in the practice of medicine, and all but 2 or 3 are serving non-Indian patients.

S. 522 promises both to increase the number of health professionals serving Indians either as Indian Health Service staff members or private practitioners and to open new opportunities for young Indian men and women to enter the health professions for eventual service to their own people.

By and large the problems discussed above relate to those Indians who live on or near reservations and are members of federally recognized tribes of Indians. However, a substantial segment of the Indian population—a total of more than 400,000 Indians—resides away from the reservation, mostly in large urban centers. A different set of health service problems afflicts the urban Indians and yet the result is a health status for them quite similar to that of the reservation Indians.

S. 522 contains provisions aimed specifically at assisting urban Indians to develop health leadership among their own members and to establish a means of resource identification which will help to meet their most pressing health needs. An integral aspect of this effort will be the establishment of outreach programs to seek out individuals and families who require health care and refer them to services at the earliest possible date. In addition while current Indian policy prohibits the extension of the Indian Health Service hospital and medical care program to the urban centers, S. 522 proposes a new program which will permit the provision of basic health services to Indians concentrated in a number of major cities throughout the United States. It should be emphasized, however, that the funds designated for this program will in no way reduce the level of funding proposed to meet the serious health and medical needs for the thousands of Indian people residing on federally recognized reservations and in Indian communities. The members of federally recognized tribes and urban Indians should understand that S. 522 in no way sets up a "tug-of-war" between them for limited financial resources and services. Rather the measure addresses itself to the needs of both groups.

Conclusion

The Indian Health Service is the chief instrument through which a whole range of health care services can be delivered to the Indian people. Despite its record of accomplishment, the available evidence clearly demonstrates that the time has come to further strengthen that instrument.

The purpose, then, of S. 522 is to give the Indian Health Service the financial and human resources and the legal mandate to meet the continuing challenges of promoting better health and providing better health care among Indians.

III. THE INDIAN HEALTH MANPOWER SHORTAGE: BACKGROUND AND AN ANALYSIS OF TITLE I OF S. 522, AS AMENDED

The Shortage

INTRODUCTION

The degree of success of any health care delivery system is often measured by the extent to which its manpower—doctors, dentists, nurses, and other health personnel—meets the needs of the population it serves. Effective health personnel are a primary factor in the provision of quality health care; where manpower is in short supply or under-utilized the health care system is placed in serious jeopardy. These statements are particularly applicable to the Indian Health Service. At a time when Indians are expressing increasing confidence in the Indian Health Service by making greater use of its services, its capacity to fully meet this demand is being crippled by a manpower shortage of serious dimensions. Title I is designed to meet the challenge of the health manpower shortage in the IHS.

SOURCES OF MANPOWER

As noted in the preceding section of this report, Federal health services for Indians began under the auspices of the War Department in the early 1800's when Army physicians participated in a large scale effort to curb contagious diseases among Indian tribes located in the vicinity of military posts. In 1849, when the Federal responsibility for Indians was transferred from the War Department to the newly created Department of the Interior, the position of Chief Medical Supervisor was established and civil service health professionals were employed to deliver health services. For almost a century the source of manpower for health care was provided through the civil service until 1926 when officers of the Public Health Service Commissioned Corps were detailed to the Indian Health Service program.

Since 1926, the Commissioned Corps has been the primary source of health manpower for the Indian Health Service. Over the last few years, the great majority of these health professionals have entered the Commissioned Corps as a result of the selective Service which allows doctors and other medical personnel to serve their two year military commitment through the Public Health Service. In fact, in 1971 it was reported that nearly 70 percent of the physicans and dentists in the Indian Health Service were there in lieu of military service.

THE CURRENT CHALLENGE: INCREASE IN DEMAND AND DECREASE IN PERSONNEL

A combination of events has produced a manpower shortage of severe, if not crisis, proportions for the Indian Health Service.

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THE CURRENT CHALLENGE: INCREASE IN DEMAND AND DECREASE IN PERSONNEL

A combination of events has produced a manpower shortage of severe, if not crisis, proportions for the Indian Health Service.

First, the Indian Health Service has experienced a sharp increase in the demand for its services since 1955. For example, hospital admissions have jumped 107 percent during this 19 year period. During the same period the hospital utilization rate (admissions per 1,000 persons) for Indian Health Service and contract facilities has risen 41 percent.

HOSPITAL UTILIZATION RATE—INDIAN AND ALASKA NATIVES, FISCAL YEARS 1955–74

Fiscal year	Total		Indian health service		Contract	
	Number of admissions	Utilization rate per 1,000 population	Number of admissions	Utilization rate per 1,000 population	Number of admissions	Utilization rate per 1,000 population
1974	103,853	212.4	73,402	150.2	30,457	62.3
1973	102,350	213.5	75,245	157.0	27,105	56.5
1972	102,472	218.2	76,054	161.9	26.418	56.3
1971	94,945	206.6	70,729	153.9	24,216	52.7
1970	92,710	205.7	67,877	150.6	24,833	55.1
1969	94,490	213.9	69,560	157.5	24,930	56.4
1968	92,186	213.0	68,086	157.3	24,100	55.7
1967	89,556	211.3	65,456	154.4	24,100	56.9
1966	91,799	221.3	67,049	161.6	24,750	59.7
1965	91,744	226.1	67,744	166.9	24,000	59.1
1964	89,934	226.7	65,934	166.1	24,000	60.5
1963	87,549	225.7	64,749	166.9	22,800	58.8
1962	81,476	214.4	59,976	157.8	21,500	56.6
1961	74,313	195.5	54,313	142.9	20,000	52.6
1960	76,754	201.9	56,874	149.6	19,880	52.3
1959	73,268	198.0	54,568	147.5	18,700	50.5
1958	71,859	199.1	55,649	154.2	16,210	44.9
1957	66,455	188.8	53,160	151.0	13,295	37.8
1956	57,975	169.0	46,218	134.7	11,757	34.3
1955	50,143	150.2	42,762	128.1	7,381	22.1

Source: Indian Health Service, HEW, "Indian Health Trends and Services," 1974 Edition.

Outpatient visits to IHS hospitals, health centers, and field stations have increased each year since fiscal year 1955. Total outpatient visits in fiscal year 1974 were 2,361,654—five times as many visits as reported in 1955. Outpatient visits to field clinics have increased almost tenfold during the period 1955–1974.

NUMBER OF OUTPATIENT MEDICAL VISITS [1] TO IHS HOSPITALS AND FIELD HEALTH CLINICS—FISCAL YEARS 1955–74

Fiscal year	Total	Hospitals	Field clinics
1974	2,361,654	1,366,564	995,090
1973	2,329,160	1,330,660	989,500
1972	2,235,881	1,275,726	[2] 960,155
1971	2,195,240	1,202,030	993,210
1970	1,786,920	1,068,820	718,100
1969	1,661,500	982,300	679,200
1968	1,575,440	926,640	648,800
1967	1,494,600	849,800	644,800
1966	1,367,000	788,500	578,500
1965	1,325,400	757,700	567,700
1964	1,295,000	742,400	552,600
1963	1,271,400	721,700	549,700
1962	1,142,300	673,200	469,100
1961	1,022,600	628,700	393,900
1960	989,500	585,100	404,400
1959	957,900	546,900	411,000
1958	900,000	533,440	366,560
1957	650,000	510,000	140,000
1956 [3]	540,860	415,860	125,000
1955 [3]	455,000	355,000	100,000

[1] Excludes visits for dental services.
[2] Decreased because of underreporting of grouped services.
[3] Estimate.

Source: Indian Health Service, HEW, "Indian Health Trends and Services," 1974 Edition.

In the same nineteen year period, dental services have risen 415.4 percent.

NUMBER OF DENTAL SERVICES PROVIDED—FISCAL YEARS 1955–74

Year	Services provided	Percent increase over 1955
1974	927,701	415.4
1973	863,057	379.
1972	844,724	369.3
1971	776,168	331.2
1970	646,580	259.2
1969	634,479	252.5
1968	613,084	240.6
1967	545,509	203.1
1966	502,710	179.3
1965	495,006	175.0
1964	462,981	157.2
1963	398,452	121.4
1962	364,988	102.8
1961	348,776	93.8
1960	307,248	70.7
1959	283,206	57.3
1958	282,372	56.9
1957	249,048	38.4
1956	219,353	21.9
1955	180,000	----------

Source: Indian Health Service, HEW, "Indian Health Trends and Services," 1974 Edition.

This increase in the utilization rate of Indian Health Service hospitals has been the result of the increasing Indian awareness of medical care programs, gradually improving transportation, greater community stress on improved health, and direct Indian involvement in IHS program operations. Additionally, recent factors in this increase have been the impact of the Community Health Representative program and the work of Community Health Representatives in explaining IHS medical care services in Indian communities and assisting Indians in making use of IHS facilities.

These increases in demand have placed considerable pressure on existing facilities and, more importantly, on the medical staff of the Indian Health Service. The need for increased numbers of health care personnel dominates the current problems facing the Indian Health Service, as the following figures clearly illustrate.

STAFF SHORTAGES BY PROFESSION

PHYSICIANS

	Funded positions	Actual number Dec. 31	Vacancies on Dec. 31	Actual needs [1]	Shortage including vacancies
Fiscal year:					
1970	437	432	5	613	181
1971	466	456	10	625	169
1972	522	506	16	637	131
1973	536	514	22	649	135
1974	523	492	31	661	169
1975	528	495	31	664	169

[1] Based upon an estimate of 1 physician for 750 people. The overall U.S. average is 1 physician for every 600 people.

NURSES

	Funded positions	Actual number	'Vancancies	Actual needs	Shortage including vacancies
R.N.S—including PHN's, fiscal year—					
1970	1,101	967	134		134
1971	1,118	1,015	103		103
1972	1,165	1,012	143		153
1973	1,169	1,017	152		152
1974	1,189	1,069	120	1,463	394
1975	1,194	1,068	126	1,468	400
All other nursing personnel, fiscal year—					
1970	1,221	1,164	57		57
1971	1,278	1,225	53		53
1972	1,285	1,221	64		64
1973	1,264	1,162	102		102
1974	1,229	1,173	56	2,215	1,042
1975		162	150	332	172

PHARMACISTS

	Funded positions	Actual number	Actual needs	Shortage including vacancies
Pharmacists:				
1971	137	137	307	137
1972	157	157	307	150
1973	158	158	323	165
1974	162	160	322	162

OTHERS

	Funded positions	Actual number [1]	Actual needs	Shortage including vacancies
Community health representatives,[2] fiscal year—				
1971	(3)	410	1,840	1,430
1972	(3)	618	1,876	1,258
1973	(3)	718	1,916	1,198
1974	(3)	968	1,992	1,024
Community health medics (excludes Alaska), fiscal year—				
1971		0	100	100
1972	0	0	100	100
1973	0	25	100	75
1974	0	41	[4] 200	159

[1] CHR's and CHM's are not counted while in training status.
[2] CHR's are contractor employees, not IHS employees.
[3] As these personnel are tribal employees, no position authority is required.
[4] Estimate of total need revised on experience with CHM's.

Staff shortages in IHS faciilties, fiscal year 1974

Hospitals:
Number of hospitals (out of 51) meeting staffing standards:
1. 80 (100 percent) ---- 18
2. 60 (79 percent) ---- 19
3. 40 (59 percent) ---- 14
4. Less than 40 percent ---- 0

Outpatient clinics:
Number of clinics (out of 51) meeting staffing standards:
1. 80 (100 percent) ---- 9
2. 60 (79 percent) ---- 12
3. 40 (59 percent) ---- 13
4. Less than 40 percent ---- 17

Number of health centers (out of 57) meeting staffing standards:
1. 80 (100 percent) ---- 28
2. 60 (79 percent) ---- 26
3. 40 (59 percent) ---- 3
4. Less than 40 percent ---- 0

Yet, instead of relief from personnel shortages, the Indian Health Service suffered a significant setback with the end of the military draft.

During the twenty-five year existence of the military draft, the Public Health Service experienced no difficulty in obtaining physician manpower since male professionals completing training could serve their 24 month Selective Service obligation in the Public Health Service in lieu of the military services. Many took the opportunity which this option offered and joined the Public Health Service—so many in fact that the PHS enjoyed an application rate of about three physicians for every available position. Following the end of the draft on June 30, 1973, however, the Public Health Service experienced a shortage of 200 physicians. The Indian Health Service found itself with twenty-two physician vacancies, six after one year of service. By the fall of 1972, the IHS had applications from only approximately 100 physicians wishing to begin service as of July, 1973. This compares unfavorably to the fall of 1971, 1970, and 1969, when respectively, 300, 500, and 700 applications were received. As of November 1, 1974, the Indian Health Service had received only 39 applications from physicians wishing to serve as of July, 1974. In addition, the IHS anticipates calling to duty approximately 52 physicians now interning who participated in the Early Commissioning Program of the Public Health Service and are obligated for two years service. These figures are particularly discouraging to the IHS which, with a total complement of approximately 500 physicians, annually must fill 170–200 vacancies created by departing medical officers, usually after two years of service.

In essence, the elimination of the "doctor draft" and its stable source of manpower has placed the Indian Health Service in a precarious position. Without immediate help to alleviate its shortage in personnel, the Indian Health Service could suffer a major crisis because demand for health care services will substantially exceed the ability of the IHS to deliver them.

The issue, however, is not just maintaining current levels of manpower, but developing a program which will bring health manpower levels up to parity with the general population.

The number of Indian Health Service physicians and registered nurses per 100,000 persons served by the IHS has continually lagged behind the rate for the general population, although a degree of success in closing the gap was registered prior to the end of the doctor draft. The number of physicians per 100,000 population in 1971 in the Indian Health Service, was 58 percent of the U.S. rate. In 1960 the IHS rate was less than 40 percent of the U.S. rate. Whereas the rate for registered nurses in the general population has experienced a continual increase from 1956 through 1971, the rate for registered nurses within the IHS has remained almost constant. The rates for the IHS range from a low of 213 registered nurses per 100,000 population in 1967 to a high of 230 in 1956.

The figures below clearly indicate present need—a need which is becoming greater as the demand for services increases.

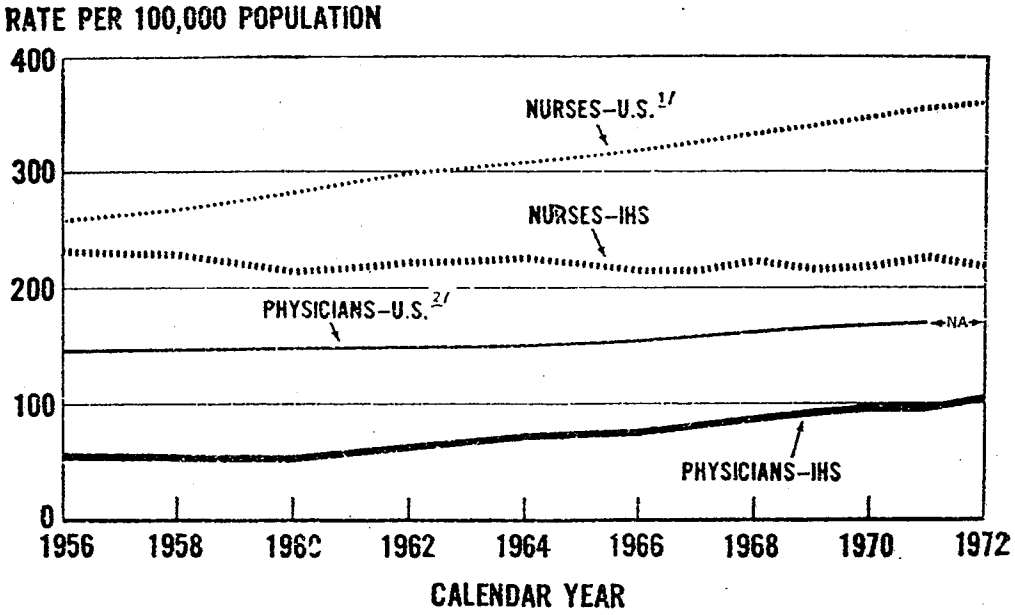
NUMBER OF REGISTERED NURSES AND PHYSICIANS—INDIAN HEALTH SERVICES AND UNITED STATES ALL RACES

Year	Registered nurses			Physicians		
	Number IHS staff	Rate per 100,000 IHS	Rate per 100,000 United States [1]	Number IHS staff	Rate per 100,000 IHS	Rate per 100,000 United States [2]
1973	1,079	225	NA	479	100	178
1972	1,057	225	361	479	102	174
1971	1,073	228	356	458	98	[3] 170
1970	1,007	219	347	449	98	[3] 166
1969	981	217	338	425	94	[3] 163
1968	984	222	331	392	88	[3] 161
1967	930	213	325	357	82	158
1966	909	212	319	335	78	156
1964	913	222	306	299	73	151
1962	875	221	298	256	65	NA
1960	809	213	282	216	57	148
1958	828	229	268	209	58	NA
1956	790	230	259	195	57	NA

[1] Facts about nursing.
[2] Health resources statistics, 1972–73.
[3] Estimated.
NA—Not available.

Source: Indian Health Service.

PHYSICIAN AND REGISTERED NURSE RATES
INDIAN HEALTH SERVICE AND U.S.



Source: Indian Health Service.

Statistics can never describe a situation as well as the experience of living it. The following poignant letter from an IHS physician to Senator Jackson, Committee Chairman, tells of the frustrations the doctor has felt in attempting to provide decent health services in an environment of chronic staff shortages:

WINSLOW, ARIZ., *October 2, 1974.*

Hon. HENRY M. JACKSON,
U.S. Senate, Permanent Subcommittee on Investigations, Russell Senate Office Building, Washington, D.C.

DEAR SENATOR JACKSON: I am writing in support of the Indian Health Improvement Act S.B. 2938.

I am a physician who has been working with the IHS for 15 months. I would like to state at the outset that this is my personal opinion and is not necessarily representative of my Service Unit in general.

I came to IHS, by choice, *after* the draft was over. There are many aspects of my job that I find fascinating, challenging, and fulfilling. I could make this my permanent job. However, there are also many aspects of my job that I find most frustrating.

Our hospital is ancient and run down—I knew this and was willing to work around the physical deficits. However, equipment and staff shortages have compounded small problems, making them into almost insurmountable obstacles.

Our nursing staff has always been short even when our "quota" is full—as it seems to me. We've barely been able to get by when full, but we've been below "quota" for almost the entire time I've been here. Multiple reasons for this. Nurses quit and we wait 6–8–10 weeks for a replacement. In the meantime, remaining nursing staff work 12–16 hour shifts to provide coverage. They work when they're sick because there's no one to take their place. They get called in on their annual leave or simply can't take annual leave because of no one to take their place. Besides this, they have never, since I've been here, had time to act as a nurse. They spend a good half or more of their time doing housekeeping, orderly work, and aide work because these positions are not provided in sufficient amount. Consequently, nursing, for which they trained so long, gets neglected for lack of time. The nurses put up with this for 3 months or 6 months, or maybe a year and then leave out of frustration. Last week, there was not a blanket or a towel in the whole hospital and a newborn had to be wrapped in sheets. If a new patient was admitted then, that patient would sleep on a bed without sheets because all the sheets were used to wrap the baby.

Patients on the average have to wait 4–5 hours to be seen. Many reasons for this. There is not enough lab personnel, by any stretch of the imagination or statistics—this delays things and backs up the clinic. The physical setup is horrible for a clinic. There are 6 small rooms, crowded together with patients wandering in and out, interrupting nurses and doctors and getting in the way. There was no appointment system. There was no appointment clerk or receptionist to answer simple questions.

We changed that. We took an aide (which left us one more short in that area) and made her into an appointment clerk. I set up an appointment system one month in advance. Setting up 1 month's appointment schedule took 6 hours to do at night on my free time as we were short of physicians and I had no other time to do it. I put up signs and broadcasts over the radio that we would now have an appointment system. I promised people, that if they could be on time,

even though they drive up to 80 miles on dirt roads, that they would not have to wait. This system could only work with 3 nurses in the clinic. For the first two weeks, I had 3 nurses. I have had 1 or 2 since because of shortages, sickness, or leave. Many extra hours of work are going down the drain. Patients are mad because I lied and told them they wouldn't have to wait so long any more. Many patients are travelling additional distances to other Service Units because they have to wait so long here. The ones that do come here won't listen to a word we say about health because they're mad after waiting four hours to be seen.

Doctors and nurses have come and gone rapidly. There has been no continuity of care and no long range ongoing programs. We work so hard just to keep up that there's little time to develop new programs, and no money or personnel to fulfill them if we did.

For a full month, I was in the hospital day and night. I hardly saw my wife and kid. At the same time, patients were screaming at *me* for making them wait. They told me I was a lousy doctor. They demanded instant care day and night and expected me to smile and serve them because—I worked for the IHS.

I'm tired of working an average of 80–90 hours a week under these conditions.

I'm tired of lying to people.

I'm tired of not seeing my wife who's threatened divorce, not out of lack of love, but out of lack of visual contact with me.

To put it quite bluntly, the government has to fund the program, provide equipment and staff or get out.

As I said before, there are so many aspects of this job that are challenging, fascinating, and fulfilling. I'd like to stay here. If things don't change, I'll leave, just like so many other dedicated people have left because of the "system" and the shortages.

Sincerely,

THOMAS DUDLEY BECK, M.D.

THE RESPONSE TO THE CHALLENGE

On November 19 and 20, 1973, the Subcommittee on Indian Affairs held hearings on the manpower problems facing the Indian Health Service. Dr. Charles C. Edwards, former Assistant Secretary of Health, Department of Health, Education, and Welfare, testified regarding his Department's response to these problems:

> The issue which this Committee has asked us to address is namely, "What is being done to overcome these disparities?" Before addressing the specifics of our efforts, I would like to suggest that the total manpower needs can be affected by optimum utilization of manpower currently on duty. In this connection it is important for the Committee to know that the last several years, the Indian Health Service has been emphasizing the health team approach to the delivery of health services. This approach is designed to extend the capability of certain team members to provide high quality services. An

example of this team approach may be found in the Community Health Medic activity. In this activity the CHM's work is an integral part of the health care delivery team, relieving the physician of many tasks which can be accomplished equally as well by one who has less training. In addition, the CHMs provide assistance to communities to organize and attack underlying causes of health problems. A preliminary analysis of the effect of this activity indicates that the capability of physicians to render health care services has been greatly extended. While such activities tend to increase efficiency, they obviously do not eliminate the need for physicians, especially in view of the increasing Indian population being served along with increased use of services.

Both the team approach and the improved utilization of scarce manpower resources are management considerations, Another management consideration is the acceptance of the physician assigned to an Indian community by the members of that community, and interest in the needs of the community by the physician. Without such mutual acceptance, the chances of retaining physicians in the Indian Health Service are decreased. The Indian Health Service has made a significant effort to get Indian people involved in their health program. Not only does this effort help the Indian people towards self-determination, but it also helps the people in the community served and the physician who is providing the service to increase the chances of mutual acceptance.

Personnel practices of the type which appear to offer some promise regarding professional staff retention include outside the Service long term training coupled with payback assignments, short term training, and rotation of personnel assigned to less desirable stations with those assigned to more desirable stations.

Other projects now being carried out by the Department may also affect the utilization of and the need for physicians. The health agencies have participated with other parts of HEW and other agencies and departments, for that matter, in experiments in telecommunications directed toward improving the care to Indians with use of sophisticated technologic support. The ATS–1—Applications Technologic Satellite—was used to provide communications to 26 villages in Alaska via two-way audio to improve diagnostic discussions. Radio communications are effective only about 25 percent of the time in those localities. Reliable communications provided important diagnostic information and aided in appropriate use of air flights to bring needy patients to sources of emergency medical services. Plans are underway to do additional studies with the satellite which will evaluate the use of audio-video devices by paramedics communicating with Public Health Service hospitals for advice. There are also plans for an extensive study of primary care to the Indian reservations using a variety of telecommunications mechanisms . . .

Recognizing the increasing severity of the personnel problem resulting from the end of the "doctor draft", the Department—through the Office of the Assistant Secretary for Health—has mobilized a substantial recruitment program. Recruiters are now recruiting in every one of the Nation's medical schools and a number of medical organizations and hospitals throughout the Nation to make known the professional rewards available to career physicians in Public Health Service programs, such as the Indian Health Service.

In addition to the Departmental emphasis, in the fall of 1972 the Indian Health Service separately launched several programs to enhance its physician recruitment efforts. Such programs included mass mailing to all interns, medical students, and practicing physicians; mass advertising in medical periodicals; classified advertising; a program to actively involve Indian leaders and communities in physician recruitment; personal correspondence and phone conversations with interested physicians; visitations to medical schools, hospital centers, and professional meetings; and enhancement of a program to provide short-term periods of 2–3 months of clinical experience for medical students at reservation facilities. The results have been promising and an additional 69 physicians were recruited for duty beginning in the summer of 1973, this past summer. We are hopeful that the long-range impact of these efforts will be even more substantial.

To aid in the recruitment effort, there are three programs authorized which would provide incentives for scarce health manpower to seek assignments in the Public Health Service. These programs include:

1. The Early Commissioning Program during the 1972–73 school year supported 250 students in their senior year of medical school. Of this number, 56 are obligated to serve 2 years in the Indian Health Service following completion of internship or residency training. About 47 of these physicians are scheduled to commence service with the Indian Health Service in July 1974. The remainder will be deferred until the completion of residency training in fiscal year 1976–78.

2. The Public Health-National Health Service Corps Scholarship Program, enacted by the Congress in October 1972, as section 225 of the Public Health Service Act, authorized us to provide scholarship support for students in health disciplines. Unlike our early commissioning program, which is limited to 1 year of training, the new scholarship program will permit up to 4 years of support in exchange for obligated service on a year-for-year basis, but not less than 2 years. Although the enabling legislation limited this scholarship authority to an expenditure of $3 million during fiscal year 1974, the President's 1974 Budget contemplates not only full funding for this program, but a substantial expansion of the program beyond its present authorization level, for a total of $22.5 million in 1974. Funding of the program at that level would provide full support for approximately 2,000 health

professional students. The provisions of section 225 which created NHSC as presently drawn, however, are unnecessarily restrictive. The appropriations authorization not only is too low to permit funding of the program at $22.5 million, but in addition covers only fiscal year 1974. We believe that substantially larger funding than $3 million is warranted for this program and that it should be available for use indefinitely. Legislation has been submitted to the Congress to accomplish this purpose.

3. The Commissioned Officer Residence Deferment Program—CORD—was a program operated during the existence of the draft. This program permitted physicians to complete residency training prior to the commencement of their draft obligation in the Public Health Service. Although the draft has ended, we do expect that some of these professionals feel morally obligated to fulfill their agreed period of service following training. For next fiscal year, we expect to retain some trained specialists in the Indian Health Service from this program.

While we are confident that these programs will provide a part of our manpower needs, they are not, certainly, a total solution. Without the incentive of the draft, we must now address realistically the need to bridge the gap between the professional opportunities in the Public Health Service and those available in the private sector, particularly with regard to retention.

The disparity between income levels of health professionals inside and outside the Indian Health Service is a contributing factor to the recruitment and retention of Public Health Service officers. The circumstance is similar in the military and a variety of bills, including S. 368, Uniformed Services Special Pay Act, attempt to partially resolve this dilemma by creating pay bonuses of up to $15,000 per year for physicians and other health professionals. The Department will be requesting authority to offer bonuses to health professionals of the Commissioned Corps under this provision so that the Secretary may offer additional financing incentives to health professionals in programs experiencing shortages of such personnel. We are confident that if legislation is enacted, which includes bonuses for our health professionals, an obstacle to sufficient health professional staffing will have been removed.

[NOTE: On May 6, 1974, the President approved legislation (PL 93–274) to increase special pay and re-enlistment bonuses for physicians in the Armed Services. Specifically, this legislation increases monthly special pay for doctors to $350 after completing 2 years of service; under prior law, doctors became eligible for the $350 monthly special pay only after 10 years of service. The legislation also authorizes the Defense Department and the Department of Health, Education, and Welfare to pay an annual bonus of up to $13,500 to physicians who agree to remain on active duty for any number of years under a written agreement.]

> The authorized programs are in various stages of implementation. In some cases, they are already underway. In other cases, the Department has requested necessary legislation or appropriations. In all cases, it is hoped by the Department that the overall effect of these programs when fully implemented will contribute substantially to meeting the manpower needs of the Public Health Service.

Other programs available to meet manpower needs include the Bureau of Indian Affairs Scholarship Program and Federal health manpower scholarship programs which take the form of either scholarship assistance in return for service, or loans with a cancellation feature when the students elect to serve, in health manpower shortage areas. There are numerous programs but most employ one of these approaches as an incentive to service in a shortage area. The four major programs are described below. The first three are administered under the Health Professions Student Assistance Program in the Bureau of Health Resources Development (BHRD) of the Health Resources Administration, Department of Health, Education, and Welfare. The fourth program is administered by the Public Health Service.

1. The Health Professions Loan Cancellation Program was authorized by the Health Professions Educational Assistance Act of 1965 (P.L. 89–290) and amended by the Allied Health Professions Personnel Training Act of 1966 (P.L. 89–751). Under this program, if a physician, dentist, or optometrist practices in a health manpower shortage area and the State Health Authority certifies that such practice helps to meet that areas's need for health services, then 50 percent of the practitioner's Federal Health Professions Student Loan that is unpaid on the first day of such practice, plus interest, may be cancelled by the Secretary of HEW at the rate of 10 percent for each complete year of practice. If the health manpower shortage area is designated a rural, low-income area, the total unpaid balance may be cancelled at the rate of 15 percent per year of practice.

Any individual who wishes to participate in this program must: (1) be licensed to practice medicine, osteopathy, dentistry, or optometry; (2) practice his or her profession in a designated shortage area for 12 consecutive months; and (3) have the appropriate State health authority certify his or her eligibility for loan cancellation.

Since the program is a cancellation program, no funds are authorized or appropriated. Cancellation benefits are credited to the loan recipient's account at the school from which he received the loan. At the time this program was in effect a student could receive a maximum loan of $2,500 per academic year.

2. The Health Professions Loan Repayment Program—replacing the loan cancellation program—was authorized by the Comprehensive Health Manpower Training Act of 1971 (P.L. 92–157). The repayment program authorizes the Secretary of HEW to repay up to 85 percent of an individual's educational loans—from any source—

incurred for the costs of education at a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy in return for service in a health manpower shortage area.

To be eligible for the loan repayment program, an individual is required to demonstrate: (1) licensure or completion of steps necessary for licensure to practice in a health manpower shortage area; (2) completion of necessary arrangements for practice; (3) professional education and receipt of a professional degree in medicine, osteopathy; dentistry, veterinary medicine, optometry, pharmacy, or podiatry; and (4) unpaid educational loans eligible for partial repayment.

In order to participate in the program, the individual must enter into an agreement with the Secretary of HEW to practice his profession (as an individual private practitioner or as a member of the National Health Service Corps) in a health manpower and shortage area for two or three years. Shortage areas are determined by the Secretary after consultation with the appropriate State health authority.

Under the terms of the program, the Secretary will repay those portions of an individual's professional educational loans, plus interest, which are outstanding on the beginning date of the agreement, at the rate of 60 percent for the first two years of service in a shortage area and an additional 25 percent for a third year of service.

Although no funds are specifically authorized in P.L. 92–157 for the loan repayment program, the Administration requested $400,000 for fiscal year 1974 and $600,000 for fiscal year 1975 to make repayment of loans. Congress appropriated $400,000 for fiscal year 1974. P.L. 92–157 expired on June 30, 1974. Legislation is currently pending in Congress to reauthorize it.

3. The Physician Shortage Area Scholarship Program was authorized by the Comprehensive Health Manpower Training Act of 1971 (P.L. 92–157). An eligible medical or osteopathic student may receive up to $5,000 a school year for a maximum of four years. For each academic year of support, the scholarship recipient must agree to practice primary care for a 12-month period in an area short of physicians or where a substantial number of patients are migratory farm families. A recipient of a scholarship for four years may repay one year by serving an internship or residency in primary care in a hospital located in a shortage area or having a substantial number of patients who are migratory farm workers or their dependents. If a recipient of a scholarship fails to complete his or her service obligation, he or she must repay a proportionate amount of the scholarship plus interest and only half of his or her service time will be credited.

Scholarships are awarded to students of medicine or osteopathy according to the following priorities: (1) applicants from low-income families who reside in a physician shortage area and agree to return there, after completing training, to practice primary care; (2) applicants who reside in a physician shortage area and agree to return there,

after training, to practice primary care; (3) applicants from low-income families; and (4) other applicants.

Physician shortage areas are designated by BHRD in consultation with State and local health authorities. Primary care refers to general practice, family practice, internal medicine, and pediatrics.

Public Law 92–157 expired on June 30, 1974. However, legislation has been approved by the Senate to extend this program through fiscal year 1975 while Congress considers the reauthorization of Federal health manpower programs.

4. The Emergency Health Personnel Act Amendments of 1972 (P.L. 92–585) established the Public Health and National Health Service Corps Scholarship Training Program to obtain trained physicians, dentists, nurses, and other health related specialists for the National Health Service Corps and other units of the Public Health Service. Currently, only students of medicine and osteopathy are eligible to receive scholarships.

To be eligible for acceptance and continued participation in the program, an applicant must be: (1) enrolled as a full-time student in an accredited U.S. school of medicine or osteopathy; (2) a citizen of the United States; (3) physically qualified; and (4) maintaining an acceptable level of academic standing.

Depending upon the need for health manpower, scholarship recipients may serve in a variety of work environments and geographic locales, including: National Health Service Corps providing health care to medically underserved communities, Public Health Service hospitals and outpatient clinics, Indian Health Service hospitals, clinics and field stations, U.S. Coast Guard medical facilities, or Federal prison medical facilities.

Under the scholarship program, students are obligated for one year of service for each year of academic training (with a minimum obligation of two years). Obligatory service generally begins upon completion of one year of post-graduate training (internship). A limited number of professionals may be approved by the Public Health Service for additional specialty training outside the PHS and obligatory service may be deferred until completion of such training.

No funds were authorized for the program in fiscal year 1973—the year the program was enacted. Congress authorized $3.0 million for the program for fiscal year 1974 and appropriated the full authorization.

P.L. 92–585—the legislation authorizing the scholarship program—expired on June 30, 1974. New legislation is currently pending in Congress to reauthorize the scholarship program. In anticipation of reauthorization, the Administration has requested $3.0 million to be appropriated for the program for fiscal year 1975. In addition, the Administration made a supplemental request for $19.5 million for the program for fiscal year 1975, which was approved.[1] In addition, the

[1] More complete descriptions of these programs, including the sizes of the scholarships, the numbers of recipients, and methods of administration, are contained in a July 8, 1974, Congressional Research Service, Library of Congress, report commissioned by the Committee.

Senate approved recently legislation to increase the number of positions for health professionals as members of the Corps.

In summary, it appears to be the position of the Administration that shortages in health manpower can be met by more effective use of current staff, existing recruitment and scholarship programs, and financial incentives.

PROGRAM AND POLICY INADEQUACIES

While the Committee wishes to commend the current effort to overcome the shortages in health manpower facing the Indian Health Service, it nevertheless is convinced that the existing programs and policies are substantially inadequate to meet the *total* manpower needs of the IHS.

It is the Committee's view, after considerable study, that current policies and programs are too limited in scope, lack sufficient incentives, or are unrelated to Indian Health Service needs. Specifically, the Committee has noted the following deficiencies in the three basic Federal programs which have the potential of providing IHS staff.

The *Military Bonus Program* does offer additional assitance to physicians in the Public Health Service to help overcome the monetary disparities which exist between PHS personnel and physicians in private practice. While this may prove helpful to physicians serving in the Indian Health Service, other health personnel, such as dentists, are not covered.

Existing *HEW scholarship programs* designed to alleviate manpower shortages by providing financial assistance in return for service are inadequate, poorly administered, and, except for the National Health Service Corps Scholarship Training Program, do not relate to the Indian Health Service.

Several recent reports have highlighted problems concerning these various scholarship programs:

Two reports—a General Accounting Office report, *Congressional Objectives of Federal Loans and Scholarship to Health Professions Students Not Being Met*, and a CONSAD Research Corporation independent study, *An Evaluation of the Effectiveness of Loan Forgiveness as an Incentive for Health Practitioners to Locate in Medically Underserved Areas*—evaluated the loan cancellation program and both found it wanting. The GAO Study found that less than 1 percent of the individuals eligible for the Federal loan forgiveness program chose to participate in the program. About 30,000 medical and dental students received health professions student loans between 1965 and 1972. Of that total, by October 1973, only 86 physicians and 133 dentists had obtained cancellation of a portion of their loan for practicing in a designated shortage area. Equally significant,

however, the study concluded that those individuals requesting loan cancellation would probably have located their practice in shortage areas anyway. The study indicated that loan forgiveness was not an effective incentive with respect to choice of practice location.

The independent study supports GAO's conclusions:

> On balance, the forgiveness programs have as yet contributed very few health practitioners to shortage areas. Unless the current levels of performance change radically in the next few years, it appears unlikely that loan forgiveness will have a noticeable impact on the distribution of health practitioners in underserved areas. Further, the participtation rates for dentists, most of whom have made location decisions, suggests that the current levels of performance are not likely to change radically for physicians.
>
> We cannot conclude from this data that foregiveness was an incentive to enter shortage areas for those whose loans were forgiven. They may have entered for other reasons and accepted forgiveness as a windfall. But we can infer that if few practitioners are attracted to the forgiveness program, it is likely to be a rather weak incentive.

The GAO study reviewed not only the Health Professions Loan Cancellation Program but also the other scholarship programs under the Health Professions Student Assistance Program. The GAO found that, in brief, the entire program has not had "a significant impact on increasing the output of the Nation's medical and dental schools, improving the quality of medical and dental students, and influencing medical and dental school graduates to locate in shortage areas. Although the program undoubtedly had made the health professions more accessible to students from low-income families, its efficiency and impact in this regard could be greatly improved."

Clearly, the dominant theme of these reports is that existing Federal scholarship programs are weak in their capacity to meet health manpower shortage needs.

They fail, for example, to effectively link the scholarship recipient to areas of need. In fact, it appears to the Committee that the current programs often make it difficult for the recipients to arrange for service in manpower shortage areas. Such a situation hardly builds confidence in the argument that such programs could help eliminate health manpower shortages.

In addition, the existing programs provide scholarships which are often financially insufficient to attract interest and participation. Because of this weakness the effort to meet health manpower needs is severely impaired.

The GAO report also indicated administrative weaknesses in the scholarship programs. In regard to the loan cancellation provisions, the GAO indicated that this program had a "negligible impact on medical and dental school graduates' decisions on the location of their practices because most of the students have not been made aware

of the provisions before graduation." This lack of interest by current program administrators makes it difficult to believe that through these kinds of programs health manpower needs could be effectively met.

Finally, a special problem has arisen with regard to those scholarship loan programs which can be cancelled in return for service. Apparently, the Internal Revenue Service has determined that "forgiven" loans should be considered income and that taxes must be paid in the year they are cancelled. This decision makes such provisions even more unattractive.

Although these reports did not discuss the relationship of existing scholarship programs to the needs of the Indian Health Service a number of problems are apparent:

First, the existing programs do not link the recipients directly to the Indian Health Service. Many of the existing programs are either administered by financial aid officers at colleges and universities or by agencies other than the IHS in the Department of Health, Education, and Welfare. Under this form of administration there is little appreciation for the manpower needs of the Indian Health Service. Without a direct relationship with the IHS, the recipient feels little obligation to meet his service commitment which is required under these scholarship programs.

Second, the current programs are not designed to recruit and support Indians. In brief, they fail to attract Indians because they lack sufficient Indian orientation. Yet, all observers agree that, if the Indian Health Service is to succeed in meeting its manpower needs, it must attract Indian people to its staff. In 1974, the IHS, out of 500 doctors, had only 3 Indian physicians.

Third, existing programs cannot provide sufficient financial support to health professions students, particularly Indians who usually require more resources than non-Indians. A recent study by the Indian Medical Program (INMED) revealed that a number of Indian students either could not obtain any funding, though fully qualified, or had to obtain financial support from a number of different sources. In regard to the latter problem, which affects both Indian and non-Indian alike, the applicant must confront a maze of applications for various programs and considerable uncertainty. Under such conditions any effort to meet manpower objectives is endangered simply because the existing system lacks the ability to effectively match resources with need. The Committee was impressed by stories of students, many of whom were Indians, who gained acceptance to medical schools, or other health service training programs, but could not obtain sufficient funding for their education from any one source or even any combination of sources.

The following table contained in the INMED study demonstrates that study's findings:

[NHA—Navaho Health Authority; NMF—National Medical Fellowship; PSS—Physical Shortage Area Scholarship; PHS—Public Health Scholarship Program]

Name	Need	Tribe	Agency	School accepted	Funding	Applied for
Larry Dauphanias		Chippewa	Turtle Mountain	North Dakota	$1,220 BIA	NHA, NMF.
Richard Asher	$10,000		Muskogee	Colorado	½ by BIA	NHA, BIA, PHS, NMF, PSS.
Ed. Chapabitty	9,220	Comanche/Apache	Anadarko	Colorado	½ by BIA	NHA, NMF, BIA.
Bob Sarcarell		Stockbridge/Munsee		University of North Dakota	GI Bill	
Linda Schultz			Klamath	University of North Dakota		NHA, NMF, PSS, PHS.
Tom Abe		3 tribes	Fort Berthold	University of North Dakota		NHA, PHS, PSS, BIA.
Mike Vinson		Chickasaw		Harvard	½ BIA	PSS, BIA.
Anthony Orme		Comanche		Creighton	½ BIA	
Lois Steele	11,200	Assiniboine	Fort Peck	University of Minnesota (Duluth)	Part-time job	NMF, PSS, PHS.
Gary Pitt		Flathead		Dental School, University of Minnesota (Duluth).		
Margo Powers			Montana	Creighton		
Wally Brown	8,500		Red Lake	University of Minnesota		BIA, AIS, Donne, NHA.
Joseph Jacobs		New York		Yale (junior)		
Vicki Stevens	3,000	San Carlos Apache	Arizona	Arizona (junior)		Meade Johnson scholarship.
Irvin Lewis		Navajo		New Mexico (junior)		
Mike Quimett	6,500	Chippewa		Duluth (sophmore)		BIA, AIS, Donne NHA.
Don Bowen		Creek		Tennessee (junior)		BIA.
Ed LaDue	8,400		White Earth	University of Minnesota (sophmore)		BIA, AIS, Donne NHA.
Allen Johns	4,100	Oneida	Wisconsin	University of Minnesota (sophmore)		BIA, AIS, Donne NHA.
Paul Campagna		Oneida		Darthmouth (sophmore)	Loans	School Financial Aide.

Source: INMED, University of North Dakota, Grand Forks, N. Dak. The data are drawn from the 1974–75 school year.

Finally, most Federal health manpower programs provide support to a limited category of health professionals. For example, under the Physician Shortage Area Scholarship Program, only medical or osteopathic students are eligible for financial assistance. Other programs do include additional student categories, but none provide support for the whole range of health manpower personnel. The result is that current programs are uneven in scope and opportunity.

All of these problems clearly lend support to the Committee's view that the current HEW scholarship programs do not respond to the needs of the Indian Health Service.

The *Bureau of Indian Affairs Scholarship Program* is equally, if not more, inadequate. At the present time the BIA supports approximately 13,500 students. Of these, 200 students are enrolled in courses in the health sciences of which 17 are in medical schools and 6 are in dental schools.

The deficiencies in the BIA program, however, would make it difficult for the BIA to support a broad scale attack on the health manpower shortages of the Indian Health Service. First, the BIA received almost $23 million for scholarship support in 1974 and approximately $32.5 million in 1975 against an estimated need of $42 million. In light of this need, BIA support of training health professionals would have to be necessarily limited. Second, the Committee believes it makes little sense to have a program in one agency which provides financial support for the training of personnel for another agency. Instead the Committee suggests that the administration of health training programs more properly belongs to the Indian Health Service, not to the BIA.

In conclusion, the available evidence supports the Committee's view that current programs and policies are inadequate to meet the challenge of overcoming the serious health manpower shortages in the Indian Health Service. What is needed is a new approach which the Committee, through S. 522, is committed to realizing.

Title I of S. 522, as Amended

COMMITTEE OBJECTIVES

After evaluating the capacities of existing programs and their potential for responding to the manpower shortages in the Indian Health Service, the Committee is convinced that the Indian Health Care Improvement Act should include provisions which would achieve the following objectives:

First, that an Indian oriented health manpower program be established.

Second, that the health manpower program be designed to support the broad objective of eliminating health manpower shortages in all health care areas affecting the Indian Health Service.

Third, that the various elements of the health manpower program be interrelated and be subject to effective coordination and management.

Fourth, that the administration of an Indian oriented health manpower program be assigned to the Indian Health Service.

Fifth, that a scholarship program be designed to specifically increase the supply of health professionals for the Indian Health Service.

Sixth, that the scholarship program provide sufficient financial support to attract highly qualified participants, especially Indians, and to fully meet their educational needs.

These objectives were followed in developing the provisions found in Title I of S. 522.

PROVISIONS OF TITLE I

Title I contains six separate but interrelated programs designed specifically to meet the health manpower needs of the Indian Health Service and to produce more Indian health professionals. The Committee assigned the administration of this comprehensive "package" of programs to the Indian Health Service because it believes that the IHS, as an established agency with the specific mission to provide health care to Indians, possesses the necessary administrative machinery and the relevant expertise to effectively manage those programs. More importantly, however, the Committee expects that under this administrative assignment the Indian Health Service will quickly realize that it is in their own "self-interest" to assure the successful implementation of these programs. Failure to do so will surely plunge the Indian Health Service into a prolonged and likely dangerous manpower shortage.

This linkage of agency self-interest and manpower programs represents a significant change in the present approach to administering Federal health manpower programs. Instead of continuing to follow the pattern of unrelated manpower programs, most of which are administered by colleges and universities on behalf of individual students, Title I definitely establishes in the Indian Health Service a manpower program to directly service the interests of that agency. No longer will the Indian Health Service have to wait for assistance, often in vain, from other program sources but will be able to control events so as to realize its manpower objectives on a rational basis.

Following is an outline of the various manpower programs of Title I:

Health Professions Recruitment Program for Indians

Program Description.—The Health Professions Recruitment Program for Indians to be established by section 102 is a grant program designed to enable public or non-profit private health or educational agencies, Indian tribes, or tribal organizations to identify Indians who have the potential for pursuing health careers, to assist them in enrolling in schools offering courses in health careers, to help prepare such students to qualify for enrollment through post-secondary training, to publicize existing sources of financial assistance, and to establish such other programs as will facilitate the enrollment of Indians in health care training programs.

Program Rationale.—The Committee believes that a recruitment provision is vitally necessary to the realization of the objective of increasing the number of Indian health professionals. In addition, the Committee feels that a recruitment program is necessary if the other programs in Title I are to succeed.

Although the Bureau of Health Manpower of the Health Services Administration, Department of Health, Education, and Welfare, has ended an Indian health recruitment program which had been operating for two years, the Committee believes that such a program

is necessary and appropriate and should be continued in the Indian Health Service.

With respect to the administration of this program, the Committee wishes to stress that, because of the social, cultural, and geographical isolation of Indians, Indian organizations experienced in working with the Indian community should be given preference in the awarding of contracts to fulfill the purposes of section 102.

Expected Results.—In the seven fiscal year period for which authorizations are provided in S. 522 it should be possible to contact 250,000 students from 300 tribal groups to determine their potential for training in the health professions.

Cost.—For the seven fiscal year period there is authorized a total of $25 million at $1,500,000 for fiscal year 1977, $2,500,000 for fiscal year 1978, $3,000,000 for fiscal year 1979, $4,000,000 for fiscal year 1980, $4,500,000 for fiscal year 1981, $5,000,000 for fiscal year 1982, and $4,500,000 for fiscal year 1983.

Health Professions Preparatory Scholarship Program

Program Description.—Under section 103, scholarships are to be provided to qualified Indians (Indians who have either completed high school or high school equivalency and who have demonstrated the capability to complete courses of study involving the health professions), regardless of whether or not they are reservation Indians, for the final two academic years of any pre-professional health education curriculum. The scholarships, the amounts of which are not specified, are to be sufficient to cover costs of tuition, books, transportation, board, and other necessary related expenses.

Program Rationale.—The Committee views the Preparatory Scholarship Program as a necessary link between recruitment and post-graduate health training. In addition to finding and supporting a pool of qualified Indians who have the potential for further training, the program will also serve to prepare those Indians who do not have sufficient academic backgrounds to gain entrance in post-graduate health professional programs.

Expected Results.—Approximately 4,000 Indian youngsters will receive training during their final two years of academic work.

Cost.—For the seven fiscal year period there is authorized a total of $24 million. The breakdown is as follows: $2,000,000 for fiscal year 1977, $2,500,000 for fiscal year 1978, $3,000,000 for fiscal year 1979, $3,500,000 for fiscal year 1980, $4,000,000 for fiscal year 1981, $4,500,000 for fiscal year 1982, and $4,500,000 for fiscal year 1983.

Health Professions Scholarship Program

Program Description.—Under section 104, scholarship grants are to be made available to students enrolled in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions. These grants are to be awarded to any qualified individuals but with Indians identified as priority recipients. In return for the scholarships the recipients must agree to provide their professional services to Indians, either through the Indian Health Service or private practice.

The Indian Health Service would be authorized to establish scholarship priorities according to existing health professional needs. For example, should the priority in health manpower needs be nurses then the IHS would have the authority to direct a greater proportion of its scholarship funds to support training of nurses.

Each scholarship must fully cover the cost of tuition. In addition, an amount is to be provided to cover the costs of books, transportation, board and other necessary related expenses. This amount is to be based on the financial resources of the grantee, but must not exceed $8,000 annually.

As the condition for the scholarship, each grantee is obligated to serve in the Indian Health Service for a period of years equal to the number of years he or she receives scholarship support. Under certain conditions, private practice would be permitted as a pay-back for scholarship support if that private practice involves serving a substantial number of Indians.

Program Rationale.—The Committee believes the key to realizing increased numbers of health care professionals in the Indian Health Service is a scholarship program which encompasses the major health professions and which links financial assistance to service in the IHS. The Committee is aware that there are other Federal health manpower programs which offer financial assistance through loans or scholarships in return for professional service and recognizes that a charge of duplication will undoubtedly be made. Nevertheless, the Committee believes that the Health Professions Scholarship Program is distinguished by the following:

First, the program offers scholarship support to students in a wider range of health professions. In doing so, the Indian Health Service is assured of the opportunity to meet its total manpower requirements and to achieve parity with health manpower levels for the general population, as the charts below demonstrate.

PROFESSIONAL TRAINING REQUIREMENTS TO ARRIVE AT PARITY WITH HEALTH PROFESSIONALS IN THE GENERAL POPULATION

Title: Manpower development	National 1975 totals	Training needs for parity of health professions among 500,000 Indians served by IHS
1. MOD-VOPP group:		
(a) Medical	350,000	818
(b) Osteopaths	16,000	37
(c) Dentist	130,000	303
(d) Optometrist	20,000	46
(e) Podiatrist	10,000	23
(f) Pharmacist	135,000	315
(g) Veterinarians	27,000	63
2. Registered nurses	750,000	17,896
3. Allied health:		
(a) Practical nurse	350,000	1,336
(b) Audio and speech	16,000	37
(c) Clinical laboratory technician	144,000	334
(d) Dental group: Dental hygienist and technologist	58,000	133
(e) Administration	26,000	165
(f) Environmental health: Engineers, scientists, technologist	109,000	126
(g) Radiology technician	109,000	251
(h) Dietitian and nutritionist	30,000	138
(i) Social work	20,000	92
(j) Health education	20,000	92
(k) Library services	3,000	13
(l) Physical therapy	13,000	60
(m) Occupational therapy	6,500	32
(n) Mathematical group	2,400	9
(o) Psychologist	9,000	41
Total	2,353,900	6,250

Source: Response of IHS to question posed by Senator Henry M. Jackson, Chairman of the Committee. Printed in U.S. Senate Committee on Interior and Insular Affairs. Subcommittee on Indian Affairs, Hearings: Indian Health Care Improvement Act (S. 2938) Apr. 3 and 5, 1974.

ESTIMATED NUMBER OF INDIANS WHO WOULD BE TRAINED IN VARIOUS HEALTH PROFESSIONS AND OCCUPATIONS IN 5, 7, AND 10 YEARS IF S. 522 AUTHORITIES BECOME AVAILABLE

	Length programs in years	Number of Indians currently enrolled	5 yr	7 yr	10 yr	Health professions among 500,000 Indians served by IHS assuming parity
MOD-VOPP group:						
(a) Medical	4	82	266	499	698	818
(b) Osteopath	4	----------	12	23	32	37
(c) Dentist	4	28	98	184	257	303
(d) Optometrist	4	2	16	30	42	46
(e) Podiatrist	4	----------	8	15	21	23
(f) Pharmacist	5	32	50	138	213	315
(g) Veterinarian	4	8	20	28	53	63
Registered nurse	2-4	59	542	1,013	1,419	1,786
Allied health:						
(a) Practical nurse	2	129	1,259	1,752	1,752	1,336
(b) Audiologist	4	----------	12	23	32	37
(c) Laboratory technician	4	25	110	206	289	334
(d) Dental group: Dental hygienist dental technician	2	49	44	83	119	133
(e) Administrators	4-6	11	54	101	142	165
(f) Environmental health engineers, scientist, technologist	4	5	42	79	110	126
(g) Radiology technician	4	23	82	154	215	251
(h) Dietician and nutritionist	4	----------	46	86	121	138
(i) Social work	4	11	30	56	79	92
(j) Health education	4	----------	45	74	94	92
(k) Library science	4	4	14	8	11	13
(l) Physical therapy	4	10	10	28	53	60
(m) Occupational therapy	5	----------	10	19	26	32
(n) Mathematical group	4	----------	1	3	4	9
(o) Psychologist	4	----------	14	26	37	41
Total		478	2,785	4,628	5,819	6,250

Source: Response by the IHS to question posed by Senator Henry M. Jackson, Chairman of the Committee. Printed in U.S. Senate Committee on Interior and Insular Affairs, Subcommittee on Indian Affairs, Hearing: "Indian Health Care Improvement Act (S. 2938)," Apr. 3 and 5, 1974.

Second, the program offers substantially greater financial assistance to participating students. Expanded scholarship support is a primary key to overcoming resistance by many medical students to serving in rural areas or, in the case of the IHS, on reservations. As previously noted, the GAO report, *Congressional Objectives of Federal Loans and Scholarships to Health Professions Students Not Being Met*, indicates that the loan cancellation provisions in existing scholarship programs do not provide enough financial incentive to attract physicians and dentists to practice in manpower shortage areas. In view of this analysis, the Committee approved a program of scholarships which would provide sufficient financial assistance to attract health professionals to the Indian Health Service. In addition, the Committee chose not to adopt provisions found in other health scholarship programs with service requirements which allow the grant recipients to pay back grant funds instead of fulfilling their service obligations. This will insure that the objective of eliminating IHS manpower shortages will not be sacrificed when grant recipients, upon completion of residency, become tempted by the immediate financial rewards of private practice.

The Committee felt that, because of the high costs of tuition currently being charged by medical schools, S. 522 should authorize full payment of tuition. The Committee also authorized the payment of

expenses, other than tuition. The amount for expenses is to be based on consideration of each student's financial capacity, but is not to exceed $8,000 annually.

In drafting Title I, the Committee considered the following chart of tuition and expenses at public and private institutions:

PROFESSIONAL SCHOLARSHIP PROGRAM: TUITION CHARGES

University	Resident	Nonresident	Supplies and books
A. PUBLIC INSTITUTIONS			
Alabama	$625	$1,875	$250
Arizona	960	1,850	500
Arkansas	850	1,700	400
California, Davis	670	2,170	350
California, Irvine	892	2,392	300
California, Los Angeles	681	2,181	1,100
Colorado	1,092	4,369	300
Connecticut	950	1,850	350
Florida	1,050	2,250	500
Hawaii	1,400	1,200	350
Illinois	1,230	2,340	200
Indiana	1,000	1,200	400
Iowa	870	1,870	800
Kansas	1,025	2,025	250
Kentucky	910	1,805	200
Maryland	1,200	2,300	225
Michigan	1,600	3,200	500
Oklahoma	749	1,667	225
Average cost	986	2,124	400
B. PRIVATE INSTITUTIONS			
Southern California	3,250	3,250	350
Yale	3,800	3,800	400
Georgetown	3,500	3,500	400
Miami	2,660	2,660	300
Emory	2,750	2,750	235
Chicago	4,000	4,000	475
Tulane	3,500	3,500	300
Johns Hopkins	3,000	3,000	250
Harvard	3,250	3,250	300
St. Louis	2,850	2,850	300
Creighton	3,410	3,410	350
Dartmouth	3,745	3,475	350
Albany	3,000	3,000	400
Duke	2,960	2,960	425
Case Western Reserve	2,800	2,800	350
Thomas Jefferson	2,750	2,750	350
Stanford	3,765	3,765	180
Brown	3,500	3,500	400
Meharry	2,175	2,175	275
Wisconsin	2,700	2,700	300
Average cost	3,154	3,154	334

Source: Association of American Medical Colleges, "Medical School Admission Requirements, 1975-76—USA and Canada," Washington, D.C. 20036.

In addition, in arriving at the $8,000 ceiling on expenses, the Committee considered a profile of 37 Indian students currently enrolled. This profile, presented below, indicates that current Indian students are usually older, have more dependents, and experience greater transportation expenses than white students.

Profile of Indian students based upon 37 students

Average age	26+
Number of dependents	3.8
Percent married	58
Travel out of geographic region (percent)	68
Transportation cost (per person)	$200

Source: American Association of Indian Physicians.

The Committee recognizes that, if S. 522 is enacted, the Health Professions Scholarship Program will offer greater financial assistance than any other current Federal health manpower program. In view of that fact, the Committee wishes to stress that it expects the Indian Health Service to develop, through regulations, appropriate standards for assessing financial need so as to avoid the errors concerning financial need found by the GAO in their report, *Congressional Objectives of Federal Loans and Scholarships to Health Professions Students Not Being Met.* The primary purpose of the Health Professions Scholarship Program is to attract qualified students who will be able to serve in the Indian Health Service. The Committee would not want that opportunity to be jeopardized by any mismanagement of scholarship grants.

Expected Results.—An estimated 10,000 students would be provided scholarship assistance at approximately $10,000 per student. This would include tuition payments and expenses.

Costs.—For the seven fiscal year period there is authorized a total of $110 million. The breakdown by fiscal year is as follows: $6,000,000 for fiscal year 1977, $7,500,000 for fiscal year 1978, $9,000,000 for fiscal year 1979, $12,500,000 for fiscal year 1980, $19,000,000 for fiscal year 1981, $26,000,000 for fiscal year 1982, $30,000,000 for fiscal year 1983, and, for each succeeding fiscal year, such sums as may be necessary to continue to make scholarship grants under this section to individuals who have received such grants prior to the end of fiscal year 1983 and who are eligible for such grants during each such succeeding fiscal year.

Indian Health Service Extern Programs

Program Description.—Under section 105, the Indian Health Service would be authorized to employ either individuals receiving scholarship grants under the Health Professions Scholarship Program or other individuals engaged in professional training during any non-academic period of the year.

Program Rationale.—The purpose of this program is to facilitate employment by the Indian Health Service of medical students to expand further the students' opportunities for training. In addition, this program will complement the recruitment program authorized elsewhere under Title I. By enlisting students for short periods of training, the Indian Health Service will have an opportunity to interest such students in permanent positions of employment. Of course, in the case of those students participating in the scholarship program this effort will enhance their understanding of the people they will be serving upon graduation.

Expected Results.—Approximately 6,400 students could be exposed to actual work situations in the IHS.

Cost.—For the seven fiscal year period there is authorized a total of $15.350 million. The breakdown of authorizations by fiscal year is as follows: $800,000 for fiscal year 1977, $1,200,000 for fiscal year 1978, $1,600,000 for fiscal year 1979, $2,200,000 for fiscal year 1980, $2,800,000 for fiscal year 1981, $3,200,000 for fiscal year 1982, and $3,550,000 for fiscal year 1983.

Education and Training Programs in Environmental Health, Health Education, and Nutrition

Program Description.—Under section 106, the IHS would be authorized to make grants to individuals, non-profit entities, appropriate public or private agencies, educational institutions or Indian tribes or tribal organizations to implement educational or training programs on behalf of Indians in the following areas: environmental health, health education, and nutrition.

Program Rationale.—As a result of the President's Special Indian Message of July 8, 1970, the Department of Labor provided funding for training of residents of Indian communities to serve as special assistants to health professionals in the fields of environmental health, health education, and nutrition. Funding under this program was to end on June 30, 1974. This provision will extend and expand this program.

Dr. Paul Cornely, the past president of the American Public Health Association in testifying on S. 2938 said: "Health care extends far beyond the question related to the doctor-patient relationship. Taking into account all the factors that affect health, many steps can be taken or obviate or reduce the number of doctor-patient encounters and the need for hospital services." This program is designed to meet Dr. Cornely's objective of extending health services to other segments of the Indian community through community residents.

Expected Results. — Under the programs funded through the Department of Labor more than 2,700 tribal leaders, technicians, and other community health workers were trained in a 2-year period at a cost of slightly more than $4.3 million.

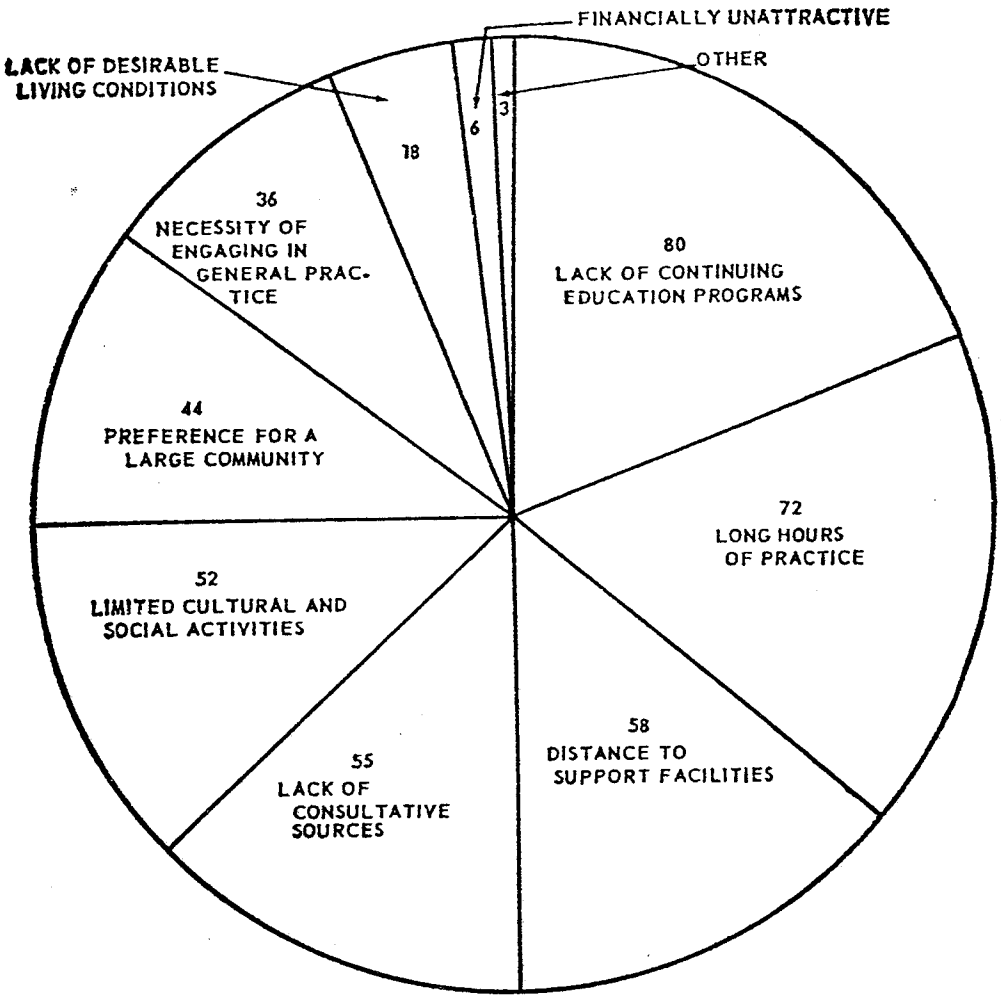
Cost.—For the seven fiscal year period there is authorized a total of $5 million at $500,000 for fiscal year 1977, $600,000 for fiscal year 1978, $700,000 for fiscal year 1979, $800,000 for fiscal year 1980, $900,000 for fiscal year 1981, $900,000 for fiscal year 1982, and $600,000 for fiscal year 1983.

Continuing Education Allowances Program

Program Description.—Under section 107, the Indian Health Service would be authorized to provide allowances to its health professionals to enable them for a period of time each year to take leave of their professional responsibilities to participate in continuing education programs, attend profession-related conferences, or enroll in training courses.

Program Rationale.—The need for this provision is obvious if IHS health professionals are to keep abreast of technical changes in their given professions. More importantly, however, is the fact that opportunities for continuing education are essential in attracting and retaining health professionals in and to the Indian Health Service. In this connection, the GAO report, *Congressional Objectives of Federal Loans and Scholarships to Health Professions Students Not Being Met*, indicated that the lack of continuing education programs in rural areas was a major reason why many medical graduates preferred not to locate in rural areas. The following chart illustrates this point.

MEDICAL GRADUATES' RANKING OF
UNDESIRABLE ASPECTS OF RURAL AREA PRACTICE



Source: Comptroller General of the United States, "Congressional Objectives of Federal Loans and Scholarships to Health Professions Students Not Being Met," May 1974.

Expected Results.—It is expected that 3,750 health professionals in the Indian Health Service would be afforded continuing education opportunities in the seven fiscal year period.

Cost.—For the seven fiscal year period there is authorized a total of $1,875,000. The breakdown of authorizations by fiscal year is as follows: $100,000 for fiscal year 1977, $200,000 for fiscal year 1978, $250,000 for fiscal year 1979, $300,000 for fiscal year 1981, $350,000 for fiscal year 1982, and $325,000 for fiscal year 1983.

IV. DEFICIENCIES IN INDIAN HEALTH SERVICES

Background and an Analysis of Title II of S. 522, as Amended

Good health is a fundamental right. To insure enjoyment of that right is a difficult task because good health is a product of such a wide variety of factors: safe water and adequate waste disposal systems; adequate protection from the elements; nutritionally adequate food; and an available health services delivery system which protects against contagious diseases by immunization, provides for early detection and treatment of disease, provides health educators to promote practices which will prevent disease, and gives services in a culturally acceptable way. Good health among Indians is of particular concern to the Federal government for the Indian people, without an adequate health status, will be unable to fully avail themselves of the many Federal economic, educational, and social programs available to them. Therefore, health services are the cornerstone upon which rests all other Federal programs for the benefit of Indians.

Major Indian Health Problems

Unfortunately, the general health level of the American Indian is deplorable. Despite the measurable progress made by the Indian Health Service, the statistics cited in section II of this report and below reveal that the vast majority of Indians live in an environment characterized by inadequate and understaffed health facilities, improper or non-existent waste disposal and water supply systems, and continuing dangers of deadly or disabling diseases. As noted in section II, health concerns which most of our communities have forgotten as long as 25 years ago continue to plague Indian communities. Beside the obvious physical ill effects which accompany the low health status of Indians, the frequency and prevalence of disease among Indians cannot help but impact adversely on the social and cultural fiber of their communities, contributing to general societal disintegration and attendant problems of mental illness, alcoholism, accidents, homicide and suicide.

Statistics about the state of health of American Indians are available mainly for the Public Health Service and its patient population. A few of these statistics, with discussion, are set forth below:

MORTALITY

As previously noted, Indians experience higher rates of illness and have shorter life expectancies than the overall U.S. population. The following table compares the life expectancy of Indians and the general population for the years 1950, 1967, and 1970.

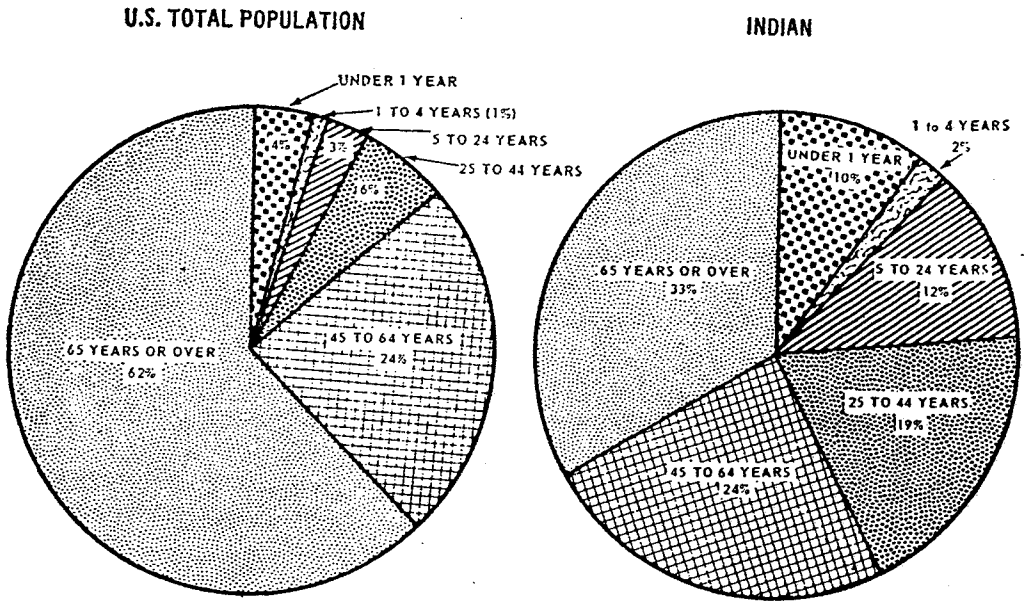
Year	Indian life expectancy	Life expectancy of U.S. total population [1]
1950	60	68
1967	64	71
1970	65	71

[1] Includes Indians.

Source: Comptroller General of the United States, "Progress and Problems in Providing Health Services to Indians," March 1974.

The following chart displaying the distribution of deaths among the Indian people and the general population by age during 1971 portrays dramatically the tragic results of a low health status for Indians—shortened life-spans:

DISTRIBUTION OF DEATHS BY AGE DURING 1971



Set forth below is a schedule of the leading causes of death among Indians and the Indian death rates for each cause. Following the schedule is a discussion of several of these causes of death.

Cause of death	Indian deaths per 100,000 population		Percent of increase or decrease (—) in Indian death rate since 1955
	1955 [1]	1973	
Accidents	156.2	174.3	12
Heart diseases	135.2	131.0	—3
Malignant neoplasm	62.1	62.0	0
Cirrhosis of liver	16.0	45.5	184
Cerebrovascular disease	46.1	42.8	—7
Influenza and pneumonia	92.2	41.1	—55
Certain diseases of early infancy	70.5	19.6	—72
Diabetes mellitus	14.1	20.4	45
Homicide	15.0	25.5	70
Suicide	9.4	19.4	106
Congenital malformations	17.9	10.1	—44
Tuberculosis	55.5	6.8	—88
Enteritis and other diarrheal diseases	39.5	5.5	—86

[1] Average 3-yr total (1954–56).

Source: Comptroller General of the United States, "Progress and Problems in Providing Health Services to Indians," March 1974.

Accidental Deaths

Accidents are the major cause of death in Indians. Information is not available to fully classify accidents as to location, age of victims or circumstances; however, the IHS Aberdeen Area Office, responsible for Indian health care in a seven State area, reports mortality from accidents for calendar years 1969–71 as follows:

	Total rate per 100,000	Motor vehicle	All other
Indian	199.8	108.1	86.8
United States (all races)	54.6	29.2	29.4

Source: Michal, Bradford, Honda, and Sherman, "Health of the American Indian: Report of a Regional Task Force". Department of Health, Education, and Welfare, April 1973.

Diabetes Mellitus

The 1973 death rate from diabetes mellitus among Indians was 20.4 per 100,000 population, compared to a 17.7 per 100,000 rate for the U.S. total population, N.A. for the U.S. white population, and N.A. for the U.S. nonwhite population. To account for the higher rate among Indians compared with the white population, there is a poorly documented but general belief that Indians have some differences from other races in carbohydrate metabolism.

The importance of diabetes mellitus in maternity patients and its relationship to infant mortality is being studied at the Phoenix Indian Medical Center with support from the National Institute of Arthritis, Metabolism, and Digestive Diseases and the Indian Health Service.

Cirrhosis of the Liver

The Indian death rate from cirrhosis of the liver is 45.5 per 100,000, almost 3 times that of the general population. This particular cause of death has achieved its high status in dramatic fashion—its death rate among Indians has risen 184 percent since 1955. Whether the cirrhosis is of an infectious origin or secondary to alcoholism (see discussion below), it constitutes the fourth leading cause of death among Indians.

Infant Deaths

The rate of death of Indian infants, although higher than that of the general population, has enjoyed a decline of more than 60 percent in the last two decades. Infant deaths for every 1,000 live births are compared below:

Year	Indians	U.S. total population
1955	62.5	26.4
1967	32.2	22.4
1971	23.5	19.1

Source: Indian Health Service, HEW, "Indian Health Trends and Services," 1974 edition.

A comparison of infant death rates for Indians with those of other opulation groups is presented in the following table:

Population	Year	Infant deaths per 1,000 live births
S. Indian total [1]	1967	32.2
Neonatal		15.3
Postneonatal		16.9
S. white total [1]	1967	19.7
Neonatal		15.0
Postneonatal		4.7
S. nonwhite total [1]	1967	35.9
Neonatal		23.8
Postneonatal		12.1
erdeen area	1969–71	24.8
Neonatal		12.2
Postneonatal		12.6
ivajo [2]	1966	45.7

[1] Charles A. Hill, Jr., and Mozart I. Spector: "Natality and Mortality of American Indians Compared with U.S. Whites d Nonwhites," HSMHA Reports, vol. 86, No. 3, March 1971.
[2] Archie S. Golden: "The Other Poor and Their Children," Clinical Pediatrics (Philadelphia), vol. 10, No. 2, February 71.

Source: Printed in Michal, Bradford, Honda, and Sherman, "Health of the American Indian: Report of a Regional Task rce," Department of Health, Education, and Welfare, April 1973.

As can be seen in the above statistics, the Indian infant stands as ood a chance as the white infant of surviving the neonatal period birth through 27 days). In fact, the 1971 death rate for neonatal ndian infants was lower than the provisional rate for the total popu- ıtion—12.5 and 14.3 deaths, respectively, for every 1,000 live births. ıccording to Indian Health Service officials this high health status or neonatal infants is due in part to increased health education hich has resulted in about 99 of every 100 registered Indian live irths in 1971 occurring in hospitals. The leading cause of death in he Indian neonatal is immaturity; mortality due to this cause in 1966 mounted to 3.6 deaths per 1,000 live births, the same as the rate for hite neonatals.

Death rates in the postneonatal period (28 days through 11 months) ndicate the special vulnerability of Indian infants. In the postneo- atal period, Indian infants are at a risk four times as great as white nfants and 50 percent greater than non-white infants as a whole. he higher death rate of the Indian postneonatal is due, in part, to roblems associated with low economic status, poor housing, and ack of sanitation facilities. As the following table, based on 1966 lata, discloses, the leading causes of death in this age group were espiratory, digestive, infectious and parasitic diseases and accidents:

Causes	Postneonatal deaths per 1,000 live births	
	Indian	U.S. total
espiratory diseases	7.1	2.5
igestive diseases	3.6	.5
ccidents	1.9	.8
nfective and parasitic diseases	1.6	.3
ongenital malformations	1.3	1.1

Source: Michal, Bradford, Honda, and Sherman, "Health of the American Indian: Report of a Regional Task Force," epartment of Health, Education, and Welfare, April 1973.

A comparison of death rates of Indians and the general population for the leading causes of neonatal and postneonatal deaths is set out below:

Leading causes of neonatal and postneonatal deaths—3-year average rates (1968, 1969, 1971)

[*Rates per 1,000 live births*]

Neonatal	13.2
Certain causes of mortality in early infancy	9.5
Asphyxia of newborn unspecified	1.9
Immaturity, unqualified	1.9
Respiratory disease syndrome	1.2
All other complications of pregnancy and childbirth	1.0
Hyaline membrane disease	.9
All other anoxic and hypoxic conditions not elsewhere classifiable	.5
Conditions of placenta	.4
Difficult labor	.3
Congenital anomalies	1.6
Diseases of the respiratory system	.7
Septicemia	.3
Diseases of the digestive system	.3
Postneonatal	13.6
Influenza and pneumonia	3.4
Symptoms and ill-defined conditions	2.4
Diarrheal diseases	1.7
Accidents	1.3
Congenital anomalies	1.0
Other infective and parasitic diseases	.7
Meningitis	.6
Septicemia	.3
Other diseases of respiratory system	.3
Diseases of the digestive system	.3
Other diseases of nervous system and sense organs	.3

Source: Indian Health Service, HEW "Indian Health Trends and Services," 1974 Edition.

Maternal Mortality

Although declining, maternal death rates for Indians are generally two times higher than those for the white population. Maternal death rates in the United States show the following trends for Indians and other population groupings:

MATERNAL DEATHS PER 100,000 LIVE BIRTHS

Year	Indian	U.S. total	U.S. white	U.S. nonwhite
1972	30.8	18.8	14.3	38.5
1967	49.1	28.0	19.5	69.5
1966	54.6	29.1	20.2	72.4
1964	74.2	33.3	22.3	89.9
1962	89.7	35.2	23.8	94.9
1960	67.9	37.1	26.0	97.9
1958	82.6	37.6	26.3	101.8

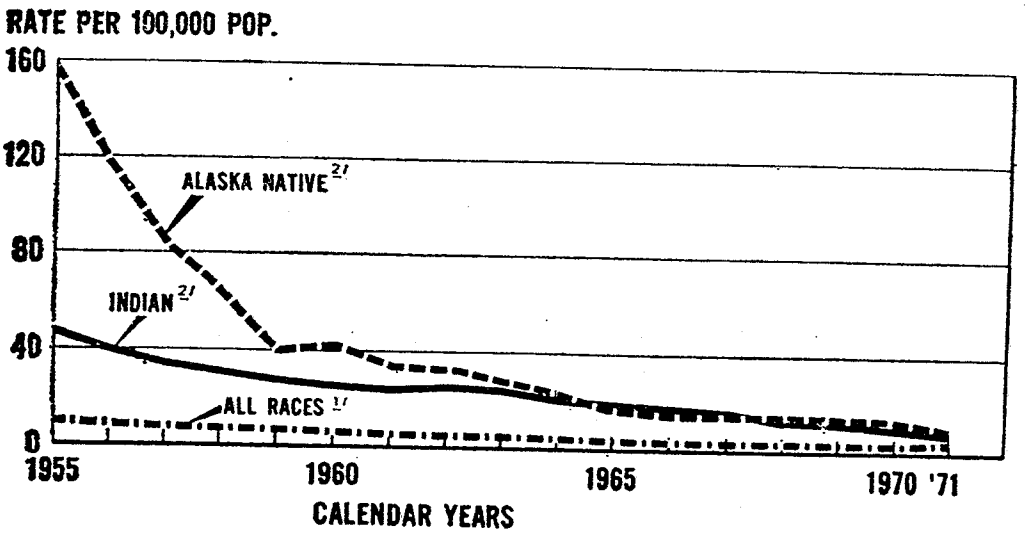
Source: Michal, Bradford, Honda, and Sherman, "Health of the American Indian: Report of a Regional Task Force," Department of Health, Education, and Welfare, April 1973.

Tuberculosis

Although the morbidity of, and deaths from, tuberculosis have been significantly reduced in both the Indian and the total U.S. population as a result of better treatment and therapy, Indians die of or contract tuberculosis about 4 times as often, respectively, as individuals in the general U.S. population. In the total population, the 1955 incidence—about 9 tuberculosis deaths per 100,000 population—declined 80 percent to about 2 deaths per 100,000 population in 1973. The Indian death rate during the same period declined 89 percent, from about 55 to 6 deaths per 100,000 population.

The tuberculosis death rate for Indians, Alaska Natives, and the general population from 1955 to 1971 are shown in the following graph:

TUBERCULOSIS DEATH RATES *
INDIAN, ALASKA NATIVE, AND U.S. ALL RACES

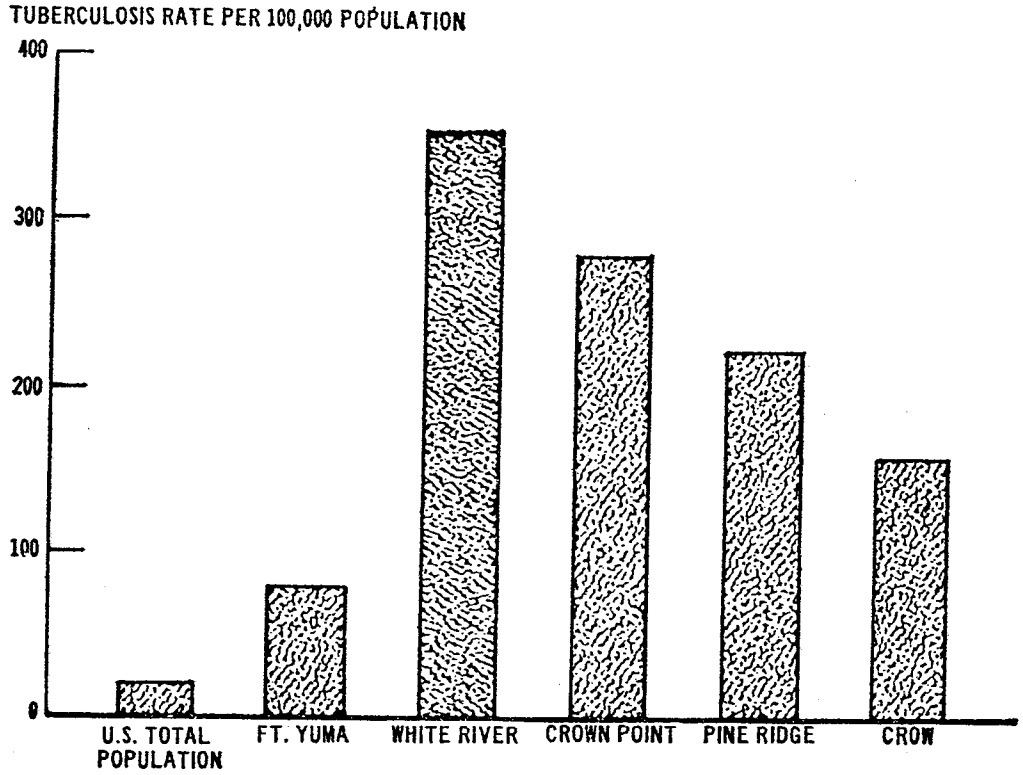


*INDIAN AND ALASKA NATIVE RATES ARE BASED ON 3-YEAR MOVING AVERAGE THRU 1968. ALL OTHER RATES ARE BASED ON SINGLE YEAR DATA.

1/ PROVISIONAL MONTHLY VITAL STATISTICS REPORT, NCHS VOL. 20, NO. 13, 1970, 1971.
2/ ESTIMATED 1970.

Source: Indian Health Service, HEW, "Indian Health Trends and Services," 1974 Edition.

The following graph illustrates the tuberculosis morbidity rates for five Indian Health Service units as compared with the total U.S. population in 1972:



Source: Comptroller General of the United States, "Progress and Problems in Providing Health Services to Indians," March 1974.

MORBIDITY

While the mortality rate of the service population of the Indian Health Service has improved over the past 19 years since the IHS assumed control of the Federal Indian health care system, morbidity rates have continued to rise in a majority of reportable classifications. Indian morbidity rates are still higher than for any other group in the country in nearly every reported classification.

The 10 leading reportable diseases among Indians in 1968 were, in order of frequency: otitis media, gastroenteritis; strep sore throat; pneumonia; influenza; gonorrhea; trachoma; chickenpox; mumps; and dysentery bacillary. The Public Health Service Orientation Manual for 1971 lists the leading Indian health problems in the following order: communicable diseases among children, accidents, mental health, nutritional health conditions. The manual states that most illnesses are due to infectious diseases (gastroenteritis, dysentery, influenza, pneumonia, tuberculosis, otitis media, trachoma, measles).

The following data illustrate the gap between the health of Indians and the health of the general population:

Disease	Incidence rate per 100,000 population for 1973		Ratio of Indian disease incidence to that of U.S. total population
	Indians	U.S. total population	
Gonococcal infection	1,794.2	404.9	4.4
Mumps	425.2	36.2	11.7
Dysentery (amebic and bacillary)	455.1	10.8	42.1
Hepatitis	296.4	24.2	12.2
Syphilis	149.9	42.0	3.6
Tuberculosis, new active cases	107.6	14.8	7.3

Source: Comptroller General of the United States, "Progress and Problems In Providing Health Services to Indians," March 1974.

A number of illnesses and health problems not discussed above under "Mortality" are discussed below:

Otitis Media

Otitis media—inflammation of the middle ear—has ranked as the number one reportable disease among Indians since 1964. From 1962 to 1973 the reported incidence of otitis media increased 218 percent among Indians—up from 3,802 cases per 100,000 population to 12,104 cases per 100,000 population. Affecting mostly children, otitis media can result in serious, permanent damage to the ears which severely limits children's ability to progress in school and reduces their vocational and social opportunities. If left untreated, the disease can develop life-threatening complications including the formation of a growth in the middle ear or on the bone structure behind the ear. Without surgical intervention, the growth may erode into the brain and terminate in a fatal meningitis or brain abscess.

Inflammation of the middle ear is usually caused by extension of infection from the nose and nasopharynx. The underlying cause, therefore, is usually a viral upper respiratory infection. Acute and chronic forms of otitis media result from an invasion of the middle ear by virulent bacteria.

As with many infectious diseases, there is a strong relationship between otitis media and impoverished living conditions. Crowded housing helps spread upper respiratory infections, and inadequate sanitary facilities and nutritional intake increases susceptibility to the disease.

According to a report by the Association on American Indian Affairs, basic immunological and epidemiological studies now being conducted may result in a good prevention program. At present, however, there are no known vaccines to prevent the disease. Meanwhile, controlling the disease must depend upon programs of: (1) early detection and treatment to prevent progression to stages which cause permanent hearing loss and which may threaten life, and (2) identification of those Indians who have hearing losses and providing them with restorative surgery or rehabilitation.

According to IHS studies, pre-school-age children, particularly those under 2 years of age, are the most susceptible to otitis media. If the first attack of ear infection occurs before the first birthday, the

risk of repeated attacks is greater than if the first attack occurs later. The following table compares the incidence of acute and chronic otitis media in school-age and pre-school-age children treated in fiscal year 1972 at the six IHS Service Units reviewed in the March 1974 GAO report, *Progress and Problems in Providing Health Services to Indians*. Considering that adequate surgical methods exist to cure the disease, these figures dramatically demonstrate the gross deficiency in health care provided Indians and Alaska Natives.

	Outpatients				Inpatients, acute and chronic otitis media		
	Acute otitis media		Chronic otitis media				
	Up to 5 yr	6 yr and over	Up to 5 yr	6 yr and over	Up to 5 yr	6 yr and over	Total
Fort Yuma	117	41	9	21	3	2	193
Crownpoint	901	491	73	440	8	1	1,914
Whiteriver	398	294	77	142	25	7	943
Pine Ridge	926	291	83	216	60	3	1,579
Red Lake	290	173	36	74	74	7	654
Crow Agency	313	184	39	90	42	10	678
Total	2,945	1,474	317	983	212	30	
	4,419		1,300		242		5,961

Source: Comptroller-General of the United States, "Progress and Problems in Providing Health Services To Indians," March 1974.

Increases in Indian Health Service appropriations by Congressional action in fiscal year 1971 enabled the IHS to establish a special program, in part through contracts with medical schools, to prevent and control the disease. However, as the March, 1974, General Accounting Office study disclosed this program is decidedly inadequate in relation to the substantial backlog of unmet otitis media surgical needs and the screening of children.

Dental Health

Oral conditions such as caries, periodontal disease, orthodontic problems and missing teeth are chronic, ubiquitous and persistent. Indian people consistently rank dental health first, second or third among their health priorities. Frustration is common because the conditions are obvious, the means of prevention and correction are known, and, where resources permit, the Indian Health Service is capable of effective and rapid response to the desires of each community.

The Indian Health Service dental program has demonstrated a high order of efficiency and effectiveness. Among children, where IHS services are concentrated, tooth mortality has steadily declined relation to infected teeth. Orthodontic conditions have also steadily improved among the young. However, the young still have a large reservoir of corrective service needs and adults remain without most oral health services.

Dental services currently provided through the Indian Health Service dental program are directed toward preventive and corrective care among children and emergency care among adults. In fiscal year 1974, 2,199,000 dental services were required by the 55.4 percent of the American Indian and Alaska Native population which

practically could be provided dental care each year. Only 928,000 dental services (42.2 percent of an estimated annual need of 2,199,000 services) were provided. It is estimated that 955,000 dental services (45.5 percent of the estimated annual need) will be provided in fiscal year 1975. Although the average efficiency of Indian Health Service clinical dental staff appears to be near the maximum level, the resources currently available to the IHS dental program are capable of providing less than half the dental services demand. The following table discloses the extent of unmet dental care needs among Indians:

UNMET DENTAL NEEDS OF 55.4 PERCENT OF AMERICAN INDIAN AND ALASKA NATIVE POPULATION

	Services required	Services provided		Unmet need	
		Amount	Percent	Amount	Percent
xaminations	270,817	195,615	72.2	75,202	27.8
eeth requiring fillings	941,631	424,882	45.1	561,749	54.9
eth requiring extractions	349,083	120,453	34.5	228,630	65.5
rowns, bridges, and dentures	154,909	12,120	7.8	142,727	92.2
reatment of tissues supporting teeth	201,488	25,224	12.5	176,264	87.5
ther dental services	281,074	149,706	53.3	131,368	46.7
Total dental services	2,199,000	928,000	42.2	1,271,000	57.8

Note: Fiscal year 1971 data.

Source: Indian Health Service.

Nutrition

Malnutrition is another health problem of Indians and Alaska Natives, especially children. In a recent monograph, *Nutrition, Growth, and Development of North American Indian Children*,[1] consisting of conference papers and discussions, a number of studies on Indian children diagnosed clinically or biochemically as having malnutrition were reported. These studies revealed incidences of malnutrition ranging from .001 percent to 14 percent of hospitalized children, with malnutrition being diagnosed as general malnutrition, anemia or weights below the norm for chronological age. Nutrition surveys using the norms of the Iowa and Boston Standards reveal a preponderance of children falling well below the normal growth rate.

Studies show that, while other Americans have been getting taller and heavier with each generation, Indians have not. Only experience with good nutrition will show if American Indians are currently reaching their genetic potential for height. Dietary surveys have revealed mild to marked deficiencies in the intake of a number of specific nutrients. The 1964 White Mountain Apache study showed that Apache children had intakes of calories, calcium, riboflavin, vitamins A and C that were substantially below those considered adequate to meet normal needs. A survey of Blackfeet and Fort Belknap Indians of Montana, the Dakota Study of eight BIA boarding schools, and a study of Alaska Natives showed deficient intakes of vitamins A and C and calcium and, except among Eskimos, borderline protein intakes.

[1] Moore, Silverberg, and Read, "Nutrition, Growth and Development of North American Indian Children", Department of Health, Education, and Welfare, 1972.

A recent Department of Health, Education, and Welfare regional task force report on Indian health [2] contained the following discussion of the causes and effects of malnutrition among Indians:

> The cause of malnutrition among Indians is complex. Eating patterns are affected by food acculturation, limitations in food availability, changes in breast-feeding patterns, and poverty, and lack of cooking, refrigeration and storage facilities for food in the home.
>
> All American Indians, and the Alaska Natives, have been forced into extensive food acculturation because of loss of lands, disappearance of game, and hunting restrictions. New foods introduced by trading posts as a result of modern food technology and advertising campaigns have often been low in nutritive values. Unenriched flour, sugar, coffee, salt, lard, soda pop, Kool-Aid and candy are foods with poor nutritive value that have replaced native foods. Such a high carbohydrate diet also has implications for the extent of dental disease.
>
> Frequently the trading post is the only source of foods, and fruits and vegetables are not available. When the trading post or grocery store is many miles from home, transportation difficult, and refrigeration absent, high carbohydrate foods are apt to be chosen. Welfare recipients may get commodity foods on many reservations but availability depends on current surplus and the local administration. The number of foods deemed surplus is steadily decreasing. Many of the surplus foods are unfamiliar to Indians, and if the women are not taught how to prepare them, they will not be eaten. Furthermore, commodity foods available to Indians do not always provide good sources of Vitamins A and C.
>
> Another serious effect on acculturation of food habits is the increased use of bottle feeding rather than breast feeding. In Alaska it is common to breast feed but frequently only until the child is 2 months of age. Also, a study found a substantial number of infants over 12 months of age on breast milk or formula without supplementary foods. Traditionally, Navajo mothers have breast fed their infants, for the first six months of life, and substantial numbers continue this practice now. Among the Micmac, Ojibwa, and Iroquois, breast feeding has declined both in popularity and duration, with canned milk being substituted almost universally. The decline in breast feeding is a problem because Indian mothers may substitute formula which is hard to prepare sanitarily.
>
> The role of breast feeding in immunological development is still poorly defined. Nonetheless it is known that in developing countries as women become sophisticated and stop breast feeding, both malnutrition and infant mortality increase.

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[2] Michal, Bradford, Honda, and Sherman, "Health of the American Indian: Report of a Regional Task Force," Department of Health, Education, and Welfare. April 1973, pp. 11–12.

The extreme poverty of most Indians is another factor in their poor nutritional status. The average Indian family of five on a reservation is living on an annual income of below $2,000. Many families are receiving welfare but the payments vary from State to State. In Montana the monthly allowance for a family of five is $226 and in Wyoming it is $215. The cost of a nutritionally adequate low-cost diet is computed at $131.24 per month for a family of five.

The consequences of poor nutrition status are highly significant. With reduced nutrition status, a child is more susceptible to disease, and the course of the disease is apt to be more difficult. The preschool and school-aged child may reflect poor nutrition by retarded growth. Other complications of states of chronic undernutrition are lowered energy and lessened concentration and attentiveness in the learning situation. If the child has had a poor physical and nutritional start, we can expect his achievement to be poor.

Eye Care

The delivery of eye care within the Indian Health Service is now grossly deficient. The population at risk needing refractions is estimated at 188,600—88,600 adults and 100,000 children.

Up until 1973, adult refractions were practically non-existent and eye glasses were not purchased except for school children. This situation is catastrophic for the adults, since the majority of Indian adults need glasses for reading and close work. Gainful employment is often hampered by the lack of glasses.

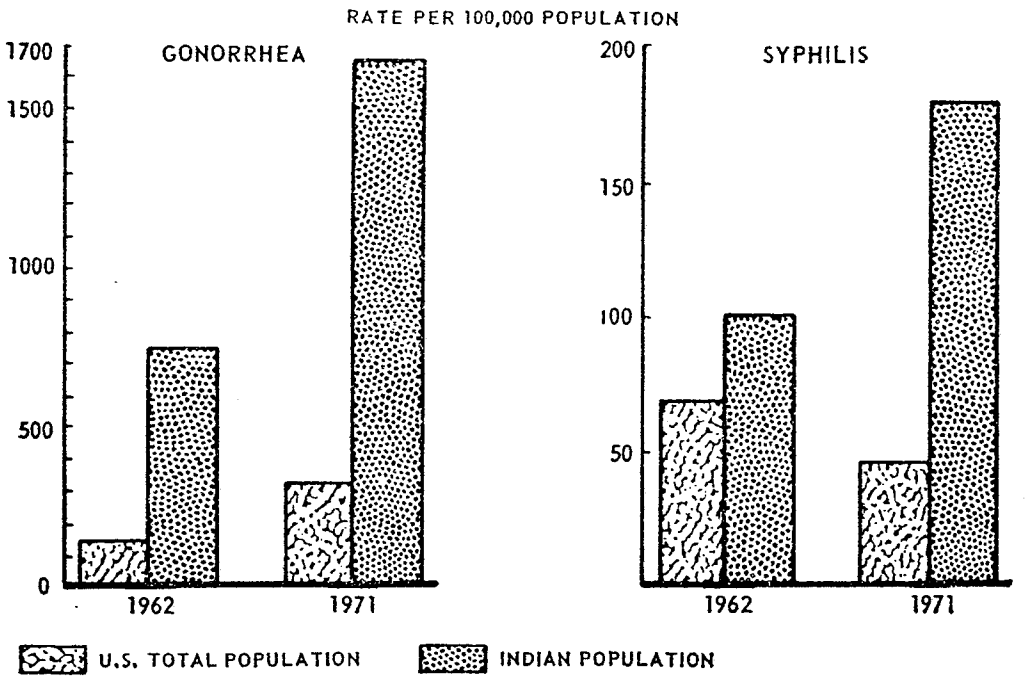
To enable the Indian Health Service to provide the estimated 190,000 refractions and provide necessary eye glasses would require 50 ophthalmic and optometric professional and para-professional personnel. The identified unmet need of 50 positions represents less than 1 position for each of the 86 Service Units.

Veneral Disease

According to the Department of Health, Education and Welfare, venereal disease is a national health problem of epidemic proportions. The number of gonorrhea cases had doubled in the past 5 years—making gonorrhea second only to the common cold as the most widespread contagious disease in the Nation. During fiscal year 1972 about 24,000 cases of infectious or potentially infectious syphilis were reported, more than in any year since 1950. Gonorrhea, with 718,401 cases reported in fiscal year 1972, was at its highest recorded level. Since public health authorities believe that only about 17 percent of all cases of syphilis and gonorrhea are actually reported, the total number of cases is much higher.

Despite these depressing statistics for the general population, the growth in the venereal disease rate between 1962 and 1971 is several times less in that population than in the Indian population, as shown below:

GROWTH IN THE VENEREAL DISEASE RATE BETWEEN 1962 AND 1971



Source: Comptroller General of the United States, "Progress and Problems in Providing Health Services to Indians," March 1974.

As the chart shows, the reported incidence of venereal disease among Indians, specifically syphilis and gonorrhea, has increased dramatically from 1962 to 1971; the syphilis incidence rate rose by 117.6 percent, the gonorrhea rate by 79.4 percent.

The fiscal year 1972 venereal disease rates in the six Service Units reviewed in the GAO report were generally much higher than those for the U.S. total population. The table below shows how many times greater the reported venereal disease rate per 100,000 population for Indians was than the rate per 100,000 for the U.S. total population.

	Syphilis	Gonorrhea
Fort Yuma	13.3	3.2
Whiteriver	21.4	6.6
Crownpoint	39.5	6.4
Pine Ridge	4.2	8.6
Red Lake	8.3	2.3
Crow Agency	13.4	6.4

Source: Comptroller General of the United States, "Progress And Problems In Providing Health Services To Indians," March 1974.

These statistics should be viewed with caution, however. Indian Health Service officials say that, although there is probably a greater

rate of syphilis and gonorrhea cases in the Indian population than in the U.S. total population, the difference is not as significant as indicated by the reported rates because there are probably many more unreported cases of veneral disease in the total population than in the Indian population.

According to the American Public Health Association, interviewing patients to identify their sexual contacts and tracing and treating these contacts so that the spread of the disease to others can be avoided are fundamental steps to control veneral disease. Mass screening to identify asymptomatic women (showing no clinical symptoms until the late stages of the disease) is also an important method of controlling gonorrhea. These activities, however, require a commitment of significant human and financial resources presently unavailable in the IHS.

Mental Health

Poverty, forced abandonment of traditional ways of life, inadequate schools, degradation of Indian family life, and a harsh physical environment are elements of a situation in which many American Indians are frustrated in their attempts to live self-respecting, productive lives and, in some cases, in despair and anger, feel a need to lash out in self-destructive ways. The results of these conditions are seen in the form of excessive use of alcohol, suicide, violence, family disorganization, and neglect of children. Recognizing that these elements had combined to produce a large variety of mental health problems in young and old, the Congress established a mental health program for Indians in 1966. The Indian Health Service is now able to provide a few essential mental health services in some communities, including psychotherapy in languages such as Navajo and Lakota and group and individual consultation with Indian school children, alcoholics, and Indian community agencies.

These services are still unavailable to many Indian people because funds have not yet been made available to provide for the full development of Indian Health Service mental health activities in all areas. The modestly funded mental health program has done little more than demonstrate what can be done and how to plan for necessary future expansion should the necessary financing be forthcoming.

Alcoholism

That alcoholism is one of the most serious health problems facing the Indian people today is a fact now clearly recognized by Indian leaders and by the Indian Health Service.

Historically, alcohol was introduced into most Indian cultures from the outside. Most authorities agree that none of the Indians north of Mexico knew distilled alcoholic drinks prior to the arrival of the Europeans in the 16th and 17th century, although there is evidence that some tribes made fermented beers or wine, which were usually employed only in ceremonies and religious rituals. The Indian and Alaska Native people were therefore quite unprepared to deal with the distilled beverages the explorers and traders offered them first as a sign of friendship and later as barter for goods. Most tribes had no traditional way of coping with the problem of alcoholism. There was no system for punishing crimes committed while a man was drunk, since the drunken man was not considered in control of his actions.

A recent report of the Indian Health Service, entitled *Alcoholism: A High Priority Health Problem*, contains a summary of official efforts to control the sale of alcohol to, and the use of it by, Indians:

> As early as the 17th century, thoughtful Indian leaders recognized the real and potential gravity of the alcohol problem. Many requested the traders and others not to permit liquor to be sold to their people, though usually their efforts were in vain. Because of the mounting seriousness of the alcohol problem during the 18th and 19th centuries, several Indian religious prophets, notably, the Seneca, Handsome Lake and the Pauite, Wewoka, advocated a return to the old ways, including total abstention from alcohol. The contemporary Native American Church advocates some of the same principles.
>
> An Indian Chief, Little Turtle, appealed directly to President Thomas Jefferson in January 1802. Among other things, he pointed out that Indians were an industrious people kept poor by liquor and that they had become less numerous and less happy since the introduction of this "fatal poison." Partly in response to Little Turtle's request for the prohibition of liquor sales to Indians, President Jefferson, less than a month later, called upon Congress to take steps to control the liquor traffic. "These people," he pointed out, "are becoming very sensible of the baneful effects produced on their morale, their health, and existence, by the abuse of ardent spirits; and some of them earnestly desire a prohibition of that article from being carried among them." Congress acted promptly, authorizing the President "to prevent or restrain the vending or distributing of spirituous liquor among all or any of the said Indian Tribes . . . "
>
> Thirty years later, on July 9, 1832, Congress passed the first general statutory prohibition on liquor traffic, based on the constitutional authority of Congress to regulate commerce with the Indian Tribes. The law, as expanded over the years, covered sale, gift, transportation and possession of liquor on reservations or sometimes adjoining Indian land, without regard to State boundaries. Later, ale, beer and wine were added to the list of prohibited drinks. Other restrictions on liquor traffic were incorporated into individual treaties and agreements with different tribes.
>
> These laws were originally designed mainly to protect the Indians from cruel exploitation by the unsavory whiskey traders. Both the Government and the tribal leaders recognized the need for such control, though undoubtedly from somewhat different points of view. Enforcement of these laws was never markedly successful, however, since bootlegging and smuggling could hardly be effectively controlled in the vast, thinly populated Indian country by the few enforcement officers available for such duty. There is even some evidence that certain Government officials issued spirits to the Indians as part of their regular rations.
>
> By the 20th century, the Indian liquor laws were increasingly recognized, especially by the Indians themselves, as

being frankly discriminatory. Although Indians had become full citizens under the law in 1924, they alone were not permitted to buy drink legally after Prohibition was repealed in 1933. The bootleggers, as before, continued to fluorish. Not only did the Indians have to pay far more for their drinks than others, they also had to drink covertly to avoid being arrested, imprisoned or fined. The very illegality of drinking may in fact have increased its appeal, especially for the adolescents and young adults.

Many Indians felt increasing humiliation and resentment against the Government for this unequal treatment before the law. Finally, as a result of many pressures, Congress repealed the Federal Indian liquor laws in August 1953, leaving the question to the individual States for off-reservation communities and to Tribal Councils for reservation lands. A number of reservations still retain local restrictive laws of their own, some forbidding liquor entirely and others controlling or monopolizing its sale and distribution.[3]

Although valid information is scarce, the effects of alcohol on the health, family relationships and society of Indians—a people who had no traditional way of coping with it—have generally been considered to be profound and in some cases disastrous. Special surveys have documented that the prevalence of drinking is high in many Indian communities, that drinking is primarily a social activity, and that intoxication is the common, but by no means inevitable, outcome. Probably a majority of suicides, murders, accidental deaths and injuries are associated with excessive drinking, as are many cases of infection, cirrhosis and malnutrition. By far the majority of arrests, fines and imprisonments of Indians are for drinking or are the results of drinking. The associated loss of productivity and the resulting abnormal social adjustments are by-products of considerable importance.

In calendar year 1973, there were 399 Indian deaths primarily attributed to alcoholism, alcoholic psychosis, or cirrhosis with alcoholism in the 24 Federal reservation States, for an overall mortality rate of 51.9 per 100,000. These deaths made up 6.9 percent of all Indian and Alaska Native deaths that year. A substantial but unknown percentage of the 1,000 other Indian deaths from accidents was due directly or indirectly to the problem of excessive drinking. According to the IHS alcoholism report, in a Lower Plateau tribe, there were 56 deaths directly associated with drinking and 5 others indirectly associated with drinking in a population of 1,581 in an 11 year period. Of the 61 deaths, 47 were males and 14 were females. The causes of death included: 12 suicides, 12 "over-consumption of alcohol," 11 auto accidents, 8 other accidents, 6 murders and 12 miscellaneous. On the same reservation, the IHS Service Unit Director stated that 38 percent of all hospital days for 1967 were attributed to the use of alcohol.

An overall view of the age and sex distribution patterns for simple intoxication and cirrhosis is best shown by a table of discharge rates, which are derived from primary discharges from all Indian Health Service and contract hospitals for fiscal year 1968:

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[3] Indian Health Service Task Force on Alcoholism, "Alcoholism: A High Priority Health Problem," Department of Health, Education, and Welfare, 1970, pp 2–3.

Age	Simple intoxication			Cirrhosis with alcoholism		
	Male	Female	Total	Male	Female	Total
0 to 14	0.2	[1] 0	0.1			
15 to 19	2.4	0.9	1.6			
20 to 24	8.3	2.8	5.5	0	[1] 0	[1] 0
25 to 34	13.7	5.5	9.5	1.4	2.6	2.0
35 to 44	17.2	7.0	12.1	2.9	3.6	3.2
45 to 54	10.0	3.9	7.1	2.4	2.6	2.5
55 to 64	6.3	1.7	4.1	1.8	1.7	1.8
65-plus	2.8	1.0	2.0	.5	.2	.4
All ages	5.1	2.0	3.5	.7	.9	.8

[1] Numbers too small for calculation of a reliable rate.

Note: This table clearly shows for both sexes the gradual increase in rates with age, a peaking in the age group 35 to 44 and a gradual decline thereafter. The sex ratio for simple intoxication remains fairly constant with age at an average of 2.55/1, whereas for cirrhosis with alcoholism the overall sex ratio is reversed at 0.78/1.

Source: Indian Health Service Task Force on Alcholism, "Alcholism: A High Priority Health Problem," Department of Health, Education, and Welfare, 1970.

Alcoholism in Indians has many underlying causes. It is a means of coping with feelings of anger, frustration or boredom, all of which are related to the comparably low position in which many Indians find themselves today. Inferiority feelings about their lack of education, meaningful employment, status and economic autonomy too often are expressed in excessive drinking. These features of modern Indian life particularly affect the adult men and adolescents of both sexes. The latter group is further faced with unique problems in both the home and school environment, such as the breakup of family relationships (often due to drinking) and the disparagement in the schools of their parents' way of life.

These underlying social, economic, and cultural causes of alcoholism make an extremely difficult health problem to remedy, particularly when it competes for scarce health care resources with the numerous other health problems listed above—many of which respond better, more quickly, and with less expenditure of funds.

Prior to fiscal year 1971, no Federal monies were spent on Indian alcohol programs. With the President's message on the American Indians in July 1970, $10 million was allocated from several departments and agencies to support Indian health initiatives to develop needed special programs. Among these monies, $1.2 million were pledged from the Office of Economic Opportunity, and $750,000 were pledged from the National Institute of Mental Health (NIMH). None of these monies were actually transferred to the Indian Health Service. Nevertheless, in fiscal year 1971 interagency cooperation was effected and 39 alcoholism projects were funded by both the OEO and the NIMH under the leadership of the Indian Health Service.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), established pursuant to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 92–554), has declared the development and implementation of Indian alcohol programs to be one of its six priority areas. Having assumed control of the existing Indian alcoholism projects, the NIAAA is presently the sole mechanism for funding Indian alcoholism programs. The role of the Indian Health Service is limited to providing liaison with Indian communities, identifyng critical needs,

assisting with technical expertise, and helping review, as a permanent member of an all Indan Review Committee, all program proposals received by the NIAAA.

Today, there are 153 Indian alcoholism demonstration programs totaling $12 million and 166 mini-grants for Alaska Natives totaling $1.7 million.

Despite this effort, however, a number of problems concerning the administration of Indian alcoholism programs would strongly suggest the need to increase their size and to transfer them to the Indian Health Service. The immediate concern of both the NIAAA and the IHS and of the Indian communities is what happens to existing Indian alcoholism programs beyond their July 1975 termination date. The long-term concerns are set out below:

Under the present policy of the Department of Health, Education, and Welfare, National Institute on Alcohol Abuse and Alcoholism, Indian programs are considered to be for demonstration purposes only. This interpretation is based on one of the enumerated purposes of NIAAA projects, which is "to conduct demonstration, service and evaluation projects" (PL 93–282, sec. 111). During hearings held by the Senate Subcommittee on Alcoholism and Narcotics in March 1973, Administration officials explained their interpretation of this phrase. Dr. Morris E. Chafetz, Director of NIAAA, stated that "there was never an understanding by the Department that support from the funds provided through Public Law 91–616 would be an ongoing commitment in all categories of project grants support." Dr. John S. Zapp, Deputy Assistant Secretary for Legislation (Health), Department of Health, Education, and Welfare, said, "At this point the Federal Government is saying the usefulness and purpose and validity of these projects has been demonstrated, and we feel it is now your (the local community's) responsibility."

In a letter to Senator Edward M. Kennedy dated August 8, 1974, Dr. Chafetz reiterated this position, but did recognize the need for an ongoing responsibility to provide this support:

> While it is still my position that continued support of time-limited projects grants is not an ongoing commitment of this Federal agency under present legislative authority, I also recognize that there are some programs, which for a variety of reasons, will not be able to procure non-Federal support upon the expiration of their project period, and that the Federal government does have a responsibility for their continuation.

The Federal Government has a trust responsibility to provide for the health care of American Indians, and the Indian Health Service is the agency having the primary responsibility for Indian health care. Yet, the Committee has discovered that neither the IHS nor any other federal agency is legally obligated to provide Indian alcoholism services; no existing statute makes this specific requirement. Public Law 91–616, as amended by PL 93–282, does not authorize funds specifically for Indians; in fact, the law does not even mention Indians. Thus, legally, Indians receive a portion of NIAAA funds because of

their status as U.S. citizens, not because of their status as Indians. The decision to allocate a portion of NIAAA's funds for Indian programs and to establish an Indian desk within NIAAA to assist in the administration of these programs was purely discretionary, and, therefore, neither constitutes a guarantee that alcoholism monies will be available for Indians nor indicates that the Federal Government has any responsibility to provide alcoholism programs for Indians.

Due to the failure of the Congress to place a specific responsibility on the IHS or any other Federal agency for the treatment of alcoholism among Indians, no Federal agency has undertaken a continuous program for the control and treatment of Indian alcoholism. This situation was described in the March 1974 GAO study, *Progress and Problems in Providing Health Services to Indians:*

> According to IHS, alcoholism probably adversely affects more aspects of Indian life than any other health factor and has been an Indian health problem since the 17th century. IHS reports that alcoholism causes cirrhosis, disintegrates family relationships, and adversely affects the economic functioning of the whole Indian society. Most accidents, homicides, assaults, and suicide attempts are associated with drinking. IHS officials have stated that a significant part of their medical services workload can be traced to alcohol abuse and alcoholism. However, IHS has done little to explore the nature of extent of, and solution for the alcohol problem in most Indian communities. * * *
>
> We found that, although IHS provided medical treatment to alcoholics, almost all the funds for projects to prevent drinking problems or rehabilitate alcoholics were provided by the Office of Economic Opportunity until July 1972 and thereafter by HEW's National Institute on Alcohol Abuse and Alcoholism. * * *
>
> IHS headquarters and service unit officials said they had little data on the magnitude of community alcoholism and had no data on how effectively the projects were dealing with the alcohol problem. IHS officials believed these programs, for the most part, to be incomplete, fragmentary, and lacking substantial impact on the problem.[4]

Drug Abuse

The recent experience of the Indian Health Service mental health programs has disclosed an alarmingly rapid increase in the occurrence of drug abuse among Indian people—particularly children, adolescents, and young adults. In the first quarter of calendar year 1974, the number of cases seen increased by almost 50 percent over the preceding 6 months. In many communities, a majority of the children are regular users of toxic inhalants, and there are indications that harder, more expensive drugs are being introduced. The same factors which

[4] Comptroller General of the United States, "Progress And Problems In Providing Health Services To Indians," March 1974, pp. 53–54.

have produced several generations of alcohol abusers may today be producing a generation that abuses alcohol as only one of a variety of dangerous substances. Immediate treatment is needed, but in the long run prevention must be seen as most important. Indian Health Service mental health workers in the field attempt to reach the causes of the problem by strengthening Indian families, communities, and schools and by helping them identify the problem and alleviate the stresses which enhance it. During recent months, IHS mental health workers have been seeing approximately 4,000 new cases of individual and family disturbances per month including 200 contacts with schools about student problems. In addition, in the first quarter of 1974, mental health workers participated in 114 school mental health projects. Unfortunately, this workload is only occurring in some communities and all the evidence indicates that the need is just as great where there are few or no resources.

Response of the Indian Health Service

As demonstrated in the lessening of death and illness rates among Indians in recent years, the Indian Health Service has succeeded in providing markedly improved health care to the Indian people. However, as noted above, such progress can only be viewed as a modest beginning in that it is measured from a deplorably low initial health status for Indians. Unfortunately, continued progress is not certain.

The Indian Health Service has simply never had enough funds to provide all of the necessary health care to the reservation Indian population. Some well conceived programs cannot be fully implemented and other needed programs cannot be undertaken. Many of the facilities cannot accommodate additional health staff should they become available.

In addition to its financial needs, the IHS is hampered by the great distances and commuting problems to its facilities. Many patients have to depend on hitchhiking or costly rides from neighbors to gain access to health facilities. Such dependency frequently makes it impossible to keep appointments. In addition there are still sizeable portions of the older Indian population which do not speak English. Although interpreters are used in the health facilities, there may be much lost in the translation.

A number of additional factors inhibit the elimination of the perceived unmet health needs of Indians, not the least of which is the fact that rampant inflation is constantly eroding the purchasing power of the fiscal resources available to the IHS. Resources predicted to be necessary to meet the requirements of long range planning become woefully inadequate when actually realized because of the sharply decreased buying power brought about by recent inflationary trends.

As this eroding of resources occurs, the ability of the Indian Health Service to meet its unmet needs constantly diminishes. Several recent independent, studies have substantiated this alarming fact. An August 1974 study by Urban Associates, Inc. entitled *A Study of the Indian Health Service and Indian Tribal Involvement in Health*, amply

reinforces this contention. The report states, "There is little question but that IHS is trying as hard as it can and is attempting to plug the big holes in the Indian health situation. But under the present system, an individual will never have the right to a specified service, and an Indian Health Board will never be able to define IHS's responsibility until IHS is funded for 100% of need (an unlikely occurrence) and until some effort is made to predetermine a health care package that is guaranteed to all Indians."

The General Accounting Office in its March 1974 report highlights the unmet health needs and the difficulties involved in the satisfaction of these needs. This report states in part, ". . . IHS data indicates significant shortages of doctors, dentists, nurses, and support personnel . . . IHS officials estimated that they need 4,200 more personnel and an additional $130 million for the health services program. This estimate excludes the need for new construction and for correcting known deficiencies in existing IHS facilities."

Finally, the Council on Medical Services of the American Medical Association, in a report entitled *Health Care of the American Indian*,[5] specifically cited as important factors contributing to Indian health deficiencies the grossly inadequate facilities and lack of adequate professional and support staff. To remedy these deficiencies the Council recommended that programs be implemented which would facilitate private, as well as Federal, care for Indians and Alaska Natives; that an immediate construction and modernization program be begun to bring the Indian Health Service facilities up to current standards of practice and accreditation; and that new methods be employed to attract sufficient new physicians to maintain and improve the current level of care provided by the IHS. The Council concluded its report by noting that its position could be stated best by repeating a statement which was first published 25 years ago in the Journal of the American Medical Association of January 1949:

> Many of the recommendations and conclusions which we arrived at in the course of this survey have been made before by officials of the Indian Health Service. Largely because of inadequate budgets, either these recommendations have not been carried out at all or have not been carried beyond the initial steps. It is high time that Congress realized the situation and gave adequate financial support so that these recommendations can be effectively carried out.[6]

In short, the Indian Health Service is severely handicapped in its attempts to meet the objective of elevating the health of Indian people to the highest possible level. Illustrative of the failure of IHS to accomplish this objective are the following data showing the unmet need of five selected categories of surgery surgical needs beginning with fiscal year 1975:

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[5] American Medical Association, Council on Medical Services, "Health Care of the American Indians," December 1973.

[6] Journal of American Medical Association, "Medical Care Among the Upper Midwest Indians," January 1949.

INDIAN HEALTH SERVICE SELECTED UNMET SURGERY—BEGINNING FISCAL YEAR 1975

	Number of cases [1] (1)	Surgery cases required (2)	Surgery cases performed [1] (3)	Surgical cases unmet need [2] (4)	Average length of stay [1] (5)	Hospital days required [3] (6)	Per diem rate [4] (7)	Hospital cost (rounded) (8)	Physician fees [5] (9)	Physician cost (rounded) [6] (10)	Projected cost/IHS unmet need [7] (11)	Surgery performed through CHS [8] (percent) (12)	Projected cost unmet need OHS [9] (13)
Otitis and mastoiditis	58,679	[10] 14,670	1,563	13,107	7.4	96,991	142	13,773,000	1,103	14,457,000	28,230,000	32	9,033,000
Hernia of abdominal cavity	2,212	[11] 2,101	327	1,774	11.9	21,111	142	2,998,000	497	882,000	3,880,000	42	1,630,000
Gallbladder and bile duct	5,453	[12] 4,090	1,227	2,863	14.2	40,655	142	5,773,000	662	1,895,000	7,668,000	39	2,990,000
Utero vaginal prolapse	413	[13] 392	137	255	9.8	2,499	142	355,000	662	169,000	524,000	39	204,000
Cataract of the eye	2,687	[14] 2,687	357	2,330	13.2	30,756	142	4,367,000	881	2,053,000	6,420 000	20	1,284,000
Total	69,444	23,940	3,611	20,329	----------	192,012	----------	27,266,000	----------	19,456,000	46,722,000	----------	15,141,000
Patient and escort travel													752,000
Total													15,893,000

[1] Derived from special on-request report No. 28 for fiscal year 1974, CHS–IHS DPSC.
[2] Required surgery cases minus surgery cases performed equals unmet surgery needs.
[3] ALOS multiplied by unmet need (col. 4).
[4] Estimated G.M. & S. per diem rate for fiscal year 1976 Presidential budget.
[5] Fees derived by use of Portland area unit value of 7 (experience) and the California relative value schedule, 1964 plus 12.6 percent for cost increase experienced in physician fees, fiscal years 1974 to 1975.
[6] Physician fees multiplied by unmet need equals physician costs.
[7] Sum of hospital cost (col. 8) and physician cost (col. 10).
[8] Historical percentage of surgery performed through CHS.
[9] Based on experience of percentage of IHS surgery performed through CHS as identified in col. No. 3.

[10] It is estimated that 25 percent of the reported otitis media and mastoiditis cases will require surgical intervention.
[11] It is estimated that 95 percent of the reported hernia cases will require surgical intervention.
[12] It is estimated that 100 percent of the cholelithiasis; 40 percent of the cholecystitis; and 20 percent of the unspecified gallbladder disease will require surgical intervention.
[13] It is estimated that 95 percent of the utero-vaginal prolapse cases will require surgical intervention.
[14] It is estimated that—100 percent of the cataract cases will require surgical intervention.

Note: Does not include unmet need for dental, eye care, or hearing aids.

STAFFING

As noted in section III of this report, the Indian Health Service is facing serious deficiencies in staffing its facilities. The number of Indian Health Service physicians, dentists and registered nurses per 100,000 persons served has continually lagged behind the rate for the U.S. general population. A degree of success has been shown in closing the gap between the physician and dentists rates for the Indian Health Service and the United States general population. The number of physicians per 100,000 population in 1973 in the Indian Health Services was 56 percent of the U.S. rate. In 1960 the IHS rate was less than 40 percent of the U.S. rate. The number of dentists per 100,000 population in 1974 in the IHS was 71 percent of the U.S. rate. In 1960, the IHS rate was 42 percent of the U.S. rate. Whereas the rate for registered nurses in the general population has experienced a continual increase from 1956 through 1972, the rate within the Indian Health Service has remained almost constant since 1967. The IHS registered nurses rate ranged from a low of 213 registered nurses per 100,000 population in 1966 to a high of 230 in 1956.

FACILITIES

As will be treated in much greater detail in section V of this report, the Indian Health Service also has a compelling need for additional funds to repair and maintain its existing facilities. The Indian Health Service maintains over 5,300,000 square feet of space of which 914,000 is located in Alaska alone. There are 51 hospitals, 86 health centers, over 300 clinics, and over 1,700 units of personnel quarters. The management of the Indian Health Service's facilities is the responsibility of the IHS Area Offices located in 10 geographical locations.

The Department of Health, Education and Welfare's Facilities Engineering and Property Management Deep Look Surveys have indicated gross deficiencies in the maintenance of the Indian Health Service facilities. These problems are attributable to the lack of resources both in funds and manpower. Over $24,000,000 would be required to initiate a program to eliminate the backlog of essential maintenance and repair items.

In addition, the Deep Look Surveys indicated a need for approximately 479 maintenance and repair personnel to adequately maintain the Indian Health Service's real property inventory. With approximately 325 people presently involved in this work, an additional 154 maintenance and repair personnel will be required.

LONG RANGE PLAN

The deficiencies in Federal Indian health care services are displayed in the Indian Health Service's long range plan. This plan assesses the future health care needs of Indians and attempts to forecast the re-

sources necessary to meet those needs. The plan calls for continued incremental program expansion to achieve the goal of raising the health status of the Indian and Alaska Native peoples to that of the U.S. general population. To accomplish this end, the plan focuses on these major long term objectives:

To achieve a steady decrease in Indian morbidity and mortality rates.

To assure high quality health care from both professional and consumer perspectives.

To serve as the primay provider for special Indian health needs not met by general service programs.

To serve as the principal Federal advocate for the health of Indians.

To promote Indian participation in general service programs.

To stimulate general service programs to reach out and serve Indians.

To encourage and to enable the Indian population to assume control of their health programs.

And to create and to maintain administrative conditions which will foster the success of Indian-managed health programs.

The operating theory of this plan is to use an incremental approach to the enormous health care backlogs. The Indian Health Service has attempted to forecast the amount needed each fiscal year to achieve their projected goals in 5 years:

FORWARD PLAN, 1975–79 PROGRAM INCREASES—BACKUP DATA FOR FINAL PLAN SUBMITTED APR. 16, 1973

	1975		1976		1977		1978		1979		Total positions	Total increases
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount		
Patient care:												
Employment community health medics	35	700,000	40	800,000	40	800,000					115	2,300,000
Laboratory quality control	6	266,000	8	266,000	8	266,000	6	266,000	7	266,000	35	1,330,000
Patient care	170	1,900,000	474	6,659,000	350	5,197,000	480	6,800,000	480	6,800,000	1,954	27,356,000
Otitis media program	16	954,000	6	371,000	6	125,000	6	125,000			34	1,575,000
Health information system	15	1,000,000	7	1,500,000	7	1,500,000	7	1,500,000			36	5,500,000
Maintenance and repair	34	6,000,000	30	4,000,000	30	4,000,000	30	4,000,000	30	3,000,000	154	21,000,000
Indirect (contract) (total)		6,000,000		7,600,000		6,000,000						19,600,000
Dental		679,000		700,000		700,000						2,079,000
All other		5,321,000		6,900,000		5,300,000						17,521,000
Field health:												
Environmental health	60	719,000	60	720,000	55	660,000	55	660,000	47	564,000	277	3,323,000
Dental	60	860,000	74	680,000	74	680,000	74	660,000	61	640,000	343	3,520,000
Public health nursing	60	700,000	60	700,000	60	700,000	60	700,000	60	700,000	300	3,500,000
Health education	31	400,000	30	400,000	30	400,000	29	400,000			120	1,600,000
Field medical:												
Ambulatory care	83	1,100,000	21	356,000							104	1,456,000
Eye care	17	1,400,000	11	300,000	11	300,000	11	300,000			50	2,300,000
Mental health	50	1,100,000	40	1,000,000	40	1,000,000	40	1,000,000			170	4,100,000
Nutrition		245,000		245,000		245,000		245,000		245,000		1,225,000
Alaska communications		475,000		525,000								1,000,000
Tribal health program development (total)		5,491,000		5,859,000		3,000,000		3,500,000		3,500,000		21,350,000
Trans project (emergency medical)		370,000		500,000		500,000		500,000		500,000		2,370,000
Pilot urban health projects		482,000										482,000
CRIHB		2,000,000		2,304,000								4,304,000
50 CHR's		262,000										262,000
Alaska clinics				180,000								180,000
Training		1,177,000		675,000								1,852,000
Tribal community health development		1,200,000		700,000		500,000		1,000,000		1,000,000		4,400,000
School dormitory				1,500,000		2,000,000		2,000,000		2,000,000		7,500,000
Total	637	29,310,000	861	31,981,000	711	24,873,000	798	20,156,000	685	15,715,000	3,692	122,035,000

Source: Indian Health Service.

TITLE II OF S. 522, AS AMENDED

COMMITTEE OBJECTIVES

In spite of the effort of the Indian Health Service to improve the level of health care for Indians and Alaska Natives, the Committee finds that this effort, as demonstrated by IHS' own long range plan, has fallen far short of that required. Clearly more is needed. The Committee proposes, through S. 522, to provide the financial wherewithal and legal mandate necessary to increase the IHS health care effort.

The approach that the Committee has taken in S. 522 is one of planned growth of the Indian Health Service's delivery system and facilities. There must necessarily be a reasonable use of resources which implies a planned, orderly approach to the enormous backlog of unmet needs confronting the Indian Health Service. An immediate massive input of Federal money is neither desirable nor required because this would do no more than inundate the IHS with useless funds. The present facilities could not service the increased load; adequate well-trained staff are not now available (and will not be until the effects of implementation of title I of S. 522 are felt); and the state of the medical-administrative art is inadequate to meet the loads which would be placed upon it.

It is proposed, therefore, to build upon the existing IHS capability by increments until such time as unmet health care needs can be fully serviced, rather than to adopt a crash program to attack existing health deficiencies and then, once the deficiencies are removed, find it necessary to dismantle the unwieldly system which inevitably results from such a crash program. The phased approach favored by the Committee in drafting Title II will not only result in the removal of those deficiencies but also the establishment of a firm program base which will enable the IHS to continue to provide the levels of health services beyond the life span of S. 522.

PROVISIONS OF TITLE II [7]

Direct Patient Care

To remove the backlogs in direct patient care, section 201(c)(1) provides $198.5 million over seven fiscal years. These funds would be used exclusively for direct patient care including operation of the 51 Indian Health Service Hospitals and attached outpatient clinics and maintenance of IHS facilities consisting mainly of hos-

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[7] The authorization figures found below and in the text of section 201(c) differ from those found in section X ("Cost") of this report. This is due to subsection (a) of section 201, which contains the following language:

> Funds appropriated pursuant to this section each fiscal year shall not be used to offset or limit the appropriations required by the Service to continue to serve the health needs of Indians during and subsequent to such five-fiscal-year period but *shall be in addition to the funds authorized for the previous fiscal year* and to the annual appropriations required to continue the programs of the Service." (Emphasis added.)

The effect of this language is to treat each fiscal year's appropriation authorization as an add-on to the authorization of the prior fiscal year. Therefore, this treatment of each authorization as the base to which the next authorization is to be applied will result in an actual cumulative new obligational authority of $511,925,000 instead of the sum of $173,150,000, obtained by simply adding the figures in the text of section 201(c).

Subsection (b) of Section 201 provides for a similar cumulative treatment of the positions authorized in subsection (c).

pitals, health centers, health stations, school clinics and staff quarters. The breakdown by fiscal year of the funds and positions authorized is as follows: $4,000,000 and one hundred and fifty positions for fiscal year 1977, $10,000,000 and two hundred and twenty-five positions for fiscal year 1978, $18,000,000 and three hundred positions for fiscal year 1979, $26,500,000 and three hundred and twenty positions for fiscal year 1980, $36,000,000 and three hundred and sixty positions for fiscal year 1981, $46,000,000, and three hundred and seventy-five positions for fiscal year 1982, and $58,000,000 and four hundred and fifty positions for fiscal year 1983.

Field Health Services

Section 201(c)(2) provides $100.5 million for seven fiscal years for Field Health Services which provide environmental health, public health, nursing, health education, and field medical services, including ambulatory medical care, preventive medical services, and public health services. Field Health Services are provided to Indians outside of hospitals through a system of 86 health centers and several hundred satellite health stations and special emphasis programs. In addition, Field Health Service funds will be used to support and extend Indian Health Service communication programs, such as the Arizona Telemedicine Project, which can affect the timely delivery of needed health services in remote areas of many Indian reservations. The breakdown by fiscal year of the funds and positions authorized is as follows: $3,000,000 and ninety positions for fiscal year 1977, $6,000,000 and ninety positions for fiscal year 1978, $9,000,000 and ninety positions for fiscal year 1979, $13,000,000 and one hundred and twenty positions for fiscal year 1980, $18,000,000 and one hundred and fifty positions for fiscal year 1981, $23,000,000 and one hundred and fifty positions for fiscal year 1982, and $28,500,000 and one hundred and sixty-five positions for fiscal year 1983.

Dental Care

In recognition of the tremendous backlog in dental services, the Committee, in section 201(c)(3), provided $16.4 over seven fiscal years for direct and indirect dental care for Indians and Alaska Natives. The breakdown by fiscal years of the funds and positions authorized is as follows: $800,000 and eighty positions for fiscal year 1977, $1,500,000 and seventy positions for fiscal year 1978, $2,000,000 and fifty positions for fiscal year 1979, $2,500,000 and fifty positions for fiscal year 1980, $2,900,000 and forty positions for fiscal year 1981, $3,200,000 and thirty positions for fiscal year 1982, and $3,500,000 and twenty-five positions for fiscal year 1983.

Mental Health

Because of the clearly demonstrated deficiencies in the area of mental health services, the Committee has inserted provisions to establish six major mental health programs.

First, section 201(c)(4)(A) provides $19.4 million for seven years in support of *community mental health services*. The Committee believes that many of the mental health problems which befall Indians are capable of local solution through the use of local facilities on

either an in- or out-patient basis. Many Indians could remain in the familiar surroundings of their homes rather than be confined in institutions far from their reservations and families—an alternative which often proves not only to be unnecessary but counterproductive in applying stresses which result in a worsening in the confined person's mental condition. The breakdown by fiscal year of the funds and positions authorized is as follows: $900,000 and forty positions for fiscal year 1977, $1,700,000 and thirty positions for fiscal year 1978, $2,400,000 and thirty positions for fiscal year 1979, $3,000,000 and twenty-five positions for fiscal year 1980, $3,500,000 and twenty positions for fiscal year 1981, $3,800,000 and ten positions for fiscal year 1982, and $4,100,000 and fifteen positions for fiscal year 1983.

Second, $5.9 million over seven years is provided in section 201(c)(4)(B) for *inpatient mental health services.* Such care is presently available only through contract facilities and is not particularly suited to the needs of the Indian patients. This authorization would satisfy the demand for Indian-oriented services for treatment of acute and long term mental illness and would provide those services at a lower cost than that of the present program. The breakdown by fiscal year of the funds and positions authorized is as follows: $200,000 and fifteen positions for fiscal year 1977, $400,000 and fifteen positions for fiscal year 1978, $600,000 and fifteen positions for fiscal year 1979, $800,000 and fifteen positions for fiscal year 1980, $1,000,000 and fifteen positions for fiscal year 1981, $1,300,000 and twenty positions for fiscal year 1982, and $1,600,000 and twenty-five positions for fiscal year 1983.

Third, section 201(c)(4)(C) provides $6,250 million over four fiscal years for a *Model dormitory mental health services program.* Such a project was begun in the fall of 1970 and has operated through three school years. It consisted of increases in the size, training and supervision of the staff of a single dormitory at the Toyei Elementary Boarding School at Ganado, Ariz. The dormitory housed approximately 200 children ranging in age from five to nine. The staff, which was originally seven instructional aides and a supervisor, was increased to about 40 and given training. Progress of the children was monitored by one independent group of evaluators and compared with a control school. The children did better in a number of measures of physical, emotional, and intellectual growth and worse in none. The program to be established by this provision would permit the IHS to build upon this successful pilot effort. The breakdown by fiscal year of the funds and positions authorized is as follows: $625,000 and fifty positions for fiscal year 1977, $1,250,000 and fifty positions for fiscal year 1978, $1,875,000 and fifty positions for fiscal year 1979, and $2,500,000 and fifty positions for fiscal year 1980.

Fourth, $3.450 million is provided in section 201(c)(4)(D) over the seven-fiscal-year period for *therapeutic and residential treatment centers for Indian children.* The underlying (and often unconscious) purpose of most Indian programs has been to "civilize" the Indians, and it is perhaps most fully reflected in the historic method of treating children's problems or dealing with problem children on reservations—the removal of those children to an institution of some kind or to a

non-Indian foster home. The Committee believes these are pernicious tendencies which must be reversed. Therefore, the Committee fully supports efforts of the Indian Health Service to convince Indian people, by education, persuasion and example, that they should remain in control of their children's upbringing even when problems develop. Most problem children would be better treated at home if there were sufficient mental health staff to work with them and their families. Unfortunately, however, even if there were more help at home, some of these children would still need the specialized assistance available away from home in schools for disturbed or delinquent children. It is proposed, therefore, to establish therapeutic and residential treatment centers for disturbed Indian children to provide these children with intensive care in a residential setting. The costs of this care using available non-Indian facilities range from $20,000 up per child per year. The plan is to develop a major cooperative care agreement between the IHS and the BIA using suitable BIA facilities in convenient locations. Each center, under the cooperative agreement, would have an estimated cost of $800,000, would need 50 positions, and would provide for 100 children at a considerable saving over what is now being spent.

The breakdown by fiscal year of the funds and positions authorized is as follows: $150,000 and ten positions for fiscal year 1977, $300,000 and ten positions for fiscal year 1978, $400,000 and five positions for fiscal year 1979, $500,000 and five positions for fiscal year 1980, $600,000 and ten positions for fiscal year 1981, $700,000 and five positions for fiscal year 1982, and $800,000 and five positions for fiscal year 1983.

Fifth, section 201(c)(4)(E), which authorizes $1.575 million over the seven-fiscal-year period for the training of *traditional Indian practitioners in mental health*, reflects a recognition of the continuing value of the native culture both as a socially cohesive force and as an important adjunct to health services of a more recent vintage. In a number of instances the Indian Health Service has benefited from the advice and teaching of medicine men who have been hired as consultants, and in areas where traditional medicine is still an important community resource there is a frequent referral of patients between medicine men and psychiatrists. The breakdown by fiscal year of the funds authorized is as follows: $75,000 for fiscal year 1977, $150,000 for fiscal year 1978, $200,000 for fiscal year 1979, $250,000 for fiscal year 1980, $300,000 for fiscal year 1981, $300,000 for fiscal year 1982, and $300,000 for fiscal year 1983.

Treatment and Control of Alcoholism

Section 201(c)(5) provides for a seven year $102 million authorization for the treatment and control of alcoholism among Indian and Alaska Native peoples.

As discussed above under "Alcoholism" in this section of the report, the threshold problem concerning alcoholism among Indians is the lack of any legislative mandate to any Federal agency to undertake the responsibility for the control and treatment of Indian alcoholism. Section 201(c)(5) contains the necessary language to provide the authority for and recognize the responsibility of the Indian Health Service to undertake the control and treatment services. The Com-

mittee shares the belief expressed by Senator Hughes at the hearings on S. 2938 that:

> * * * [U]ltimately the prevention and treatment of alcoholism among Indians must be integrated with the full range of health, education, and social services designed for, and increasingly by, Indians and funded by the Indian Health Service and the Bureau of Indian Affairs. Alcoholism is both a cause and a result of most of the problems which these agencies are seeking to overcome, and it cannot be ignored or treated as a separate and unrelated problem.

The provisions of section 201(c)(5) concerning the treatment and control of alcoholism are intended to remedy the problems experienced under the NIAAA projects and to mirror the Committee's intent as discussed above. These provisions would authorize additional funds to supplement those NIAAA funds allocated for Indian programs and provide the IHS with the requisite authority to continue worthwhile NIAAA demonstration projects as they mature. These provisions, therefore, would not interfere with, and would in fact complement, the NIAAA policy of funding both new Indian alcoholism projects and new operations within mature programs in order to demonstrate their value. The Committee expects that the Indian Health Service, in coordination with the NIAAA, would arrange to continue NIAAA demonstration projects as they mature. In his August 2nd letter to Senator Kennedy, Dr. Chafetz wrote:

> Your legislative efforts to amend the Indian Health Care Improvement Act have been discussed and it is our feeling that earmarked alcoholism funds to the Indian Health Service can be utilized by IHS, in collaboration with NIAAA's efforts, in ways which will be of maximum benefit for the American Indian people. Such a combination of our respective responsibilities, authorities and funds, I believe, is the most appropriate way for the Federal government to meet reservation and urban American Indian health and alcohol abuse problems.

With the funding authorized for alcoholism treatment and control, programs would be established and implemented to increase public understanding and awareness of the problems of alcoholism, change community attitudes, support rehabilitation sources, develop preventive programs for Indian youth, and design education and training programs in the field of Indian alcoholism. Projects would be designed to provide residential care, individual counseling, job placement, referral services, group therapy, Indian AA groups, recreation and self-government. The essential aspect of these projects would be the integration of Indian cultural patterns into the rehabilitative and learning processes. This would be accomplished, in part, by hiring Indian staff, working through individual tribal entities, and emphasizing the Indian's image of himself.

In drafting section 201(c)(5), the Committee took care to provide that the same Indian population eligible for demonstration project contracts is also eligible for continuous project contracts or grants. This will insure that no gap in the delivery system will be created as

the demonstration projects mature. In other words, the Committee believes that the legal definition of the Indians to be served by IHS continuous alcoholism programs must not be so narrowly drawn as to exclude from participation in these programs any of the Indians who demonstrate the value of their time-limited NIAAA projects.

The $20 million cumulative authorization for the fifth fiscal year is in keeping with an assessment of a Task Force Analysis of Mental Health that a total of at least $20 million per year for Indian alcoholism programs is necessary if this serious problem is to be effectively managed if not eliminated.

The breakdown by fiscal year of the funds authorized is as follows: $8,000,000 for fiscal year 1977, $10,500,000 for fiscal year 1978, $13,000,000 for fiscal year 1979 $15,000,000 for fiscal year 1980, $17,000,000 for fiscal year 1981, $18,500,000 for fiscal year 1982, and $20,000,000 for fiscal year 1983.

Health Care Personnel in Primary and Secondary Bureau of Indian Affairs Schools

Section 201(c)(6) provides $17 million for seven fiscal years for health care personnel in primary and secondary schools serving Indians. Information prepared by the Bureau of Indian Affairs for Senator Domenici indicates there are at least 50 Indian schools in the country with inadequate health facilities. These schools possess student bodies with as few as 15 children up to as many as 494 students. In some cases the nearest health facility could be as far away as 75 miles. This report concluded that a visiting official—a person who visited only on a rotation basis—provides inadequate health care since it is highly unlikely that accidents and illnesses occur on only a once a day or once a week basis or only from 9 to 10 in the morning. It is apparent, therefore, that the children attending these schools are bearing the burdens of inadequate health care. These children need proper attention, health instruction, and dependable health services as offered in most public schools. Section 201(c)(6) would provide that comparable health care. The breakdown by fiscal year of the funds authorized is as follows: $600,000 and thirty-three positions for fiscal year 1977, $1,000,000 and twenty-two positions for fiscal year 1978, $1,300,000 and sixteen positions for fiscal year 1979, $1,700,000 and twenty-two positions for fiscal year 1980, $2,500,000 and forty-four positions for fiscal year 1981, $3,900,000 and seventy-six positions for fiscal year 1982 and $6,000,000 and one hundred and fifteen positions for fiscal year 1983.

Maintenance and Repair

Finally in recognition of the inadequate level of maintenance and repair funds and personnel, section 201(c)(7) authorizes $21 million over seven fiscal years to provide additional maintenance and repair staff and funds. The breakdown by fiscal year of funds and positions authorized is as follows: $3,000,000 and twenty positions for fiscal year 1977, $3,000,000 and twenty positions for fiscal year 1978, $4,000,000 and thirty positions for fiscal year 1979, $4,000,000 and thirty positions for fiscal year 1980, $4,000,000 and thirty positions for fiscal year 1981, $2,000,000 and fifteen positions for fiscal year 1982, and $1,000,000 and five positions for fiscal year 1983.

Research

In order to insure optimum effectiveness of the increased care provided for in S. 522, the Committee inserted a provision directing the Secretary of Health, Education, and Welfare to expend a fixed percentage of certain funds (not less than 1% of the funds appropriated pursuant to the authorizations under section 201(c) (1) through (5)) for research in the areas of patient care, field health, dental care, mental health and alcoholism. The Indian Health Service has carried out several operational research projects over the last several years which have benefited the IHS in the more efficient use of resources, such as development of the outpatient clinic simulator which permits the IHS to simulate patient flow and waiting time in the outpatient clinic in order to choose the most efficient employment of staff. The Committee hopes that these types of projects would continue and, at the same time, research in other areas, such as drug abuse, alcoholism, tuberculosis, and otitis media, which have been deemphasized due to budget and staff deficiencies, would be initiated.

The need for expanded research was described during the hearings on S. 2938 by Dr. Everett R. Rhodes, Vice-Chairman of the National Committee on Indian Health of the Association on American Indian Affairs and Member of the Executive Committee of the Association of American Indian Physicians:

> A section or amendment should be added establishing a research mission for the Indian Health Service. An amount of $5 million would be a reasonable sum to begin a research activity.
>
> It is recognized that, where research and education are emphasized, medical care will be best. The resultant intellectual stimulus would be a positive factor for recruitment.
>
> It is of interest that Members of Congress are usually hospitalized in teaching hospitals.
>
> There is another reason for establishment of a research mission for the Indian Health Service. There are many biological phenomena which separate Indians from non-Indians. Some of these include important differences in the incidence of obesity, diabetes, gall bladder disease, cancer of the lung, cancer of the intestinal tract, and several other types of illnesses.
>
> Thus, we have before us a great natural experiment which, if studied, would certainly yield important fundamental knowledge relating to disease processes themselves. This knowledge would have important implications, not only for Indians, but for non-Indian groups as well.
>
> Present research facilities in the United States are unable to address these questions in a well-defined, coordinated fashion. It is unlikely that existing research programs will be able to attack the diverse problems. For example, it seems unlikely that the National Institutes of Health, as presently organized into disease categories, could coordinate the various disciplines involved.

An important aspect of research on American Indian groups is that the research must be directed and carried out by Indian personnel insofar as this is possible. The day is past when Indian groups will submit quietly to irrelevant research by outsiders. This fact alone is further argument for the establishment of a center or institute by Indians.

There is one area of health which is worthy of being singled out for special consideration. In the general field of mental health, practically no basic research is going on. There have not yet even been established standards, norms, and proper measurements for evaluating Indian behavior. There is no reliable way to detect early deviations from the norm.

Measuring Indians by non-Indian parameters will always measure Indians incorrectly and may place them in an abnormal category. A new basic science must be established.

The Committee expects that through the provisions of title II of S. 522, the objectives of the long range plans of the Indian Health Service can be met, recognizing that their direction and approach may be continually revised as communications with the Indian and Alaska Native peoples indicate a change or shift in emphasis and need.

V. DEFICIENCIES IN INDIAN HEALTH AND SANITATION FACILITIES: BACKGROUND AND AN ANALYSIS OF TITLE III OF S. 522, AS AMENDED

Deficiencies in Health Facilities

There is an obvious, significant relationship between the standard of health care provided in a given geographical area and the quality of the facilities through which such care is administered. Inadequate, outmoded or unsafe hospitals and other health facilities inhibit the potential for quality health care. Moreover, recruitment and retention of highly competent personnel at all levels of the medical profession is frustrated, if not made impossible, in areas where the facilities are inadequate to provide even the most basic of health services.

The Indian Health Service provides comprehensive health care to Indians and Alaska Natives on or near reservations from 51 hospitals, 86 health centers and over 300 health stations and clinics. A list of major Indian Health Service facilities by Area and State as of July 1, 1974, follows:

MAJOR PHS INDIAN HEALTH FACILITIES BY AREA AND STATE (AS OF JULY 1, 1974)

Area and State, service population	Hospitals (bed size)[1]	Service population	Health centers	Service population	School health centers
Aberdeen area:					
Minnesota:					
2,346	Cass Lake (24)	2,612	White Earth		
3,039	Red Lake (30)				
Nebraska: 2,193	Winnebago (60)				
North Dakota:					
6,254	Belcourt (50)	1,844	Fort Totten	425	Wahpeton.
3,899	Fort Yates (30)	2,327	Minni-Tohe (Four Bears).		
South Dakota:					
4,030	Eagle Butte (33)	1,690	McLaughlin	715	Flandreau.
10,366	Pine Ridge (58)	2,654	Rapid City	197	Pierre.
2,654	Rapid City (84)	1,165	Wanblee		
6,942	Rosebud (52)				
2,325	Sisseton (32)				
1,101	Wagner (26)				
Albuquerque area:					
Colorado		2,150	Ignacio		
New Mexico:					
16,223	Albuquerque (75)	4,748	Dulce	386	Albuquerque.
1,840	Mescalero (15)	5,184	Laguna	904	Southwestern Polytechnical Institute.
11,038	Santa Fe (40)	1,106	Taos		
6,324	Zuni (36)				
Anchorage area:					
Alaska:					
13,554	Anchorage (259)	2,661	Fairbanks	495	Mount Edgecumbe.
2,672	Barrow (14)	890	Fort Yukon	195	Wrangell.
12,591	Bethel (42)	2,183	Juneau		
2,583	Kanakanak (29)	2,005	Ketchikan		
8,552	Kotzebue (40)	857	Metlakatla		
7,987	Mount Edgecumbe (82).	8,552	Nome		
163	St. George (6)				
450	St. Paul (8)				
5,154	Tanana (26)				

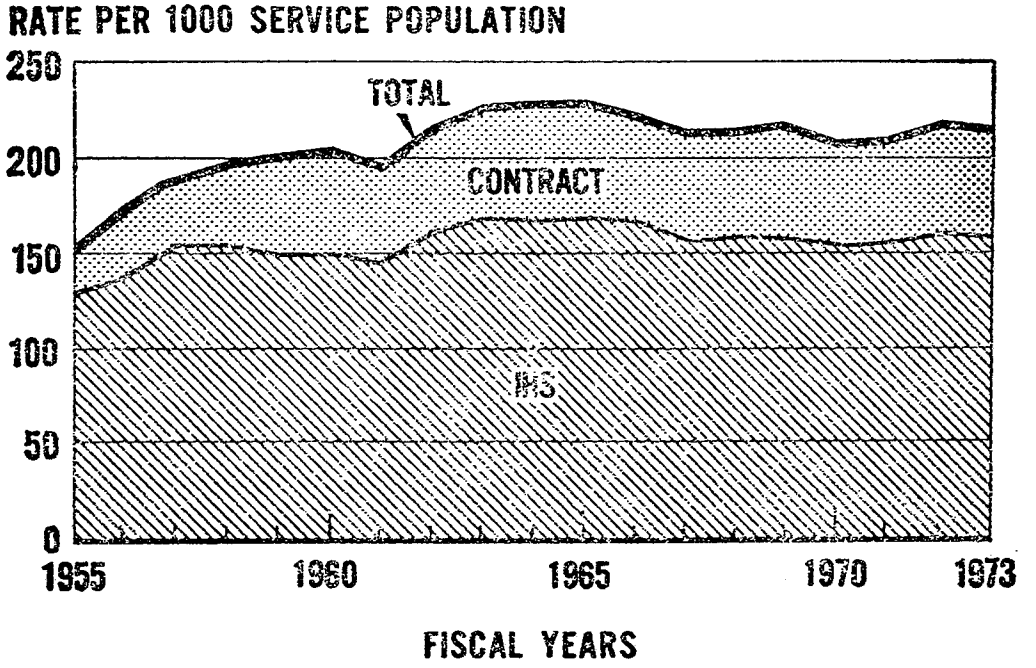
MAJOR PHS INDIAN HEALTH FACILITIES BY AREA AND STATE (AS OF JULY 1, 1974)—Continued

Area and State, service population	Hospitals (bed size)[1]	Service population	Health centers	Service population	School health centers
Billings area:					
Montana:					
5,188	Browning (34)	2,573	Lame Deer		
7,315	Crow Agency (34)	1,463	Poplar		
3,673	Harlem (22)	1,635	Rocky Boy's		
		3,927	St. Ignatius		
		2,908	Wolf Point		
Utah				1,416	Brigham City.
Wyoming		2,606	Fort Washakie		
		1,443	Arapahoe		
Navajo area:					
Arizona:					
11,033	Fort Defiance (110)	9,012	Chinle	790	Chinle.
5,924	Tuba City (75)	1,375	Dilkon	404	Holbrook.
8,537	Winslow (40)	3,570	Kayenta	556	Leupp.
		253	Toyei	1,099	Tuba City.
		3,784	Many Farms		
		866	Lower Greasewood		
		1,025	Teec Nos Pos		
		1,702	Shonto		
New Mexico:					
9,197	Crowpoint (56)	1,284	Tohatchi	849	Crownpoint.
18,737	Gallup (200)	907	Fort Wingate	1,760	Fort Wingate.
23,586	Shiprock (66)			624	Shiprock.
				535	Sanostee.
				383	Gallup (dormitory).
Oklahoma area:					
Kansas, Oklahoma:					
		836	Holton	1,331	Haskell (Lawrence).
33,496	Claremore (66)	1,573	Anadarko	662	Chilocco.
4,390	Clinton (26)	1,808	Broken Bow (Idabel)	339	Concho.
10,292	Lawton (80)	3,198	Delaware District (Jay).	196	Jones Academy (Hartshorne).
7,357	Pawnee (32)	3,907	Okemah	455	Sequoyah.
16,566	Tahlequah (W. W. Hastings) (57).	2,310	Okmulgee		
		1,078	Pawhuska		
9,287	Talihina (94)	20,542	Shawnee		
		6,672	Tishomingo		
		652	Watorga		
		2,766	Wyandotte (Seneca)		
Phoenix area:					
Arizona:					
5,197	Keams Canyon (38)	729	Peach Springs	988	Phoenix.
3,367	Parker (20)		Bylas		
11,552	Phoenix (173)		Cibecue		
6,817	Sacaton (35)		Second Mesa		
5,931	San Carlos (36)				
6,814	Whiteriver (52)				
California: 1,669	Winterhaven (14)				
Nevada:				639	Riverside.
2,065	Owhyee (17)				
6,853	Schurz (26)			461	Stewart.
Utah		2,024	Roosevelt (Fort Duchesne).		
Portland area:					
Idaho		2,736	Fort Hall		
		1,798	Northern Idaho		
Oregon		2,636	Warm Springs	699	Chemawa.
Washington		2,561	Colville		
		2,806	Lummi		
		1,570	Neah Bay		
		2,002	Taholah		
		965	Wellpinit		
		4,206	Yakima		
Tucson program area: Arizona: 10,411.	Sells (50)	1,515	Santa Rosa		
		2,813	Tucson		
United southeastern tribes:					
Mississippi: 3,595	Choctaw (37)				
	(Philadelphia)				
North Carolina: 3,227	Cherokee (26)				

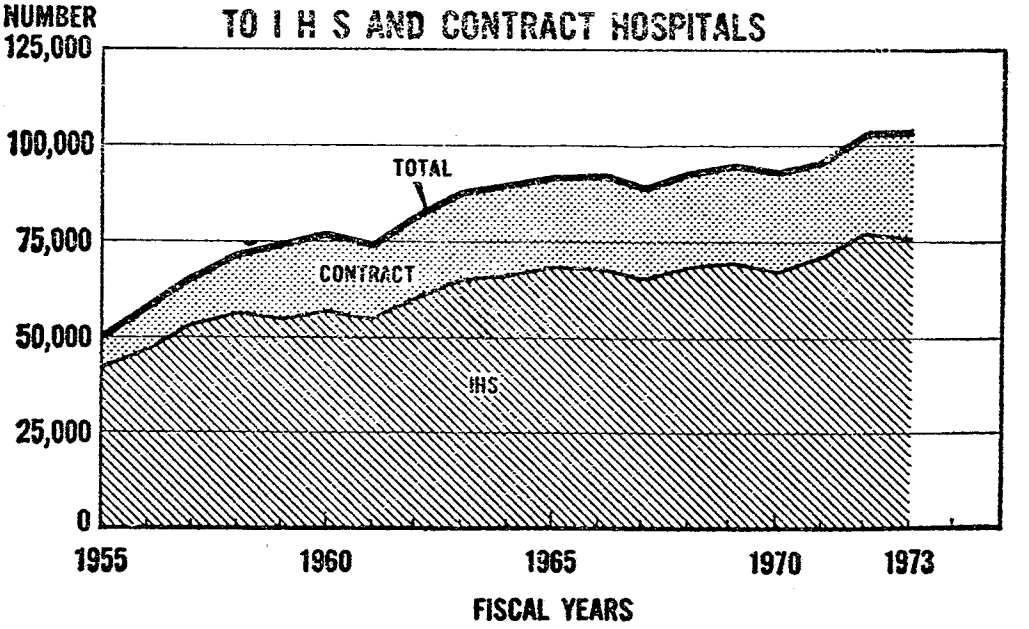
Source: U.S. Senate Committee on Interior and Insular Affairs, Subcommittee on Indian Affairs, Hearings: "Indian Health Service Recruitment Problems," Nov. 19 and 20, 1973.

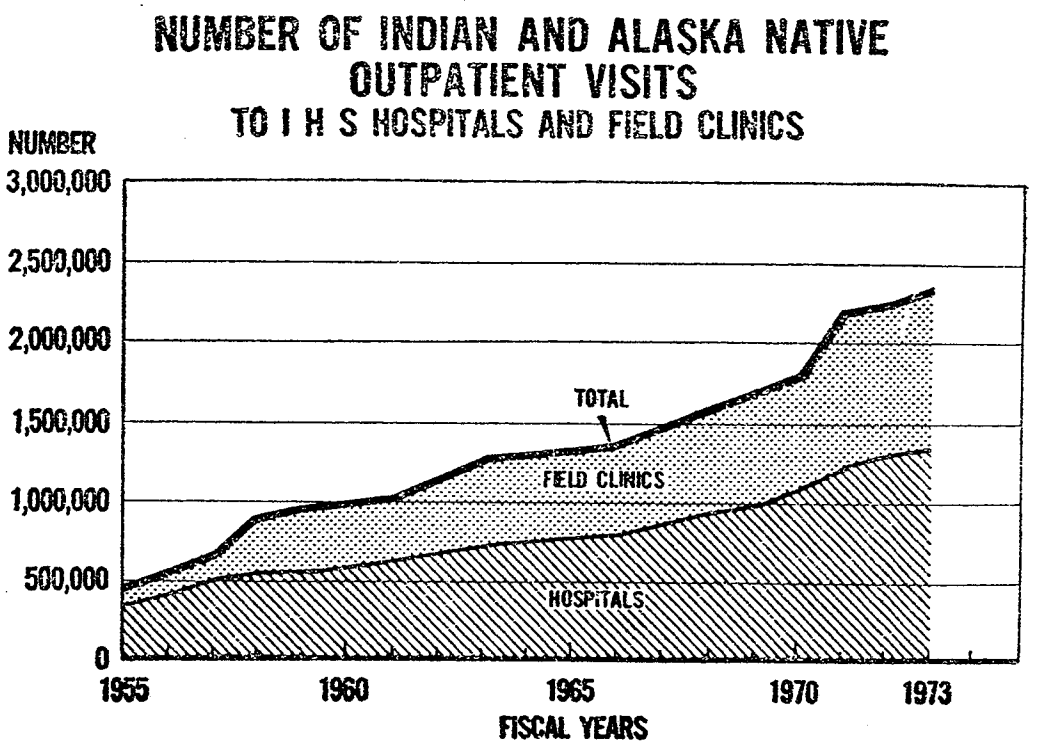
The demands upon these facilities have increased rapidly as Indians and Alaska Natives experience a growing confidence in the Indian Health Service. The following charts, prepared by the Indian Health Service, illustrate this fact by showing the use rates, admission rates and outpatient visits to Indian Health Service and contract facilities since 1955:

HOSPITAL UTILIZATION RATE
INDIAN & ALASKA NATIVE



NUMBER OF INDIAN AND ALASKA NATIVE ADMISSIONS
TO I H S AND CONTRACT HOSPITALS





Source: U.S. Senate Committee on Interior and Insular Affairs, Subcommittee on Indian Affairs, Hearing: "Indian Health Care Improvement Act (S. 2938)", April 3 and 5, 1974.

While attempting to meet the health needs of Indians and Alaska Natives and, at the same time, eliminate some of the enormous backlogs in health services, the Indian Health Service has had to contend with an initial and fundamental impediment: outdated or inadequate health facilities. Thirty-one of the hospitals were constructed during the period 1900–1939, six during 1940–1954, and fourteen between 1955–1974. Since its inception, the Indian Health Service has constructed 13 new hospital facilities, and has modernized or constructed major additions to 11 facilities built during the period of 1900–1939, two facilities during the period 1940–1954, and one facility during the period 1955–1974. However, as the following data clearly illustrate, on the average, the facilities through which the IHS provides health care to Indians and Alaska Natives are severely outdated and consequently inadequate to meet patients needs.

AGE OF IHS HEALTH FACILITIES

	Year constructed			
	1974–55	1954–40	1939–1900	Age
Aberdeen:				
Belcourt, N. Dak	1967			7
Cass Lake, Minn.:				
Original			1937	37
Addition	1962			12
Eagle Butte, S. Dak	1960			14
Fort Yates, N. Dak	1965			9
Pine Ridge, S. Dak.:				
Original			1912	62
Addition	1961			13
Rapid City, S. Dak			1938	36

AGE OF IHS HEALTH FACILITIES—Continued

	Year constructed			
	1974–55	1954–40	1939–1900	Age
Aberdeen—Continued				
Rediake, Minn.:				
Original			1916	58
Addition	1962			12
Rosebud, S. Dak.:				
Original			1915	59
Addition	1961			13
Sisseton, S. Dak			1936	38
Wagner, S. Dak.:				
Original			1937	37
Addition	1965			9
Winnebago, Nebr			1933	41
Alaska:				
Anchorage		1953		21
Barrow	1964			10
Bethel:				
Original		1954		20
Addition	1962			12
Kanakanak		1940		34
Kotzebue	1961			13
Mount Edgecumbe		1946		28
Tanana			1926	48
St. George		1952		22
St. Paul			1933	41
Albuquerque:				
Albuquerque, N. Mex			1934	40
Mescalero, N. Mex	1968			6
Santa Fe, N. Mex. (modernized 1959)			1929	45
Zuni, N. Mex			1937	37
Billings:				
Browning, Mont.:				
Original			1937	37
Addition	1960			14
Crow Agency, Mont.:				
Original			1937	37
Addition	1966			8
Harlem, Mont			1931	43
Navajo:				
Crownpoint, N. Mex			1939	35
Fort Defiance, Ariz.:				
Original			1938	36
Addition	1962			12
Gallup, N. Mex.:				
Original	1961			13
Addition	1965			9
Addition	1970			4
Tuba, City, Ariz	1955			19
Winslow, Ariz			1933	41
Shiprock, N. Mex	1960			14
Oklahoma City:				
Claremore, Okla			1929	45
Clinton, Okla			1933	41
Lawton, Okla	1967			7
Pawnee, Okla			1930	44
Tahlequah, Okla.:				
Original			1937	37
Addition	1964			10
Talihina			1938	36
Phoenix:				
Keams Canyon, Ariz	1961			13
Owyhee, Nev			1937	37
Parker, Ariz			1930	44
Phoenix, Ariz	1971			3
Sacaton, Ariz.:				
Original		1942		32
Addition	1960			14
San Carlos, Ariz	1963			11
Schurz, Nev			1930	44
Whiteriver, Ariz.:				
Original			1939	35
Addition	1960			14
Fort Yuma, Ariz			1936	38
Tucson: Sells, Ariz	1961			13
United Southeastern Tribes:				
Cherokee, N.C			1937	37
Philadelphia, Miss			1931	43

Source: Indian Health Service.

The antiquated state of these hospitals is reflected in their dismal accreditation record. Only twenty-five (less than half) of these facilities are accredited by the Joint Commission on Accreditation of Hospitals (JCAH). Many of them are old one-story, wooden frame buildings with inadequate electricity, ventilation, insulation, and fire protection systems and of such insufficient size as to seriously jeopardize the health and safety of patients and staff alike. To meet the needs of some 530,000 Indians and Alaska Natives, Indian Health Service and contract facilities provide some 3,700 hospital beds. Compared with a national average of one hospital bed per 125 persons, the IHS facilities provide one bed for 132 persons, a shortage of more than 200 beds under existing standards of service and demand.

In response to questions posed to the Department of Health, Education, and Welfare by Senator Jackson, Chairman of the Committee, the Department identified ten facilities which will be brought up to JCAH standards within the next five years (assuming continuation of current funding levels):

Ft. Yates	Mescalero	Philadelphia [1]
Belcourt	Shiprock	Owyhee [1]
	Talihina	Zuni [1]
		Claremore [2]
		Winnebago

[1] Construction funds available for a replacement facility which will conform to JCAH standards.
[2] Construction funds requested in FY 1975 to replace the existing hospital facility.

Responding to another question asked by the Chairman, the Department disclosed that the following ten facilities would "require major modernization and/or expansion or replacement" in order to meet JCAH standards:

Red Lake	Santa Fe [2]	Crownpoint
Rosebud [1]	Clinton	Sisseton
	Eagle Butte	Tanana
		Wagner
		Cherokee

[1] Master Planning Study completed.
[2] Planning for a replacement health facility is underway.

Source: U.S. Senate Committee on Interior and Insular Affairs, Subcommittee on Indian Affairs, Hearing: "Indian Health Care Improvement Act (S. 2938)", April 3 and 5, 1974.

The deplorable state of these antiquated Indian Health Service facilities is underscored by the fact that only twelve of the facilities meet current National Fire Protection Association (NFPA) standards and that 16 cannot meet those standards unless further improvements are undertaken. A list of hospital facilities showing those which do and do not meet those standards follows:

Will meet NFPA standards by end of fiscal year 1974.

Belcourt	Albuquerque	Lawton
Rapid City	Mescalero	San Carlos
Barrow	Gallup	Sells
Kanakanak	Shiprock	Bethel

Will meet NFPA standards by end of fiscal year 1975.

Phoenix	Parker
Keams Canyon	Schurz

Will meet NFPA standards by end of fiscal year 1975.

Cass Lake	Mt. Edgecumbe	Tahlequah
Eagle Butte	Tanana	Talihina
Fort Yates	Browning	Ft. Yuma
Sisseton	Crow Agency	Cherokee
Wagner	Harlem	
Anchorage	Crownpoint	
Kotzebue	Ft. Defiance	
	Tuba City	

Further improvements to meet NFPA standards.[1]

Pine Ridge	Santa Fe	Owyhee [2]
Red Lake	Zuni [2]	Sacaton
Rosebud	Winslow	Whiteriver
Winnebago	Claremore [2]	Philadelphia (Choctaw)
St. George	Clinton	
St. Paul	Pawnee	

[1] These facilities will require extensive modernization or replacement to comply with NFPA standards.
[2] Replacement facility under construction.

Source: U.S. Senate Committee on Interior and Insular Affairs, Subcommittee on Indian Affairs, Hearing: "Indian Health Care Improvement Act (S. 2938)", April 3 and 5, 1974.

The deteriorated or outmoded state of certain of these facilities is so severe that either complete replacement or major modernization work will be required. The Indian Health Service and the Department of Health, Education, and Welfare, Office of Facilities Engineering and Property Management, through detailed "Deep Look" Surveys, have determined that subsequent to fiscal year 1974, 33 hospital facilities (almost two-thirds) fall in either of two categories: those requiring complete replacement and those needing major modernization. *Not considered* was the need to provide hospitals in locations where no Indian Health Service facilities presently exist. Moreover, 30 health stations require replacement and 12 require major modernization work.

The following summaries of the HEW "Deep Look" Surveys and the JCAH reports on five Indian Health Service facilities starkly illustrate the severity of the deficiencies involved:

Bethel, Alaska

—Department of Health, Education, and Welfare, Office of Facilities Engineering and Property Management, "Deep Look" Survey, August 9, 1970: Extensive deterioration is evident resulting from foundation movement, lack of vapor barrier and roof leaks. Inadequate ventilation and fire hazards exist.

—Department of Health, Education, and Welfare, Office of Facilities Engineering and Property Management, National Fire Protection Association Survey, September 11, 1973: Building construction does not comply with Code requirements. The structure is a one story unprotected wood frame completely sprinklered building. Other than constructing a new building, deficiencies have been corrected as much as possible. Therefore, no further major corrections can be achieved.

—Joint Commission on Accreditation of Hospitals, July 25, 1969: Because of the high incidence of infectious and contagious diseases seen at this hospital, it is recommended that the plans for alleviation of the overcrowded conditions in patient care areas, be expedited . . . [I]f the Public Health Service is to continue the present Native medi-

cal program in Bethel, it is recommended that plans be expedited for a major modification or replacement of the present facility in order to provide an environment commensurate with the requirements of modern medical care.

Pine Ridge, S. Dak.

—Department of Health, Education, and Welfare, Office of Facilities Engineering and Property Management, "Deep Look" Survey, May 19, 1970:

> The needs for additional outpatient clinic facilities, storage space, and a garage for hospital vehicles should be included in a major project for the facility. With the extensive need for rehabilitation and functional rearrangement in the old section, complete replacement of the old section may prove economically desirable, and should be considered. Continued use of the facility for an extended period should not be planned without correction of the serious fire safety and environmental hazards identified.

—Joint Commission on Accreditation of Hospitals, May 4, 1972:

> Severely hazardous areas, such as the soiled linen collection room, shall be protected by 2-hour fire-sensitive construction, together with the approved automatic fire extinguishing system already installed.

Rosebud, S. Dak.

—Department of Health, Education, and Welfare, Office of Facilities Engineering and Property Management, "Deep Look" Survey, May 20, 1970:

> The old hospital section is so grossly substandard and hazardous that it should be discontinued in use at the earliest possible date. Only the fire safety deficiencies should be corrected in the interim, as other expenditures would not be justified except for an extended period of use. This building should be razed and replaced.

—Department of Health, Education, and Welfare, Office of Facilities Engineering and Property Management, National Fire Protection Association Survey, September 26, 1973:

> The age and structural condition of the 1915 wing negate any correction work. The structure is of combustible frame, narrow corridors, narrow stairs, structurally deteriorating, cracks in walls, floor joists appear to exceed maximum allowable span, etc. No estimate on cost of updating can feasibly be made.

Santa Fe, N. Mex.

—Department of Health, Education, and Welfare, Office of Facilities Engineering and Property Management, "Deep Look" Survey, July 9, 1970:

> This facility definitely represents an unsafe hospital environment not only from its many life/fire safety deficiencies, but also the many deficiencies relating to patient care. Further, the existing condition of the bearing walls and load-bearing beams constitutes a hazard to the structure and occupants.

—Joint Commission on Accreditation of Hospitals, January 1, 1970:

> As previously recommended in 1967, the present physical plant should be replaced by a new and modern facility as soon as possible.

Winslow, Ariz.

—Department of Health, Education, and Welfare, Office of Facilities Engineering and Property Management, "Deep Look" Survey, August 6, 1970:

> We recommend that IHS abandon any idea of using the existing structure for acute patient care, and that a new building be provided for this use. The existing building is of such heavy construction that it would be very costly to demolish. We suggest that the IHS program try to find a new use for the existing building. This should be done as a team effort with an architectural consultant.

—Schwan and Associate Inc., Consulting Engineers-Structural Evaluation and Report, June 1973:

> The cost involved in the extensive repair in order to bring the structure up to modern standards would surely exceed the cost of a modern new facility of the same size. Furthermore the loss of the "use" of the facility over that period of time would be hard to determine. With the known seismic activity in the Flagstaff-Winslow region and the inadequacy of the structure to withstand same, it becomes obvious that the building must be abandoned and replaced.

In addition to hampering the provision of quality health care to Indians and Alaska Natives, the lack of adequate facilities has the collateral effect of seriously limiting the availability of qualified staff for the Indian Health Service. It has been demonstrated that a comfortable and convenient place to live and a health facility which is responsive to quality health care are the two basic ingredients for recruiting and retaining qualified staff for the Indian Health Service. If one or both are lacking it becomes exceedingly difficult to fully staff the more isolated IHS facilities with qualified health professionals.

With all its other myriad problems, the Indian Health Service also suffers from a lack of adequate staff housing (as noted above, the second of the two basic ingredients necessary to mount a successful health professionals recruitment effort). Existing staff housing does not provide a sufficient number of units to permit full time staffing of the IHS program. Present estimates reveal that 479 units are needed to meet current staffing needs while 193 of the existing units are inadequate and require replacement. The following chart shows the need for additional and/or replacement units by IHS Area:

Area office	Replace inadequate units	Additional units needed for current staff
Aberdeen	32	89
Albuquerque	13	7
Anchorage	19	
Billings	12	24
Navajo	81	321
Oklahoma	12	0
Phoenix	12	20
Portland	8	9
Sells/Tucson	4	1
USET		1
Total	193	479

Source: Response by the IHS to a question posed by Senator Henry M. Jackson, Chairman of the Committee. Printed in U.S. Senate Committee on Interior and Insular Affairs. Subcommittee on Indian Affairs, Hearing: "Indian Health Care Improvement Act (S. 2938)," Apr. 3 and 5, 1974.

In response to these needs, the Department of Health, Education, and Welfare has provided, in its budget requests, funds to replace or remodel outmoded Indian Health Service hospitals and related facilities, and to upgrade others. This is accomplished pursuant to a plan which was submitted in response to hearings on November 19 and 20, 1973, before the Subcommittee on Indian Affairs of this Committee concerning recruitment problems of the Indian Health Service.

That plan was predicated upon a 5-year construction schedule (fiscal years 1975–79) and appeared in a table on pages 100–102 in Report No. 93–1283 on S. 2938. At the request of committee staff, the IHS revised the table to reflect any projects included in the President's fiscal year 1976 budget and an extension of the construction schedule from 5 to 7 years. The revised table follows:

TITLE III—FACILITIES—7-YEAR PLAN (FISCAL YEAR 1977 THROUGH FISCAL YEAR 1983)

[In 1976 dollars]

Facilities and type and size	Previous funds	1975 appropriations	1976 President's budget	Fiscal year— 1977	1978	1979	1980	1981	1982	1983	Total known deficiencies, 1977–83
Hospital, new and replacement:											
Claremore, Okla., replacement, 70–80	200,000	8,560,000	[1] 1,280,000								
Owyhee, Nev., replacement, 15	3,200,000		[1] 350,000								
Philadelphia, Miss., replacement, 30–40	4,550,000		[1] 560,000								
Acomita, N. Mex., new, 30–40	340,000	1,000,000		5,555,000	1,100,000						
Santa Fe, N. Mex., replacement, 45–55	170,000			9,281,000	1,360,000						
Whiteriver, Ariz., replacement, 60–70	377,000			9,900,000	1,881,000						
Winslow, Ariz., replacement, 55–65		475,000		8,800,000	1,672,000						
Bethel, Alaska., replacement, 70–80	600,000			[2] 27,400,000	6,576,000						
Harlem, Mont., replacement, 15	88,000			4,800,000	816,000						
Sacaton, Ariz., replacement, 55	60,000			11,000,000	2,200,000						
Rosebud, S. Dak., replacement, 65–70	28,000			9,400,000	1,786,000						
Red Lake, Minn.,[3] replacement, 30–40				9,100,000	1,729,000						
Pawnee, Okla., replacement, 30–40				6,600,000	1,122,000						
Parker, Ariz., replacement, 30–40					6,200,000	1,054,000					
Schurz, Nev., replacement, 30–40					6,200,000	1,054,000					
Tahlequah, Okla., replacement, 60–78					11,000,000	2,200,000					
Anchorage, Alaska, replacement, 225						1,000,000	36,900,000	8,856,000			
Central, Okla. (Ada), New, 75						11,000,000	2,200,000				
Chinle, Ariz., new, 125							13,200,000	2,772,000			
Fort Yuma, Ariz., replacement, 15							4,200,000	714,000			
Crownpoint, N. Mex., replacement, 60–70								10,500,000	2,100,000		
Talihina, Okla., replacement, 60–70								10,500,000	2,100,000		
Winnebago, Nebr., replacement, 25–35									5,700,000	969,000	
Taanna, Alaska, replacement, 20–30									7,600,000	1,444,000	
Kanakanak, Alaska (equipment), replacement, 20–30										7,600,000	
										1,444,000	
Cherokee, N.C. (equipment), replacement, 30–40										6,200,000	
										1,054,000	
Total, hospital new and replacement	10,035,000	2,190,000		101,836,000	43,652,000	16,308,000	56,500,000	33,342,000	17,500,000	18,711,000	287,849,000

See footnotes at end of table.

TITLE III—FACILITIES—7-YEAR PLAN (FISCAL YEAR 1977 THROUGH FISCAL YEAR 1983)—Continued

[In 1976 dollars]

Facilities and type and size	Previous funds	1975 appropriations	1976 President's budget	Fiscal year— 1977	1978	1979	1980	1981	1982	1983	Total known deficiencies, 1977–83
Hospitals, major modernization and repair:											
Shiprock, N. Mex., modernization, 150	392,000			19,300,000	4,439,000						
Browning, Mont., modernization, 30–40	19,000			440,000	6,500,000	1,105,000					
Pine Ridge, S. Dak., modernization, 65–75				60,000	450,000	6,000,000	1,020,000				
Clinton, Okla., modernization, 25–35					40,000	320,000	3,200,000	480,000			
Fort Defiance, Ariz., modernization, 100					50,000	500,000	6,000,000	1,020,000			
Eagle Butte, S. Dak., modernization, 30–35					40,000	350,000	3,000,000	450,000			
Crow, Mont., modernization, 30–35						40,000	350,000	3,000,000	450,000		
Sisseton, S. Dak., modernization, 30–40						40,000	400,000	4,000,000	680,000		
Keams Canyon, Ariz., additions and alterations, 38						40,000	220,000	2,300,000	345,000		
San Carlos, Ariz., additions and alterations, 36							40,000	300,000	3,000,000	450,000	
Fort Yates, N. Dak., modernization, 30–40							40,000	350,000	4,050,000	680,000	
Cass Lake, Minn., modernization, 20–30							40,000	350,000	3,000,000	450,000	
Rapid City, S. Dak. (equipment), modernization, 100								60,000	650,000	{6,400,000 / 1,088,000}	
Albuquerque, N. Mex., modernization, 220										[4] 6,000,000	
Subtotal, major modernization				19,800,000	11,519,000	8,395,000	14,310,000	12,310,000	12,175,000	15,068,000	93,577,000
Minor modernization: [5]											
Rosebud, S. Dak., repairs				460,000							
Winnebago, Nebr., repairs				400,000							
Mount Edgecumbe, Alaska, miscellaneous alterations				748,000							
Tahlequah, Okla., repairs				636,000							
Subtotal, minor modernization and repair				2,244,000							2,244,000
Total, modernization and repair				22,044,000	11,519,000	8,395,000	14,310,000	12,310,000	12,175,000	15,068,000	95,821,000
Total, hospitals		10,035,000		123,880,000	55,171,000	24,703,000	70,810,000	45,652,000	29,675,000	33,779,000	383,670,000
Outpatient care facilities:											
Lame Deer, Mont., center, replacement		1,000,000									
Riverside, Calif., center, replacement		275,000									
Tohatchi, N. Mex., center, alterations		100,000									
Chemawa, Oreg.[6] center, replacement	100,000			1,860,000	(270,000)						
Tsaile, Ariz., center, new				1,900,000	(265,000)						
Torreon, N. Mex., center, new				550,000	(85,000)						

Cibicue, Ariz., center, new	680,000	(102,000)							
Lummi, Wash., center, new	1,300,000	(195,000							
Kaskell, Kans.[6], center, replacement	670,000	(100,000)							
Espanola, N. Mex., center, new		600,000	(90,000)						
Phoenix, Ariz., SHC, replacement		500,000	(75,000)						
Red Shirt Table, S. Dak., station, new		350,000	(52,000)						
St. Mary's, Alaska, center, new		1,035,000	(155,000)						
Poplar, Mont., center, replacement		1,400,000	(210,000)						
Fort Washakie, Wash., center, replacement		1,300,000	(195,000)						
Nahtawash, Minn., station, new		350,000	(52,000)						
Fort McDermitt, Nev., center, new		520,000	(78,000)						
Toppenish, Wash., center, alterations		170,000	(25,000)						
Fort Yukon, Alaska, center, new			1,360,000	(204,000)					
Nespelem, Wash., center, alterations			380,000	(57,000)					
Ignacio, Colo., center, replacement			400,000	(60,000)					
Bylas, Ariz., center, replacement			510,000	(76,000)					
Salt River, Ariz., center, replacement			560,000	(84,000)					
Low Mountain, Ariz., center, new			510,000	(77,000)					
Gila Crossing, N. Mex., center, alterations				250,000	(38,000)				
Bisti, N. Mex., center, new				640,000	(96,000)				
Pinion, Ariz., center, replacement				635,000	(95,000)				
Unalakleet, Alaska, center, new				1,035,000	(155,000)				
Stewart, Nev., center, replacement				620,000	(93,000)				
Hotevilla, Ariz., center, replacement				520,000	(78,000)				
Tahola, Wash., center, alterations				140,000	(21,000)				
Supai, Ariz., center, replacement				600,000	(90,000)				
Rocky Boys, Mont., center, replacement					800,000	(120,000)			
Hayes, Mont., station, replacement					440,000	(66,000)			
Fort Hall, Idaho, center, replacement					320,000	(48,000)			
Carrizo, Ariz., station, new					200,000	(30,000)			
East Fork, Ariz., station, new					200,000	(30,000)			
Toadlena, N. Mex., center, alterations					215,000	(32,000)			
Rough Rock, Ariz., center, alterations					160,000	(24,000)			
Samerton, Ariz., station, new						200,000	(30,000)		
Wolf Point, Mont., center, addition						150,000	(22,000)		
Houch, Ariz., station, replacement						300,000	(45,000)		
Duckwater, Nev., station, replacement						230,000	(35,000)		
Lapwai, Idaho, center, alterations						210,000	(31,000)		
Nixon, Nev., station, new						220,000	(33,000)		
Battle Mountain, Nev., station, new						220,000	(33,000)		
White Rock, Utah, station, new						230,000	(34,000)		
Kaibab, Ariz., station, new							230,000	(34,000)	
Cameron, Ariz., station, replacement							280,000	(42,000)	
Redrock, Ariz., station, replacement							240,000	(36,000)	
Wellpinit, Wash., center, alterations							210,000	(31,000)	
Warm Springs, Oreg., center, alterations							120,000	(18,000)	
Tucson, Ariz., center, alterations							475,000	(71,000)	
Taos, N. Mex., center, alterations							455,000	(68,000)	
Pinepoint, Minn., station, new							350,000	(53,000)	
Total, outpatient care facilities	1,375,000	6,960,000	6,226,000	3,720,000	4,440,000	2,335,000	1,760,000	2,360,000	27,801,000

See footnotes at end of table.

TITLE III—FACILITIES—7-YEAR PLAN (FISCAL YEAR 1977 THROUGH FISCAL YEAR 1983—Continued

[In 1976 dollars]

Facilities and type and size	Previous funds	1975 appropriations	1976 President's budget	Fiscal year— 1977	1978	1979	1980	1981	1982	1983	Total known deficiencies, 1977–83
Personnel quarters with construction projects: [7]											
Tuba City, Ariz., (207) at 27,000		5,500,000	[1] 248,000								
Owyhee, Nev., 13 at 34,600			466,000								
Lame Deer, Mont., 20 at 35,000				724,000	(24,000)						
Tohatchi, N. Mex., 13 at 35,000				471,000	(16,000)						
Tsaile, Ariz., 19 at 35,000				688,000	(23,000)						
Torreon, N. Mex., 5 at 45,000				231,000	(6,000)						
Cibicue, Ariz., 8 at 45,000				370,000	(7,000)						
White River, Ariz., 81 at 35,000					2,932,000	(97,000)					
Winslow, Ariz., 85 at 35,000					3,077,000	(102,000)					
Harlem, Mont., 15 at 35,000					543,000	(18,000)					
Bethel, Alaska, 129 at 80,000					10,475,000	(155,000)					
Rosebud, S. Dak., 140 at 35,000					5,068,000	(168,000)					
Red Lake, Minn., 66 at 35,000					2,389,000	(79,000)					
Shiprock, N. Mex., 427 at 35,000					15,457,000	(512,000)					
St. Mary's, Alaska, 6 at 100,000					607,000	(7,000)					
Poplar, Mont., 16 at 35,000					579,000	(19,000)					
Fort Washakie, Wyo., 13 at 35,000					471,000	(16,000)					
Fort McDermitt, Nev., 4 at 45,000					185,000	(5,000)					
Parker, Ariz., 47 at 35,000						1,701,000	(56,000)				
Schurz, Nev., 58 at 35,000						2,100,000	(70,000)				
Browning, Mont., 32 at 35,000						1,518,000	(38,000)				
Fort Yukon, Alaska, 9 at 110,000						911,000	(11,000)				
Nespelem, Wash., 5 at 45,000						231,000	(6,000)				
Bylas, Ariz., 4 at 45,000						185,000	(5,000)				
Salt River, Ariz., 2 at 45,000						93,000	(3,000)				
Low Mountain, Ariz., 4 at 45,000						185,000	(5,000)				
Pine Ridge, S. Dak., 140 at 35,000							5,068,000	(168,000)			
Gila Crossing, Ariz., 2 at 45,000							92,000	(2,000)			
Bisti, N. Mex., 40 at 35,000							1,448,000	(48,000)			
Pinon, Ariz., 8 at 45,000							370,000	(10,000)			
Unalakleet, Alaska, 6 at 100,000							607,000	(7,000)			
Tahola, Wash., 2 at 45,000							92,000	(2,000)			
Supai, Ariz., 1 at 35,000							46,000	(1,000)			
Chinle, Ariz., 269 at 35,000								9,738,000	(323,000)		
Fort Defiance, Ariz., 123 at 35,000								4,453,000	(148,000)		
Eagle Butte, S. Dak., 94 at 35,000								3,403,000	(113,000)		
Rocky Boys, Mont., 8 at 45,000								370,000	(10,000)		
Fort Hall, Idaho, 3 at 45,000								139,000	(4,000)		

Toadlena, N. Mex., 3 at 45,000							139,000	(4,000)		
Rough Rock, Ariz., 5 at 45,000							231,000	(6,000)		
Crownpoint, N. Mex., 113 at 35,000								4,091,000	(136,000)	
Talihina, Okla., 21 at 35,000								760,000	(25,000)	
Crow, Mont., 26 at 35,000								941,000	(31,000)	
Sisseton, S. Dak., 106 at 35,000								3,837,000	(129,000)	
Keams Canyon, Ariz., 10 at 45,000								462,000	(12,000)	
Wolf Point, Mont., 8 at 45,000								370,000	(10,000)	
Lapwai, Idaho, 3 at 45,000								139,000	(4,000)	
Winnebago, Nebr., 41 at 35,000									1,484,000	(49,000)
Tanana, Alaska, 28 at 35,000									2,274,000	(34,000)
San Carlos, Ariz., 51 at 35,000									2,355,000	(61,000)
Fort Yates, S. Dak., 105 at 35,000									3,801,000	(126,000)
Kanakanak, Alaska, 29 at 35,000									2,355,000	(35,000)
Wellpinit, Wash., 4 at 45,000									185,000	(5,000)
Taos, N. Mex., 2 at 45,000									92,000	(2,000)
Subtotal	5,500,000	714,000	2,484,000	41,783,000	6,564,000	7,723,000	18,473,000	10,600,000	12,037,000	99,664,000
Balance of current program deficiency: [8]										
Aberdeen, 47 at 45,000										
Albuquerque, 17 at 45,000										
Anchorage, Alaska, 6 at 100,000										
Navajo, 120 at 45,000										
Phoenix, 12 at 45,000										
Portland, 2 at 45,000										
Tucson, 5 at 45,000										
Subtotal, 209	([9])			1,667,000	1,667,000	1,667,000	1,667,000	1,667,000	1,667,000	10,002,000
Total, personnel quarters	5,500,000	714,000	2,484,000	43,450,000	8,231,000	9,390,000	20,140,000	12,267,000	13,704,000	109,666,000
Primary and secondary school health facilities			1,500,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	7,500,000
Subtotal, health facilities	16,910,000	2,904,000	134,824,000	105,847,000	37,654,000	85,640,000	69,127,000	44,702,000	50,843,000	528,637,000
Sanitation facilities	40,521,000	38,554,000	60,000,000	60,000,000	60,000,000	60,000,000	60,000,000	52,000,000	26,000,000	378,000,000
Grand total	57,431,000	41,458,000	194,824,000	165,847,000	97,654,000	145,640,000	129,127,000	96,702,000	76,843,000	906,637,000

[1] Reflects prior year equipment requirements only.
[2] Includes balance of planning funds ($800,000).
[3] Master plan study completed with tribal grant funds.
[4] Includes planning funds.
[5] Includes some projects scheduled for replacement or major modernization but requiring interim measures until major project is approved.
[6] Contingent upon concurrent funding by BIA school expansion program.
[7] Includes current program deficiency as well as program expansion.
[8] Reflects current deficiencies not included with those shown with construction projects.
[9] 35 units per year.

Notes: (a) For hospitals where no planning funds are indicated, design-construct process will be utilized based on performance specifications and system-component developed for previously constructed projects which precludes need for advance planning funds. (b) More costly projects such as Bethel and Shiprock could be accomplished in 2 or 3 funding stages. (c) Equipment requirements for hospitals are reflected in succeeding year as NOA for that year. Equipment for clinics and quarters is part of project total. Amount is indicated in parentheses as nonadd following project amount.

In fiscal year 1974, funds were authorized for the purpose of replacing the old and obsolete health facilities at Zuni, New Mexico; Owyhee, Nevada; and Choctaw, Mississippi. A replacement hospital at Tuba City, Arizona, will be completed in fiscal year 1975. Funds are also available for planning a replacement facility at Bethel, Alaska. The current budget provides construction funds for the replacement of the health facilities at Claremore, Oklahoma; Acoma-Laguna Canoncito, New Mexico; Lame Deer, Montana; and the school health facility at Riverside, California. Funds to construct a small addition to the existing health center at Tohatchi, New Mexico, and to construct 207 units of housing at Tuba City, Arizona, are also contained in the fiscal year 1975 program. Finally, planning funds for construction of a new facility at Winslow, Arizona, were also appropriated.

Title III, Sections 301 and 303, of S. 522, as Amended

NEED FOR A CONGRESSIONAL RESPONSE

As the discussion in this section of the report reveals, numerous substandard IHS facilities remain despite these modest funding efforts. In fact, if the present appropriation levels continue, simple mathematics suggests that it will take decades to eliminate even some of the more severe deficiencies.

As a result, the Congress has become actively involved in the funding process with various Members sponsoring "add-ons" to the annual appropriations bill for the Indian Health Service to permit construction or renovation of health facilities in their respective States. The existing hospitals at Lawton, Oklahoma; Belcourt, North Dakota; and Phoenix, Arizona, were constructed with funds obtained in this way. Also, the present budget contains "add-on" funds for construction of the Acoma-Laguna-Canoncito hospital and the Lame Deer health center and the planning funds for the Winslow hospital. Unfortunately, this approach favors the Indian tribe or group which has the ear of a powerful Senator or Congressman leaving those without such access in the unfavorable position of having to wait for their needs to reach the top of the priority list which is being continually altered by "add-on" actions.

The data below on the sizes and sources of increases in IHS appropriations for fiscal years 1971 through 1975 demonstrate the important role the "add-ons" approach has played in IHS funding:

HISTORY OF INCREASES FOR INDIAN HEALTH SERVICE

[Dollar amounts in thousands]

	Fiscal year—						
	1971	1972	1973	1974	1975	1976 [2]	Total
President's request:							
Program increase (includes total construction—NOA)	$20,967	$28,166	$46,675	$42,647	[1] $65,546	$50,848	$254,849
Mandatory increases (e.g., full funding of staff authorized previous fiscal year, etc.)	10,262	12,137	11,059	16,551	13,329	20,727	84,065
Congressional add-on	5,534	19,777	7,068	15,525	4,436	----------	52,340
Total appropriation increase	36,763	60,080	64,802	74,723	83,311	71,575	391,254
Less cost for inflation	−10,462	−13,370	−11,859	−16,551	−13,329	−20,727	−86,298
Net increase for program	26,301	46,710	52,943	58,172	69,982	50,848	304,956

[1] Reflects reduction in President's Budget for GSA payment.
[2] Represents appropriation request.

The Committee firmly believes that an expedited but orderly and measured response to the facilities construction and renovation problem is far more preferable to the present highly discriminatory "add-on" approach. Section 301 of S. 522 would provide such a measured response by authorizing $528,637,000 according to a 7-year plan already developed by the Indian Health Service for construction and renovation of health facilities. This section, if enacted, would constitute a decisive effort to eliminate some of the more archaic health facilities and at the same time provide new facilities in geographic areas where they are critically needed.

PROVISIONS OF TITLE III, SECTIONS 301 AND 303

To accomplish this purpose, this section 301 specifically authorizes $383,670,000 over a 7-year period for the construction and renovation of Indian Health Service hospitals, with an additional $27,801,000 for health centers and health stations; $109,666,000 for the construction of staff housing; and $7,500,000 for the construction of primary and secondary BIA school health facilities. The breakdown of funding authorizations per fiscal year is as follows:

(1) Hospitals: $123,880,000 for fiscal year 1977, $55,171,000 for fiscal year 1978, $24,703,000 for fiscal year 1979, $70,810,000 for fiscal year 1980, $45,652,000 for fiscal year 1981, $29,675,000 for fiscal year 1982, and $33,779,000 for fiscal year 1983.

(2) Health centers and health stations: $6,960,000 for fiscal year 1977, $6,226,000 for fiscal year 1978, $3,720,000 for fiscal year 1979, $4,440,000 for fiscal year 1980, $2,335,000 for fiscal year 1981, $1,760,000 for fiscal year 1982, and $2,360,000 for fiscal year 1983.

(3) Staff housing: $2,484,000 for fiscal year 1977, $43,450,000 for fiscal year 1978, $8,231,000 for fiscal year 1979, $9,390,000 for fiscal year 1980, $20,140,000 for fiscal year 1981, $12,267,000 for fiscal year 1982, and $13,704,000 for fiscal year 1983.

(4) Health facilities for primary and secondary Bureau of Indian Affairs schools: $1,500,000 for fiscal year 1977, $1,000,000 for fiscal year 1978, $1,000,000 for fiscal year 1979, $1,000,000 for fiscal year 1980, $1,000,000 for fiscal year 1981, $1,000,000 for fiscal year 1982, and $1,000,000 for fiscal year 1983.

Section 301 also provides that prior to the expenditure of funds for construction or renovation of a facility, the Secretary of Health, Education, and Welfare must consult with the affected Indian tribe or tribes and honor, whenever practicable, their preferences concerning the size, location, type and other characteristics of that facility. This provision should invite meaningful Indian participation in the planning and funding stages of the construction or renovation of Service facilities, and is vitally necessary if the policy of self-determination is to have any significance for Indians or Alaska Natives.

Because the Committee believes that one of the most immediate, pressing concerns of the Indian Health Service is the number of facilities which do not meet the standards of the Joint Commission on Accreditation of Hospitals, section 301 provides that, prior to any expenditure of funds for construction and renovation of any facility, assurance must be given to the Secretary of Health, Education, and Welfare that, where practicable, the facility will meet the standards

of the Joint Commission on Accreditation of Hospitals within five years of its construction or renovation. The Committee believes this is a vital provision for two reasons: First, unaccredited facilities impair the provision of adequate health care and limit the ability to recruit and maintain adequate staff. Second, these facilities hamper the movement toward self-determination since it is highly unlikely that Indians or Alaska Natives, with admittedly limited resources, will aspire to assume control of already inadequate, out-dated, or unsafe facilities.

Finally, section 303 provides that where possible the Secretary of Health, Education, and Welfare, must give preference to any Indian firm in awarding contracts for the construction or renovation of IHS facilities. This provision recognizes the need for economic development on the reservations and attempts to stimulate that development through the awarding of construction and renovation contracts.

Deficiencies in Sanitation Facilities

THE DEFICIENCIES

Provision of essential sanitation facilities for Indian communities and homes is vital in the prevention of environmentally related diseases and is basic to the improvement of the health status of Indians. During the past fourteen years the Indian Health Service has worked with Indians and Alaska Natives in a cooperative effort to correct the often severe insanitary conditions existing in their communities and homes. The substantial progress which has already occurred has contributed to a reduction in the infant mortality and the gastroenteritis death rates; however, the lack of safe, available water supply and waste disposal facilities continues to be a significant deficiency in the Indian environment. This condition is in large measure responsible for the high incidence of preventable disease which still prevails among Indians and Alaska Natives. For example:

1. Gastroenteritis ranked second among the leading reportable diseases for Indians in 1972; the incidence rate for amebiasis dysentery was 2.6 times, for bacillary dysentery was 42.1 times, and for infectious hepatitis was 10.7 times, greater than the rate in the general population.

2. The Indian infant death rate was only slightly higher than that of the provisional death rate for the general population in 1973. However, for infants who returned to their home environment after hospital birth, and particularly for infants one month through eleven months of age, the death rate was over twice that of the comparable age group in the general population. This condition is in large part associated with the lack of sanitation facilities and extremely crowded living conditions in Indian homes.

3. In 1973 approximately 20 percent of the Indian patients discharged from IHS and contract hospitals received treatment for infectious diseases (respiratory, other infectious and parasitic, and skin diseases) and their residuals. Most of these are disease associated with lack of running water, insanitary conditions, and an overcrowded home environment.

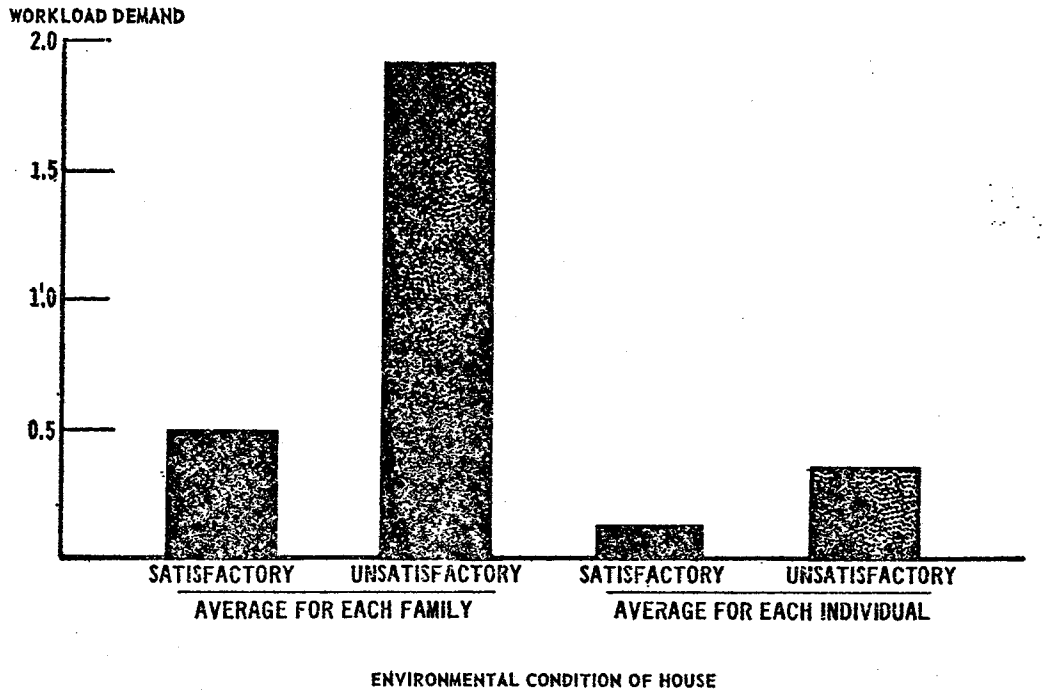
Contributing to these health problems is the widespread scarcity of safe water available to Indians and Alaska Natives for even elemental

household purposes. Thousands of Indians on many reservations still haul water for home use over distances of a quarter of a mile or more. In such instances, the amount of water used for domestic purposes is much less than that consumed by families in the non-Indian population. Contaminated streams, irrigation ditches, stock ponds, and unprotected wells and springs are often the only available water source. The excessive period of time which Indians and Alaska Natives must thus spend combating the rigors of their environment is another factor contributing to the continuing impoverished conditions under which they live.

The lack of adequate facilities for the disposal of human and other household wastes also contributes to the health problems of the Indians and Alaska Natives. The absence of these facilities results in the spread of micro-organisms responsible for diarrheas and dysenteries, insect and rodent infestations in Indian homes and communities, and contamination of foods and domestic water supplies.

The relationship between unsatisfactory environmental conditions and a low health status was dramatically stated by the General Accounting Office, in a March 11, 1974, report to Congress entitled *Progress and Problems in Providing Health Services to Indians.* The GAO found that those Indians living in housing rated unsatisfactory because of environmental conditions made demands on the Indian Health Service primary health care system for treatment of environmentally related diseases at a rate almost four times as high as those living in housing with satisfactory environmental conditions. The following graph, supporting this finding, was included in the GAO report:

WORKLOAD DEMAND ON HEALTH CARE SYSTEM IN FISCAL YEAR 1972



Source: Comptroller General of the United States, "Progress and Problems in Providing Health Services to Indians," March 1974.

The statement of the National Tribal Chairmen's Association and National Indian Health Board submitted during the hearings on S. 2938 contains a critique of this Federal effort:

> Any discussion of comprehensive health care delivery systems must include the development of community water and sanitation systems. There is no question that IHS has to reevaluate their official position regarding Indian Reservation Development programs. . . . coordinated effort must be made in planning, scheduling and implementation of environmental sanitation facilities. For example, IHS, HUD, EPA, and FHA and in special cases EDA provide funds for water and sewer systems. However, each agency has its own criteria for funding and design. A wide disparity exists in the type of water systems designed for a typical rural community versus a typical Indian community of similar population and size. Case after case can be cited whereby the non-Indian communities receive water systems that provide not only domestic water, but also take into consideration population growth, fire protection and other intangible factors. Comparably, Indian Reservation water systems are designed to provide the minimum requirements based on a formula of 50 to 80 gallons per day per capita. The design and cost criteria [do] not take into consideration fire protection and population growth potential.
>
> This has contributed to further economic burdens of Indian families who have to pay the highest rate for fire insurance and remains a major constraint for proper community development planning.

RESPONSE OF THE INDIAN HEALTH SERVICE

Public Law 86–121 authorizes the Indian Health Service to help alleviate the substandard environmental conditions described above. This law authorizes construction of domestic water supplies, waste disposal facilities and other essential sanitation facilities for Indian homes, communities, and lands. Projects include one or more of the following features: *water*—source development, treatment, storage facility, distribution systems; *waste* (*liquid and solid*)—collection system, sewage treatment, disposal facility; *household appurtenances*—such as flush toilet or sanitary pit privy, kitchen sink, lavatory, and connecting plumbing.

The Indian Health Service administers the program with the participation of Indian tribes, Alaska Native groups, and State and local health agencies. Participation by the Indians in project execution is stressed and tribes are equipped, trained and assisted to assume responsibility for continued operation and maintenance of completed community sanitation facilities. Education and training activities are also conducted for Indian householders to assure proper use, protection, and maintenance of household sanitation facilities.

These efforts have produced an increasing awareness by the Indian people of the advantages of adequate sanitation facilities. Indian governing bodies have shown a willingness to adopt the necessary measures which are required for continued operation and maintenance of completed facilities. These measures include establishment of tribal

utility organizations, appointment of responsible maintenance personnel, collection of water and sewer charges, and adoption of sanitation ordinances and regulations. Each of these measures embraces new concepts in Indian self-government and self-determination.

From the inception of this program in 1960 through fiscal year 1974, 1,957 sanitation projects have been undertaken. These include, 1,651 construction projects (923 of which were associated with Federal and tribal housing projects) and 306 engineering investigations, emergency works, and other special projects. With the completion of the above work and the projects to be initiated during fiscal year 1975, approximately 59,000 existing Indian and Alaska Native homes will have been provided new or improved sanitation facilities. In addition, facilities will have been constructed for approximately 44,200 new and improved homes built under Federal or tribal housing programs.

Despite this record of accomplishment, according to the GAO report, *Progress and Problems in Providing Health Services to Indians*, a survey of approximately 9,450 households at six IHS service units revealed that 54 percent of Indian families had no water supply source in their homes, 9 percent had inadequate food storage facilities, 65 percent did not have flush toilets, 48 percent lacked satisfactory liquid waste disposal facilities, and 26 percent of them lived in homes which had evidence of heavy fly infestation. In addition, the study contained the finding that 63 percent of a random sampling of homes were using water which was not protected from contamination or which was judged by environmental health personnel to be contaminated, and about 20 percent were consuming unsafe water as measured by the criteria for bacterial content used by State public health agencies.

Recognizing that inadequate housing is an integral part of this environmental problem, the Indian Health Service, the Bureau of Indian Affairs, and the Secretary of Housing and Urban Development have signed a tripartite Memorandum of Understanding which has as its purpose the pooling of efforts to provide adequate housing, complete with sanitary facilities, for Indians and Alaska Natives. Pursuant to this agreement, the Bureau of Indian Affairs and the Department of Housing and Urban Development have the primary responsibility for construction and renovation of housing; the Indian Health Service is responsible for providing water distribution and sewage disposal systems for communities of new and existing homes, and sanitation facilities for rehabilitated houses which lack adequate facilities.

To provide for this need the Indian Health Service received in fiscal year 1975 an appropriation of $40,521,000 for sanitation facilities construction, including $33,046,000 for facilities to serve 8,000 new or renovated housing units being built under Federal and tribal housing programs and approximately 1,500 existing homes located within or adjacent to housing project sites. Also included in the fiscal year 1975 appropriation were: $7,000,000 for projects to construct and provide new and improved facilities for approximately 3,525 existing homes at other locations and $475,000 for emergency works and special projects.

The fiscal year 1976 budget for sanitation facilities of $38,554,000 includes $38,003,000 to assist Federal (HUD and BIA) and tribal housing programs. This sum will permit the Indian Health Service to participate in the provision of sanitation facilities for approximately 8,000 new or renovated housing units and approximately 1,500 existing homes within or adjacent to housing project sites.

The budget further includes $475,000 to provide for construction of sanitation facilities for Indian ceremonial areas and for tribal buildings used for community gatherings; investigation and planning funds for urgently needed construction projects for which additional technical information is necessary before solutions can be recommended; correction of emergency problems related to Indian sanitation facilities such as occur from severe drought conditions, floods, failure of well casings and pumping equipment; and other unforeseen conditions which may require provision of materials, supplies, and equipment in order to complete the construction or maintenance and repair of sanitation facilities serving Indian and Alaska Native communities.

Title III, Sections 302 and 303, of S. 522, as Amended

Need for a Congressional Response

In spite of these efforts, an estimated 20,800 existing Indian and Alaska Native homes remain which possess inadequate means of waste disposal and unsafe running water facilities beyond fiscal year 1976. In addition, nearly 16,600 homes exist which require upgrading or other improvements to the water and/or waste disposal facilities to meet current standards. While some of these needs for existing homes may be met through the construction of new or replacement housing, this backlog is still significant. Work will also be required to provide capital improvements to community water and sewer systems (for example new wells and water storage and treatment facilities) and to establish and equip tribal operation and maintenance organizations and solid waste collection and disposal systems.

In addition, sanitation facilities must be provided for some 48,900 units of new or rehabilitated housing which, according to housing surveys made by the Bureau of Indian Affairs, are needed to replace existing substandard homes, provide for families now living with others in overcrowded housing, and account for population growth. Given the present rate of construction or renovation of homes, sanitary waste disposal and safe water systems under present appropriation levels, at least a decade will be required to satisfy the unmet needs. And the present rate of inflation growth could extend that time period significantly.

Provisions of Title III, Sections 302 and 303

To accelerate the effort, section 302 provides $378,000,000 over a seven-fiscal-year period to supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indians and Alaska Native homes and communities. The breakdown by fiscal year of funds authorized is as follows: $60,000,000 for fiscal year 1977, $60,-

000,000 for fiscal year 1978, $60,000,000 for fiscal year 1979, $60,000,000 for fiscal year 1980, $60,000,000 for fiscal year 1981, $52,000,000 for fiscal year 1982, and $26,000,000 for fiscal year 1983.

Consistent with the incremental approach to other health service backlogs, this section directs the Secretary of Health, Education, and Welfare to develop a plan in coordination with the Secretaries of the Interior and Housing and Urban Development, after consultation with the Indian tribes and Alaska Native villages, to assure that, under the seven fiscal year funding schedule, the needs will be met at the end of that period. The plan development approach has two objectives. First, and most obvious, it is designed to insure that the unmet needs are properly identified and inventoried before the authorized funds are expended. The second objective is to maintain the philosophy of self-determination as the means by which the goal of S. 522 is to be met.

Finally, section 303 provides that, where possible, the Secretary of Health, Education, and Welfare must give preference to any Indian firm in awarding contracts for the construction of safe water and sanitary waste disposal facilities. This provision recognizes the need for economic development on the reservations and attempts to stimulate that development through the awarding of construction and renovation contracts.

In conclusion, the Committee recognizes the serious deficiency in sanitary health facilities which confronts the Indian Health Service and severely limits it from achieving the goal of elevating the health of the Indian and Alaska Native people to the highest possible level. The Committee expects that title III will, when implemented, effect a significant reduction in the diseases related to deficiencies in housing and safe water and sanitary waste facilities and, consequently, will be a significant factor in the comprehensive attack on the Indian health care problems which S. 522 would mandate.

VI. LACK OF INDIAN PARTICIPATION IN THE MEDICARE AND MEDICAID PROGRAMS: BACKGROUND AND AN ANALYSIS OF TITLE IV OF S. 522, AS AMENDED

Lack of Indian Participation in the Medicare and Medicaid Programs

THE MEDICARE AND MEDICAID PROGRAMS

In 1965, the Congress established, under the Social Security Act, the Medicare Program (title 18) which provides health benefits to persons over 65 and to eligible individuals under 65 who are disabled.

Medicare is the Federal Government's largest health activity and will account for 40 percent of Federal health outlays in 1975. It includes, for the aged, disabled, and those suffering from kidney disease, both hospital insurance (Part A) which pays for inpatient care and subsequent skilled nursing home and home health benefits, and supplementary medical insurance (Part B) which pays for physicians and other outpatient services, such as: medical services and supplies, home health care services, outpatient hospital services and therapy, and independent laboratory services.

Part A is financed largely through social security taxes on earnings, while Part B is financed by premiums from enrollees (currently $6.70 per month) and matching contributions from general tax revenues. Both insurance components are administered primarily by private insurance companies under contract with the Social Security Administration. An estimated 21.6 million aged persons, comprising over 95 percent of the Nations' aged population, will be enrolled in Medicare in 1975. In addition, 1.9 million social security recipients under age 65 who are eligible for social security disability benefits and all persons covered by social security and their families who require treatment for chronic kidney disease are also eligible for Medicare benefits.

Medicare outlays pay primarily for hospital and physicians' services, which make up 71 percent and 21 percent, respectively, of benefits payments. Nearly 86 percent of benefit payments will be on behalf of the aged, while 13 percent will be for services to the disabled, and 1 percent for those requiring treatment of chronic kidney disease. The average payment for Part A beneficiaries is estimated to increase from $1,414 in 1973 to $1,589 in 1974, and the average payment for Part B beneficiaries is estimated to rise from $235 to $244 over this same period.

The following table displays basic data concerning the Medicare program coverage, benefits, and administration:

MEDICARE COVERAGE, BENEFITS, AND ADMINISTRATION

[In millions]

	1973 actual	1974 estimate	1975 estimate
Hospital insurance (HI):			
Persons with protection (millions)	20.9	23.0	23.5
Beneficiaries receiving services (millions)	4.7	5.4	5.6
Benefit payments	$6,648	$8,465	$9,831
Inpatient hospital services	$6,408	$8,138	$9,465
Skilled nursing facility services	$188	$251	$286
Home health services	$52	$76	$80
Administrative expenses	$194	$308	$332
Claims received (millions)	9.2	10.8	11.6
Supplementary medical insurance (SMI):			
Persons with protection (millions)	20.4	22.5	23.0
Beneficiaries receiving services (millions)	10.5	11.6	12.2
Benefit payments	$2,391	$2,966	$3,586
Physicians' services	$2,165	$2,595	$3,081
Outpatient services	$188	$289	$387
Home health services	$28	$40	$47
Other medical and health services	$10	$42	$71
Administrative expenses	$246	$441	$442
Claims received (millions)	69.3	84.9	92.9

Source: Office of Management and Budget, "Special Analysis: Budget of the United States Government, Fiscal Year 1975," p. 148.

The Medicaid Program (title 19), which was established along with the Medicare Program as a part of the Social Security Amendments of 1965, is a Federal health program for the poor, administered by the States, for which the Federal Government and the States match expenses.

Under Medicaid, health services are provided to those individuals receiving public assistance through State welfare programs. In States where Medicaid is operating, the State must pay for at least these eight services: inpatient hospital care, outpatient hospital services, other laboratory and x-ray services, skilled nursing home services, physicians' services, family planning, home health, and early and periodic screening, diagnosis, and treatment services for persons up to age 21.

In many States, at their option, Medicaid also pays for such additional services as dental care, prescribed drugs, eye glasses, clinic services, and other diagnostic, screening, preventive, and rehabilitative services. States may also choose to provide medical services to the medically needy, e.g., those persons with income slightly above the public assistance level who are unable to pay all medical expenses. Federal matching assistance ranges from 50 percent to 83 percent of the costs of providing these benefits, depending upon States' per capita incomes. The States determine the level and types of medical benefits.

Medicaid can pay for services that Medicare does not cover for people who are eligible for both programs. In addition, Medicaid can pay the deductibles for both Part A and Part B of Medicare and monthly insurance premium (Part B of Medicare) for eligible people as well.

In 1975, health care services under Medicaid will be provided to approximately 28.6 million welfare recipients and other low-income

persons. The Federal outlays will be $6.5 billion. This represents a 200 percent increase in persons helped and a 182 percent increase in funding since 1969. Early and periodic screening of children for dental and other health problems will be emphasized in fiscal year 1975 in order to identify health problems before they reach an advanced stage and become unnecessarily costly to treat. The following table depicts Federal outlays and other selected program indicators, based on State estimates:

MEDICAID COVERAGE BENEFITS AND ADMINISTRATION

	1973 actual	1974 estimate	1975 estimate
Payments to medical vendors (millions)	$4,402	$5,505	$6,148
Administrative costs (millions)	$198	$322	$360
Recipients of service (millions)	23.5	27.2	28.6
Aged 65 or over	4.0	5.2	5.1
Blind and disabled	2.1	2.5	2.6
Children under 21	10.8	12.1	12.9
Adults in AFDC families	6.6	7.4	7.9
Average benefits payments per recipient	$187	$202	$217
Aged 65 or over	$385	$400	$465
Blind and disabled	$476	$470	$522
Children under 21	$90	$98	$99
Adults in AFDC families	$132	$143	$141

Source: Office of Management and Budget, "Special Analysis: Budget of the United States Government Fiscal Year 1975" p. 148.

Approximately 67 percent of Federal Medicaid funds will finance inpatient and long-term care in 1975. The remaining dollars will finance outpatient services, as shown below:

ESTIMATED MEDICAID PAYMENTS, 1974

	Outlay (millions)	Percent
General and TB hospitals	$1,745	28
Mental hospitals	336	5
Skilled nursing facilities	1,245	20
Intermediate care facilities	864	14
Physicians' services	656	11
Outpatient drugs	431	7
Dental care	100	2
Outpatient services (hospitals)	192	3
Outpatient clinic services	129	2
Medicare buy-in (SMI premium payments)	115	2
Laboratory and X-ray services	53	1
Other	282	5
Total	6,148	100

Source: Office of Management and Budget, "Special Analysis: Budget of the United States Government, Fiscal Year 1975," p. 149.

Although the Medicaid matching formula provides higher Federal matching assistance to low-income States, most of the program funds go to high-income States. This results from the fact that more affluent States have been better able to expand the population and services covered. Five of the highest income States received over 50 percent of all Federal Medicaid funds in 1973, and two States—New York and California—received nearly 40 percent of those funds.

INDIAN PARTICIPATION

Although Indians are eligible for Medicare and Medicaid benefits in the same manner as any other citizens, they have experienced an inability to take advantage of those benefits.

This lack of participation in the Medicare and Medicaid Program is a result of accessibility. Since most Indians reside on remote reservations lands, access to services supported by either Medicare or Medicaid is severely limited. In most cases the only available health delivery system is that of the Indian Health Service, yet the IHS, as a Federal facility, cannot, under existing law, receive payments from Medicare or reimbursements for services provided under Medicaid. As a result, Indian citizens are unable to receive Medicare or Medicaid payments for necessary care.

TITLE IV OF S. 522, AS AMENDED

The purpose of the Committee in adding title IV to S. 522 was to remedy this problem of access for Indians to Medicare and Medicaid supported services. The remedy, as provided in sections 401 and 402, is in the form of authorizations of payments through the two programs to qualified Indian Health Service hospitals and long-term care facilities for services rendered to Medicare and Medicaid patients. In addition, section 402 would provide 100% Federal Medicaid matching funds for services provided to any Indian in an IHS facility, if that Indian is eligible for both Medicaid coverage and coverage through the Indian Health Service program.

In adopting the 100% Medicaid reimbursement formula, the Committee took the view that it would be unfair and inequitable to burden a State Medicaid program with costs which normally would have been borne by the Indian Health Service. In this connection the Senate Finance Committee, which has primary legislative responsibility for the Medicare and Medicaid Programs, adopted a similar reimbursement provision as a part of H.R. 3153, the Social Security Amendments of 1973. In the report accompanying this legislation, the Finance Committee justified the 100% reimbursement method by noting "that with respect to matters relating to Indians, the Federal Government has traditionally assumed major responsibility. The Committee wishes to assure that a State's election to participate in the Medicaid program will not result in a lessening of Federal support of health care services for this population group, or that the effect of Medicaid coverage be to shift to States a financial burden previously borne by the Federal Government."

It is the intent of the Committee that any Medicare and Medicaid funds received by the Indian Health Service program be used to supplement—and not supplant—current IHS appropriations. In other words, the Committee firmly expects that funds from Medicare and Medicaid will be used to expand and improve current IHS health care services and not to substitute for present expenditures. Section 403 would require the Secretary of Health, Education, and Welfare to

report to the Congress annually on the use of the additional funds available to the IHS because of the Medicare and Medicaid reimbursements received by the Indian Health Service program.

Title IV would also require that the Indian Health Service facilities which receive reimbursement from Medicare or Medicaid meet the applicable quality standards and conditions of participation established under the two programs. The Secretary would be expected to assure that each facility could meet the standards by not later than two years from submission of a plan by the IHS to bring the facility in compliance with those standards.

Additionally, it is the intent of the Committee that the Indian Health Service facilities cooperate fully with the Medicare and Medicaid programs in providing the cost data necessary for calculating reimbursement.

VII. ACCESS TO HEALTH SERVICES FOR URBAN INDIANS: BACKGROUND AND AN ANALYSIS OF TITLE V OF S. 522, AS AMENDED

Urban Indians' Access to Health Services

Today a significant number of American Indians live in urban or semi-urban centers. According to estimates of the Bureau of Indian Affairs, less than one-half of the one million Indian population resides permanently on reservations or in Native villages of Alaska. Over the past several decades, the migration of Indian people to the cities has gathered momentum to the point where the "vanishing" first Americans have reappeared in increasing numbers as highly visible members of our urban population. All too often, however, the migrants are unprepared for what they will find in their new locations and, as a consequence, will suffer a host of afflictions.

The rural to urban Indian migration in this century has been influenced by several major developments: first, Indians were provided an opportunity to work and share in the Nation's prosperity in industries prior to and during World War II; second, thousands of Indian men and women served in the Armed Forces away from their reservations, traditional communities, or Alaska Native villages; third, formal government relocation programs moved many Indian families from low employment, rural areas to urban areas where "employment opportunities" were considered more readily available; and fourth, countless numbers of other Indians attempting to escape depressed conditions on their reservations voluntarily relocated.

Unfortunately, far too many Indians who move to the cities, because of inadequate academic and vocational skills, merely trade reservation poverty for urban poverty. Urban Indians are much more likely than non-Indians to live in crowded and deteriorated housing, be unemployed, drop out of school, become victims of ill health, fall into juvenile delinquency or alcoholism, and appear in an excessively high proportion of police and court cases.

THE HEALTH PROBLEMS OF URBAN INDIANS

Indians and Alaska Natives who reside in the large urban areas of this Nation have a lower standard of health than that of the general population. Furthermore, two recent studies indicate that disease and mortality rates among urban Indians are just as high, and in some instances higher, than the rates for reservation Indians. First, a recent article published in *Minnesota Medicine* [1] reported that in the Minneapolis area Indian people suffer from decidely poorer health levels than do both the white community and the resident reservation popu-

[1] McClearly, Deegan, and Thompson, "Indian Health in Minnesota," *Minnesota Medicine*, No. 2, Volume 56, October 1973, pp. 87–90.

lation. For example, the following comparisons were made concerning infant deaths:

> The infant death rate among Indians in the metropolitan area is higher than that of the white community. The Indian death rate for Hennepin County was 35.3 infant deaths per 1,000 live births per year for 1968–1970. At Hennepin County General Hospital from 1967 through 1970 there were 615 Indian births and 23 infant deaths. The rate was 37.4 deaths per 1,000 live births. The infant death rate for all races in Minneapolis for 1968–1970 was 22.9 infant deaths per 1,000 live births per year.
>
> Indian infant death rates are higher in the metropolitan area than on the reservations. In 1968–1970 the Indian infant death rate per year in Hennepin County was 35.3 and in Ramsey County 31.9. In contrast, the rates in two major reservation counties were 23.9 (Beltrami County) and 13.2 (Cass County).

These findings were based in part on a survey conducted in 389 of the more than 700 households in Minneapolis in which Indian people were known to have lived. The survey results, as reported in the *Minnesota Medicine* article, included the following:

> At the time the Indian Health Board staff visited in the households, they found someone who required immediate inpatient hospitalization in 45 (11.6%) of the households. In these 45 cases, the Indian Health Board made immediate arrangements and admitted 18 people to Hennepin County General Hospital, four people to other public hospitals, and 23 people to private hospitals. The following Table lists the types of health problems interviewers found in the 389 households.

HEALTH PROBLEMS FOUND IN INTERVIEW SURVEY OF 389 MINNEAPOLIS INDIAN HOUSEHOLDS

	Households[1]	
	Number	Percent
Dental problem	131	34
Eye or vision problem	54	14
Hearing problem	22	6
Preventive or diagnostic concerns	94	24
Mental health problem	25	6
Alcohol or drug problem	37	10
Chronic disease and disability	44	11
Acute medical problems	84	21
Other problems	3	10
No medical or dental problem	44	11

[1] More than 1 problem was found in many households.

A recent report by the Seattle Indian Health Board on the health status of its urban Indian constituents [2] closely parallels these findings. Even though there were no directly comparable data on other Indian populations served in similar settings, the report concluded that "the frequency of diagnosis of alcohol abuse, otitis media, and minor trauma, corroborates, in general terms, data available from the Indian Health Service on Indian health programs."

The following tables list individual diagnoses as well as the most frequent diagnoses by age categories.

Most frequent diagnosis and conditions (July 1973–April 1974):	
Common cold—URI	479
Laceration, abrasion, contusion, crushing (i.e., minor trauma)	319
Vulvitis, vaginitis	296
Alcohol, drug abuse	274
Otitis media—acute	242
Abdominal pain other than colic	194
Pharyngitis/tonsillitis nonstrep	191
Localized infection—skin or subcutaneous tissue	189
Essential HBP	187
Family problems [1]	164
Neuro musculoskeletal pain	161
Obesity	145
Atopic dermatitis	135
Systemic febrile—URI	116
Total diagnoses	3,092
All other diagnoses	6,893
Total number of individual patients	5,265
Total number of visits	7,157
Preventive procedures [2] (October 19[illegible]–April 1974):	
Physical exams (adult)	420
Physical exams (child)	228
Cervical smear (PAP test)	195
VDRL [3]	67
Diphtheria immunization	404
All other immunizations (measles, rubella, mumps)	216
Tuberculin tests [3]	122
Total preventive procedures	1,652
Total number of patients	3,372
Total number of visits	5,293

[1] Includes marital, child-parent, all immediate household interpersonal conflicts.
[2] Prior to October 1973 preventive procedures were underrecorded. Therefore, the time period of October 1973 through 1974 was used.
[3] Due to changes in our recording system during this time period, VDRL and tuberculin tests were underrecorded.

Source: Seattle Indian Health Board, "Data Analysis and Program Activities Report. July 1973–April 1974," June 1974.

[2] Seattle Indian Health Board, "Data Analysis and Program Activities Report, July 1973–April 1974," June 1974.

MOST FREQUENT DIAGNOSES BY AGE CATEGORIES, JULY 1973–MARCH 1974

	Under 5	5–9	10–14	15–19	20–24	25–34	35–44	45–54	55–64	65 and over
Common cold URI	9.7	9.1	5.7	3.8	3.3	3.3	2.6	2.9		
Minor trauma[1] (percent)	2.2	3.4	4.5	2.9	5.2	3.1	2.6			
Vulvitis, vaginitis				6.1	5.5	3.6	2.6			
Alcohol, drug abuse						4.1	5.8	2.9		
Otitis media—Acute	11.6	3.6	3.2							
Abdominal pain[2]						2.7			2.8	
Pharyngitis/tonsilitis[3]		3.6	3.6	3.2						
Essential HBP							3.0	4.7		7.7
Family problems					2.7				2.8	
Neuro musculoskeletal pain								2.6		2.4
Obesity							2.8			
Atopic dermititis		3.4								
Systemic febrile URI	3.2									
Otitis media—Chronic	2.7									
Localized infection[4]			2.8							
Pregnancy detection				6.5	3.1					
Diabetes mellitus								3.3	3.0	1.7
Osteo-Arthritis									2.8	
Depression									2.8	
Refractive error									2.8	
Vertigo										3.5
CHF[5]										2.4
Total diagnoses[6]	920	524	460	655	1,089	1,991	1,341	855	425	285
Grand total					8,545					
Percent	10.7	6.1	5.3	7.6	12.7	23.3	15.6	10.0	4.9	3.3

[1] Laceration, abrasion, contusion, crushing.
[2] Other than colic.
[3] Nonstrep.
[4] Skin or subcutaneous tissue.
[5] Congestive heart failure.
[6] The total diagnoses row includes many diagnoses that are not listed on this table.

Note: The ones listed are only the most frequent diagnoses for these age categories.

Source: Seattle Indian Health Board, "Data Analysis and Program Activities Report, July 1973–April 1974", June 1974.

These data suggest that the urban Indians served by the Seattle Indian Health Board are characteristic of the general Indian population. The report concluded that the disease spectrum indicated by the data is characteristic of a young population, not unlike the population characteristics of Indians as a whole since "Indians are more likely than whites to die in young adulthood or in middle age than do whites." The reason is simple, as stated in the Minnesota study: "Indians tend not to live long enough to die of the disease of aging (heart disease, cancer and cerebrovascular disease) which are the major causes of death among whites. Indians tend to die during their productive years whereas whites are more likely to remain alive until they have attained old age and retirement." [3]

Traditionally, urban Indians, prior to their move to the cities, looked to the Indian Health Service as the primary source of services in meeting their health needs. In their newfound urban environment where no IHS facilities exist or services are offered, many urban Indians may require personal counseling and assistance in seeking basic health and medical care. Far too many are unaware of the medical, welfare and other services available to them as citizens and they fail to comprehend the requirements they must fulfill in order to obtain such services. In too few instances have Indian centers and other community agencies

[3] McCleary, Deegan, and Thompson, "Indian Health in Minnesota," *Minnesota Medicine*, No. 2, Vol. 56, October 1973.

in urban centers acquainted Indians with available community health and medical services and the steps to be taken to make use of those services. Additionally, urban Indians for the most part cannot afford to pay for the ever-rising hospital and medical care costs faced by all citizens in our Nation's cities. In the urban Indian population, with its critically high unemployment rate, only the fortunate few who are gainfully employed have been able to take advantage of prepaid health insurance plans to meet their health needs.

Data gathered by the Seattle Indian Health Board Medical Clinic on its urban Indian patients between March 1972 and February 1973 document the last two barriers to urban health services discussed above: lack of income and failure to participate in prepaid health programs. Nearly 80 percent of the patients had annual incomes of less than $5,000 and 14 percent had annual incomes of less than $1,000. According to the following table, approximately 57 percent of the patients seen during 7 months in 1973 had no health insurance:

Health Insurance

Type	*Percent*
None	57
D.P.A	19
Medicare	3
I.H.S	7
Private	14
Total	100

NOTE.—Excludes 25% of patients for whom no insurance information is available.

Source: U.S. Senate Committee on Interior and Insular Affairs. Subcommittee on Indian Affairs, Hearing: "Indian Health Care Improvement Act (S. 2938)," April 3 and 5, 1974.

An April 1973 regional task force report to the Department of Health, Education, and Welfare, entitled *Health of the American Indian*, contained a discussion of the physical and cultural barriers to health services for urban Indians:

> The Indian who comes to live in the city faces new problems in seeking health care. Familiar with receiving free health services from IHS facilities, he must now learn to find a physician and buy health services. Finding a satisfactory physician in a new city is a problem for many U.S. citizens.
>
> The indigent Indian usually does not use Medicaid because of his lack of knowledge about this source of assistance, his fear of the white man's institution and because of pride. He may find it difficult to prove eligibility, and the welfare agency may think he is ineligible because IHS is taking care of him.
>
> If the Indian goes to a public facility, he must learn to use identification cards, to respond to questions about income and expenditures in order to prove eligibility and to cope with part-payment mechanisms. In addition, he has the new experience of mingling with patients of other ethnic groups and may be additionally handicapped with transportation problems and language difficulties.

> Long waits in clinics and the impersonality of the clinic staff are complaints of the urban Indian. He may also become confused about jurisdictional boundaries for delivery of service, such as the possibility of being eligible for services if he lives on one side of the street but not if he lives on the other.
>
> Most off-reservation and some reservation Indians must use private hospital facilities. The staffs of urban hospitals are usually completely unknowledgeable about cultural differences, community resources, and special Indian needs. Consequently the services offered may not be acceptable to the Indian user. Medical practice in the United States in private offices and particularly in clinics is characterized by impersonality, long waits for service, and brief explanations. For the Indian, whose life style is based on interpersonal relations, this can mean cultural shock.[4]

These circumstances have served to create a serious health dilemma for urban Indians. Many receive only limited assistance or go without health services altogether; many appear as emergency cases at the hospital doors; and some have even resorted to a long and expensive trip back to their home reservations or communities to avail themselves of the Indian Health Service. In virtually all cases requests for health care is deferred until the more costly curative rather than preventive services are required.

FEDERAL POLICY AND URBAN INDIAN HEALTH CARE

The Committee views the health dilemma of urban Indians as a serious obstacle in their quest to become self-sufficient and participating citizens. Fortunately, an evolving Congressional policy addressed to this problem has served to provide the essential experience and information for the provisions contained in Title V of S. 522. That evolving policy has been built on the concept of self-determination with the Indians themselves managing federally subsidized health efforts tailored to fit the health circumstances of Indian populations residing in specific urban centers.

Limitations of funds and jurisdiction have precluded direct care to urban Indians. Federal policy has placed the urban Indian beyond the jurisdiction of the Indian Health Service. Furthermore, the critical backlog in unmet health needs on Indian reservations requires the full attention of all financial and human resources available to the IHS. Accordingly, during the last seven years Congress has expressed on at least four occasions a desire to provide some form of separate health care assistance to urban Indians which would not compete with the assistance already available to the reservation Indians.

In fiscal year 1967, in recognition of the growing health problems of urban Indians, Congress increased the Indian Health Service's budget by $321,000 to operate a clinic program for the Indians in Rapid City, South Dakota. (This special program continues today.)

Then, in fiscal year 1972, the Congress added to the IHS appropriation $150,000 to conduct a study of the urban Indian problems in the

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[4] Michal, Bradford, Honda, and Sherman, "Health of the American Indian: Report of a Regional Task Force," U.S. Department of Health, Education, and Welfare, April 1973, p. 19.

city of Minneapolis. The project was to achieve the following objectives: (1) to identify community health resources which can be effectively used by Indian people; (2) to assist those health resources in serving the Indian people of the community; (3) to assist Indian people in becoming familiar with and in utilizing those resources; (4) to identify gaps between resources and needs; and (5) to produce recommendations to resource agencies on methods of improving health service programs to meet the needs of urban Indian people. Subsequent to the study, an outreach program was established to assist Indians living in metropolitan Minneapolis to gain access to available health services.

In fiscal year 1973, the Congress added additional money to the Indian Health Service appropriation for three other urban projects to be patterned after the Minneapolis project. The three urban centers selected for these projects were Oklahoma City, Seattle, and the California Urban Indian Health Council (an umbrella entity including nine urban Indian organizations located in various cities in the State of California; San Francisco, San Jose, Sacramento, Fresno, Santa Barbara, Compton, Huntington Park, Los Angeles, and San Diego).

Finally, again in fiscal year 1974, the Congress added $500,000 to the IHS appropriation to fund additional urban projects modeled after the Minneapolis program.

Experience gained from the Minneapolis Pilot Urban Indian Health project underlines the critical need for special attention to health problems of the urban Indian. It was found, for instance, that Indians would seldom take advantage of existing health services, until an Indian program was started. Almost immediate improvement in the use of those services was manifested upon the hiring of Indian outreach workers. Additional improvement occurred with establishment by urban Indians of their own centers which provided them with more confidence to approach those services. Finally, current studies indicate referral and outreach services further improved with the establishment of all-Indian boards of directors. Pride in running their own programs was the principal reason for the establishment of Indian free clinics in Oklahoma City, Seattle, San Francisco and Los Angeles. These clinics have limped along with volunteer services, donations and the limited agency grants resulting from past appropriations.

Despite this inadequate funding, many of these clinics have experienced rapid growth. The Seattle Indian Health Board began promoting culturally acceptable, readily accessible health care for the Seattle area Indian community in 1970. In four years, the community controlled program has grown from an entirely volunteer program operating on a limited evening schedule to a comprehensive primary level health delivery system with a registered patient population of over 6,000 persons. The program includes medical and dental services; alcoholism counselling; education, family planning, and prenatal care; and health outreach services. Patient records show 2,000 to 2,500 patient visits per month and the program now employs 46 people, 75 percent of whom are Indians or Alaska Natives. The California Urban Indian Health Council now encompasses nine health projects

in various stages of development from comprehensive health delivery agencies to referral and outreach centers tied closely to existing urban health delivery services. The estimated urban Indian service population is approximately 150,000.

This growth is the best possible evidence of the critical need for an expanded urban Indian health program and of a Federal commitment to support that program. Preliminary studies of the Indian Health Service indicate there is a demonstrated backlog of unmet Indian health needs not only in the above named cities but in some 25 other metropolitan areas as well. Substantial Indian populations (according to Standard Metropolitan Area Statistics) exist as follows:

Phoenix	11,159	Oklahoma City [1]	13,033
Tucson	8,837	Tulsa	15,519
Los Angeles [1]	30,000	Portland [1]	4,011
San Diego [1]	5,880	Dallas [1]	5,022
S.F.-Oakland [1]	15,000	Salt Lake City	2,005
San. Jose [1]	4,048	Seattle [1]	9,496
Bakersfield [1]	2,039	Tacoma	3,343
Fresno [1]	2,144	Milwaukee [1]	4,075
Sacramento [1]	3,559	Chicago [1]	8,996
Denver [1]	4,348	New York	12,160
Detroit	5,683	Cleveland	1,750
Minneapolis [1]	9,859	Omaha	1,401
Duluth	1,781	St. Louis	1,931
Great Falls	1,509	Kansas City	2,402
Billings	1,063	Topeka	981
Albuquerque	5,839		

[1] These communities currently have limited contracts with the IHS for development of health outreach type programs.

Source: 1970 Census of the Population.

Title V of S. 522, as Amended

COMMITTEE INTEREST

The American Indian has demonstrated all too clearly, despite his recent move to urban centers, that he is not content to be absorbed in the mainstream of society and become another urban poverty statistic. He has demonstrated the strength and fiber of strong cultural and social ties by maintaining an Indian identity in many of the Nation's largest metropolitan centers. Yet, at the same time, he aspires to the same goal of all citizens—a life of decency and self-sufficiency. The Committee believes that the Congress has an opportunity and a responsibility to assist him in achieving this goal. It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs which failed to provide the Indian with an improved life style on the reservation have also failed to provide him with the vital skills necessary to succeed in the cities. His difficulty in attaining sound physical and mental health in the urban environment is a grim reminder of this failure.

The Committe is committed to rectifying these errors in Federal policy relating to health care through the provisions of title V of S. 522. Building on the experience of previous Congressionally-approved urban Indian health propects and the new provisions of

title V, urban Indians should be able to begin exercising maximum self-determination and local control in establishing their own health programs. The Committee believes that contracts negotiated between urban Indian organizations and the Secretary of Health, Education, and Welfare hold greater promise for success than the extension of the Indian Health Service's jurisdiction to serve the urban Indian population. The former arrangement will afford an opportunity to urban Indian organizations to provide primary health services (i.e. medical, dental, x-ray and laboratory) to their own members and to strengthen outreach and referral services to facilitate greater use of community health resources by Indians. As the various programs authorized under title V progress, the Committee believes they will yield more accurate information on the population and basic health problems of urban Indians. The Indian Health Service can serve as the administrative mechanism to analyze that information, channel title V's funds, provide technical assistance, and monitor and evaluate specific programs and activities.

In drafting Title V, the Committee took cognizance and incorporated the policy principles contained in the following resolution of the National Congress of American Indians:

SUPPORT OF HEALTH CARE FOR URBAN INDIANS

Whereas, there are approximately $35,000 American Indians residing in off-reservation areas and communities; and

Whereas, the off-reservation Indian population experiences serious difficulty in obtaining adequate health care in their off-reservation environments; and

Whereas, within the established priorities, the Indian Health Service does not have adequate funds to provide services to off-reservation Indian people who have not maintained a residency on a reservation within the past twelve months; and

Whereas, there is a need: (1) to identify community health resources that can be effectively utilized by Indian people of the community; (2) to assist these health resources in serving the Indian people of the community; (3) to assist Indian people in becoming familiar with and utilizing such resources; (4) to identify unmet health needs; and (5) to recommend methods of improving health service to meet the needs of off-reservation Indian people;

Now, therefore, *be it resolved*, That the National Congress of American Indians supports all off-reservation Indians efforts to create health care and requests the Federal Government to seek funds allocated in the Indian Health Service budget to support urban Indians' Health Boards or groups; and

Be it further resolved, That the National Congress of American Indians realizes that funding is not adequate enough to cary on existing programs on reservations or eligible groups for Indian Health Service. Such funds should be additional funds allocated through special appropriations and that every effort will be made through Congressional channels to resolve this problem.

For the thousands of Indians currently residing in urban centers and for those who may opt to move to such centers in the future, the Committee views Title V of S. 522 as a vital tool to assist such Indians in the difficult transition from traditional reservation life to the urban world. Title V clearly represents a Federal policy commitment to provide the essential authorities and financial resources to permit urban Indian organizations to develop needed health services and to strengthen relationships with existing community health and medical care programs.

PROVISIONS OF TITLE V

The purpose of this title is to establish programs in urban areas to make health services more accessible to the urban Indian population.

Authority is vested in the Secretary to enter into contracts with urban Indian organizations for the purpose of establishing and administering programs which meet specific requirements set forth in the title. Such requirements provide sufficient latitude to urban Indian organizations to permit them to provide primary health services to the urban Indian population. The need for these services was eloquently and forcefully addressed by the urban Indian witnesses who testified in support of S. 2938 during the April 3, 1974, hearing before the Committee.

The Secretary is directed to establish criteria which will govern the selection of urban Indian organizations which may be considered as potential contractors under Title V.

In addition, title V would exempt contracts with urban Indian organizations from certain Federal procurement regulations which have served as obstacles to such contracting in the past; provide for advance payments to urban Indian organization contractors to facilitate initial operations; permit the Secretary to amend or revise a contract upon the request or consent of a contractor; provide the procedure under which a contractor may request contract retrocession.

To strengthen the likelihood of improved management and administration of urban Indian health programs, title V requires the contractor to maintain adequate records, and subjects such record to audit by the Secretary and the Comptroller General of the United States. The Committee considers this provision essential if contracting urban Indian organizations are to be held accountable for their actions.

Title V authorizes a total appropriation of $30 million over 3 fiscal years as follows: $5,000,000 for fiscal year 1977, $10,000,000 for fiscal year 1978, and $15,000,000 for fiscal year 1979. These authorizations represent a substantial increase over the original authorizations contained in S. 2938, as introduced. The increases are required to support direct health care which is now authorized under the title (only referral services were originally authorized), and are based upon known cost ratios from such programs as the Neighborhood Health Centers which were funded by the former Office of Economic Opportunity.

VIII. AN ANALYSIS OF THE MISCELLANEOUS PROVISIONS OF TITLE VI OF S. 522, AS AMENDED

In order to assess the measured response to Indian health needs as authorized in titles I through V of S. 522, the Committee, in section 601(a), directs the Secretary of Health, Education, and Welfare to provide the Congress with several appropriate, detailed reports and recommendations.

First, the Secretary is required to report annually to the President and the Congress on the progress he has achieved in effecting the purposes of S. 522. This Committee is acutely aware of the reluctance of executive agencies to meet annual report requirements imposed on them by the Congress. However, in this instance, the Committee is determined that its mandate shall be met in order to ascertain whether the health status of an entire people is being substantially improved through the programs and funds authorized by this Act.

Second, within 3 months after the end of fiscal year 1979, the Secretary is required to review expenditures and authorization levels under the act and submit his recommendations to Congress, reflecting appropriate increases or decreases in the authorizations for fiscal year 1981 through 1983.

Third, to assist Congress in charting the future course of Indian health programs and efforts, the Secretary, within 3 months after the end of fiscal year 1982, is required to undertake a thorough and searching review of the programs authorized by S. 522.

The Committee views this undertaking as an opportunity for the Secretary to measure the performance of a health delivery system strengthened by three years of assistance under this bill when applied against the overwhelming health needs of the Indian people. Such a review by the Secretary and his subsequent report to the Congress may point to the necessity of reordering objectives, goals, and priorities in the IHS health care program. The Secretary's report should contain whatever recommendations for additional programs and assistance appear warranted to afford Indians and Alaska Natives a health status which is at parity with the general population.

The Committee expects the Secretary to respond to these provisions in a timely and thorough manner so that it may have at its disposal the most accurate information and data reflecting the health status of Indian people. The six fiscal year deadline for the comprehensive report was chosen so as to provide the Congress with a one-year period prior to the termination of the seven-year programs authorized in S. 522 to consider the Secretary's recommendations, solicit the views of the Indian community and the health professionals who serve it and, then, act upon those views and recommendations in tailoring whatever future Indian health legislation is required.

In addition to those two reporting requirements, an appropriation of $150,000 is authorized by section 601(b) to permit the Secretary to support a one year study by the National Indian Health Board of mental health problems, including alcoholism, among Indians. Because these problems are so closely interwoven with the social and cultural fabric of the individual Indian, his family and community, the Committee concluded that any introspective study of such problems should be under the aegis of an Indian organization. While the National Indian Health Board may not include among its members the full range of mental health and other health professionals to undertake such a complex study, the Committee believes that the Board, in its pivotal liaison role between the Indian community and the health community, can assemble the necessary expertise to insure a successful study.

The Committee fully agrees with the opinion expressed during the hearings on S. 2938 by Dr. Everett R. Rhoades, Vice Chairman of the National Committee on Indian Health of the Association on American Indian Affairs and Member of the Executive Committee of the Association of American Indian Physicians:

> In the general field of mental health [among Indians], practically no basic research is going on. There have not yet been established standards, norms, and proper measurements for evaluating Indian behavior. There is no reliable way to detect early deviations from the norm.

The mental health problems emanating from the Indians' cultural disruption and the social upheaval in their communities are described in section IV of this report. S. 522 authorizes programs and financial resources addressed to the most serious of these problems affecting the mental health and social behavior of Indian adults and children. However, the Committee believes the mental health study envisioned in this title is urgently needed to assist the Congress, the Indian people, and the Federal agencies to chart a longer range Indian mental health effort.

Section 602 contains provisions concerning general rulemaking authority and authority to amend the rules. The Committee has established a strict timetable to be adhered to by the Secretary in adopting rules and regulations to implement the various provisions of S. 522. In the past, the Congress has witnessed a deliberate frustration of its will by a failure of Executive branch agencies to promptly adopt rules and regulations for the implementation of Congressionally approved programs. The Committee is determined that this measure shall not be subjected to such tactics and believes that the timetables will preclude any delay on the part of the Secretary in implementing the Act following its passage.

Additionally, the Committee has mandated the Secretary, to the extent practicable, to consult with various national and regional Indian organizations to obtain their views in the formulation of rules and regulations. It is the Committee's belief that such participation is vital if the concept of self-determination for the Indian people is to become a reality.

Under the provisions of section 603, the Secretary is authorized to enter into leases with Indian tribes for periods not in excess of 20 years. This provision is designed to meet two objectives: First, it would strengthen the self-determination effort by permitting contracts with tribal groups who desire to construct health facilities for lease to the Indian Health Service and allow the tribes constructing such facilities to realize a return from their capital investment. Second, this provision would strengthen the health delivery system by providing the new facilities to the IHS by lease upon completion of their construction.

Such leasing would be in lieu of Federal construction. For example, in Oklahoma, a number of communities are building health facilities using the local tribal construction workers and know-how. Upon completion, these buildings are leased to the Indian Health Service for use by the IHS in delivery of health services to the tribes. Leasing includes the full complement of costs for drug inventories, equipment and supplies, as well as personnel salaries and benefits. This situation in Talihina, Oklahoma, provides an example of the benefits which can accrue from this type of leasing arrangement. The communities of Hugo (population 3,000), 50 miles south of Talihina, and McAlester (population 2,200), 50 miles west of Talihina, are both presently dependent upon the Indian Health Service facility at Talihina. Thus, new tribal facilities leased by the Indian Health Service in those two towns will assure a substantial improvement in the availability of health services to persons living within a 20-mile radius of each facility.

In Alaska, several hundred villages are entering into similar leasing arrangements in order to provide local health services where inclement weather, poor roads, or both make travel to an existing IHS facility virtually impossible.

There are several advantages to both parties when leasing arrangements can be established by direct negotiation between the health services deliverer and the community. Among these are: (1) the health services deliverer is more responsive to the needs of the people and transactions can be consummated in a more timely fashion; (2) staffing of the leased facility can occur rapidly with a minimum of time lost between the effective date of the lease and completion of the staffing; (3) the health services deliverer is, through experience, familiar with local tribal customs and practices which others may find troublesome; and (4) leasing agreements can have greater flexibility to meet the varying needs and conditions at each lease location.

In short, in small communities in the less populous States with substantial Indian populations, such as Oklahoma and Alaska, the direct leasing authority would provide assistance to the Indian Health Service program in fulfilling its responsibility to provide high quality health care to the Indian people. Furthermore, the authority is consistent with the Federal goal of providing American Indians and Alaska Natives with sufficient options to permit maximum tribal involvement—a policy of self-determination.

The final section of title VI, section 604, stipulates that funds appropriated pursuant to S. 522 are to remain available until expended. A substantial portion of the funds authorized to be appropriated in the Act relate to construction of health facilities and environmental improvements in Indian communities. Because of the often uncertain and lengthy nature of construction cycles it is essential that appropriated funds remain available until expended in the completion of specified construction projects. In addition, there may be certain programs which will require a carry-over of appropriated funds from one fiscal year to the other. Because of the over-riding health needs of Indian people, the Committee is determined that no administrative obstacle shall stand in the way of using funds appropriated for the purpose of meeting those needs.

IX. LEGISLATIVE HISTORY

S. 522, the "Indian Health Care Improvement Act," was introduced by Senator Jackson on February 3, 1975. The following are cosponsors of S. 522: Mr. Fannin, Mr. Abourezk, Mr. Bartlett, Mr. Burdick, Mr. Cannon, Mr. Church, Mr. Dole, Mr. Domenici, Mr. Goldwater, Mr. Gravel, Mr. Philip A. Hart, Mr. Haskell, Mr. Hatfield, Mr. Humphrey, Mr. Kennedy, Mr. McGee, Mr. McGovern, Mr. Metcalf, Mr. Montoya, Mr. Moss, Mr. Nelson, and Mr. Stevens.

S. 522's predecessor in the 93d Congress, S. 2938, was introduced by Senator Jackson on February 2, 1974. Hearings on S. 2938 were held before the committee on April 3 and 5, 1974. The bill was substantially amended and ordered reported by unanimous voice vote in open markup session on July 23, 1974. S. 2938 was passed by the Senate on voice vote on November 25, 1974. The House did not consider the bill.

The Chairman and Ranking Minority Member of the Committee agreed to move S. 522 directly to full Committee for consideration in the belief that the proposed measure had been thoroughly justified through hearings on its predecessor in the last Congress, S. 2938, and as reflected in the Committee Report (S. Rept. No. 93–1283) filed with the Senate on that bill. S. 522, therefore, was amended and ordered reported by unanimous voice vote in open markup session on April 16, 1975.

The 93d Congress might appropriately be remembered as the "Indian health Congress" as a result of the Senate's attention to this critical area of Indian concern. The Senate's efforts the last 2 years established the base upon which S. 522 has been considered this Congress.

First, in addition to the Interior Committee reporting and Senate passage of S. 2938, the Subcommittee on Indian Affairs, chaired by Senator Abourezk, held hearings on November 19 and 20, 1973, on "problems experienced by the Indian Health Service in their efforts to recruit physicians and other health personnel to staff hospitals, health centers, and clinics serving the Indian people." These hearings gave impetus to the drafting of Title I of S. 2938.

Second, on September 17, 1974, the Government Operations Committee's Permanent Subcommittee on Investigations, chaired by Senator Jackson, held an investigatory hearing on health care conditions on certain Indian reservations. Staff of the Interior Committee participated in the preparations for that hearing and the initial findings in the pre-hearing investigations were employed in the mark-up of S. 2938.

X. COST

In accordance with subsection (a) of section 255 of the Legislative Reorganization Act, the following is a statement of estimated costs which would be incurred in the implementation of S. 522, as amended:

Sections of S. 522	Programs	1977 1st fiscal year	1978 2d fiscal year	1979 3d fiscal year	1980 4th fiscal year	1981 5th fiscal year	1982 6th fiscal year	1983 7th fiscal year	Total by program
	TITLE I—MANPOWER								
102(c)	Health professions recruitment program	$1, 500, 000	$2, 500, 000	$3, 000, 000	$4, 000, 000	$4, 500, 000	$5, 000, 000	$4, 500, 000	$25, 000, 000
103(d)	Health professions preparatory scholarships	2, 000, 000	2, 500, 000	3, 000, 000	3, 500, 000	4, 000, 000	4, 500, 000	4, 500, 000	24, 000, 000
104(e)	Health professions scholarships	6, 000, 000	7, 500, 000	9, 000, 000	12, 500, 000	19, 000, 000	26, 000, 000	30, 000, 000	110, 000, 000
105(d)	IHS extern program	800, 000	1, 200, 000	1, 600, 000	2, 200, 000	2, 800, 000	3, 200, 000	3, 550, 000	15, 350, 000
106(c)	Educational and training programs in environmental health, health education and nutrition	500, 000	600, 000	700, 000	800, 000	900, 000	900, 000	600, 000	5, 000, 000
107(b)	Continuing education allowances	100, 000	200, 000	250, 000	300, 000	350, 000	350, 000	325, 000	1, 875, 000
	Total by fiscal year	10, 900, 000	14, 500, 000	17, 550, 000	23, 300, 000	31, 550, 000	39, 950, 000	43, 475, 000	181, 225, 000
	TITLE II—HEALTH SERVICES								
201(c)(1)	Patient care	1, 000, 000	10, 000, 000	18, 000, 000	26, 500, 000	36, 000, 000	46, 000, 000	58, 000, 000	198, 500, 000
201(c)(2)	Field health	3, 000, 000	6, 000, 000	9, 000, 000	13, 000, 000	18, 000, 000	23, 000, 000	28, 500, 000	100, 500, 000
201(c)(3)	Dental care	800, 000	1, 500, 000	2, 000, 000	2, 500, 000	2, 900, 000	3, 200, 000	3, 500, 000	16, 400, 000
201(c)(4)	Mental health:								
	(A) Community services	900, 000	1, 700, 000	2, 400, 000	3, 000, 000	3, 500, 000	3, 800, 000	4, 100, 000	19, 400, 000
	(B) Inpatient facilities	200, 000	400, 000	600, 000	800, 000	1, 000, 000	1, 300, 000	1, 600, 000	5, 900, 000
	(C) Model dormitory services	625, 000	1, 250, 000	1, 875, 000	2, 500, 000	----------	----------	----------	6, 250, 000
	(D) Therapeutic and residential treatment centers	150, 000	300, 000	400, 000	500, 000	600, 000	700, 000	800, 000	3, 450, 000
	(E) Training of traditional Indian practitioners	75, 000	150, 000	200, 000	250, 000	300, 000	300, 000	300, 000	1, 575, 000
201(c)(5)	Treatment and control of alcoholism	8, 000, 000	10, 500, 000	13, 000, 000	15, 000, 000	17, 000, 000	18, 500, 000	20, 000, 000	102, 000, 000
201(c)(6)	Health care personnel in primary and secondary BIA schools	600, 000	1, 000, 000	1, 300, 000	1, 700, 000	2, 500, 000	3, 900, 000	6, 000, 000	17, 000, 000
201(c)(7)	Maintenance and repair	3, 000, 000	3, 000, 000	4, 000, 000	4, 000, 000	4, 000, 000	2, 000, 000	1, 000, 000	21, 000, 000
	Total by fiscal year	21, 350, 000	35, 800, 000	52, 775, 000	69, 750, 000	85, 800, 000	102, 700, 000	123, 800, 000	491, 975, 000
	TITLE III—FACILITIES								
301(a)(1)	Hospitals	123, 880, 000	55, 171, 000	24, 703, 000	70, 810, 000	45, 652, 000	29, 675, 000	33, 779, 000	383, 670, 000
301(a)(2)	Health centers and health stations	6, 960, 000	6, 226, 000	3, 720, 000	4, 440, 000	2, 335, 000	1, 760, 000	2, 360, 000	27, 801, 000
301(a)(3)	Staff housing	2, 484, 000	43, 450, 000	8, 231, 000	9, 390, 000	20, 140, 000	12, 267, 000	13, 704, 000	109, 666, 000
301(a)(4)	Primary and secondary BIA school health facilities	1, 500, 000	1, 000, 000	1, 000, 000	1, 000, 000	1, 000, 000	1, 000, 000	1, 000, 000	7, 500, 00
02(b)	Safe water and sanitary waste disposal facilities	60, 000, 000	60, 000, 000	60, 000, 000	60, 000, 000	60, 000, 000	52, 000, 000	26, 000, 000	378, 000, 000
	Total by fiscal year	194, 824, 000	165, 847, 000	97, 654, 000	145, 640, 000	129, 127, 000	96, 702, 000	76, 843, 000	906, 637, 000
	TITLE V—URBAN INDIANS								
506	Health services for urban Indians	5, 000, 000	10, 000, 000	15, 000, 000	----------	----------	----------	----------	30, 000, 000
	TITLE VI—MISCELLANEOUS								
601(b)	Mental health study	150, 000	----------	----------	----------	----------	----------	----------	150, 000
	Grand total	232, 224, 000	226, 147, 000	182, 979, 000	238, 690, 000	246, 477, 000	239, 352, 000	244, 118, 000	1, 609, 987, 000

XI. COMMITTEE RECOMENDATION

The Committee on Interior and Insular Affairs, by unanimous voice vote in open mark-up session on April 16, 1975, recommended that S. 522, as amended, be enacted.

XII. TABULATION OF VOTES CAST

The unanimous voice votes by the Committee on the amendments to and the reporting of S. 522 were taken in open public session. As these votes were previously announced by the Committee in accord with the provisions of section 133(b) of the Legislative Reorganization Act of 1946, as amended, tabulation of the votes in this Committee Report is unnecessary.

XIII. EXECUTIVE COMMUNICATIONS

Set forth in full below is the report of the Department of Health, Education, and Welfare on S. 522 submitted to Chairman Jackson by the Honorable Caspar W. Weinberger, Secretary of the Department.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
April 15, 1975.

Hon. HENRY M. JACKSON,
Chairman, Committee on Interior and Insular Affairs, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of February 21, 1975, for a report on S. 522, a bill "To implement the Federal Responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes." The bill may also be cited as the "Indian Health Care Improvement Act." This bill is identical to S. 2938, 93d Congress, as passed by the Senate.

Title I of the bill would authorize the Secretary of Health, Education, and Welfare, acting through the Indian Health Service: to make grants to public or non-profit or tribal organizations for the recruitment of Indian persons having a potential for health professional careers; to make scholarship grants to Indian individuals enrolled in health professional schools; to entitle those receiving professional scholarship grants to employment in the Indian Health Service during the non-academic period of the year without regard to employment ceilings; to make scholarship grants to train individuals in environmental health, health education and nutrition; and to authorize appropriations for continuing educational allowances for health professional employees of the Indian Health Service.

Title II of the bill would authorize additional appropriations totaling over $490 million for health services over the next five years. Title III would authorize additional appropriation authority of $561 million over the next five years for construction and renovation of Indian Health Service facilities and $378 million for sanitation facilities for Indian homes and communities.

Title IV of the bill would authorize Medicare and Medicaid eligible Indian persons served by Indian Health Service facilities to participate in those programs by having those programs reimburse the Indian Health Service for services it provides.

Title V would establish a program of contracts with Indian organizations in urban areas for the purpose of making health services more accessible to the Urban Indian population. Title VI would require the Secretary to make an annual report to the President and the Congress on progress made in effecting the purposes of the Act; would

authorize a study by the National Indian Health Board of mental health, including alcoholism and related problems; would authorize regulations to implement the Act, and it would authorize the Secretary to enter into leases with Indian tribes for periods not to exceed twenty years.

In signing Public Law 93–638, the Indian Self-Determination and Education Assistance Act, President Ford stated that its provisions would enable the Administration to work for the betterment of all Indian people by assisting them in meeting the goals they themselves have set. Accordingly, the Administration already has under way a comprehensive program of Indian self-determination, expanded efforts to train Indians for health careers, and a strengthened Federal effort to advance the health of these Americans.

The Indian Health Service (IHS) within this Department has primary rsponsibility for providing health care services to Federal recognized Indians and Alaska Natives. The IHS budget has grown from $113 million in FY 1969 to $311 million proposed for FY 1976, an increase of 175% in six years. This growth is enabling the program to make substantial improvements in the health care available to the Indian people. Based upon an estimated 500,000 beneficiaries, in 1976, IHS will spend over $640 per Indian and Alaska Native, or over $2,500 yearly per family of four for health care alone. This compares to the national average per capita expenditure for health from all sources of about $600 in 1976. A staff of over 8,000 full-time dedicated Federal employees assures that the Indians' health needs are met. These figures represent firm evidence that the Administration has placed high priority on investing in health services for Indian people.

S. 522 attempts to add $1.64 billion in spending over a five-year period which we believe is unwarranted and highly inflationary. Moreover, S. 522 would specify over 20 narrow categorical appropriation authorization activities—including full-time employment position authorizations in 7 of those categories—where none exists in current law. This would severely limit the management flexibility that IHS now has to allocate its resources according to priorities. S. 522 would also create new Federal health services and outreach programs for urban Indians who, like any other American citizen in need, have available access to a variety of health services through Medicare, Medicaid and other financing and service delivery mechanisms. The President has stated, with respect to new spending programs "I have . . . concluded that no new spending programs can be initiated this year, except those for energy."

The Department has made advances in improving the health status of American Indians and Alaska Natives over the years. Indians and Alaska Natives participate in health programs administered by the Department on the same basis as any other citizen; other health activities are contributing more than $11 million in 1975 for a broad range of services.

The true measure of our Indian health efforts is found in the continuing improvement of the health status of the Indian people. The improvement has been both profound and enduring. It can be illustrated by the dramatic reduction of Indian death rates between 1955 and 1973. The infant death rate has declined 69 percent; the tubercu-

losis death rate is down 89 percent; the gastritis and related diseases death rate has dropped 86 percent; and the death rate for influenza and pneumonia is down 54 percent. Moreover, in recent years, the overall health status of Indians and Alaska Natives has come closer to that of the general United States population.

These figures represent firm evidence that the Administration's decision to place high priority on investing in health services for Indian people has been a wise one, and that the methods it has employed to deliver services have been effective. We believe, on the other hand, that almost all of the program provisions of S. 522 are programmatically unsound. Title I, for example, authorizes several different programs for subsidizing the training of Indians as health professionals. Sufficient authority and many programs already exist to train Indians for health careers through the Department of Interior's scholarship program, DHEW's National Health Service Scholarship program—for which $22.5 million have been requested for 1976, training programs within the Indian Health Service, and various other health manpower programs administered by this Department. Efforts continue to increase the number of Indian participants in all of these programs. There is no sound programmatic basis for the establishment of a multiplicity of duplicative categorical programs, particularly when these programs overlap existing authority of the Department.

The unnecessary and unrealistic authorizations which are specified in Titles II and III would create undue expectations and inflationary pressures during a time when the Federal Government simply cannot afford expenditures which are above the increases already budgeted for these purposes. The authorizations in Title II are particularly objectionable in that they specifically exempt existing program levels and commitments from being credited toward the authorizations.

Title IV of S. 522 contains a provision of the bill which we endorse, i.e., authorizing Medicare and Medicaid reimbursements for services provided to eligible beneficiaries in IHS facilities. The Department is firmly committed to the idea that third party reimbursements remain available for use in Indian Health Service program activities. We oppose the provision contained in Title IV that would prohibit consideration of reimbursements in determining appropriation levels because it would introduce an artificial and infeasible administrative step into IHS budget formulation. We also oppose the provision for 100% reimbursement for services provided to Indians under Medicaid because no exceptions are made in the financing of public assistance programs by Federal-State matching contributions, and by parity of reasoning none should be for Medicaid. Our position is that Indians residing in a State should receive the same support as any other residents having similar resources.

With respect to Title V, authority already exists for the Department to assist urban Indians in meeting their health needs. This authority is provided by the so called "Snyder Act" (25 U.S.C. 13) and in the broader authorities of the Department to assist State and local units of government in meeting the health needs of their citizens. The Department already spends $500 million to assist Indians and other citizens in gaining access to available health services and resources. Indians and Alaska Natives are also eligible for Medicare and Medic-

aid on which the Federal Government to Indians and those of State and local governments to Indians as citizens. We, therefore, strongly oppose the concept of a statutory categorical program solely for Indians residing in urban centers.

We believe that the reporting requirements contained in Title VI of this bill are unnecessary. The oversight and appropriation hearings of the Congress during its deliberations on substantive legislation and appropriations are much more effective and informative than lengthy written reports.

As to the study of mental health and related problems, authority for such an activity already exists. Accordingly, we would oppose section 601 of the bill as unnecessary.

Section 603 authorizes the Secretary to enter into long-term leases with Indian tribes. We believe that this authority is not essential to the conduct of the mission of the Indian Health Service. Moreover, the Department can achieve the same objectives under existing authority.

In summary, we believe that the Department can accomplish the major objectives stated in this bill without the additional provisions proposed in S. 522. Moreover, we do not believe we can urge Presidential approval of any bill presented for his consideration containing the objectionable features and inflationary authorization levels contained in S. 522.

We are advised by the Office of Management and Budget that there is no objection to the submission of this report and that enactment of S. 522 would not be consistent with the objectives of the Administration.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

XIV. ADDITIONAL VIEWS OF MESSRS. FANNIN, HANSEN, McCLURE, AND BARTLETT

The Indian Health Care Improvement Act constitutes a long overdue legislative effort to meet the health care needs of the American Indians. This legislation will provide for the development of a health manpower base, drawing on members of the Indian community whenever possible, the elimination of the awesome backlog of Indian health care needs, the construction and/or renovation of health facilities, and the expansion of primary health care services for urban Indians.

There is no doubt that this legislation is necessary. It is equally clear that the estimated cost of $1,609,987,00 to be spent over 7 fiscal years, which is in addition to the existing IHS budget over those same 7 years, is reasonable if we really intend to do a thorough job. In order to accommodate this important program, however, we believe it is incumbent on the Congress to cut back other Federal expenditures where the priorities are less crucial. In a time of chronic inflation we hope our colleagues will agree.

PAUL. J. FANNIN.
CLIFFORD P. HANSEN.
JAMES A. MCCLURE.
DEWEY F. BARTLETT.

XV. CHANGES IN EXISTING LAW

In compliance with subsection (4) of rule XXIX of the Standing Rules of the Senate, the Committee states that no changes in existing law would be made by S. 522, as amended.

As Title IV does, however, for all intents and purposes, amend Titles XVIII and XIX of the Social Security Act, as amended, the title is set forth in full, as follows:

TITLE IV—ACCESS TO HEALTH SERVICES

SERVICES PROVIDED TO MEDICARE ELIGIBLE INDIANS

SEC. 401. (a) Notwithstanding any other provision of law, for the purpose of title XVIII of the Social Security Act, as amended, a Service facility (including a hospital or skilled nursing facility), whether operated by the Service or by any Indian tribe or tribal organization, shall hereby be deemed to be a facility eligible for reimbursement under title XVIII: *Provided*, That the requirements of subsection (b) are met.

(b) Prior to the provision of any care or service for which reimbursement may be made, the Secretary shall certify that the facility meets the standards applicable to other hospitals and skilled nursing facilities eligible for reimbursement under title XVIII, or, in the case of any facility existing at the time of enactment of the Act, that the Service has provided an acceptable written plan for bringing the facility into full compliance with such standards within two years from the date of acceptance of the plan by the Secretary. The Service facilities shall not be required to be licensed by any State or locality in which they are located: *Provided, however*, That the Secretary shall include in his certifications appropriate assurances that such facilities will meet standards equivalent to licensure requirements.

(c) Any payments received for services provided to beneficiaries hereunder shall not be considered in determining appropriations for health care and services to Indians.

(d) Nothing herein authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

SERVICES PROVIDED TO MEDICAID ELIGIBLE INDIANS

SEC. 402. (a) Notwithstanding any other provision of law, for the purpose of title XIX of the Social Security Act, as amended, a Service facility (including a hospital, skilled nursing facility, or intermediate care facility), whether operated by the Service or by an Indian tribe

or tribal organization, shall hereby be deemed to be a facility eligible for reimbursement under title XIX: *Provided*, That the requirements of subsection (c) are met.

(b) The Secretary is authorized to enter into agreements with the appropriate State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are beneficiaries under title XIX of the Social Security Act, as amended.

(c) Prior to the provision of any care or service for which reimbursement may be made, the Secretary shall certify that the facility meets the standards applicable to other hospitals, skilled nursing facilities, and intermediate care facilities eligible for reimbursement under title XIX, or, in the case of any facility existing at the time of enactment of this Act, that the Service has provided an acceptable written plan for bringing the facility into full compliance with such standards within two years from the date of acceptance of the plan by the Secretary. The Service facilities shall not be required to be licensed by any State or locality in which they are located: *Provided, however*, That the Secretary shall include in his certifications appropriate assurances that such facilities will meet standards equivalent to licensure requirements.

(d) Any payments received for services provided recipients hereunder shall not be considered in determining appropriations for the provision of health care and services to Indians.

(e) Notwithstanding any other provision of law, with respect to amounts expended during any quarter as medical assistance under title XIX for services which are included in the State plan and are received through a Service facility, whether operated by the Service or by an Indian tribe or tribal organization, to individuals who are (i) eligible under the plan of the State under title XIX and (ii) eligible for comprehensive health services under the Service program, the Federal medical assistance percentage under title XIX shall be increased to 100 per centum.

(f) Nothing in this section shall authorize the Secretary to provide services to an Indian beneficiary with coverage under title XIX of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

REPORT

SEC. 403. The Secretary shall include in his annual report required by subsection (a) of section 601 a report on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements through titles XVIII and XIX of the Social Security Act, as amended.

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